Power Plays and Intersecting Inequalities: The International Medical Graduate Experience of Medical Dominance in Australia

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SUMMARY

This thesis uncovers, explores and analyses Australia's medical culture through the positioning of International Medical Graduates (IMGs). There is currently a health workforce shortage. Australia, while hoping to produce sufficient Australian trained medical doctors to service the population in the future, actively recruits doctors from overseas. Despite Australia's need for IMGs, the process journey they encounter in this country makes accreditation of qualifications and registration a particularly arduous and lengthy ordeal. The justification for such intense scrutiny is unconvincingly linked to the perceived need for Australia to maintain a high standard of health care. The result for some IMGs is to join the medical unemployed and Australian communities miss out on their skills and experience. The Australian medical profession is the provider of expert medical knowledge and as a result, retains the status of an elite profession. This thesis argues that IMGs however are not assigned the same status. IMGs are 'othered', presented as problematic and less qualified. IMGs are positioned as an underclass. The maintenance of a self-interest agenda drives the need to 'other' IMGs. Intersecting inequalities of Class, Race and Nation validate and reinforce their positioning.

The innovative work of Evan Willis (1989) on medical dominance, comprehensively explains how medical dominance is created and maintained. The original contribution to knowledge offered by this thesis delves beyond to why it exists and continues. Much of the research and literature on medical dominance argues that it is being challenged and changing shape. Nevertheless, its dominance remains.

The research presented in the thesis chapters has a broad scope and for this reason, has taken a multidisciplinary approach. An anti-oppressive theoretical framework allows for the voices of lived experience to penetrate throughout and a social justice platform engages the participants and the reader into the interwoven conversations. The data set reveals rich and sometimes shocking evidence to paint a stark picture. Other medical voices from outside the data join the thesis via media responses to revelations of experiences not only from IMGs but also from Australian trained doctors. Coverage has exposed a toxic culture endemic with bullying and sexual harassment.

This thesis argues that the positioning of IMGs is organised through the dimensions of Structural Power, Hegemonic Power and Interpersonal Power. These dimensions allow for an exploration of power relations between the structures of the health system, the Australian medical profession and the agency of IMGs. The Australian narrative presented to the world espouses a community of social justice and human rights. Instead, an historical lens traces the formation and persistence of difference represented in ethnocentrism, racism and xenophobia from 1788 to the present.

The original contribution to knowledge made by this thesis confirms the positioning of IMGs as an underclass within Australia's powerful yet toxic medical culture where jealousy, conflict of interests, commercial gains and market share drive a power/knowledge nexus of unethical, discriminative and uncompetitive behaviours. While there are many decent, ethical medical doctors within the profession, clearly there are also many who are not.

DECLARATION

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

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INTRODUCTION: WELCOME TO AUSTRALIA, THE LAND OF A FAIR GO FOR ALL

> We have to stamp out medical racism before it takes hold. Overseas trained doctors do not practice inferior medicine. Nor are they less committed to patient care (Haikerwal 2005, p.5).

> The sociological imagination enables us to grasp history and biography and the relations between the two within society. That is its task and its promise (Mills, 1959, p.6).

In 2003, Dr Jayant Patel moved to Bundaberg Queensland to take up an appointment as Director of Surgery at the Bundaberg Base Hospital. The initial conception for this thesis was triggered by what became the Dr Patel tragedy. Reported by a whistle blower nurse, it was alleged that between 2003 and 2005, 30 patients died while under his care. Dr Patel was accused of negligence and was eventually convicted of manslaughter, grievous bodily harm and fraud (Keim et al. 2013). As a result, Dr Patel attracted the nickname 'Dr Death'. Dr Patel, an International Medical Graduate, was born in Jamnagar India where he studied medicine. Dr Patel subsequently undertook further surgical training in the United States of America and became a US citizen.

I thought about the Bundaberg community - where I had once lived and worked for 18 months - and I personalised to some extent the ensuing trauma which resonated through the community as a result of the tragedy. As the narrative unfolded every evening on my

television, I was able to imagine myself back in my past Bundaberg workplace and visualised peoples' conversations about Dr Patel. I imagined the close knit, busy little town a buzz with the story which was perhaps also fuelled by the arrival of the media. During my time in Bundaberg, I visited the Bundaberg hospital on a couple of occasions and I imagined the tense atmosphere there. I wondered how the Bundaberg region's IMGs would feel about their colleague's alleged misconduct, particularly those who worked at the hospital. I was still living in Queensland and felt quite closely connected as the crisis evolved. Bundaberg is a rural Community and I was living in another rural Community just four hour's drive away. The ramifications from the Bundaberg tragedy were widespread, not only were there families in Bundaberg who suffered loss of life or loss of quality of life due to medical mistakes, but it seemed that medical doctors across Australia, particularly those trained overseas and of Indian appearance were being subjected to abuse (Haikerwal, 2005). Hostility towards IMGs surfaced from within the Australian community and there was a growing perception that IMG qualifications and skills were sub-standard.

Remembering this case, I was disturbed by a speech made to the National Press Club in Canberra in July 2005. In his speech, the then president of the Australian Medical Association (AMA) Dr Murkesh Haikerwal (an IMG himself) made the observation that Australia, as a result of the Dr Patel case, was experiencing, 'medical racism'. Dr Haikerwal (2005) stated:

> Because of the Patel case, doctors with funny names, accents, coloured skin and different   backgrounds are getting a hard time. Some patients are avoiding them, some patients are abusing them…we cannot allow honest, highly skilled doctors to be made pariahs in the communities they are committed to serving…because of the negligence of others, they are bearing a burden that isn't theirs. They are under scrutiny for getting a medical degree from overseas, or for having darker skin, or a different faith, or English as a second language (Haikerwal 2005, p.3).

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I became interested in what IMGs could be experiencing as a result of the Patel case. This interest only further enticed me to want to explore how IMGs experience living and working in Australian rural and remote communities generally. The Patel case was only one aspect of potential influence in the way IMGs experience Australia. Further Information and discussion regarding the Patel Saga will be provided in following chapters. My sociological imagination was keen to begin the exploration and I became imaginatively curious about the promise of my work (Mills 1959). I was now keen to begin to know much more about IMGs. One of the first things I noticed was the seeming interchangeable use of the terms Overseas Trained Doctors (OTD) and International Medical Graduates (IMGs).

Throughout this thesis I will refer to participants and others as IMGs except when quoting from literature which sometimes refers to these doctors as Overseas Trained Doctors (OTDs), (notably the terms of reference for the Parliamentary Inquiry). There has been an interchange of both terms but I have followed the preferred terminology recommended by the Australian Medical Council (AMC) below:

> Over the years considerable confusion has arisen regarding the classification of overseas trained doctors because of the different terminology used. The most common term - Overseas Trained Doctors (OTDs) was considered in the mid-1990's to imply some value judgement and was gradually replaced by the term International Medical Graduates (IMGs). This classification is now the international standard terminology… Australian Medical Council (AMC) 2012, Submission 42 p.4).

Before I could appreciate the experiences of IMGs, I needed to know much more about the practice of medicine and the role of a medical practitioner in Australia.

FOUNDATION OF THE STUDY – THE FIELD WORK

What did I know about the practice of medicine in Australia? What might the lived

experience of a medical practitioner be like and how would this experience perhaps differ from the lived experience of an internationally trained medical practitioner? What could be the issues, challenges and rewards of medical practice in Australia, particularly in rural communities? I realised that I knew little about the complex system which regulates IMGs through various colleges and other agencies. It was obvious that I needed a foundation on which to build my background knowledge, the knowledge which would underpin my research.

Firstly, I needed to find an opportunity to generally listen to and observe medical doctors who practice medicine in Australian communities. I reasoned that if I had a basic appreciation of life as a medical practitioner in these communities, I would then be able to explore and have a better understanding of how life as an international medical graduate practitioner in these locations might be. I did know however; that IMGs have made and continue to make a significant contribution to rural and remote primary health care. For example, in rural, regional and remote Queensland, the situation reported by Health Workforce Queensland (2011) found that 48.4% of the medical workforce in remote, rural and regional Queensland obtained their basic medical qualifications overseas. In 2015, IMGs still made up just under half (46.9%) of the medical practitioners in remote, rural and regional Queensland. Health Workforce Queensland (2015, p.9) notes that: "since 2011 the percentage of overseas trained doctors has been relatively stable and has only varied by approximately five per cent".

I did not know about the expectations, concerns, challenges, and lived experiences of IMGs in these settings. There was no better way to gain insight into lived experience than

to hear it directly from IMGs. I began searching relevant websites and fortuitously found an upcoming Australian College of Rural and Remote Medicine (ACRRM) conference to be held in Adelaide. I approached the person in charge of ACRRM's research and explained my research proposal. I was delighted to be invited to attend the conference under student registration. The event was beneficial not only for my increased understandings, but also for the opportunity to chat to some doctors and establish helpful contacts. Communication was not easy however, the only free times were meal and coffee breaks and during these, conference participants appeared to be a somewhat closed group of people who conversed comfortably within their own established circles and did not easily allow a stranger to infiltrate. It also appeared to be a great opportunity for doctors who already knew each other to catch up in person, there seemed to be many conversations about past associations and updates.

The ACRRM conference assisted me to begin to form some ideas. Two obvious aspects of rural/remote medical practice emerged from conversations and from the conference presentations. Firstly, there was a sense of pride among conference participants, several presentations highlighted the passion these doctors had for their work as well as their seemingly endless commitment and loyalty to their profession and the communities they served. I felt admiration for them as I listened to some of the ways their commitment was tested. Many faced issues such as small country hospitals struggling to survive, losing services and being under constant threat of closure. Some doctors were located in understaffed practices, worked long hours with minimal access to specialist consultation and other services far away in the cities. Some doctors experienced professional isolation.

Secondly, as I listened to the various conference presentations, it became apparent that rural medicine was framed as less valued than medical practice in cities and metropolitan

centres. Conference presentations by several medical practitioners acknowledged that unless one is trained in big city teaching hospitals one can be considered by those who do practice in these locations as less qualified, less capable and possibly as having made a poor career decision. This was a surprise to me. Rivett (cited in Gregory, Armstrong & Van Der Weyden 2006, p.654) confirms: "There's an intrinsic, inbuilt feeling in a lot of tertiary hospitals that rural practice is not second rate, but even third rate". I considered if the perceived lower status of rural medicine was reason enough to keep some doctors away from taking a rural pathway, therefore contributing to the health workforce shortage in these areas. It was also implied that universities with medical faculties were more inclined to direct teaching and research funding away from rural, remote medicine in favour of mainstream medicine. Moreover, once recruited to rural areas, hospitals experience more difficulty than urban facilities to keep medical staff. This is often due to heavier workloads; with less staff to cover on call rosters and diminished access to specialist services. From their study of nurses working in these areas, Currie et al (2016, p.64) concluded: "while GPs continue to provide clinical support in rural areas, they aren't necessarily seen as the essential health care professional. However, Malatzky & Bourke (2016) while accepting that the dominant discourse places rural practice as inferior to urban locations; they challenge the embedded power relations and call for a re-framing of rural health to highlight the attractions associated with rural practice. In view of the above, I asked myself if rural medicine is somehow seen as having a lower status, does the fact that many IMGs are required to practice in rural locations mean that IMGs may also be connoted as less valued. These questions will be explored in the following chapters. My sociological imagination was keenly expanding and I was increasingly tempted to further my exploration. Even though I felt that I had a basic idea of what the experience of rural and remote medical practice might entail, I did not yet know enough to further develop my

research ideas. The next step was to explore against a backdrop of rural practice, the experiences of IMGs particularly, in these settings. To assist me with this, I was able to attend another event, this time an IMG Forum organised by the Royal Australian College of General Practitioners (RACGP) (Qld). The forum was held over three days in Brisbane and covered many aspects of the registration process including extras such as visa information, exam preparation and general information regarding changes to the Queensland health system. Again, I attended as a student to listen and observe, the RACGP kindly allowed me to distribute information about my research at the forum. Attending the forum was extremely enlightening and several aspects were added to my existing and expanding understanding.

Engaging doctors in conversation was again quite difficult. However because the room was organised into tables with approximately six – eight people, I was able to converse a little easier with the people at my table. Forum participants were not directed to any designated table but tended to return on subsequent days to the table they found themselves at on the first day. Three doctors at my table later participated in interviews for my research. Also at my table was a general practice manager who employed IMGs. She provided a different perspective. During meal breaks the doctors communicated well with each other. Again, they were insular, so rather than try to force my way in, I took advantage of these times to make my way around various sponsors/exhibitors who were set up in the foyer of the building. This provided me with the opportunity to ask questions and establish good contacts such as an organisation which specifically recruited IMGs.

Throughout the three day forum, I had the opportunity to observe and listen to IMGs who were at various stages in the registration process. There were numerous presentations made and a plethora of information was disseminated to participants. My observations

indicated that some doctors were agitated and confused about the processes and associated rules and regulations and many seemed generally overwhelmed. I was not only amazed at how complex the registration process was, but despite the provision of information associated with the process and lengthy explanation, I was also confused. In addition, some doctors seemed annoyed about changes in the system, such as a requirement to re-sit certain exams.

The personal impact of these stressors became evident when there was a presentation about taking time out, refreshment and renewal in terms of general doctor well-being. The presenter sought participation from IMGs regarding how they cared for themselves. A few doctors volunteered their personal experiences and some became emotional while sharing their coping strategies. It was evident that many of the forum participants were generally stressed about their situation and the numerous requirements the system was making of them. This situation seemed to constitute additional pressure to what is commonly regarded as an already stressful occupation.

Every day, medical doctors are required to cope with patient illness, pain and death. In addition, doctors also have to deal with, "A medical-legal and regulatory environment perceived as more threatening, changes to the organisation and funding of health care, and increased accountability of doctors for health outcomes" (Breen, KJ et al. 2010 p.xxii). Further, a 2005 study into the psychological health of rural GPs revealed that: "At least one-third to one-half of GPs indicated that they had either 'some degree' or 'quite a lot' of distress directly related to rural general practice" (Gardiner et al. 2005, p.151). A key finding in the Beyond Blue (2013, p.2) report on doctor mental health was that: "doctors reported substantially higher rates of psychological distress than other Australian professions." Medical practice then can be perceived as a generally stressful occupation.

A doctor in rural general practice, which appears to be less valued, may be even further stressed due to the conditions of that type of practice. In addition, IMGs in rural or remote locations have a set of other stressors in that they must also negotiate their way through the numerous processes to become registered in Australia.

Several questions began to emerge which gave me a starting point for a research question, what was it I wanted to know? I wanted to explore how IMGs experience medical practice in Australia. I wanted to explore associated aspects which perhaps might impact on or influence that experience, such as a doctor's interaction with colleagues and the local community. For example, perhaps a doctor's cultural background would play a significant role in the experience, or the transition to life in Australia for a doctor's family would constitute an important influence on experience. Ultimately, for this study, I wanted the IMG voice to drive the research. I wanted the participants to raise the aspects of experience which they felt were important in the construction of their experiences and therefore their realities. I was now at the point where the design of the study began to emerge and take shape.

At this point, I realised that my study required a more comprehensive data set than one focus group and ten semi-structured individual interviews to capture and theorize the experiences of IMGs in Australia. The additional voices needed to address this came in 2012 via the submissions to a Parliamentary Inquiry and in 2016 via the submissions to a Senate Committee. The associated issues and subsequent decisions around this are discussed more fully in the following Methodology chapter. I began my data collection with a focus group comprised of IMGs.

THE FOCUS GROUP

The focus group was my first opportunity to talk with a small group of IMGs. Four of the participants were employed in private practices and one participant was the principal of his own practice. There were six participants (3 men and 3 women). One woman did not make a contribution to the discussion. Three broad themes emerged from the one hour session: ***New ways of approaching clinical practice; information and orientation; working conditions.*** The group was comfortable and shared experiences in a relaxed way. As the researcher I wanted the session to flow on their terms with little input from me. The responses given helped focus the research more closely on the experiences of IMG General Practitioners in a particular rural community. Participants enlightened me through a discussion about the cultural differences they faced in terms of their values, beliefs and clinical practice compared to values, beliefs and practice in Australia. I had not realised that the practice of medicine, what is permitted and not permitted, could be quite different from country to country. Cultural aspects of care was not raised specifically in the Inquiry submissions but was raised in individual interviews.

There was lengthy discussion regarding the information and the orientation process, or lack thereof, for IMGs. Participants alerted me to just how much an IMG beginning practice in Australia has to know and grapple with. The need for localised information was emphasised, because IMGs need to be familiar with services and contacts for immediate patient referral. These issues were not raised specifically in the Inquiry submissions and only in two individual interviews. Working conditions for IMGs vary depending on their particular type of employment. The term bullying was not used specifically by focus group participants but it became quite clear that some of the workplace practices raised equated to bullying behaviours. Participants viewed their position as constituting cheap labour. Experiences of bullying were shared in only one interview but featured prominently in both the 2012 and 2016 Inquiry submissions. Bullying behaviours were strongly associated with

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hospital cultures.

Discussion around working conditions introduced me to the system. Participants made it very clear that the system and its requirements was problematic and several accounts of negative experiences were shared (Pascoe 2011). The system was mentioned extensively throughout the data and was featured especially in the Inquiry submissions. I did not realise at the time of the focus group session, that the system would become a major focus of this study. The focus group data gave me a more personalised account and a kind of micro snap shot of IMG GPs within a particular rural community than the field work experiences. I felt well prepared to progress to the semi-structured interviews. Ten individual semi structured interviews and submissions to the 2012 Parliamentary Inquiry and 2016 Senate Committee constituted the next stage of data collection.

THE INTERVIEWS

The individual interviews afforded me the opportunity to converse with IMGs one to one. Three of the ten were conducted over the phone. The face to face interviews were more productive than the phone interviews. Nevertheless, I was glad to be talking with busy medical practitioners on any terms and particularly on their terms. Each interview allowed me into the world of the participant and that was a privilege in itself. The duration of the interviews was around an hour allowing enough time for participants to tell individual stories of lived experience in greater detail. ***New Ways of clinical Practice; Working Conditions; Demands of the System,*** were the emergent themes from the interviews. However, I required more voices to build the depth and breadth of my research, a wider representation of the IMG voice around Australia.

In 2010 when I was grappling with the need to expand my data set, the submissions made to a 2012 Parliamentary Inquiry (House of Representatives Standing Committee on Health

and Ageing 2012) provided the extra voices required for my doctoral research. The motion for an inquiry was successfully made by Bruce Scott, member for Maranoa on the 18th October 2010. This occurred after much heated parliamentary debate about various aspects related to the treatment of IMGs in Australia by the system. For example, Mr. Scott reported concerns in relation to discrimination in the processes associated with the assessment of IMGs. Mr Scott also raised concerns related to lack of transparency and accuracy within the system and revealed that he knew of IMGs who passed the Royal Australian College of General Practitioners (RACGP) fellowship only to fail their Pre-employment structured clinical interview (PESCI). Mr Scott went on to criticise immigration practices at the time which could deport temporary resident IMGs while they awaited the outcome of an appeal. Member of Parliament for Blair Mr Neuman and Mr. Laming Member of Parliament for Bowman joined the debate and accused the government of ignoring the problem. Mr. Katter Member of Parliament for Kennedy, said he knew of cases where IMGs were subjected to "petty vicious and personal vendettas", and Mr. Entsch Member of Parliament for Leichhardt, likened the specialist colleges to "the mafia".[1]

As a result of the debate, on Tuesday 23 November 2010, the then Minister for Health and Ageing, the Hon. Nicola Roxon MP, announced that she would task the House of Representatives Standing Committee on Health and Ageing to inquire into and report on *Registration Processes and Support for Overseas Trained Doctors.* I now had representation of the IMG community across Australia to include in my data set. The committee conducted twenty one public hearings throughout Australia in every State and

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[1]Media Release: Passionate cries in Parliament--- "There needs to be fairer go for overseas traineddoctors"http://www.connectingup.org/organisation/australian-doctors-trained-overseas-association Accessed 27 May 2011.

Territory in twelve different cities. The committee took direct evidence from 145 witnesses during the public hearings. They received 175 submissions from IMGs and interested others from across Australia as well as 22 supplementary submissions. From the total of 216 submissions, 109 were from IMGs and 91 from the various organisations and agencies involved in the registration, regulation, training and support of IMGs. The subsequent findings of the inquiry along with 45 recommendations were produced in a report entitled: "Lost in the Labyrinth"

THE 2012 PARLIAMENTARY INQUIRY ON REGISTRATION PROCESSES AND SUPPORT FOR OVERSEAS TRAINED DOCTORS: SUBMISSIONS

The submissions enabled me to access a diverse source of voices across the IMG community, and a diverse set of experiences. The IMGs who made submissions, not only included GPs but also contributions from IMGs in other specialist areas. This data was particularly rich as many of the voices wrote heart-felt accounts of personal misadventure and career crisis. Graphic details of bullying and inadequacies in the system led many doctors to the point where they felt the need to inform an Inquiry of their experiences. Therefore, the data from the Inquiry submissions was primarily negative. The submissions rendered the following key themes: ***Working Conditions; Demands of the System; Difficulties dealing with the System; Bullying; Dr well-being.*** The theme of Bullying was particularly prominent in the submissions compared with the focus group and interviews (except for one) where, there was evidence of bullying practices (in the researcher's opinion) but the practices were not identified directly as "bullying" by participants.

Some of the 2012 inquiry submissions gave graphic examples of bullying and I was shocked that professional adults would exhibit these behaviours, particularly within a

perceived esteemed profession. In 2016 I had another opportunity to add to my data set.

On 2nd February 2016 the Senate referred the medical complaints process in Australia to the Senate Community Affairs References Committee on Medical Complaints process in Australia, for inquiry and report (The Senate Community Affairs References Committee 2016). Although this inquiry was on a somewhat smaller scale than the 2012 inquiry it held two public hearings during 2016; (one in Sydney, the other in Canberra) and it received 129 submissions. The impetus for this inquiry came from media exposure of bullying, sexism, and sexual harassment within the medical profession, particularly within the surgical specialities. Complaints to the Royal Australasian College of Surgeons led the College to appoint an expert advisory group to investigate (Knowles, R & Bannon 2015). The subsequent report revealed a disturbing culture. High profile Neurosurgeon Dr Charlie Teo, citing adverse personal experiences of this culture (Teo 2015a), together with Senators Nick Xenophon and John Madigan successfully lobbied the Senate to establish the 2016 inquiry.

THE 2016 SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE ON MEDICAL COMPLAINTS PROCESS IN AUSTRALIA: SUBMISSIONS

The Committee published additional guidance on the inquiry's terms of reference to clarify that the inquiry's focus was on the intersection between bullying and harassment in Australia's medical profession and the medical complaints process (2016, p.2). As stated above, the submissions to the 2012 inquiry included many cases of IMGs experiencing bullying. The 2016 inquiry also contained many examples of bullying and harassment. The 2016 inquiry gifted me the opportunity to further enhance the strength of the research in two ways. Firstly, I was able to gauge whether or not examples of bullying had changed or escalated over that four year period and secondly, I was able to share in not only IMG

experiences of bullying but also the stories of affected others within medicine, such as medical students and medical colleagues bullying each other. The submissions to the 2016 inquiry revealed the themes of: ***Bullying; Sexism, Sexual harassment, Racism, Dr well-being, Difficulties dealing with the system and Vexatious complaints***. The 2016 Committee noted that a key issue in evidence received, was the use of the complaints process as a tool of bullying and harassment to make vexatious complaints (Senate Inquiry, 2016, p.19). What behaviours constitute bullying? There are varying definitions. For example, In their 2016 online survey of bullying, discrimination and sexual harassment for the College of Intensive Care Medicine, Venkatesh et al. (2016, p.231) defined bullying as:

> The use of force, threat or coercion to abuse, intimidate or aggressively dominate others; systematic and/or continued unwanted and annoying actions of one party or a group, including threats and demands.

Similarly, The 2016 Senate Community Affairs References Committee utilised the definition of bullying offered by the Expert Advisory Panel to the Royal Australasian College of Surgeons (Knowles, R & Bannon 2015):

> Bullying is unreasonable and inappropriate behaviour that creates a risk to health and safety. It is behaviour that is repeated over time or occurs as part of a pattern of behaviour. Such behaviour intimidates, offends, degrades, insults or humiliates. It can include psychological, social, and physical bullying (Appendix 1, p.19).

In their definition of bullying at work, Matthiesen and Einarsen (2007, p.735) provide a more formal, academic definition of workplace bullying which importantly mentions the vulnerability of victims in a bullying situation to defend themselves:

> A situation in which one or more persons systematically and over a long period of time perceive themselves to be on the receiving end of negative treatment on the part of one or more persons, in a situation in which the

person (s) exposed to the treatment on the part of one or more persons, in a situation in which the person (s) exposed to the treatment has difficulty in defending themselves against this treatment.

There are also various definitions of harassment. A clear definition of harassment offered by Knowles and Bannon (2015) is:

Unwanted, unwelcome or uninvited behaviour that makes a person feel humiliated, intimidated or offended. Harassment can include racial hatred and vilification, be related to a disability, or the victimisation of a person who has made a complaint (Appendix 1, p.19).

What became clear from both the 2012 and 2016 Inquires was that bullying is a systemic behaviour within medicine itself and for IMGs particularly. Why is there so much controversy surrounding IMGs and their treatment in this country, enough to initiate a parliamentary inquiry? The fundamental research question here is: there are medical schools within Australian universities and from these, Australian trained medical doctors graduate. Why then are there medical doctors from overseas practicing medicine in Australia?

WHY DOES AUSTRALIA NEED IMGS?

Ultimately Australia is working towards health workforce self-sufficiency. However, Australia will still need the skills of IMGs well into the future. In their submission to the 2012 Inquiry, the National Rural Health Alliance (2011) highlighted the fact that in reality it takes approximately thirteen years for a doctor to become fully qualified. Consequently, IMGs will be needed to assist with the training and supervision of Australian graduates. Professor Steyn (2011, p.19), informed the Parliamentary Inquiry committee that it was critical to retain an experienced IMG cohort not only to provide medical services but to also provide clinical oversight of Australian trained health professionals. From his observations,

he stated:

> Our foreign doctors are our current teachers, let alone our current providers of care. They teach our local students, our local health workers and our local specialist trainees. So it is more than just the provision of health care.

Table 1 below shows the general practice medical doctor workforce trend over a ten year period. This indicates that all of the net growth in GP numbers in Australian cities, and most of the growth in regional areas is linked to the contribution of IMGs.

Table 1: GP Workforce Numbers by regional grouping and training (Aust. or Overseas)

Years	Major Cities		Regional Centres		Remote Centres	
	Aust.	Overseas	Aust.	Overseas	Aust.	Overseas
2000-2001	12,902	4,300	3,933	1,534	238	178
2008-2009	12,649	5,742	4,048	2,670	379	238
Change	-253	1,442	115	1,136	141	60
Percentage Change	-2.0%	33.5%	2.9%	74.1%	59.2%	33.7%

Source: Adapted from NHRA, 2011, submission 113, p.7

Why have the numbers of Australian trained GPs declined? The reasons are multi-faceted and according to the Rural Health Workforce Australia (2011) include: Ageing and subsequent retirement of the GP workforce; inadequate numbers of medical graduates choosing general practice, and of those, fewer still choosing rural practice. Also noted was increasing numbers of GPs wanting to work part-time (particularly women); the lack of appeal of solo practices and overall decline in some rural communities.

As a result, prospective employers of IMGs continue to seek their skills. The House of Representatives' Committee report (2012, p.18) identified two key issues which were constantly evident in Australia's medical workforce. Firstly, "an inadequate supply of

doctors generally" and secondly, "an uneven geographical distribution of doctors, with workforce shortages remaining acute in some regional areas and particularly in rural and remote locations." This has not always been the case however and the Australian medical workforce situation has also been perceived as in a state of over-supply. Therefore government policy over the last two decades has been influenced by concerns of over-supply (1992) to concerns of under-supply (2005) resulting in active recruitment of IMGs (Australian Medical Council 2011).

The Committee of Inquiry into Medical Education and Medical Workforce (1988), advised the Federal Government of the increase in the numbers of IMGs obtaining professional registration and implicated the increase as a significant issue in the subsequent increased outlays nationally via Medicare. In 1992 the Medical Workforce Supply Working Party investigated the supply and requirements of the general practice workforce in Australia and noted a continued trend of over-supply. It was also noted that immigration was the primary influence on the size and shape of the medical workforce. Consequently, the government introduced a number of measures throughout the 1990s in an effort to reduce doctor numbers (Iredale & Gluck 1993). Some of these included: a decrease in the number of medical school places and restrictions on new permanent resident IMGs who successfully gained Australian Medical Council (AMC) accreditation to access Medicare billing for 10 years after registration. There were also various other restrictions on IMG practice if they came to Australia with temporary appointments (Hawthorne & Birrell 2002). According to Dr Haikerwal (2005, p.5): "The Government got it wrong back in 1996…They did it at precisely the time we were going into deficit supply. Now we are paying the price." The price has been paid heavily in rural and remote Australia and continues, where communities struggle to recruit medical staff and to retain them. Many people living in these communities as a consequence, have to travel long distances to attend the nearest

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medical care.

By 2003, there was a decline in bulk billed medical services in regional areas generally and in regional and metropolitan hospitals. Rural communities were in health care access crisis because they were unable to recruit doctors. The government's approach to medical workforce policy shifted to one of medical workforce expansion based on the apparent challenge of too few doctors. Several new medical schools were proposed and financial assistance was introduced for the recruitment of IMGs. Recruitment was especially sought for those IMGs with temporary visas required to work in a sponsored position (Hawthorne & Birrell 2002). Despite these measures shortages in rural and remote locations persisted.

There has been debate as to the continued reliance on overseas doctors to supplement the medical workforce shortage. Some have argued that this trend will be ongoing while others believe that the need for IMGs has diminished (see Birrell 2011). The House of Representatives' Committee report (2012, p.14) however, noted that: "the more widely held view is that there are still too few medical practitioners to meet Australia's needs." Currently, there is no limit to the number of IMGs a sponsor can employ. Recruitment occurs under the permanent-entry employer-sponsorship visa subclass. Organisations can sponsor a doctor trained overseas to work in Australia for up to four years. However, IMGs must have gained general registration before a visa is granted.

THE ORIGINAL CONTRIBUTION TO KNOWLEDGE MADE BY THIS THESIS

My thesis is a qualitative, empirical study which explores the experiences of International Medical Graduates (IMGs) in Australia. The aim of this study is to raise the visibility of IMGs and their experiences by locating them in the centre as a professional community. The objective is to explain why IMGs in reality are positioned as an underclass within Australia's medical dominance and therefore make an original contribution to knowledge.

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Following a social justice imperative and an anti-oppressive framework, I have collected my data in the form of one focus group and 10 semi structured interviews. I have also utilised submissions given to the 2012 Parliamentary Inquiry which was tasked to report on Registration Processes and Support for Overseas Trained Doctors and the 2016 Senate Community Affairs References Committee tasked to conduct inquiry and report on Medical complaints process in Australia. What has been revealed is a power relations struggle. Initially power is examined through the rise of Medicine and the Medical profession to its position of medical dominance over all other medical/paramedical professions. The power structure bureaucracy created by the Australian health system is referred to as 'the system' which is made up of numerous agencies, bodies and organisations. 'The system' has constructed a complex and confusing set of processes to regulate and control International Medical Graduates as 'the other'. They constitute 'the other' because they are not Australian trained; they have not obtained their basic medical qualification in Australia. I view IMGs as a community of people based on a common professional qualification. While IMGs belong to a high status profession, 'the system' ensures that IMGs are treated differently than Australian trained doctors and IMGs appear to constitute a community which can be classified as an under-class within the profession. 'The system' communicates with IMGs via a deficit discourse which I argue is underpinned by xenophobia (a fear of things foreign), racism and ethnocentrism (Australian culture is superior to other cultures). Analysis of how IMGs experience Australia utilises an Intersectionality framework where the intersecting inequalities of class, race and nation are unpacked. The experiences of IMGs in Australia and the possible foundations for those experiences are explored throughout the following six chapters of this thesis. The original contribution to knowledge offered by this dissertation expands the concept of medical dominance in Australia to focus on the positioning of IMGs within medical dominance.

Much of the literature around medical dominance focuses on how medical dominance is created and maintained (see Willlis, 1989, 2006, Broome, 2006, Germov, 2014). The focus of this thesis is directed towards an understanding of why medical dominance exists. IMGs are medical doctors, as are Australian trained medical doctors, and the medical profession itself constitutes an elite profession. However, I argue that IMGs as the 'other' constitute an underclass within an elite profession. Has the elite profession of medicine become too powerful? It is revealed that a toxic culture has festered and become chronic within medicine itself. A culture of bullying, sexism, sexual harassment and self-interest has been revealed as endemic. From colleagues bullying each other and vexatious complaints made against each other, to the bullying of IMGs and medical students via "pedagogy of humiliation" (Australian Medical Students' Association 2016, Submission 10). It is argued that the medical profession has experienced a power failure, where the source of its implosion has come from within. As such, the obligations of service and care delivery from consummate medical professionals to the Australian public, via a social contract of faith, are questionable (Susskind & Susskind 2015). IMGs that come to Australia come to this environment. Their voices shared throughout the chapters paint a picture of their lived experience in Australia. Other voices shared via the media and submissions, enable the reader to not only appreciate IMG experiences but also other rich narratives of experience which unfold within Australia's dominant medical culture.

CHAPTER OVERVIEW

Chapter one commences the research presentation and the advancement to establish its original contribution to knowledge; the positioning of IMGs within Australia's medical culture. Underpinned by a social justice stance and an anti-oppressive approach, methodological decisions and dilemmas are outlined and justified for the reader. As

researcher, I identify myself and my positioning within the research process, that of a scholar writing as a colonised other, an allied other and a third world intellectual. Also revealed is my questioning of the suitability for this study of a single discipline approach and the restrictions which accompany same. I required a model from the heart, one that embraces empathy, emotionality as well as personal accountability (Hill-Collins, 1991; Hill Collins & Bilge 2016). As a result, a multidisciplinary perspective allows for a more comprehensive and thorough exploration and representation of the IMG voice. In this chapter the participants are introduced to the reader as well as the recruitment journey and associated challenges. Confidentiality and anonymity are highlighted with particular rigour for these participants, due to the nature of their precarious position and possible repercussions. The processes of ethical clearance and data collection are explained and limitations shared. Post-structural feminism and the concepts of elites and studying up bring useful perspectives to the study. I argue that social justice, anti-oppressive approaches (Strega & Brown 2015), through to the identification of intersecting inequalities to underpin analysis, best facilitate a move towards the explanation of the IMG experience in Australia. Biographies as well as history are fundamental to the investigation of the positioning of IMGs and in chapter two a historical lens provides background that sets the scene and flags significant stages. These allow the reader to explore some of the important influences and events that have shaped the Australian nation and its peoples. Discussion traces the journey of western medicine in Australia from the discovery and subsequent British invasion of the Great Southern Land through to today. The encounters of the newcomers with Australia's Indigenous peoples, the custodians of the land, and their ancient medical practices (Gunstone 2008) are advanced and the first IMGs are introduced. Further discussion progresses through to the arrival of refugee IMGs following the Second World War (Iredale 2009; Kunz 1975) to the current context of medical

practice. The emergence of a powerful, high status medical profession with the ability to successfully lobby governments to further its own agenda becomes evident (Willis, Reynolds & Keleher 2016). Colonial history shows the development of a fearful xenophobic nation, one which feels threatened by 'others'. Subsequently, IMGs also came to be regarded with suspicion and were eventually ascribed an inferior underclass status. Their credentials and skills were called into question. Chapter two also reveals an ethnocentric and racist Australia where, despite a black Indigenous population, the notion of white supremacy and western cultural superiority not only flourished but racism was institutionalised in the 1901 Federation of the 'new' nation and the White Australia Policy. The position of status and power afforded Australian trained medical doctors is perpetuated and reinforced via the development of the Australian nation (Plage et al. 2016) and the intersecting oppressions of class, race and nation. The phenomenon of power and its relationship with IMGs is explored further in chapter three. A matrix of domination facilitates the separation of power into ***Structural Power, Hegemonic Power and Interpersonal Power*** dimensions (Hill Collins 1990; Hill Collins & Bilge 2016). The power found structurally within the health system and other related organisations which are tasked with the regulation and control of IMGs is further unpacked for the reader. Chapter three provides an outline of the policies and procedures of the system which IMGs must navigate to obtain accreditation and registration in Australia. The IMG voices tell of their experiences in their dealings with the system. The hegemonic power of the medical profession as gatekeepers to the health system is revealed (Willis 1989) and the interpersonal power interaction between IMGs, the system and medical dominance is exposed. Further explanation and exploration of the concept of medical dominance continues into chapter four. Firstly, discussion traces the rise of the medical profession in Australia from the 1870s. Today, Medical dominance wields power over other health

professionals in that the medical profession in Australia is the sovereign expert, sanctioned by governments. Medicine's ownership and custodianship of medical knowledge and clinical skills facilitates the profession's expert status. Discussion acknowledges that there are changes in and challenges to medical dominance, but despite its changing nature, medical dominance still manages to evolve as conditions require, while retaining its dominant position (Coburn, D. 2006; Willis 2006). Also revealed in chapter four is the unsavoury side of Australia's medical culture. The toxic culture within the profession has surfaced (particularly since 2015) via the media. Reports of systemic sexism and sexual harassment, bullying, uncompetitive and even unlawful behaviours have been revealed. The surgical specialities were especially exposed initiating the Royal Australasian College of Surgeons to appoint an expert panel to investigate (Knowles, R & Bannon 2015). The toxic culture even infiltrates down the hierarchy to medical students prompting the Medical Students' Association to not only speak out against bullying but also to allege that bullying had pushed some medical students to suicide (Campus Review 2015). Here, the reader is invited into the stories of experience from some of those medical professionals, including senior surgeons, who have suffered at the hands of the profession itself. The voices come from the media to join the voices of their colleagues in the IMG community. Chapter five asks the question: "what's the problem with IMGs, is there a problem?" Initially, IMGs as a global resource comes into question within a growing climate of the international exchange of ideas, technologies and goods and services. Global conditions have facilitated a migratory workforce and IMGs are in demand.

This leads to an ethical argument in that not only do countries with a medical workforce shortage actively entice and recruit medical doctors from other countries, but they are poached from developing countries to practice in wealthy countries. In opposition to this is the basic human right argument, advancing that a medical doctor should have the freedom

to live and work where ever he or she chooses. In addition, medical doctors also move from developed country to developed country such as from the UK to Australia (Dwyer 2007). The reasons behind doctor migration are outlined and include a relocation to experience adventure and life in a new country to those doctors who flee unsafe situations and come as refugees. Medical doctors who leave their country of origin for safety reasons and are unable to return home are rendered vulnerable to the requirements of the Australian system. Perhaps arriving in Australia, already having experienced significant stress could be compounded by the necessity for vulnerable IMGs to place their careers at the mercy of the Australian health system.

A discussion around the need for safety is advanced as well as reasons for coming to Australia are shared by the IMG voices from the data. Historically, Australia's poor human rights record is acknowledged along with idealised perceptions of Australia as an egalitarian country which professes a "fair go for all" (Plage et al. 2016). Further, chapter five notes that IMGs appear to constitute a problem simply because of the numerous inquiries which have been conducted into aspects related to them and their experiences. Organisations that deal with the processes IMGs must navigate through are often criticised with very similar recommendations being made from these inquiries, and very little action being taken. The concept of a wicked problem is introduced in relation to the situation for IMGs in Australia. These problems have a power differential at their core, are multi-causal and have multiple interdependencies. As a result, they are highly resistant to a solution. Following a problem representation approach, Bacchi's (2009) six questions are adapted to scrutinise the problematisation of IMGs. Scrutiny includes revealing, identifying and reflecting on inherent silences within problematisations. For example, in this case the need to maintain the high standard of health care in Australia as justification for discriminatory and unprofessional behaviours towards IMGs. Discussion assists an integrated analysis

where the focus is shifted from a problem solving focus to a problem questioning focus. Further analysis continues in chapter six where the intersecting inequalities of *class, race* and *nation* are explored. Through the analytic tool of intersectionality unequal power relations are viewed as intersecting oppressions which conspire together to assign IMGs in Australia an underclass status within the elite profession of Australian medicine. The original contribution to knowledge made by this thesis; is consolidated synergistically in chapter six to explain why IMGs are positioned as an underclass. It can be seen how xenophobic, racist and ethnocentric norms, values, assumptions and beliefs have developed to weave their way through Australian society, its governments, its institutions and its laws. The Australian nation influences the socialisation of its peoples, a nation underpinned by a long history of systemic oppressions. In terms of IMGs, the system entrusted with their regulation and control harbours a systemic frustration of aspirations (Eckermann et al. 2006) where medical dominance furthers its own agenda based on self-interest.

This thesis positions IMGs as a professional community construct and reflects the interconnectedness of the intersections. The intersections of class, race and nation best reflect the positioning of IMGs. Many intersectionality studies include gender as an intersecting oppression but this thesis has not. While acknowledging that gender is indeed a very important intersection, in this case I did not want to divide the IMG community in any way. Similarly, then ethnicity (also, a much explored intersection in many studies) has not been selected. I sought to empower the IMG community and their voices, not divide them into other categories of IMGs. In this way, as a professional community, IMG solidarity, agency and the associated voices gifted to this study can stand together as one. Chapter six, the final chapter before concluding this doctoral dissertation also looks more widely for socio-political phenomenon. The current emergence and influence of right wing

conservative political platforms are investigated in terms of an angry working class backlash. The political resurrection of Pauline Hanson in Australia, the election of Donald Trump to the presidency of the United States and Britain's vote to exit the European Union. These events do not represent isolated extremism but rather an underestimated and significant shift of public concerns and fears. A commonality of issues comes to light, those of: the economy, immigration, the maintenance of national identity and a nostalgic return to 'greatness.' Immigration is a primary concern for two reasons, firstly there is fear that migrants take local jobs and secondly migrants are a perceived threat to national identity and security. Muslims are particularly demonised and are often linked to terrorism (Eid 2017; Ewart, J. 2012). Australia's xenophobic stance on immigration and border protection is outlined in this chapter. Australia has a long history of exclusion and in terms of immigration, the country has moved from suspicion and caution to exclusion to ensure protection from the 'other'. The extraordinary lengths the government will go to keep the 'other' out of Australia, particularly asylum seekers arriving by boat, are unprecedented (Glynn 2016; Higgins 2016; Riley 2016). The 'life-saving' rhetoric around stopping boat arrivals and the image Australia now sends to the world is critiqued in this chapter. Also highlighted is Australia's preoccupation with 'whiteness' (Frankenberg 1993; Knowles, C 2010) and an ethnocentric belief of superiority (Grigg & Manderson 2016). Australia has always been a racist country, beginning with the massacre and dispossession of Australia's first peoples. The Australian nation's obsession with whiteness is perpetuated today through Australia's institutions and policies where racism has been institutionalised and Indigenous Australians remain marginalised (see Gunstone, 2017). For IMGs who come to Australia, what does our society reflect back to them and how do they retain their professional identity as medical doctors amidst the questioning of their credentials? (Harris, A. & Guillemin 2015). Some IMGs never have their credentials accredited and join

the medical unemployed while others may find themselves in exploitative work places where they experience bullying and discrimination (Bannon & Knowles 2015; Venkatesh et al. 2016). The focus of this thesis is on the IMG experience, and the voices woven throughout the following chapters reveal those experiences. Analysis concludes that IMGs in Australia are positioned as an underclass within the elite profession of medicine. The original contribution to knowledge advanced here offers an explanation of why IMGs are positioned in this way.

CHAPTER ONE

METHODOLOGY: THE PATHWAY TO FIND THE VOICES

Qualitative researchers are guests in the private spaces of the world. Their manners should be good and their code of ethics strict (Stake 2000, p.447).

It is fruitful to think that all research must be reflexive and that in many ways the researchers should treat all the researched…as elites (Tomic & Trumper 2012,p.244).

INTRODUCTION

The exploration of how IMGs perceive and experience their realities working and living in Australian communities represents a qualitative, empirical study. Qualitative research embraces the socially constructed nature of reality and the relationship between the researcher and research participants. My role as a researcher was to seek to reconstruct how participating doctors engaged with the various discourses they must interact with in their work culture and private culture spheres. In other words, how they construct their own individual unique realities and lived experience. The most suitable approach to the overarching research question: "How are IMGs positioned within Australia's medical culture" was to adopt a multi-disciplinary view. This decision was taken to avoid the constraints of discipline boundaries, which in turn, can potentially limit the breadth of explanation in answer to the question. Subsequently, this position supports the social justice, anti-oppressive approach taken. In this chapter, my research position in terms of who I am in this process will be outlined, from my initial explorations, through to putting the

research processes in place. My rationale for these methods and their strengths and weaknesses will also be outlined as well as how I moved through the process of data collection. In this chapter, the participants of this study are introduced to the reader. In addition, ethical considerations in relation to the study will be raised and discussed. Theoretical frameworks which resonate with me are also introduced in this chapter. Post-structural feminism and the concepts of elites and studying up bring useful perspectives to the study. I argue that social justice, anti-oppressive approaches (Strega 2015) through to the identification of intersecting inequalities to underpin analysis, best facilitate a move towards the explanation of the IMG experience in Australia.

MY PERSPECTIVE AS RESEARCHER

Where do I stand in all this? Who am I? I am the researcher for this study, but I am also an Indigenous Australian woman seeking the voices of IMGs who have come from other countries to live and work in Australia. A fundamental requirement of Indigenous research methodology is the identity and location of the voice of the researcher therefore I position myself at the outset. I am a Pintubi, Aranda, Arrente, Bundjalung woman. My Indigenous ancestry comes from my paternal side, this is my position. As Absolon and Willett (2005, p.97) confirm:

> the location from which the voice of the researcher emanates is an Aboriginal way of ensuring that those who study, write, and participate in knowledge creation are accountable for their own positionality.

This is a way to validate myself and my location within the research process itself. I bring to the research my own collection of experiences and feelings, which construct the many epistemological lenses I look through. Most importantly, "The sociologist requires a sensitivity to and a curiosity about both what is visible and what is not visible to immediate perception and sufficient self-understanding to make possible an empathy with the roles

and values of others" (Vidich & Lyman 2003, p.55). Observations via my field work, during the focus group and subsequent interviews reflected the situation of IMGs as being 'othered'. In addition, the submissions to the 2012 Parliamentary Inquiry and the 2016 Senate Inquiry overwhelmingly endorsed this position. This is not in terms of the simple research process of the researcher and the researched (the other). Rather, I am referring to marginalisation where the dominant culture constructs and maintains rules for regulating social action. "Dominant perspectives distort the realities of the other in an effort to maintain power relations that continue to disadvantage those who are locked out of the mainstream" (Ladson-Billings 2003, p.408). This concept will be discussed at length in following chapters.

As an Indigenous Australian scholar, I write as the colonised, another other or an "allied other" (Kaomea 2004, p.4). Indigenous Australians are marginalised by the dominant culture in this country. Commenting on her social justice work, Patricia Hill-Collins (2013, p.67) argues that a researcher located in the margins can access a creative tension:

> They develop a critical consciousness of the need to remain attentive to the connections linking their scholarship and their in-between status of belonging, yet not belonging.

Similarly, the participants in this research constitute a marginalised group. What is particularly interesting in this case is that while IMGs are essentially an elite group in that they are medical practitioners, at the same time they are a marginalised group because they are treated by the health system as the other, a different discrete group of people who are not members of the Australian trained medical group. How can I situate myself in this context? I am able to emphasise with the other because my people have experienced the

category of other since 1788 until today and will into the future[2]. I have a heightened awareness of not only what it is like to be categorised as other but also of the ramifications, and how they play out over time, for those who are categorised as other.

I am however, also familiar with the Western way, the dominant way of knowing and doing in higher education. I was raised in the Western way by adoptive Western parents, look Western (to most Westerners) and have Western ancestry. Am I then a 'post-colonial' intellectual? Perhaps I am a Third World intellectual or a 'flash black'[3]. What is ethically important here is for me to declare my position and to have it noted by the reader. This disclosure however, as highlighted by Maori academic Linda Tuhiwai Smith, can constitute a risk for the researcher's work as third world intellectuals may have their work under-valued. "Third World intellectuals have to position themselves strategically as intellectuals within the academy, within the Third World or Indigenous world, and within the Western world in which many intellectuals actually work…Their place in the academy is still highly problematic" (Smith, LT 1999, p. 71). I have a lived experience within the academy and I have a lived experience as an Indigenous Australian woman. I also have a lived experience of my other side, within the Western world in which I was raised.

Ultimately, I did not see my empathic relationship with the other and marginalised groups as problematic within this study:

> Although it is true that at some level all research is a uniquely individual enterprise-not part of a sacrosanct body of accumulating knowledge-it is also

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[2] This is clearly demonstrated for example, in the government's Stronger Futures legislation which continues the Northern Territory Emergency Response. As a result, Indigenous Communities in the Northern Territory remain under punitive federal controls (Roffee 2016).

[3] The term 'flash black' is sometimes used to refer to Indigenous Australians with a university education and/or high paying occupation.

true that it is always guided by values that are not unique to the investigator: We are all creatures of our own social and cultural pasts (Vidich & Lyman 2003, p. 95).

Critical reflection, while important, should not become the focus or purpose of the research as Strega (2015, p.146) reminds: "Our positionalities as researchers must be noticed, questioned, and taken up,...: the reader must still learn more about the puzzle or experience being analysed than about the researcher." In fact, empathy is an important tool for understanding the lived experience of others and becomes part of the research process when embodiment is key to the research (Magnat 2012). The researcher's position in this study now declared, two important concepts come to light when establishing the position of IMGs in this study, firstly the idea of researching elites and secondly the concept of studying up. The profession of medicine attracts high status and prestige across the globe and can be perceived as an elite profession. As a result, given my position (a post graduate research student) seeking to interview medical doctors, I was in fact studying up. However, while IMGs belong to the elite profession of medicine they are not granted full acceptance, equality and inclusion into the Australian trained medical doctors' exclusive status. Conversely then, rather than enjoying the same status as their Australian trained colleagues, IMGs while still a part of the medical profession, can be relegated to an underclass within an elite class. IMGs unable to have their qualifications recognised or awaiting recognition of their qualifications in Australia can be found driving taxis and delivering pizza (Pascoe 2011). Perhaps this paradox indicates that I was also studying down?

ELITES AND STUDYING UP OR PERHAPS DOWN?

Qualitative research on elites is scarce which led Savage and Williams to entitle their book "Remembering Elites "(Savage & Williams 2008b). They argue that apart from the post-

war work of C. Wright Mills (1956) who positioned elites in the economy, the military and the political arenas, there is little research on elites in contemporary sociology as opposed to classical sociology which was founded on elites and social change. The historical focus on elites began to fade in the early 1970s due to case study research being upstaged by the scientific method of the sample survey. This was a time when researchers began to abandon interviewing elites due to time constraints and access problems (Savage & Williams 2008b).

Can an elite be defined? Who is elite? The search for a definition of what constitutes an elite is problematic and ongoing. Hiller (1996) for example views contemporary elites as small highly organised and integrated groups which exhibit solidarity and cohesion. Pakulski (2011, pp.329-330) believes that there can be internal divisions within a group of elites but their cohesiveness nurtures "communication, collaboration and collusion, especially the formation of extensive networks". Historically, elite as a concept has changing meanings and moving boundaries. The contemporary view is still illusive therefore: "Elite is a fuzzy concept. From a post-structural approach elites need to be considered flexibly" (Tomic & Trumper 2012, p.248). I agree with this given my position as researcher and the somewhat dual position (members of an elite profession but an underclass within that profession) of the participants in this study. The participants, while belonging to an elite profession did not fit the images that come to mind when one thinks of elites, such as the super wealthy, celebrity, business tycoon or royalty perhaps. The participants in no way displayed an elite status and I did not feel inferior or intimidated at any time during the focus group session or during interviews (face to face or via telephone). On reflection, I wonder if I sought to interview, and managed to get access to, Australian trained doctors for this study, would my experience have been otherwise as it was for Beagan.

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Brenda Beagan, A Canadian University of British Columbia (UBC) doctoral student, in 1999 interviewed medical faculty doctors and medical students at UBC. As a female graduate student, her income and power was much less than the faculty medical doctors she was interviewing. Many of the participating doctors treated her and her research with disrespect and dismissiveness. In contrast, she found that interviewing medical students who were fellow UBC students was a more pleasant undertaking where her relationship seemed to be perceived as on the same level as the participants. Tomic and Trumper (2012, p.244) make comment on the status of medical doctors in Canada: "Medical doctors are notorious in North America for their social status, income, and a culture of superiority, unparalleled by other professions, a position actively cultivated by physicians." The data from this study and other relevant literature indicates that Australian trained medical doctors are positioned at a similar level to that of their Canadian colleagues.

I had my *idea*, to explore the experiences of IMGs in Australia. My *fieldwork* encompassed the ACRRM conference in Adelaide and the IMG forum organised by the RACGP in Brisbane. I was able to make significant contacts by attending these events and also gained the opportunity to observe, take notes and listen. These strategies are particularly helpful for infiltrating elite groups. Ortner (2010, p.213) refers to this as "interface ethnography". In her discussion of the concept of productive disorientation Virginie Magnat (2012, p.183) likens fieldwork to a form of "psycho-physical displacement" where fieldwork requires the researcher to abandon control of any research questions and any ideas about the way fieldwork should be conducted and become "displaced, transported and affected."

The research *design* was established following an interpretive approach as I was seeking thick description and analysis to understand meaning.

DESIGN OF THE STUDY

Why Qualitative research? I did not want to produce findings based on quantification and statistical analysis instead I wanted to explore substantive areas of lived experience. Quantitative methods while producing what many social scientists and public agencies believe are more reliable findings, the findings can be at the expense of substance and theory (Berg 2004). Grounded theory exponents, Glaser & Strauss (1967, p.18) believe that: "…The crucial elements of sociological theory are often found best with a qualitative method…from data on structural conditions, consequences, deviances, norms, processes, patterns and systems." Qualitative methods are also useful for obtaining details on more intricate and difficult phenomena such as: "…feelings, thought processes and emotions" (Strauss & Corbin 1998, p.11). Berg makes the case for qualitative methods as this research approach allows the combination of data collection and data analysis strategies. These strategies …"are intricately intertwined with both the substance of the issues they explore and theories grounded in these substantive issues (Berg 2004,pp. 318-319). The qualitative method was also supported by Health Workforce Queensland who I approached to seek advice on how to best undertake research about the experiences of IMGs (see Appendix 3).

As a qualitative researcher, I needed to begin the research encounter with humbling myself to the kind of humility where the researcher lets go of what is known. This state of mind that encourages the researcher to surrender to the openness and wonder of inquiry is suggested by Vagle (2014, p.15): "It is the kind of humility we engage when we try to stop being so certain of what we know and think. It is the kind of humility evinced when we truly consider new things. It is the type of humility in which we let go."

My exploration of the positioning of IMGs within Australia's medical culture is therefore a

qualitative study, one best supported by an anti-oppressive, social justice approach. Although aspects of a grounded theory (also an interpretative approach) were appealing and have been utilised to some extent, it is social justice which underpins the research methodology. This stance allowed me as researcher and writer the scope to humbly re-construct life experience where meanings resonate together with reflexivity. I did not seek to work towards finding more accurate ways to explain how something works. Rather, I sought to question, explore and expose how things are experienced by groups of people doing what they do as they live in the world.

Unlike other approaches, grounded theory does not support the idea of an initial literature review and hypothesis. This resonated with me as I did not want to jump to conclusions before I began. Instead the researcher is encouraged to delay exploration of the literature in order to develop new ideas not influenced by seeing the world through existing ideas (Glaser & Strauss 1967). This approach was well suited to my engagement with this study as I set out on the research journey with no concrete ideas or influencing prior experience of what IMGs' narratives might be like. I sought to build the story from my first hand observations and the lived experience of participants. These in turn revealed the position of IMGs and the then obvious links to literature in the search for explanation.

Ultimately the research problem should shape the methods used. The journey through the research process is assisted by field notes or memo writing, these are informal analytic notes. The memo writing tool serves to support the researcher to stop and analyse data from the early stages of the research. I found these crucial to making sense of the data because they supported the process of thinking about the data and the development of ideas. Memos then feed into the fleshing out of categories. Interview participant transcripts and the submissions to the Parliament Inquiry (2012) and the Senate Inquiry

(2016) were read and re-read many times as was my report from the focus group session (Pascoe 2007). I also listened and re-listened to the interview recordings. From this process, statements became clusters of meaning and were categorised with focus on descriptions of the experience and how the experience was experienced. My subsequent analysis became the vehicle for the construction of the story of lived experience which unfolds throughout   this thesis. I was also acutely aware that sensitively and respectfully representing the gifted voices of participants and their lived experience cannot be merely reduced to a process. The voices became so much more than just data to be clustered, categorised, analysed and reported.

Three major overarching themes emerged from my engagement with and analysis of the data: *class, race* and *nation.* The categories and related concepts from the data were comfortably organised within these themes. The establishment of *class, race* and *nation* as the key indicators towards an explanation of why IMGs are situated as they are and experience the narratives that those in this study have, only became clear after extensive and time consuming questioning and pawing over the data. It seemed to take a very long time for the themes to suddenly be crystal clear. Analysis of the data showed that the intersection of *class, race* and *nation* assisted and collaborated to create and influence the participating IMG experience in Australia. Intersectionality, a feminist emancipatory theoretical framework initially developed by critical race scholar, Kimberle Crenshaw (1991) became a useful analytic tool to highlight the intersecting inequalities found in IMG narratives against a background of structure and agency. The matrix of domination work of Patricia Hill Collins (1991) was helpful in the conceptualisation of a power differential. The intersecting oppressions of *class, race* and *nation* will be explored and discussed at length in forthcoming chapters.

Another difficult and especially in the beginning somewhat frustrating task in this study, was participant recruitment. This proved to be a lengthy process but it eventually came together and I conducted a focus group with six participants (three males and three females). This was followed by ten individual interviews with seven males and three females. Participants were aged between 37 and 48 years and were all general medical practitioners.

THE PARTICIPANTS AND RECRUITMENT

How was I to recruit participants for the study? Why would IMGs be interested in having an interview with me? They are already a very busy, highly stressed group of professionals, why should they bother? I needed to find IMGs who would firstly participate in a focus group and secondly I needed to find IMGs who would consent to a one hour interview. None of the IMGs who participated in this study had English as their first language. Two focus group participants (males) and five interview participants (three males and two females) had left their country of origin and come to practice in Australia via another country.

Initially I considered the idea of providing participating doctors with an electronic questionnaire, given that they are essentially time poor. Olu Ogunrin et.al (2007) in their study of Nigerian doctors utilised questionnaires. As a result, they noted that due to the difficulty associated with getting doctors to complete questionnaires and the understandable work demands of doctors their subsequent sample sizes were small. I wanted to obtain rich data from conversation rather than the limited responses gathered from questionnaires. I was aware that as the researcher, I may have to adapt my data collection to best suit the needs of the potential research participants. During my time at the ACRRM conference I met the CEO of Health Workforce Queensland who kindly

expressed his support for my research and invited me to contact him if I needed assistance. I made contact to seek his feedback regarding a possible questionnaire and was advised: "We fully endorse the view that OTDs and GPs in general are not in favour of written circulated questionnaires as the generally held view is that there is very rarely any end result (see Appendix 3): I had not anticipated this aspect at all.

I was pleased not to have to consider a questionnaire. Health Workforce Queensland kindly placed a link on their website for IMGs to access a description of my research. When they accessed the link, doctors were invited to contact me if they were interested in participating. I now anticipated with great excitement the recruitment of my participants and waited for the contacts to come in. My excitement was soon quelled as I only received two responses via email. The first response was from a doctor in Pakistan who attached his CV and an application for the job! The second response was from a former International Queensland PhD student now living in Dubai. This gentleman assumed that I was interested in hearing about his experiences as an international PhD student in Queensland. Clearly, this recruitment strategy was not going to work. I was back at square one in terms of interview participants. How was I to approach this? I could not just randomly phone rural and remote surgeries, ask if there were IMGs practicing there and would they be interested in an interview. I knew I would not get anywhere with that strategy. Elite groups (such as medical practitioners) are often difficult to access. Although they tend to be visible and relatively easy to find, they have the ability to put up barriers and refuse access to researchers (Hertz & Imber 1993). I was determined to not be discouraged by recruitment difficulties and took the following advice: "Obstacles to access are challenging but should not provide an excuse to avoid committing to and persevering in studying up" (Aguiar 2012, p.9).

Around this time, the university where I was employed held a health research showcase. Researchers were invited to provide a ten minute presentation on their current research. As a result of my presentation (in which I mentioned my recruitment difficulties) at this event, my first contacts for participants were made. A staff member who attended approached me afterwards and offered to copy me into an email to one of his IMG friends. Another PhD student also approached me believing that her partner (an IMG) would be interested in participating. It seemed that one needed an introductory connection to break into this guarded professional cohort. I was now utilising what is termed snowballing. Snowball sampling is a nonprobability strategy which is particularly useful to access difficult to penetrate population groups. Snowball sampling is a nonprobability strategy which is particularly useful to access difficult to penetrate population groups. Berg (2004) explains: …"In many instances, researchers conduct studies in areas in which they simply do not know anyone who can serve as the kind of entrance guide or core to a snowball sample to be rolled through the project." (Berg 2004, p.151). I now had the opportunity to contact two IMGs. At the time of the interviews I would ask a participant to provide me with the contact details of another IMG who may be interested in participating. In this way the researcher has gained access to the group and is subsequently referred to other members of the group. This strategy begins to snowball the research along with participation by way of recommendation from within the group.

The process of collecting the data for this research study was a rewarding yet challenging exercise. The very nature of medical practice itself ensures that there will be access difficulties in some instances. I was as researcher requesting busy IMGs to take one hour at the most of their time for an interview. I was grateful when an interview was organised and even more grateful when it actually took place. I very quickly realised that I had to make the best of every situation even when the situation was not ideal. Data collection in

terms of the focus group was far less complicated than organising the interviews as the recruitment and preparation had been done for me by the staff of the Division of General Practice. I was now ready to seek out the participant voice through the collection of interview data. However, I was not able to commence until I was granted ethical clearance.

ETHICAL CLEARANCE

Prior to commencing any data collection for research purposes, universities require a detailed proposal to be submitted to their Human Research Ethics Committee. The required documentation must include information about the proposed research, a Statement about the Research and Consent Form which participants receive and sign. In terms of this study, I had to request three extensions on my ethical clearance due to the difficulty in accessing IMGs. Recruitment of IMGs for interviews does not necessarily guarantee an interview shortly afterwards. The very nature of the medical profession made scheduling problematic. In some cases interviews were postponed due to unforeseen circumstances such as patient emergencies. In addition, three doctors consented to be interviewed only via telephone, instead of face to face. This constituted a deviation from my ethical clearance approval. As a result, I was required to submit a request for modification in which I informed the Committee of a change in data collection involving three participants. The Chair of the committee approved the amendment.

As the researcher, it was my role to make sure, to the best of my ability that participants felt protected and empowered throughout the research process. I wanted to build a trust relationship with participants and the research settings needed to be places where participants felt safe to share their voices. I also needed to ensure that participant information and contributions to the research remained confidential.

CONFIDENTIALITY

The participants in this research represented a somewhat fragile group. Many IMGs were currently experiencing or had in the past experienced adverse interactions with various bodies in the Australian Health System responsible for their registration and its associated processes. Some IMGs initiated complaints and appeals associated with their experiences of the processes. Moreover, some IMGs will not speak out against perceived unfair or unreasonable treatment because they fear that their transition through the processes may be jeopardised as a result of making a fuss or going public. This was also evident in the responses to the 2012 Parliamentary Inquiry, where one third of IMGs requested anonymity (House of Representatives Standing Committee on Health and Ageing 2012, p.x) The Senate Community Affairs References Committee of 2016 took anonymity further and determined that all submissions made by individual medical practitioners that detailed personal experiences of bullying were to be received in confidence (The Senate Community Affairs References Committee 2016, p.11). These submissions were made unavailable due to the sensitive nature of the content (experiences of bullying) and the possibility that some experiences could be currently under investigation.

The very first potential interview participant (a partner of a colleague) became nervous at the last minute and expressed his concern that he might somehow be identified and therefore experience ramifications for speaking. I did assure him that he would be given a pseudonym and that his location would not be revealed but he declined an interview. He was however quite happy to speak to me off the record about IMGs in general if I had any questions. Similarly, the Expert Advisory Group to the RACS reported that a culture of: "fear and reprisal stopped some Fellows, Trainees and IMGs participating in the research and consultation processes" (Knowles, R & Bannon 2015, p.5). A contact I made during

my fieldwork and who will be referred to throughout this research as my informant confirmed this. According to my informant (who also had to be careful about speaking out) most IMGs will not risk speaking out in fact, my informant had personally experienced on more than one occasion the following: "If I get pushy for example, about the progress of a doctor's paperwork through the system, that particular doctor's paperwork will move to the bottom of the pile" (personal communication).

It is also important to bear in mind that some IMGs come from countries where there is political instability, unrest, violence and corruption. Perhaps as a result, they could feel apprehensive about what may happen to them or even their families because of the information they offered to this research. For example, one of the participants in this study, Shaun (2012, interview 8) when criticising the system during our interview said: "In my country I could get arrested for this." He then laughed, but this did not detract from the seriousness of the statement. This doctor also mentioned that he had contributed an article which was somewhat critical of his country to an overseas magazine. The article was written in Spanish, not in his first language. Somehow the article found its way to his home country in the Middle East and a tense time followed as some of his family members still in his home country were questioned by authorities. I decided that I had to employ a more comprehensive level of risk management to protect participants.

In an effort to ensure confidentiality and anonymity to the best of my ability, I adopted several strategies. Firstly, in terms of confidentiality, I was the only person to interview participants, and although I received some assistance with interview transcription the electronic files sent for transcription did not have identifying information. In terms of the focus group however, the identity of the IMGs who attended was known to the staff of the Division. I was the only one to analyse the data collected at the session however and the

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report I produced for the Division did not attribute any comments to a particular participant. Secondly, I made the undertaking to collect, store and destroy data according to the National Statement on Ethical Conduct in Human Research. In addition, I also needed to protect my informant from any repercussions as a result of sharing information with me. Therefore my informant will not be named or have interest in and association with IMGs declared in any way.

ANONYMITY

Participating doctors were assured of anonymity. For example, their names would not be mentioned. Rather, I would assign them a pseudonym. However, I discovered that there are very small numbers of IMGs from particular countries practising in Australia. During a telephone conversation with my informant I mentioned that I had just interviewed an IMG from a particular country. To my surprise my informant was able to identify the doctor, as this doctor was the only doctor from that country in Australia! Apparently In addition, some rural and remote communities only have one doctor and some only have IMGs. Therefore, the exact location of a doctor and his or her country of origin could be sufficient information to identify the participant. In view of the particularly sensitive nature of the situation, I needed to be more discrete to totally protect participants not only in the recruitment/interview stage but also in analysis and writing up of the research. Richardson and Adams St. Pierre (2008) stress that: "In post-modern qualitative inquiry, the possibilities for just and ethical encounters with alterity occur not only in the field of human activity but also in the field of the text, in our writing" (Richardson & Adams St. Pierre 2008, p.491). As a result, this study and thesis will also not reveal participants', country of origin or location in Australia. I have endeavoured to select pseudonyms which do not imply a country of origin or cultural affiliation. The voices included in this research selected from

the submissions to the 2012 Parliamentary inquiry and the 2016 Senate inquiry however, where the doctor did not request to remain anonymous, retain the name of the doctor concerned, as the particular doctor expressly gave the committees in writing, permission to publish his or her name. The submissions to the 2012 inquiry were publically available on the inquiry's web site. Some of these 2012 submissions however expressly requested that the submission be utilised only by the inquiry. I did not include comments from these submissions in the data. In terms of the submissions to the 2016 inquiry, as already noted, some were not accessible and these were clearly marked on the 2016 inquiry's web site. The submissions available and utilised from the 2016 inquiry then, were made by doctors who did not give graphic detail of actual experiences but perhaps outlined how they were feeling about their experiences and the impact of those experiences. Other submissions made to the 2016 inquiry from professional associations such as the Australian Medical Students' Association (AMSA) and the Australian Indigenous Doctors' Association (AIDA) were included. Detailed below is the data collection journey for this study.

DATA COLLECTION

My first data collection experience in this study was via the focus group. According to Krueger (1994) the purpose of focus groups is to produce qualitative data that give insight into attitudes, opinions and perceptions of participants. I hoped the voices from the focus group would raise some themes which would further my perceptions of how IMGs experience medical practice in Australia. Ultimately, I hoped that the focus group data would not only contribute to my understanding on a more micro, in-depth level but also inform my ideas for the next stage of the research which would be to conduct semi-structured individual interviews. I now had the opportunity to hear the voices of a small group of IMGs. I wondered if they would be different from or similar to the more distant

voices I had been exposed to in the larger fieldwork contexts.

THE FOCUS GROUP

The focus group session came about almost by coincidence. I contacted an ex colleague of mine who had become the Chief Executive Officer (CEO) of a Queensland Division of General Practice[4] located in a rural area. I explained my research and sought advice on how to recruit my participants. The particular division concerned was cognisant of the challenging circumstances which their IMG membership experience. As a result, they were interested in seeking feedback from this membership group with a view to improving the Division's provision of support and services. Subsequently, I was invited by the CEO to facilitate a focus group of IMGs and provide the division with a report on the findings (Pascoe 2007). Participating focus group doctors were those who chose to accept an invitation issued by the Division to attend a focus group session. Most importantly, I anticipated that a focus group session would provide the context for a more in-depth exploration of the IMG experience. I also hoped that some themes would emerge from the data which could be further elaborated on during interviews.

It was a warm Queensland evening. The focus group session began at 7.30pm and was held at the office of the Division. The Division also provided a light supper and refreshments and the CEO attended to introduce me. A small conference room was set up with a central table surrounded by chairs. The room was the same one where doctors attended Division meetings, this made for a familiar and comfortable research setting. Six

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[4] There were numerous regional Divisions of General Practice across Australia. The divisions were Commonwealth funded organisations which provided free membership, professional development programs and information for general medical practitioners. They were disbanded in 2011.

doctors took part, three men and three women. The focus group provided local IMGs with an opportunity to raise and discuss aspects which were integral to their professional and personal lives. Participation also offered busy IMGs, who do not often have the opportunity, to come together to network and build relationships with each other and with the division. The doctors (except one) remained after the session to have supper and chat. When I eventually left the building at around 9.30pm some participants were still conversing in the car park.

Focus groups can facilitate access to the "natural" interaction between and among participants. According to Kamberelis and Dimitriadis (2008, p.389)"Focus groups privilege "horizontal interaction" over "vertical interaction" and become social spaces that tend to decrease the influence of the researcher in controlling the topics and flow of interaction." I wondered if conducting a focus group session with a group of professional people from different and diverse cultural backgrounds would present any particular challenges. I noted the work of Madriz (2000) who found that rapport was enhanced when the interviewer was the same "race"/ethnicity as participants. Interestingly I also noted Tomic and Trumper (2012) who found that shared ethnicity between researcher and interviewees can result in not only poor rapport but questioning of the researcher's credibility. I went to the session with an open mind and intent on establishing good rapport so that doctors felt comfortable and able to contribute. Interestingly, Gilding (2010) suggests that elites may be psychologically motivated to participate in research for the opportunity of personal therapy and self-reflection. I assumed that participants would attend because they were motivated to make a contribution to the division's request for feedback and ideas but I guess by making a contribution participants could even inadvertently experience a feeling of personal therapy and reflection.

Participants were informed before electing to take part in the focus group that the session would be recorded, facilitated by an independent researcher (myself) and anonymity maintained in any associated dissemination of information. I was prepared for participants to decline the recording of the session but there were no protests. I was glad I did not have to take frantic notes. Focus group participants were provided with an information sheet and consent form. The information sheet clearly set out the necessary detail about the research, facilitator and the use of the data collected. All participants signed the consent form.

The focus group was virtually un-structured allowing IMGs to freely raise and discuss any aspects they wished. In the invitation distributed to members, the division listed the following as prompts for discussion:

- What assistance do you need as an IMG?
- How can General Practices and this Division make the transition to Australia easier for IMGs?
- How can we put these ideas into practice?

I tried to encourage a free flowing session and only intervened to ask a new question when there was a pause or to perhaps ask a doctor to elaborate on a comment. Initially, as an ice-breaker I asked the participating doctors **why they had chosen to relocate to Australia?** Overwhelmingly, the primary reason was to live and raise a family in a relatively safe country where one's children had access to a reasonable education from an English speaking background. They did not relocate because they considered employment and living conditions more lucrative or attractive in Australia. This proved to be an effective beginning for our discussion, it also dashed another assumption I had. I imagined that

Australia would surely offer far better conditions for a doctor from another country, otherwise why would they come. I was surprised to learn that this was not the case. Ultimately, participants sought and valued safety above everything else. Two focus group participants mentioned that they had come to Australia via South Africa, a country other than their country of origin. Both doctors considered South Africa to be a very lucrative destination for IMGs, more so than Australia, but they also considered it to be unsafe.

One of the doctors stated:

> In South Africa we were treated like gods, we had everything. But it is not safe there (Pascoe 2007).

Participating IMGs raised several issues which they viewed as vital to improve the transition of IMGs into the Australian medical workforce. These issues included: orientation, access to information, mentoring and supervision. In addition, certain aspects of personal experience richly illustrated the frustrations, disappointments and difficulties faced by these doctors. These aspects included: working conditions, different cultural perceptions and beliefs, different rules and responsibilities in medical practice and feelings of powerlessness and vulnerability.

Six IMGs attended the focus group (3 men and 3 women). One woman despite encouragement and opportunity did not actively participate in the session and instead chose to just listen to the conversation. At the time of the session, all participants were currently employed in general practice in a rural community in Queensland. The setting for the focus group was the meeting room of a Division of General Practice[5]. All participants were familiar with the room which was often used for regular meetings and already knew

each other, this context made for a frank and relaxed session. Those who participated raised several issues which they viewed as vital to improve the transition and retention of IMGs into the Australian medical workforce. Certain aspects of personal experience richly illustrated the issues faced by IMGs, particularly in rural Australia. The retention rate in general of IMGs in rural and remote Australia is poor. The Australian Rural & Remote Workforce Agencies Group (ARRWAG) (2005, p.13) in its submission to the 2005 Productivity Commission on Health Workforce, identified the following barriers to retaining IMGs and their families in rural Australia:

- Poor language skills
- lack of employment for partners
- limited educational opportunities for children
- long working hours and difficulties in providing locum cover
- religious, cultural or social needs that cannot be accommodated in a small community
- isolation from cultural networks that may exist elsewhere in the country
- long distance to travel – particularly for those coming from countries with smaller geographical distances
- lack of training and orientation in rural medicine
- difficulties in obtaining support from other medical professionals
- personality types that find social isolation difficult to deal with.

In terms of the focus group session, the data is broadly grouped under the three following themes: ***New ways of approaching clinical practice; information and orientation; working conditions.***

NEW WAYS OF APPROACHING CLINICAL PRACTICE

The practice of medicine varies internationally. Australia has its own medical culture, one doctor stated:

> Every country is different, it's all very different and all very new and that seems to be something you have to learn along the way (Pascoe 2007).

Two participants had previously spent time working in hospital settings in South Africa and mentioned several differences between practice in South Africa and Australia. For example, working in Emergency in Australia usually does not involve many patients presenting with stab and gunshot wounds as is the case in South Africa. One of the doctors made the point that IMGs from other countries may be more used to dealing with infectious diseases such as HIV, rather than geriatric related problems and skin cancers which are more common in Australia. The other participant who had spent time working in South Africa stated:

> My first time in emergency here, there was a sprained ankle and a baby with a fever, I thought where's the emergency? (Pascoe 2007).

This doctor also referred to different requirements in his general practice surgery while residing in South Africa:

> In my surgery in South Africa, I could do an aspiration full tracheotomy, whereas in Australia you do it in a hospital because one of the requirements is to have emergency resuscitation equipment. These things are very important to know (Pascoe 2007).

Also raised were different cultural perceptions on 'appropriate care'. The Australian perception of appropriate medical care can also be quite different than the IMG cultural perception. For example, one participant stated:

> I come across patients who would demand the maximum in any situation…we go overboard trying to save lives here (Pascoe 2007).

Participants stressed the importance of assisting IMGs who practice in Australia to be aware of differences. Australian culture requires an IMG to put aside his or her philosophy and beliefs and think and practice in the Australian way. Another doctor gave an example:

> I personally don't believe in the morning after pill but I prescribe it. My values and beliefs are for myself not for the other person (Pascoe 2007).

This part of the discussion led another participant to raise the possibility of litigation in Australia, an action virtually unheard of in his country of origin.

> For me to accept death for example, it's very easy because when it's time it happens and that's finished. In my culture litigation would be unheard of because when the time comes it comes. The approach here is so different (Pascoe 2007).

It was agreed generally that awareness of Australian cultural norms, values and beliefs need to be formalised in training. Cultural norms cannot be readily picked up in conversations with colleagues because as one participant mentioned: "Most doctors just do not have time for these conversations" (Pascoe 2007).

It was also noted however that access to training was difficult due to distance and finding available time. Most training was held in Brisbane over weekends and this was not a preferred option. One participant also raised the fact that in Australia, there are more drugs available for doctors to prescribe than in many other countries. This doctor commented:

> Some mentoring would be particularly helpful in drug identification, prescription and management, there are so many drugs here (Pascoe 2007).

This statement moved the discussion to aspects of mentoring generally and a specific example of one doctor mentoring another. While mentoring IMGs is not a formal requirement, there is mentor training available for doctors who wish to become mentors. It was mentioned that some general practices in the area were keen to mentor IMGs, but did not due to the high turnover rate. Some participants felt that mentoring did have the potential to be formalised, one participant stated:

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There needs to be specific guidelines about mentoring where the roles and responsibilities of all parties are clearly set out…but the guidelines need to have flexibility to accommodate different levels of need (Pascoe 2007).

Another participant was currently mentoring a colleague and explained at length:

She had this set back because she had just come to Australia, got a job as a GP out in the bush by herself, with no support services. She is seeking visiting rights to the local hospital in another country town so she is currently not able to care for her patients when they are hospitalised. To get that access she is required to enrol with one of the colleges and take on mentoring (Pascoe 2007).

The mentoring doctor visits her practice and with patient permission, sits in on consultations. The mentor discusses the cases with the mentee and assesses how she relates to the staff. While this is an extra work load for the mentor he acknowledged that: "Someone has to do it" (Pascoe, 2007). The mentoring doctor has not undertaken formal mentoring training. Instead, he prefers to mentor from his own personal experience:

Whilst I was new in Australia and working towards my FRACGP[6], I mentally made a note of all that I would have liked assistance with. I didn't need to be taught all over again but just the local practice of medicine. I provide that to a person now and she feels comfortable getting it from me because, probably I'm an IMG. We both feel more comfortable with me telling her what to do and maybe that's a cultural thing (Pascoe 2007).

Mentoring while a time consuming activity, was seen as providing essential advice and support to fellow IMGs. All participants indicated that they would not only be interested in mentoring but they would also be grateful to receive mentoring.

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[6] Fellow of the Royal Australian College of General Practitioners.

Another doctor voiced legal concerns in relation to mentoring:

> Some doctors have the notion that if you are mentoring someone and that person stuffs up, does the mentor have indemnity? This is a very important issue that needs to be clear. Medical insurance needs to clarify that you may be mentoring but you are not taking that responsibility (Pascoe 2007).

It seemed that the participants wanted more information in order to be informed about what is required in Australia not just in terms of the practice of Medicine but also in terms of general knowledge.

INFORMATION AND ORIENTATION

While it was acknowledged that there is general information available participants were seeking more localised information. General information about living and working in Australia is useful but one doctor stated:

> There is no booklet out there that you receive the day you arrive in Australia which says: If you need this… (Pascoe 2007).

Participants stated that easy access to local knowledge was vital, as there are numerous situations and services to negotiate which are locally based. It was agreed that localised information should be included in a thorough orientation. According to one participant lack of orientation is:

> A major deficit in Queensland Health. A thorough orientation would make it very easy for the person that's coming in to learn quickly. When I came there was no proper orientation, there were no rules about what I could and could not do although there was credentialing…but all it was, I just had to tick a few boxes and write one or two sentences explaining what I did and it was approved (Pascoe 2007).

One doctor felt that the role of a substantial, structured orientation program would ideally:

> Walk the IMG through every aspect of living and working in Australia like information about housing and schools to information on setting up a medical practice (Pascoe 2007).

How a medical practice is managed in Australia was particularly important for one participant who did not receive any related information during orientation:

> For me the main aspect is how you manage the practice itself. How you interact with patients, staff and community. What are the networks available? All these things need to be in your grasp before you even start the practice. Now you are put with someone for a couple of days and then you have to survive on your own (Pascoe 2007).

An additional comment was then made by a female participant: "We need all the information we can get so we can fight the system" (Pascoe 2007). I found this comment intriguing and wondered why the doctor felt she had to fight the system. I soon discovered as my data collection continued that this was a constant struggle for many IMGs.

The final theme to emerge was that of working conditions. Aspects of working conditions: such as supervision, work contracts and lack of access to Medicare were highlighted. The associated feelings were illustrated by participant experiences which encompassed vulnerability, powerlessness and the concept of cheap labour.

WORKING CONDITIONS

Medical practices are legally obliged to provide IMGs with supervision. Participants indicated that in their experience many IMGs are left with very little or inappropriate supervision. When prompted to elaborate one participant made the comment that: "Many of us feel like we've been thrown in at the deep end" (Pascoe 2007). All participating focus group members were critical of their supervision.

Another doctor added:

> The supervision given to me and to another IMG was mediocre to nothing and obviously the so called supervisor did not fit any guidelines. When this person did anything it was always criticism rather than assisting in finding out the problem and offering a solution. It happened because of the lack of guidelines and the lack of orientation (Pascoe 2007)

Another participant shared the experience of a colleague who had a personality clash with his supervisor. This eventually resulted in the IMG being dismissed from his duties. The IMG was not a permanent resident so was required to leave the country within 28 days because he was now without employment:

> The very next thing we had was people coming to our house crying, the whole family and they couldn't go back to where they'd come from, they'd sold everything from where they'd come from and what do they do, how do they get another job? (Pascoe 2007).

One participant raised work conditions embedded in contracts, this was of concern to all and discussed at length. Another IMG outlined his particular work situation:

> It is very prescriptive in the sense that IMGs have to do so many hours, see this many patients from this time to that time, and basically very little time is given to them for leave or to refresh themselves. I burn out. In our practice we work 8.30 to 5.30 every day and half day Saturday for the whole year with 6 weeks leave. I have worked for 4 years and I haven't had any leave. I can't there's no one there, no one running the place (Pascoe 2007).

One doctor commented that in some contracts if leave is taken it is unpaid leave and often income received is based on the number of patients seen. It was pointed out that their colleagues employed by Queensland Health were paid for annual leave, while some IMGs employed by general practices were not. She stressed the importance of caring for self and family: "We must look at our quality of life, our partners, our families…take the leave if you need to do that" (Pascoe 2007). The IMG who had not taken any leave in 4 years

replied:

> It's easy to say but that's not the real thing because for a lot of people, they come here after leaving everything behind, they've sold everything and they want to restart and they want everything to be stabilised as quickly as possible and they need money for that. There is also a difference in where we come from and what we come to. There can be a big difference in our standard of living and those doctors who don't start as doctors, we find it more difficult (Pascoe 2007).

This prompted a participant to raise the vulnerability of IMGs particularly in relation to negotiating contracts:

> You subconsciously say yes to most of the things that they want you to do rather than what you want. It is because of that vulnerable situation that we are put into and that's one thing we should address (Pascoe 2007).

Feeling powerless in the system was mentioned and the fact that many IMGs are reluctant to speak out. One doctor stated:

> We come into a fragile situation that takes us out of our comfort zones, coming up from that takes a long time. Ideas spin in our minds, are we going to be deported because you make a wrong move? Have you missed your chance in life? Thus we are hesitant instead of saying this is what we want (Pascoe 2007).

The negotiation of a contract implies that both parties come to the table with equal bargaining powers. Many IMGs however feel vulnerable and some desperate to secure medical employment on any terms. Another participant believed that IMGs constitute a source of cheap labour:

> The greatest percentage of bulk billing doctors are IMGs. People who want to start their practices as bulk billing, they look for IMGs because they are cheap labour. We are treated indirectly in a way as cheap labour. We are not cheaper labour; we have good skills, broad-based skills (Pascoe 2007).

The concept of cheap labour led to a short discussion on Medicare. While IMGs make a

considerable contribution to health care services in the community, temporary resident IMGs cannot access Medicare benefits for themselves or their families. One doctor stated:

> Most of us would be in the highest tax bracket and I find that very unfair. We contribute the most but don't get any benefit out of it (Pascoe 2007).

There have been many attempts over the years to secure Medicare benefits for temporary resident IMGs but to no avail, see (Haikerwal 2005). Another participant made the following analogy: "It's like having your own bakery but you cannot eat the bread in there" (Pascoe 2007).

The focus group session concluded with some discussion about the Dr Patel case and the associated tragic events at the Bundaberg hospital. One participant believed that the Patel case has: "Put IMG/community relations back 20 years" (Pascoe, 2007). It was felt that the Patel tragedy had undermined the general public's trust in IMGs. Another doctor stressed that:

> Unfortunately, the general public see an Indian doctor and tend to think we are all like him. This case has highlighted the deficiencies in Queensland Health rather than us (Pascoe 2007).

Final comments made reference to the need for more opportunities to meet with each other and to gather socially with families. It was mentioned that hospital doctors and doctors in general practice do not interact together. One doctor drew general agreement when he said: "New IMGs coming in should be introduced to the community, let's all get together" (Pascoe 2007). It seemed that the participating IMGs were feeling the need to connect with each other more often outside of professional/workplace contexts. There were a couple of opportunities for some humorous responses too (particularly some examples of their reactions to Australian slang). These experiences were advanced towards the end of our time together.

Laughter was a nice informal way to conclude the session.

One doctor told of her confusion with the term 'runs' she said: "The patient said he has runs, I thought is he athlete? I had to ask the receptionist she said no it is diarrhoea!" (Pascoe 2007). Another doctor was concerned about his 'crook' patient: "He tells me he is crook…I don't want to know that you are a crook! I'm just here to provide you with medical treatment" (Pascoe 2007).

Reponses from the focus group session will be explored in subsequent chapters. All but one participant (a female doctor) actively contributed to the focus group. Throughout the session she sat with arms folded and a frown on her brow. I made several attempts to coax her to share her thoughts but she declined each time with a shake of her head. An extract from my memo notes for the evening read:

> I really enjoyed tonight, they were all very animated except for her…she presented such a contrast to the others…I wonder why she came…did she just want to listen? Maybe she was too shy to speak. Nothing I could do, you can't force people to speak…just make sure they get the opportunity…I guess. Maybe she misunderstood what it was about, the purpose. I thought I'd try to chat to her afterwards maybe…but she left straight away.

It seemed that the opportunity to contribute experiences and ideas was particularly important for the majority of those doctors who attended. In fact, one participant chose to make the one hour drive from another town to attend. I came away from the focus group feeling pleased with the depth of conversation achieved, there were many themes, questions and ideas to think about while I recruited and negotiated for interviews. The focus group was instrumental in bringing together much of the observation, conversation and presentation I had been exposed to during my fieldwork at the ACRRM Conference and the IMG forum. My next task was to undertake the individual interviews.

THE INTERVIEWS

A preferred method for data collection following the qualitative tradition is the interview. I conducted ten semi-structured individual interviews which were aimed at maximising space during the interview for the participant voice to share what was believed by the individual doctor to be most important. The interviews included some background, demographic questions but these were minimal. These questions were necessary however to enable the reader to place the doctor experiences into context, and to make the study as meaningful as possible. Particular attention was also given to assure that any background questions would not compromise anonymity. This was especially pertinent for this research cohort.

The ten interviews I conducted were all unique experiences in terms of the settings and circumstances in which they occurred. Some participants came directly to Australia from their country of origin while others came via another country. Participants were drawn from all over rural and remote Queensland from the far north and central west to the south east and west. I spoke with doctors who were rushing, doctors who were eating, doctors who were themselves unwell, doctors who did not want to share much information and doctors who could have talked for a much longer period.

The average age of participants was 41.7 years. One woman and two men participated in phone interviews while the remainder of participants were interviewed face-to-face.

The following table introduces the interview cohort:

Table 2 -   Interview Participants

Participants (Pseudonyms)	Sex	Age	Those Who Came Via Another Country other than their own
Julian	M	38	
Colin	M	41	
Nancy	F	47	
Rita	F	44	Via New Zealand
Andrew	M	41	Via Canada
Barry	M	40	Via United Kingdom
Tania	F	45	Via South Africa
Shaun	M	39	
Gary	M	35	
Alex	M	47	Via New Zealand

Before I began the interview process, I conducted some research on interview techniques. I needed to provide a framework where participants could express lived experience on their terms.

Van Manen (1990, pp.66-67) had some important advice to offer in that the interview process needs to be disciplined by the research question so that interviews do not go everywhere and nowhere. During an interview, it is vital to stay close to lived experience, asking the person to recall specific examples which allow for the whole experience to be explored to the fullest. Being careful to ask open ended questions rather than closed questions is also vital to exploring the whole experience, as closed questions often only receive either a 'yes' or 'no' response. During the process then, I was conscious of making

sure I asked participants how a particular situation affected them, rather than asking them whether or not a situation affected them.

At the beginning of each interview, I outlined the process and gave participants the information sheet. All participants subsequently signed the consent form. Phone interview participants received documentation via email. I asked each participant for some demographic details and always began with the question prompt: *"Why did you come to Australia"?* This proved (as it did for the focus group) an effective way to get the conversation started. Barry's response (2011, interview 6) was one example:

> In my country there was civil war, we had to leave for our kids for safety and English education, we came to beautiful Australia. They need me here too.

The rest of the interview I tried to keep as unstructured as possible, allowing the voice of the participant to direct the conversation. I wanted to create a space in which the doctor had freedom to voice what was most important for him or her. I also asked participants at the most appropriate time during the interview: *"Was there anything that shocked you about Australia?"* The most illuminating comment here was made by Julian who was visibly shocked when he shared the experience with me. On greeting him, one of Julian's first patients announced:

> Well finally someone from Europe, we're sick of those black ones from god knows where (2010, interview 1).

Being confronted with blatant racism on his first day at work was a shock. After repeating this testimony from a patient, Julian said: "This does not happen in Europe, I was just so shocked!"

Near the conclusion of the interview I always asked the question: *"If a former colleague from your country contacted you about coming to work in Australia, what would you*

advise"? I found that this question always provided an interesting range of responses. The responses were often quite lengthy and also included some humorous and surprising (from a Western perspective) advice. For example, Shaun wanted to alert his colleague to the terrible fact that: "They keep animals inside their houses here" (2012, interview 8). In Shaun's experience having animals inside is out of the question and a serious health concern for humans.

I was surprised to learn that in Colin's country driving a car is not necessarily the norm as it is in Australia. I found it difficult to imagine a doctor who does not drive. Colin realising that driving is important in Australia, thought it crucial for his colleague to: "Learn to drive before you come" (2010, interview 2).

Face to face interviews were challenging but overall constituted a fascinating and diverse contribution to the data. I was particularly challenged however by the phone interviews. On reflection, I would not recommend phone interviews for a qualitative study such as this one.

PHONE INTERVIEWS

Methodological texts generally advise that telephone mode is not well suited to a qualitative interview which seeks to encourage the collection of rich data. However, telephone interviews can offer more anonymity and savings in time and travel expenses (Irvine, Drew & Sainsbury 2013). No Face-to face interaction denies the researcher and participant the dynamic of non-verbal cues. This is a weakness associated with phone interviews but in this case it was the only viable method due to geographic location and participant choice (Berg 2004). An additional weaknesses of phone interviews can include the tendency for participants to speak less and interviews being shorter as well as much less researcher/participant social interaction prior to and at the conclusion of the interview

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(Irvine, Drew & Sainsbury 2013). This was the case in this study, the phone interviews were shorter and there was less interaction before and after than for the face-to-face interviews. An advantage of phone interviews however is that they offer the researcher an opportunity to make notes unobserved by the participant which can avoid participant distraction during the process. Due to the continuous advancement of technology there are better options available (such as Skype and Zoom) and in the future I would recommend those to geographically isolated participants instead. This being said the three doctors who participated in phone interviews specifically requested this mode of communication. Other technologies were not identified as their preference mode for an interview.

After each interview, I recorded my first memo notes. These constituted a reflection and clarification function for myself and provided a thumbnail sketch of the interview setting. I tried to write these as soon as possible so that my recollections were fresh. The following are introductory memo extracts from my notes made on reflection after each of the ten interviews:

JULIAN

> My first interview, (in his office). I think it went well. He was a relaxed, confident man. Unlike the focus group participants he came to Australia with his partner (a nurse) for adventure and travel rather than safety. They did not have any children or commitments and were so far loving being in a warm seaside location. If at any time they stopped loving being in Australia, they would simply just go back home (to Europe which he also considered safe). There wasn't an air of urgency or stress about him. He was due to sit exams for his full registration but wasn't concerned. His English was good which made for an easy interview (2010, interview 1).

COLIN

This was a rich interview (in his office). He was a little hard to understand at first but I found it got easier as time went on. He seemed to be really enjoying sharing his story and pleased that someone was asking him about his experiences. It was more informal than the first interview. The phone rang during our session and I was surprised that he snapped at the receptionist…"No I'm doing an interview now". He immediately returned to his relaxed and enthusiastic interview style. He did share some intense experiences though. He seemed genuinely keen to share as much as he could within our time together. Colin had successfully completed his registration exams…perhaps this was why he was so relaxed. The interview could have gone all afternoon (2010, interview 2).

NANCY

She was late and apologising when she arrived (at her office). She was clearly not well…a heavy cold. I wonder how her patients will feel about that when they see her today. Unlike the interview with Colin I was working hard to get her to respond at any length. All the way through she seemed a little distracted and towards the end she began to check her emails. I took that as my cue that she'd had enough. I feel like I worked hard for minimal responses but nevertheless I'm grateful for her time (2011, interview 3).

RITA

A great interview at a coffee shop. We sat outside and about half way through a very noisy bird decided to squawk repetitively (probably not happy that we only had coffee and no food scraps). It gave us a laugh anyway. A fascinating story…Rita for the wellbeing of her family (and herself) did not pursue medical registration in Australia. She supported her husband through the process and decided that it was far too stressful. Instead Rita was undertaking a PhD and hoped to work in public health research. This interview enlightened me to the family pressures involved in coming to another country. Rita's English was quite good but I felt that at times she struggled to express herself in the way she wanted and at times she seemed frustrated with her expression. I hope she felt satisfied that she was able to share in the way she wanted (2011, interview 4).

ANDREW

An outside interview over lunch at the IMG Forum in Brisbane. Andrew initially said he would give me 20 minutes…I guess better than nothing… but we actually talked for close to an hour, he was the one who kept the interview going. A very frank interview with a self-assured man who had no trouble expressing his feelings in perfect English. Even with the lunch time noises and distractions around us it was quite an intense interview. Unfortunately due to our being engrossed in the interview we actually missed out on lunch (2011, interview 5).

BARRY

An outside interview over coffee. A relaxed interview in the afternoon sun. He had a great sense of humour. Despite some awful experiences shared (such as discovering that he had to pay a taxi fare of $300.00 from the airport to his new Australian location) he managed to keep smiling. He enthusiastically talked about his practice and his hopes for life in Australia. A little difficult to understand at times. Our interview took place after a full day at the IMG forum in Brisbane. The combination of a long day and the sunshine seemed to help us both relax and sometimes we weren't as focused as we could have been (2011, interview 6).

TANIA

This was my first phone interview. I would have preferred face-to-face but it was not possible. Tania's responses were quite abrupt as if she had better things to do, it seemed as if she was thinking: "so let's get on with it". The interview took place before she started work for the day so perhaps she had other things on her mind. It was a bit like extracting teeth…I was working hard and getting the bare minimum in return. At times she covered the phone and said something to someone else in the room. I do not think her heart was in it. I was disappointed to some extent because Tania wore a headscarf and I was interested to know what she may have experienced as a result. Tania clearly did not want to pursue this aspect of the interview and stated: "My patients all respect my headscarf." I asked her if she could think of an example, perhaps a comment from a patient. Tania's response was to repeat the same statement above. I doubted that all her patients would have responded the same way but I realised that she was indicating to me that the subject was closed. Her English was excellent and she was very business-like (2011, interview 7).

SHAUN

My second phone interview. We were scheduled to speak on a Saturday morning after he had finished at the surgery. I phoned his home at 11.30am as agreed. His partner told me he had to stay late because of an emergency. I phoned back an hour later, this time he'd been summoned to a meeting with another doctor. Phone calls were made, phone calls were returned. We eventually spoke at 2.30pm. Shaun had just got home and was obviously very hungry. He walked around with me on his mobile at the same time he was rattling dishes and chewing on something. This was very distracting and to further complicate matters, the conversation was breaking up on occasions (he was way out in Western Qld. using a mobile phone and I was in Adelaide). Anyway, we soldiered on…all things considered, we had a great interview but unfortunately some of his responses were unintelligible due to poor phone reception. Shaun's English was excellent and very well-articulated. He laughed a lot, even when laughter didn't seem to be called for. This interview could have gone on and on… I wonder if it had of been face-to-face (2012, interview 8).

GARY

This was my third phone interview. Gary seemed very shy and was very softly spoken. I had to ask him to repeat himself or to speak up several times. Another one with me working hard…honestly I was keen to see it come to an end. He only offered minimal responses. Gary was located in his office and by some background noises I got the impression that he was looking through paperwork while talking with me. That's one problem with phone interviews you can't see what someone is doing. Perhaps Skype would have been better (2012, interview 9).

ALEX

A lively interview in his office. It was a very messy office with paperwork all over the place. Alex was enthusiastic about doing the interview and wanted to share just about everything he could think of. He was a big man, he towered over me and when we shook hands I was aware of his what seemed huge hand. It was soon evident that he was also a gentle man…It was a nice change…a breath of fresh air. In contrast to me working hard, it seemed to me that he was working hard and enjoying it. The only problem was that the more enthusiastic he became about something the faster he talked. This was challenging for my listening skills. It was a very short hour and a very frank discussion. I really enjoyed this one (2012, interview 10).

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Conducting interviews is a challenging task. Interviews with participants whose first language is one other than English was sometimes difficult, not only for me trying to hear the voice but I also sensed that it was difficult and perhaps frustrating for participants. Some doctors seemed to be not entirely satisfied that their command of English was sufficient to convey to me exactly what they wanted to express in terms of experience and feelings.   On a couple of occasions a participant would mention that it was hard to even find a suitable word or phrase in English to express what they wanted to say. Transcripts were emailed to individual doctors before their data was included in the research. I mentioned in the email that if I did not receive a response within two weeks from the date of the email, I would assume that the transcript was satisfactory. Only one doctor requested a minor change which resulted in a short statement deletion from his interview.

On reflection, as I reviewed my notes at the time of writing, it seems that the interviews I considered somewhat 'difficult' for one reason or another still took place, and despite difficulties, rendered data for this study. As the researcher, I have no right to approach interviews with expectations that need (in my opinion) to be met. Participants gave up what time they could or wanted to, revealed as much or as little of their experience as they wanted to. They shared their voices via the medium they selected.

Data collection was not only challenging but also rewarding. I was privileged to be invited into the personal spaces of the participants and privileged to be invited to hear their stories. These doctors undertake a major role in the provision of primary health care, especially in rural and remote areas. They are as a result an integral part of the community in which they practice. It was a generous gesture for them to allow a researcher to interrupt their lived experience. I was also privileged to be able to view the stories of the

doctors who made submissions to the Parliamentary inquiry. Many of the stories were stark and emotional accounts of personal experiences and I empathised with how I might feel if experiencing a similar journey. The narratives from the Parliamentary inquiry (2012) and Senate Committee (2016) will be included throughout subsequent chapters.

LIMITATIONS

Any study has limitations and this study was no exception. I began this study with the intention to focus on IMGs in rural and remote Queensland. This stance was adopted due to factors such as convenience and financial considerations. As already explained access to medical doctors was extremely difficult. I did not want to specifically travel to an interview location with significant cost involved, only to find that the potential participant was suddenly not available. I was living in Queensland as were all participants. As a result my initial participants resembled a convenience sample in that they were closer and potentially more easily accessed (Berg 2004). This stance resulted in my data (1 focus group and 10 interviews) based solely from Queensland. However, because I did travel to a destination where IMGs from all over Queensland met, not only were costs minimised but the data from interviews conducted at and after that event from contacts made there, produced data from far North Queensland, Central, Western and Southern Queensland regions. Later, the submissions to the 2012 Parliamentary Inquiry and the submissions to the 2016 Senate Community Affairs References Committee provided a more diverse, Australia wide representation of the voice.

I came to realise that a study based only on Queensland was too narrow and that IMGs across Australia experienced similar situations. As I began to analyse my interviews, many questions about why I was finding what I was emerged and it became obvious that this study had to encompass more voices. The dread set in…I had to somehow obtain

some funding to support my expenses to collect more data from outside Queensland. I had the opportunity to speak to a researcher who had interviewed medical doctors. I told her of my difficult recruitment journey and asked her if she had any tips. She mentioned that the only way to ensure interviews was to offer participants money. She indicated a substantial payment not something like a $20.00 voucher. This confirmed my dilemma about funding. Even worse was the thought of trying to recruit more IMGs for interviews. I thoroughly enjoyed the interviews I had already conducted and the complexity, diversity each one offered. It was the actual successful organisation of interviews which was daunting. I asked myself, how many more interviews should I seek? Another perfectly timed fortuitous moment saved the day! Another source of rich data from around Australia became available by way of a Parliamentary Inquiry.

THE 2012 PARLIAMENTARY INQUIRY – LOST IN THE LABYRINTH

The motion for an inquiry was successfully put forward by Bruce Scott, member for Maranoa on the 18th October 2010. This occurred after much heated debate about various aspects related to the treatment of IMGs in Australia by the system. As a result, On Tuesday 23 November 2010 the then Minister for Health and Ageing, Hon. Nicola Roxon MP, announced that she would task the House of Representatives Standing Committee on Health and Ageing to inquire into and report on Registration Processes and Support for Overseas Trained Doctors.

The terms of reference for the Committee stated: "Recognising the vital role of colleges in setting and maintaining high standards for the registration of OTDs, the Committee will:

1. explore current administrative processes and accountability measures to determine if there are ways OTDs could better understand colleges' assessment processes, appeal mechanisms could be clarified, and the community better understand and accept registration decisions:

2. report on the support programs available through the Commonwealth and State and Territory governments, professional organisations and colleges to assist OTDs to meet registration requirements, and provide suggestions for the enhancement and integration of these programs; and

3. suggest ways to remove impediments and promote pathways for OTDs to achieve full Australian qualification, particularly in regional areas, without lowering the necessary standards required by colleges and regulatory bodies" (House of Representatives Standing Committee on Health and Ageing 2012).

The House of Representatives Standing Committee noted in its March 2012 Report entitled *Lost in the Labyrinth* the following significantly disturbing information: Almost one third of IMGs who made submissions requested anonymity, citing fears that their chances of progressing through accreditation to registration would be compromised. The committee was also approached by IMGs, keen to share their views informally, but unable to make formal submissions fearing negative consequences (House of Representatives Standing Committee on Health and Ageing 2012, p.x).

The committee conducted twenty one public hearings throughout Australia in every State and Territory in twelve different cities. The committee took direct evidence from 145 witnesses during the public hearings. They received 175 submissions from IMGs and interested others from across Australia as well as 22 supplementary submissions. From the total of 216 submissions, 109 were from IMGs and 91 from the various organisations and agencies involved in the registration, regulation, training and support of IMGs. The stories contributed additional, robust, data to the voices already at the centre of this study. I worked my way through the submissions with my primary focus on the 109 from IMGs. Although many of the submissions echoed aspects of experience which were also raised in the focus group and interviews of my study, these voices were different. IMGs recorded their experiences in writing to the inquiry committee. My interviews, were largely

unstructured, were less formal and included humour at times. In contrast, the experiences communicated in the submissions to the committee were first-hand accounts untouched or unfiltered by the influence of the researcher. Many were more focused on the journey or struggle with aspects of the system and more formal, they came directly from the IMG. These accounts were made up of exactly what a particular IMG wanted to say and how he or she wanted to say it. Some submissions were stark accounts of disturbing experiences, in some cases I was appalled by what I read and reduced to tears. I was in disbelief that medical practitioners in Australia could experience such unpleasant and even traumatic interactions and events that in the worse cases adversely impacted their physical and mental health.

Submissions made by other individuals, organisations and groups provided a rich source of background knowledge, opinions and critiques. These proved invaluable as I was able to gain an insight into how parts of the system viewed the current situation for IMGs as well as the recommendations they made to improve the registration processes for and support of these doctors.

An additional source of data became available in 2016 by way of The Senate Community Affairs References Committee on Medical Complaints Process in Australia. On 2nd February 2016 the Senate referred the medical complaints process to the committee for inquiry and report. The committee received 129 submissions and held two public hearings. Unlike the 2012 Parliamentary Inquiry which was tasked with inquiry related to IMGs specifically, this inquiry while receiving many submissions from IMGs, was also open to submissions from Australian trained medical doctors, medical students, family members, organisations and associations. The 2016 Senate Inquiry's primary focus was on the intersection between bullying and harassment in Australia's medical profession and the

medical complaints process. This timely inquiry was initiated at the same time as the voices in the media were revealing an ugly side of medicine, a toxic culture within the profession. The terms of reference for the committee below show the broad scope of the inquiry:

1. the prevalence of bullying and harassment in Australia's medical profession;

2. any barriers, whether real or perceived, to medical practitioners reporting bullying and harassment;

3. the roles of the Medical Board of Australia, the Australian Health Practitioners Regulation Agency and other relevant organisations in managing investigations into the professional conduct (including allegations of bullying and harassment), performance or health of a registered medical practitioner or student;

4. the operation of the *Health Practitioners Regulation National Law Act 2009* (the National Law), particularly as it relates to the complaints handling process;

5. whether the National Registration and Accreditation Scheme, established under the National Law, results in better health outcomes for patients, and supports a world-class standard of medical care in Australia;

6. the benefits of 'benchmarking' complaints about complication rates of particular medical practitioners against complication rates for the same procedure against other similarly qualified and experienced medical practitioners when assessing complaints;

7. the desirability of requiring complainants to sign a declaration that their complaint is being made in good faith; and

8. any related matters

The submissions, along with the other data I collected, gave this study a broader and more comprehensive representation of the voice. Representation of voices in text however will always remain somewhat problematic. There is no perfect and exact representation as Lincoln and Denzin (1998, p.407) reminded:

> At its heart lies an inner tension, an ongoing dialectic, a contradiction, that will never be resolved. On the one hand there is the concern for validity, or certainty in the text as a form of isomorphism and authenticity. On the other hand there is the sure and certain knowledge that all texts are socially, historically, politically, and culturally located. We, like the texts we write, can never be transcendent.

How does a researcher engage with and present the voices of participants? This can be a complex task which is further complicated by the sometimes difficult expectation of presenting 'valid' data to the accepted methods of the academy. This became a concern for me. As I became more familiar with the voices in the data, the idea of somehow confining them only to the data chapter of the thesis did not sit well. I felt that not only was one chapter not able to give authentic representation of the voice but many voices would have to be left out. Voices would also be left out if they did not 'fit' into a selected couple of themes. I wanted to thread the voices throughout the thesis; to join the conversation and be immersed in the story. In this case the requirements of the discipline area within the academy were not able to embrace the way I needed to represent the voice. I was convinced to do the voices gifted to me justice, which I see as my responsibility, I needed a fresh approach. I viewed my responsibility as primarily to the participants in this study, not to the discipline or institution. In fact, following Foucault, Gariepy (2016) notes that If institutional and discipline politics results in the researcher reluctantly adhering to established institutionalised choices then the role of analysis concerned with uncovering

relations of and vehicles for power is meaningless.

The academy and nationalised codes of ethical conduct reflect a biased view based on both quantitative and Eurocentric preferences. Rules and established standards are being applied to researcher conduct and research design in ways that are incompatible and hostile to non-quantitative approaches. For example, Brown and Strega (2005, p.4) suggest that:

> By configuring research "subjects" in particular and limited ways, ethical review procedures are not only often problematic for social justice researchers but fail to consider ethical questions that are vitally important to them, such as voice, representation, and collaboration."

Ladson-Billings and Donnor (2005) join critical race theorists and others in the call for decolonisation of the academy, but question whether the academy has the ability to reconstruct itself into acceptance of a more flexible research framework. Foucault (1977, p.207) made the following illuminating comment:

> Intellectuals are no longer needed by the masses to gain knowledge: the masses know perfectly well, without illusion; they know far better than the intellectual and they are certainly capable of expressing themselves. But there exists a system of power which blocks, prohibits, and invalidates this discourse and this knowledge, a power not only found in manifest authority of censorship, but one that profoundly and subtly penetrates an entire societal network. Intellectuals are themselves agents of this system of power-the idea of their responsibility for "consciousness" and discourse forms part of the system.

What constitutes academic freedom is an individual construct of concept and practice. Gariepy (2016, p. xiii) notes that: "These notions, like all elements of public higher education, are inherently political; thus, they are disputed and frequently in conflict." I am a social justice researcher and as such, was required to do justice to and with the voices of this study.

Black American feminist Patricia Hill-Collins (1991, p.261) advanced exactly the research qualities I was seeking: "personal accountability, caring, the value of individual expressiveness, the capacity for empathy and the sharing of emotionality." I was not looking to discover and advance truth; rather I was seeking to uncover the knowledge constructed from IMG experience. I aligned myself with the intentions of Strega & Brown (2015, p.6):

> Our intention is to contribute to the project of having research reflect, both in terms of its processes and in terms of the knowledge it constructs, the experience, expertise, and concerns of those who have traditionally been marginalised in the research process and by widely held beliefs about what "counts" as knowledge.

A multi-disciplinary approach was required to allow me to break free from the boundaries of one discipline. This in turn empowered me to give maximum representation to the voice; as much as the scope of a doctoral thesis will allow.

REPRESENTATION OF THE VOICE

I like the work of Leslie Brown and Susan Strega (2005) (and Strega & Brown, 2015) who seek to situate social justice as mandatory for research processes and outcomes. Their appreciation of the political nature of research and push to understand different ways of being, knowing and doing resonate with me. Post-structuralism and feminist perspectives have contributed significantly to positionality, how the researcher positions themselves in relation to the participants in a study and reflexivity, the ongoing conversation the researcher has with themselves about interpretations of experiences. From a feminist poststructuralist stance Brown and Strega (2005) critique the ontological and epistemological ideas of traditional social science and advance the potential of emancipatory research methodology. I was also aware that I needed to acknowledge my participants as having active agency.

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As Moosa-Mitha (2005, pp. 65-66) asserts:

> Analyses of injustice are not predicated on one or more rigid forms of categorisation, nor are they normative, allowing for differences in self-identity and responses to oppression to be free from prescribed expectations. The self is also deeply dialogical or relational where it affects and is also affected by the multitude of relationships and experiences of oppression that it faces in society.

Perhaps I was seeking to have a romanticised or idealised view of the voice as centre and powerful as opposed to relegation in the margins. This research does seek to privilege the IMG voice, the voice of the other. However it must not silence, exclude, excuse or lose focus of the dominant power structures such as the system's role and influence in the construction of IMG experiences. The power differential became a central player in terms of exploring unequal social relations, systems and regimes. I agree with Choo and Ferree (2010, p.136): "more attention to system-level complexity can enrich micro-level analysis, tightening the connections among power relations, institutional contexts and lived experience". Post structuralism can be overly discourse dependent in that explanation of the social order is reproduced in discourse as if discourse was the only vehicle. Foucault's (1990) notion of biopower explores the techniques of power and knowledge and their interrelationship. The effect of these relationships is manifested across conduct in public and political discourse (Gariepy 2016; Macias 2015, p.232). The power of discourse should not be underestimated but not so clear is: "…how, why and by what social forces do some discourses supersede others and become hegemonic and thus organising and ruling documents" (Aguiar 2012, p.16). Ongoing patterns of economic inequalities between groups for example are not only situated within the economy via discourse but also in unequal access to the valued goods of society. C Wright Mills' (1959) concept of the sociological imagination played an important part in the formation of ideas and an underpinning structure to view and keep in focus the necessary components of analysis. A

model for sociological analysis must include four interdependent elements: historical, cultural, structural and critical. In terms of this study I found the addition of two more elements beneficial: economic and political.

I was keen to undertake analysis utilising an anti-oppressive theoretical framework in that these theories explore both social reality and the possibility for social justice. Intersectionality offered an emancipatory, anti-oppressive framework for the exploration of intersecting social phenomena and was therefore the best way to organise and explain the experiences of IMGs in Australia. Participants in this qualitative empirical study raised several critical issues which must not only impact on their integration into and retention in rural and remote practice, but also on the very wellbeing of the doctors and their families. Many of the issues revealed in this study were also raised in submissions to the Parliamentary Inquiry (2012) and the Senate Community Affairs Committee (2016). Together, this data set builds into themes and key ideas for discussion and exploration in subsequent chapters. This chapter has outlined the emergent design of the study. The participants have been introduced to the reader and my role and perspective as researcher has been discussed. My initial field work explorations have been expanded to putting the research processes in place. How I went about the process of data collection and important ethical considerations have also been raised.

CHAPTER TWO

THE LUCKY COUNTRY: IMGS AND THE HISTORY OF

ETHNOCENTRISM, XENOPHOBIA AND RACISM

Australia was invaded at the time of the heyday of unrestricted medical practice in Britain…unfettered by government intervention. Doctors in this period did not enjoy particularly high social status. British healers were a diverse lot… the physician, the surgeon, the barber, the bonesetter, the empiric, the midwife and the apothecary (Martyr 2002, p.191).

After two hundred years of medicine in Australia, no effort is spared to impose uniformity on the selection of those who would aspire to study medicine; and the training and standards of today's Medical Schools lead to a great uniformity not only in technical skills, but in professional outlook and style (Pearn 1988, p.33).

INTRODUCTION

Historical analysis can make a fundamental contribution towards understanding the present. Sociologists such as founding father Auguste Comte and later contemporary thinker C. Wright Mills particularly stressed the importance of both history and biography. Karl Marx (and Comte) believed that history was created in stages, with each stage consisting of the seeds for the next. Therefore, initially, a background history is provided to set the scene and flag significant stages. An appreciation of how Australia has evolved through the exploration of important influences and events that have helped shape the Australian nation provides the reader with a context for discussion. This chapter outlines the journey of western medicine in Australia from the discovery of the Great Southern Land and the medical practices of Indigenous Australians, to the arrival of the first IMGs,

the arrival of refugee IMGs, to the current context of medical practice. The thesis themes of class, race and nation assist to reveal the foundations of theme development and their intersection in the positioning of IMGs in medical practice and within Australian society. The emergence of the medical profession as a high status, powerful force with the ability to successfully lobby governments to further its own agenda becomes evident. The positon of status and power afforded Australian trained medical doctors is perpetuated and reinforced via the development of the Australian nation and associated racism, xenophobia and ethnocentrism. History shows the development of a fearful nation, one which feels threatened by 'others'. Subsequently, medical doctors trained overseas begin to be regarded with suspicion eventually resulting in the perception of an inferior underclass status where their training and qualifications are questionable. This chapter reveals the emergence of an entrenched pattern of well documented, deliberate long standing discrimination against IMGs.

IN THE BEGINNING: THE INVASION OF AN ANCIENT LAND

Since the 16th century, the Portuguese, Dutch, Spanish and English had been trading in the Indian Ocean. It was the Dutchman Willem Janszoon of the Dutch East India Company who sighted the Western Australian coast in 1606 and Australia was named New Holland (Przygoda 2017). The long awaited Great Southern Land that explorers such as Marco Polo romanticised about had been discovered. The Dutch sought to expand their trade activities but did not find the potential resources they were hoping for and resumed their search for another potential Great Southern Land further east. Decades later in 1688 the first Englishman, William Dampier, set foot on the continent (Blong, Kemp & Chen 2016). Modern European exploration built to a climax in the 19th century.

Etherington and MacKenzie (2016, p.1) state that: "By this time exploration was ideologically charged, closely bound up with the extension of western empires, of white settlement across the world, as well as the development of all forms of scientific study." Dampier observed Indigenous Australians and described them as: "The miserablest people in the world, thus starting a trend to place them on the lowest rung of the scale of humanity" (Muecke & Shoemaker 2004, p.13). Fellow Englishman, Captain James Cook, while undertaking cartographic and scientific exploration of the Pacific, was also instructed to continue to search for the Great Southern Land. Cook found and mapped New Zealand then sailed on to find and claim Australia, the Great Southern Land. Cook landed on the east coast and in the name of King George the third on 21 August 1770 he took 'possession' (Steinberg 2016). It was not until January 1788 however that the first fleet arrived in Australia at Botany Bay. The French also showed interest in Australia with the view of potential colonial expansion (Ma Rhea 2016; Shellam et al. 2017) In fact, a French vessel even arrived a few days after the first fleet with orders to observe what the English were doing (Muecke & Shoemaker 2004). The new boat arrivals found a vast and diverse country with a challenging climate. The convicts who arrived in Australia were from the 'causal poor' and most were hardened criminals due to the harsh conditions they experienced in England. The new society they now found themselves in was an authoritarian society that further brutalised them and there was a rigid divide between the free and the penal. Broome (1994, p.24) explains:

> They were generally seen as inferior and useless by the gaolers and used as cheap labour. About 40 per cent of all male convicts in Australia were flogged for some misdemeanour…Less than one in five of the convicts were women, and even they were generally made as callous as the men by the environment that produced them.

From these very new beginnings in a 'new' land, class division and discrimination with

associated perceptions of who constituted superior and inferior peoples was quickly established, but what of the existing population, Australia's Indigenous population?

The Great Southern Land was also an ancient land (Breen, S 2008). Australia was the last continent discovered by Europeans but was the first continent for the Indigenous inhabitants. Imagine the perceived strangeness witnessed by the first people as they observed the actions and behaviours of the intruders.

AUSTRALIA'S FIRST PEOPLES

Indigenous Australians were the first peoples to occupy this country and their habitation of the Australian continent constitutes the longest continual occupation by an ancient culture anywhere on earth (Muecke & Shoemaker 2004). Evidence gained through the use of radio-carbon dating on artefacts and human remains confirmed Indigenous occupation of Australia for at least 60,000 years. How much earlier according to Broome (1994) is unclear but charcoal dated at 100,000 years was found near Lake George in Canberra, possibly confirmation of human habitation. Moreover, Maxwell-Stewart (2016, p.359) claims that Australia's "geological history extends a further 3,070 million years."

Many Indigenous people however, reject this western view and believe that Indigenous Australians were created by the ancestral spirit beings. These supernatural beings also created the earth and the flora and fauna during the Dreamtime, which occurred at the beginning of time (Arbon 2008; Devere, Te Maiharoa & Synott 2017). The beginning of time does not have a date, and many Indigenous people dispute the established western ideas around migration theories (Stanner 1987). For example, many historians believe that Indigenous people arrived in Australia during the Pleistocene period when low sea levels allowed access from Southeast Asia via the Indonesian Archipelago.

Many Indigenous people do not acknowledge a heritage that has origins outside of Australia. "Their heritage is of being here as if forever" (Partington 1998, p.27). Country for an Indigenous Australian was a complex idea. Dunn (2017, p.76) explains the concept of country as:

> An interweaving of physical, territorial and cultural understandings of a place. While it could indeed refer to the physical landscape, country was more multidimensional as it also identified the people who lived in or managed an area, the animals, the waterways, the earth, the soil, the sky and the underground. Everyone had a country, an area of land defined by their sites and knowledge and under the care and management of a particular group. In their own country, a person might see the landscape shaped through their understanding of the Dreaming and filled with sites and stories that explained the logic of the place.

When Europeans invaded in 1788, there were approximately 300,000 Indigenous Australians living in Australia. The population was divided into over 500 tribes each with their own distinct territory, history, dialect, customs and culture (Broom, R 1994, p.11).Therefore, it can be argued, that multiculturalism is not a relatively new concept in Australia. Indigenous societies and their structures show that the continent has always been divided into many different, distinct Indigenous nations (Shellam et al. 2017). Moreover, Indigenous Australians view and identify with Australia and each other in relation to this perspective which still exists strongly today (see the map of Aboriginal Australia, Horton 1994).

At the time of invasion, Indigenous populations were highly concentrated in coastal areas where there was an abundance of food resources, water and shelter. In desert areas other Indigenous populations managed to adapt to the conditions. "Over millennia the first Australians succeeded to develop strategies for a nomadic, hunter-gatherer lifestyle whether they were located in rainforests, on coastal foreshores, in cold alpine regions or in arid seemingly waterless deserts" (Covacevich 1990, p.61). Indigenous Australians while

living in Australia, a relatively geographically isolated continent, were not totally isolated from others. They had contact with close neighbours from the north such as Torres Strait Islander peoples and peoples from Papua New Guinea and the Indonesian islands. The first Australians also established trade relationships with their neighbours. For example, Macassan fisherman negotiated with the peoples of Arnhem Land to harvest trepang[7] in Australia's north. The seasonal visits from these neighbours also provided trade and skill exchange opportunities (Shellam et al. 2017)   European invaders changed the country and the way of life of the traditional owners, they became the dominant power. Australia's first peoples and the invaders were culturally poles apart.

Indigenous Australians had survived for thousands of years in a non-materialist ethos which embraced continuity over change, whereas the European invaders came with a background of divide and conquer and the entrenched ideals of change and development conducive to an industrial society. Indigenous cultures were undermined by the frontier of intrusion perpetuated by the invaders who brought about the massacre and dispossession from land of many Indigenous peoples throughout Australia (Broom, R 1994; Lippmann 1991; Nettelback 2017; Reynolds 1987, 2013). As a result, culture and language was lost on a genocidal level (Partington 1998). According to Lippmann (1991) the Europeans did not place any value on Indigenous cultures. Indigenous peoples were described by the invaders as: "wandering bands of savages still living in the Stone Age. This perception was the beginning of a deep and long-lasting cultural misapprehension" (Muecke & Shoemaker 2004, p.11). It was assumed that a low level of western education coupled with Christianity would eventually 'civilise' Australia's Indigenous people (Kidd, R 2008; Nettelback 2017).

The invaders had no idea that they were disrupting highly structured knowledge systems,

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[7] A seafood delicacy also known as beche- de-mer or sea cucumber.

as Sykes (1986, p.30) explained:

> In traditional society, there were many highly skilled people – not only doctors and lawyers, but teachers, geographers, chemists, botanists, and people trained in communications (not only with the living, but also with nature and the spirit world). We had linguists, historians, etc., and while everybody was obliged to learn a little about most of these things, it was the lifetime duty of some people to carry the whole knowledge of each subject and pass it on to whoever would be replacing them.

Doctors or healers in Indigenous Australian cultures were the only authentic, legitimate medical practitioners in the ancient Australian continent until Europeans arrived (Reid, Taylor & Hayes 2016). Their ancient healing practices existed well before the development of western medicine: "Contemporary oral history of surviving Aboriginal lore provides a glimpse of the world's longest surviving medical practices…these medical procedures predate the teachings of Hippocrates and Galen, not by centuries but by millennia" 8 (Covacevich 1990, p.61). The Indigenous healer held great power and was awarded great respect. Much of illness and death were caused by supernatural influences. Evil spirits could cause people to become sick and sickness could result from breaking the law and payback, or the wind and the moon could be agents of illness (May 1988). Indigenous Australians today may still seek treatment from traditional healers. As Reid, Taylor and Hayes (2016, p.154) note:

> While Indigenous healers might now be contacted by phone, the principles underlying their practice remain consistent and tied to the unique but diverse world-views of Indigenous peoples. Indigenous or traditional healers are generally identified by other healers and then educated in the practice, which focuses largely on maintaining holistic well-being. Physical, psychological and social well-being are integrated in Indigenous conceptualisations of

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[8]Greek physician Hippocrates (600-500BC) developed the forerunner of western medicine based on reason rather than religion. Galen, (130-200AD) furthered Hippocratic beliefs and established a medical tradition that lasted for the next 1,000 years by merging all existing medical knowledge at the time.

health, and this traditional model still operates today throughout some parts of Australia.

Some Europeans embraced aspects of Indigenous healing especially herbal/plant remedies which, because they had been developed for the Australian context, were more effective. Others however dismissed it as "witchcraft and mumbo-jumbo…yet this medicine like other forms of non-orthodox health care has still survived" (Martyr 2002, p.15). Over time, traditional medicine was systematically overwhelmed but not eliminated by the new western medical regime. The first medical doctors trained overseas to come to Australia were naval surgeons and explorers.

THE FIRST IMGs

Naval surgeons accompanied the exploration expeditions that mapped the Australian coast. The presence of a surgeon brought a sense of comfort and safety to those who set out with uncertainty to explore the unknown. Upon arrival in 1788, the first fleet had a company of nine doctors. Surgeon John Irving came with the first fleet as a convict (convicted for grand larceny) and served as the surgeon on the Prince of Wales, he eventually became the first convict in New South Wales to be emancipated (Simpson 1988). Not all surgeons did as well as John Irving, while some came with good surgical backgrounds, others came with questionable surgical backgrounds and unstable personalities. Some did not arrive at all, such as the inebriated surgeon who cut his own throat five days after his ship The Clifton set sail from England (Woolcock 1988). Others fell into disrepute after arrival in Australia such as Irish surgeon James Murray who became a psychopath and murderer and as a result, was rejected as a member of the medical profession. Some surgeons went on to occupy different roles such as Jamison, Balmain and Arndell who all became magistrates. Some surgeons became philanthropists

and wealthy land owners. Scottish surgeon Daniel Curdie became a Senator of Melbourne University and Englishman George Bennett was a founder of the Faculty of Medicine at the University of Sydney (Pearn 1988; Pearn & Cobcroft 1990). Due to the penal nature of the colony, for 50 years after 1788: "The crown supplied almost all medical care for free settlers, as well as convicts, through the salaried Colonial Medical Service (CMS) (Lewis 2014, p.S5). In her discussion of the history of medicine in Australia, Martyr (2002, p.26) claims: "Immigrants, convicts and ship's doctors…brought with them all the hotch-potch conventional wisdoms, empiricism, rationalism, pseudo-science and inspired guesswork that made up British medicine in the late 1700s". The England the first fleet left behind was undergoing great social change and political and economic transformation. Medicine was just beginning to develop.

It was the time of the industrial revolution which saw the shift from feudalism to a new industrial society and the French Revolution (1789) which saw the end of aristocratic rule and the rise of the middle class, was soon to follow. There was a huge population shift from an agrarian society into the cities. In England crime increased dramatically as people strove to survive in cities which did not have the infrastructure to cope with dramatic population increases. Subsequently, prisons overflowed with inmates often convicted of petty crimes (see Steinberg, 2016). The transportation of convicts to penal colonies became a practice adopted by the French and British. From 1610 to the 1770s England transported convicts, political prisoners and prisoners of war from Scotland and Ireland to its American colonies. The American war of independence (1775) however saw the British defeated and as a result, the transportation of convicts to their American colonies was no longer an available option. The British therefore, required an alternative location for transportation.

The Australian continent represented a new solution for convict transportation and became a penal colony. Ships from England began with the first fleet in 1788 and transportation continued until 1868. The first fleet numbered 1,350 people, 759 of those were convicts. The voyage from England covered 15,000 miles and took 8 months and 1 week. There were forty eight deaths including seventeen convicts who died before the fleet left England (Nugent 2003; Simpson 1988). Quigley (2017, p.139) notes: "approximately one hundred and sixty thousand convicts were transported from the British Isles to Australia in the period 1787-1868. The ship's surgeon was required to treat all those on board ship, from convicts to vice-regal patients (Pearn 1988). The most common diseases suffered by passengers were transmitted by infected arthropod species such as mosquitoes, fleas and ticks and consisted of infections or parasitic illnesses. Venereal diseases were also common as well as pulmonary diseases such as tuberculosis and nutritional diseases such as scurvy (Cossart 2014; Mcleod 1988). Medical treatment at the time would, by today's standards, be considered barbaric and included clinical methods such as blood-letting, restraining, blistering and purging.

Europe was enjoying the music of composers such as Vivaldi, Bach and Mozart and the art of Turner and Constable, simultaneously poverty, malnutrition and disease impacted large segments of European society (Simpson, 1988, p.25). In Europe, caring for the sick was the responsibility of priests until a medical school was established at Salerno, Italy in 1200. This saw the practice of medicine shift from the control of the church to the laity. Women were also the carers at home, where they nursed the sick, made up home remedies, delivered babies and were agents in disease prevention (Doherty 2016). Women provided the primary care in the early days of the colony and there were self-help medical books available to inform diagnosis and treatment such as The Poor Man's Medicine Chest (1791). The contribution of women to healing went mostly unrecorded

(Martyr 2002). There were not enough doctors in Australia as the frontier of expansion moved into rural areas. Many people learned to either do without medical advice or accessed untrained and non-registered health practitioners, as the distance to travel to see a trained doctor could take as long as one week.

Scientific enquiry further developed which in turn expanded medical knowledge of disease and treatments (Cossart 2014; Thearle 1990). According to Lawrence and Brown (2016, p.150):

> Ideas of scientific exploration were fuelling a generation of men who opened the world to colonization and when surgeons were beginning to establish themselves as the major social and therapeutic presence in urban medicine.

Formal medical qualifications as required by today's standards however did not exist in 1788. In fact, it was not until the Medical Act of 1858 that English and Scottish doctors received university based training. Instead, medical students received most of their training through apprenticeship to a practitioner. "Many who completed their articles of apprenticeship went to medical school to 'top up' their medical training but many were not awarded a formal degree in medicine"(Pearn & Cobcroft 1990, p.51). As Lewis (2014, p.S5) notes:

> Under the early colonial economic and social conditions, the traditional English division of the profession into status groups of physicians, surgeons and apothecaries (recognised from 1815 in England as general practitioners) could simply not be transplanted.

It was not until the end of the 19th century however, that the foundation of medicine as practiced in today's society was laid (Lawrence & Brown 2016; Thearle 1990). After the colony was established, one of the primary tasks for Governor Phillip, (governor from 1788 – 1792) was to explore and map the continent. Explorers were keen to venture into the unknown and unmapped Australian interior. Land parties began to explore inland from

Sydney and doctors were amongst those who volunteered to join expeditions. Some doctors joined initiatives sponsored by the British government, while others came to provide medical skills to exploration sponsored by private enterprise. Unlike the naval surgeons, these doctors were civilians who sought adventure. Pearn and Cobcroft (1990, p.59) note that: "Medicine has always been a passport to adventure and to a wider world". The doctor explorers had an interest in natural history and the discovery of new plants and animals. Some doctors were also interested in Indigenous Australians and several of them recorded languages. In some instances, these records of vocabulary and syntax were of languages now lost (Pearn & Cobcroft 1990).

There was much about the unique Australian environment to learn however and in terms of medicine, especially preventive medicine; the newcomers remained virtually ignorant of the already established practices of Australia's Indigenous peoples.

> The lifestyles and medical practices of the Australian Aborigines had solved many of the problems which were to reappear when new waves of immigrants…pushed into the unknown in the 19th century. Many of the lessons of preventive medicine, formally evolved over millennia, had to be relearned by the often paternalistic and patronising…who displaced the original inhabitants (Pearn & Cobcroft 1990, p.iv).

The invaders did not generally experience good health, many convicts arrived already diseased (Cossart 2014; Lewis 2014). Common illnesses thrived such as diarrhoea and scurvy (Quigley 2017). As described by Charles Bowly : "My hands are hardly ever sound; the sun burns them into sores and then the place festers and spreads gradually over the back of the hand…it is produced from a want of fresh vegetables" (Martyr 2002, p.35). Spedding and Best (2015, p.2) note that " naval surgeon, James Lind, performed the first empirical study of scurvy in 1753, finding that citrus fruits were more helpful than salt water purges or patent medicine."   Indigenous Australians did not suffer from scurvy while they

were able to continue a hunter gather lifestyle based on intimate knowledge of local food sources. Unfortunately though, Indigenous Australians did not possess any immunity to the new diseases and when traditional food quest practices were also impacted there were many deaths. Broome (1994, p.58) explains:

> Once contact was made with Europeans…smallpox, influenza, measles and the common cold swept away many Aborigines. Even 20 years after first contact epidemics raged…lung and chest complaints killed hundreds…and later tuberculosis…and the most insidious infection venereal disease. Static living and their new diet not only caused malnutrition, but appeared to raise their blood pressure, cholesterol levels and induce diabetes.

There was much illness and disease for the new IMGs to treat but the colony depended upon imported drugs which could: "melt, become rancid or otherwise decompose en route, making them unreliable, and adding to the unpredictability of medical treatment" (Martyr 2002, p.39). The new environment must have been extremely challenging not only in terms of medical practice but also the stark change in climate, lifestyle and geographic isolation. How did IMGs adjust, did they find a solidarity amongst themselves? Did they have power and high status in the new colony?

CLASS

Lawrence and Brown (2016, pp. 149-150) in their discussion of the centralising role of the professions and science in colonisation argue that: "Surgeons boasted that their profession offered the opportunity for ordinary men to rise in society. Along with geographical explorers, they pointed to the modest origin of many of their number." Some Australian and British historians hold the view that doctors who went to the colonies were second rate and as a result could not find work in Britain. Doctors debarred in the United Kingdom were allowed to practise in the colonies without penalty. In British medical

culture at the time, one could be an excellent doctor but if one did not have the essential connections within the profession, the opportunity to emigrate could become an attractive option. Martyr (2002, p.42) argues:

> British medical culture in the 1800s was exclusive, and best served by those who had an entrée to the right medical schools, hospitals and societies. A hint toward this can be found in often anti-establishment views expressed in Australian medical journalism of the 19th century, where the insular and elitist nature of the British medical world is frequently criticised.

This is interesting and implies that the first IMGs became a cohesive professional group. Perhaps the vast distance between England and Australia also allowed IMGs to distance themselves from their past colleagues and the established British medical culture. Perhaps an IMG without the essential connections in British medical terms could be empowered in the new colony? It can be argued that despite their diversity, the first fleet surgeons did find a sense of professional solidarity. Archives provide evidence of this when surgeon Arthur Bowes Smyth on the 11th of February 1788 recorded the search for local plants to treat scurvy. His writing referred to colleagues as: "the Gentlemen of the Faculty in the Settlement". This indicated that the first fleet surgeons regarded themselves as a 'Faculty' as in the 'Faculty of Medicine' (Pearn 1988, p.53). Lewis (2014, p.S6) argues that "colonial doctors were eager to establish external symbols of solidarity, as well as to defend themselves against the considerable competition from irregulars." This was an imperative as the public was able to choose between orthodox and unorthodox practitioners.

Despite surgeons being considered as men of the Settlement Upper Class, some married convicts (Pearn 1988). For example, Thomas Arndell married his convict housekeeper and mother of their six children in 1807. Even the most senior surgeon, Surgeon General John White married a convict. Acceptance by a professional upper class for marriage with convicts was previously unheard of. Pearn (1988, p.54) argues: …"marriage with convicts,

by their personal example, cannot be overstated as one of the significant socialising influences operative in that society". However, while some surgeons lived comfortable lives with convict partners, some did not provide for their widows to care for their families after they had died. Perhaps some of these marriages did not attract the level of commitment and responsibility usually associated with a 'good' marriage made in England.

The new arrivals were born, raised and socialised into the highly structured class system of their home lands and some of these traditions and prejudices were bound to transfer to the colonies. They were fiercely divided by ethnicity and religion and were known as belonging to the three kingdoms (English, Scots and Irish). Hirst (2014, p.143) asserts that: "In their home countries they had long been enemies of one another." In addition, they were divided between Catholic and Protestant. The new immigrants provided their labour power to build a new nation aligned with a capitalist system. "The new nation had a class structure and race, cultural and gender relations that reflected the dominant groups and their interests, and the society was stratified in terms of race, ethnicity, gender and class" (Pettman 1992, p.7). Science and medicine and associated developments supported the emerging structure of the new Australian nation.

Fashions in Science and Medicine assisted the justification and perpetuation of old entrenched ideas. Phrenology, developed by German physician Franz Gall is a good example. This science was used in early 19th century Australian penal and medical practice. Phrenology sought to prove that the size and form of the skull was related to the brain and personality. The measuring of skulls, especially so called primitive skulls became an obsession with Phrenologists who claimed that level of intelligence, the cause of insanity and the predisposition to commit crimes were all related to brain size (Hughes 2017; Van Wyhe 2004). Phrenology was discredited by 1848 and Martyr (2002, p.48)

states that it constituted: "a profound embarrassment in the history of science and the history of medicine." Nevertheless, Phrenology had significant influence in the formation of opinion and was used to justify the idea of European superiority over so called "lesser" races such as the Maori of New Zealand and Australia's Indigenous population, which were classified as physiologically criminal (Broom, R 1994). In fact, Australia's new population generally was viewed by some British Phrenologists as criminalised by the continued importation of convicts who were classed as undesirable types. Phrenology also served to uphold old prejudices as Martyr (2002, p.51) argues: "To spot a criminal type also simply confirmed existing prejudices of racial inferiority and inherent criminality, not just of non-whites but of the Irish and Welch." Charles Darwin's Origin of Species (1859) when manipulated to suit the inferiority agenda, also constituted a convenient theory to absolve European Australians from responsibility for the decline of the Indigenous population. Darwin proposed survival of the fittest to explain evolution in the plant and animal worlds. Many who claimed superiority of the white race argued that Darwin's ideas offered an explanation for the depopulation of black races as a result of the process of European colonisation (see Van Wyhe, 2004). The expansion of this myth led to some bizarre claims, even from reportedly reputable sources such as The Australasian Anthropological Journal which in 1896 alleged:

> Once Aborigines passed puberty 'the sutures of the cranium begin to consolidate, and the forepart of the brain ceases to develop as it does in other races'. By the end of the nineteenth century, the general public became very familiar with phrases like 'survival of the fittest' and 'white superiority'. That was all the theory they needed to support their simple and popular form of racist thinking (Broom, R 1994, p.93).

The first Australians found themselves reduced to an ethic minority in their own country, they were relegated to an underclass position which persisted over time and still remains today. Narratives of 'Australianness' often omit Indigenous histories and identities from

nationalist discourse. Plage et. al (2016, p.3) in their discussion on cosmopolitanism, nationalism and the concept of a 'fair go' state: "Eurocentric or neo-colonial cosmopolitanism may normalize previous colonial relationships at the expense of Indigenous populations." In fact, Indigenous Australians were virtually dismissed by the dominant society and were not even officially counted in the census until 1967 (Gunstone 2017; Pettman 1992). A large wave of Chinese attracted to the goldfields during the 1850s saw the arrival of a new ethnic minority which was quickly assigned an inferior status and relegated to another underclass (Beattie 2016). Walker (1999, p.2) argues that: "the Chinese were commonly depicted as the forerunners of a subtle invasion". Moreover, Australia has always managed to racialise different groups at different times. Following a 1991 Human Rights and Equal Opportunity Commission report, Pettman (1992, p.9) sums up:

> In Australia in the late nineteenth century not only the Chinese but also the Irish were represented as belonging to a race apart, presumed to have essential qualities by virtue of their birth identities. In the 1930s Italians were not white enough; and post-Second World War migrants from southern Europe were also singled out, though more often using language or country of origin to predict otherness. 'Asians' became the most visible non-Aboriginal targets of racism in the 1980s, while Muslim and Arab Australians are the most recent groups to be racialized and victimised.

I argue that IMGs, too, became an underclass and came to be viewed as such within the medical profession in Australia. As the new dominant society in the colony evolved and developed, the first IMGs became the established Australian medical profession. After the emergence of the first Australian medical school at the University of Melbourne in 1862 (Lewis, 2014), the profession in Australia, built on the foundations of the first IMGs, now graduated the first Australian trained doctors (there were only four medical schools in Australia by 1938). As the colony became more westernised, the IMGs who now arrived from overseas became labelled as foreign. Subsequently, the long history of IMGs as an

underclass within an elite profession began. This was particularly prevalent during periods of war and the subsequent immigration of displaced persons. As a result, many doctors now arrived in Australia as refugees.

REFUGEE IMGS

During world war one (1914-1918) people of German origin in Australia, including doctors trained in Germany and practising in Australia bore the brunt of anti-German sentiment. A xenophobic mindset developed and consequently a non-acceptance of doctors now considered medical outsiders. Kamien (2006) believes that this was especially evident if IMGs threatened the 'medical turf' of Australian trained doctors. In the 1930s, due to the persecution of Jewish populations in Europe, Australia experienced a cohort of fleeing refugee Jewish doctors from Germany as well as countries such as Russia, Poland and Austria (Iredale 2009). World war two (1939-1945) created a catastrophic dislocation of populations in Europe with an unprecedented 12 million people made homeless (Kunz 1975; Markus & Semyonov 2010). Many people in Europe, while not seeking refuge from ethnic persecution, sought refuge from new adverse political change (Glynn & Kleist 2012). Post war Australia was in desperate need to boost the labour force and felt particularly vulnerable (especially from the 'yellow peril' of the pacific) as a large country with a small population of approximately seven million (Hirst 2014, p.152). The realisation of Australia's close proximity to Asia was especially heightened by the Japanese advances on the Australian coast during the war. Walker (1999, pp 3-4) sums up views at the time:

> Australia appeared as a vulnerable continent subject either to direct attack from the East or to a more gradual loss of its British heritage at the hands of Asian intruders…Australians saw themselves as an outpost of Europe facing Asia.

These circumstances led the Australian Government to introduce a Displaced Persons

migration scheme (Maley 2016; Panayi 2016). Determined to, as rapidly as possible, increase the Australian population, the scheme was fully government sponsored. According to Kunz (1975, p.1) "Australia admitted 170,000 Displaced Persons, one of the most prominent countries of re-settlement, running second only to the United States". This resulted in an influx of Displaced Persons which exposed Australians, who had mostly taken on British norms and values, to a tide of diverse non-British outsiders. Kunz (1975, p.2) contends that: "displaced persons became human guinea pigs on whom was tested the social and political feasibility of the government's intention". This was a new and challenging situation for Australia, displaced persons constituted the 'other'.

Displaced persons included medical doctors from post-war Europe. By 1947 the International Refugee Organisation (IRO) estimated their numbers at more than two and a half thousand. This number grew to approximately three thousand by 1949 with renewed movement by doctors mostly from Hungary and Czechoslovakia (Kunz 1975, p.7). The IRO provided screening for these doctors as many had lost their credentials during the war. Screening was set up in the United States zone of Hungary and the British zone of Germany. The story of Robert, born in Germany in 1922 illustrates his experience of Australia through the eyes of a German, Jewish migrant. Robert's father was a medical doctor and he lived in a very good street in Berlin, a street of doctors and lawyers and professional men. Robert recalls having a comfortable life and that Doctors in Germany were better off compared with the rest of the community. When Hitler came to power and life in Germany became extremely dangerous for Jews, he was taken to England by a Quaker organisation; the Movement for the Care of Children. Eventually Robert found himself in Australia, and after the war became an Australian citizen.

Robert remembers life in Australia:

> "Migrants weren't called "New Australians" in those days. We were refugees-"bloody reffos" was the common term-just like some people today say "Wogs" and "Dagoes". On the whole Australians were not friendly to migrants. They were so far away from Europe that they had no experience of people who came from other cultures; they were intolerant of anyone who couldn't speak English. Drunks would abuse you in the trams. Australians didn't even like the English much, and "bloody reffos", European Jews, were the end" (Lowenstein and Loh, 1977, p.57).

Doctors from overseas were required to undertake examinations. Successful doctors received a Certificate of Professional Status and were listed in the Professional Medical Register. The IRO via memorandum approached the Interim Commission of the World Health Organisation (WHO) regarding displaced persons medical practitioners and as a result, a resolution was made. The resolution requested governments to indicate the terms under which these doctors could practice medicine in their countries. Australia's response to this request in 1948 marked the beginning of discriminatory practices which continue to plague IMGs today. The Australian Health Department's response advised the WHO: "under existing conditions, medical practitioners holding only foreign degrees would not be granted registration in Australia to practise their profession" (Kunz 1975, p.8). Denied registration, doctors from overseas were directed to undergo a minimum of three years training at Australian medical schools. This was to begin a now common practice, to view IMGs as an underclass through non-acceptance of their qualifications as fully comparable to Australian medical qualifications. There was a growing anti-foreign sentiment in the Australian population and Australian doctors were no exception.

Widespread anti-foreign rhetoric infiltrated into the ranks of Australian doctors, fuelling their xenophobic non-acceptance of foreign medical practitioners. This was especially the case if it was perceived that established interests may be threatened by the newcomers

(Kamien, 2006; Iredale, 2009). Most displaced person doctors were specialists and subsequently viewed as a potential threat to Australian trained GPs. Even though displaced person doctors were considered inferior to and less competent than Australian trained doctors they were sometimes permitted to work in difficult and poorly paid positions. The AMA did not object to some displaced doctors being permitted to work as medical doctors in the Australian Antarctic and in Papua New Guinea. These locations were not attractive to Australian trained doctors and were also not considered threatening to their livelihoods (Kunz, 1988). So, it seems that perceived inferior overseas trained doctors were not suitable to serve the general Australian population, but were 'good enough', to practice in isolated, desolate places and on black people.

By 1938 there were only four medical schools in Australia (see Lewis, 2014) and there was public debate about a shortage of doctors (Committee for the Review of Practices for the Employment of Medical Practitioners in the NSW Health System, 1998, p.34). Adjustments to restrictions began to emerge. For example, in New South Wales, amendments in 1955 and again in 1957 saw 'preferred' IMGs usually from Commonwealth countries, granted temporary registration in stipulated locations for one year. After five years, full registration was possible. In 1957 the health minister in NSW was empowered to increase the number of doctors seeking 12 months temporary registration. The AMA objected and began a public attack against foreign doctors who were referred to as: "quacks and charlatans and as possessed of what may be termed eastern European standards of ethics" (Iredale 1987, p.123). A deficit discourse around assumed inferiority of IMG qualifications has a long history. The current rhetoric of the need to maintain high standards and a spirit of livelihood protection can be found back in the 1950s. According Kamien (2006, p.3) under persuasion from the AMA, the then NSW Premier, wrote to the Prime Minister advocating: "Alien and Refugee Doctors posed an unacceptable competition to Australian doctors who

had the highest standards of medical practice in the world." Refugee IMGs are still coming to Australia especially in light of increasing war and terrorism in areas such as the Middle East. Refugee IMGs are qualified medical doctors, a fact Australia seems to resist.

Many refugee doctors have made exceptional contributions to Australian society. For example, Dr Munjed Al Muderis who fled Saddam Hussein's Iraq for fear of execution, found himself on a boat from Indonesia, spent time in the now closed Curtin Detention Centre and eventually became a world leading osseointegration[9] surgeon (Al Muderis & Weaver 2014). Unfortunately, in view of the Turnbull government's current sovereign borders stance on asylum seekers and refugees, a skilled surgeon such as Dr Al Muderis, because he arrived in Australia via boat, would never (under any circumstances) be permitted to settle and work in Australia. The institutionalised foundations which underpin this extreme stance can be traced all the way back to 1901 when two significant events occurred; Federation which united Australia's colonies and the White Australia Policy.

FEDERATION

By the 1880s, many Australians began to identify with Australia as a great nation of brave pioneers rather than a nation with a weakening loyalty to Britain and Empire. A movement for the unification of the Australian colonies began. Hirst (2000, p.246) argues:

> Federation was in line with British Colonial Office policy, which encouraged
> the white settler colonies (Canada, New Zealand, South Africa and Australia)
> to become united, self-governing and self-sufficient 'dominions' within the
> imperial framework.

In 1901 the Australian colonies which had been settled and developed separately became unified as the Commonwealth of Australia. However while some argue that in 1901

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[9] This surgery involves a pioneering technique that enables amputees to walk again.

Australia became a nation-state, it is important to highlight that Australia did not have full international sovereignty.

Carter (2006, p.59) points out: …"nonetheless 'nationhood', in the form of an imagined community, had been achieved. The nation was imagined both as a united and a *separate* community with a common future-tied to but distinct from Britain's." Australia the nation was 'founded' but it was a nationalist Australia firmly intent on being white and English speaking (Lueck, Due & Augoustinos 2015). The White Australia Policy accompanied Federation.

THE WHITE AUSTRALIA POLICY

The 'new' nation of Australia endorsed by Federation's first Parliament was to be built on a foundation of white race unity. Australia's first peoples were black but that did not seem to pose a problem as it was assumed that the first peoples would die out. Although a few members of Parliament opposed the policy there was overwhelming community support. Arthur Calwell, first federal minister of Immigration proposed the Immigration Restriction Act of 1901 (commonly referred to as the White Australia Policy) (Maley 2016). Calwell, convinced the Australian public, while war was in recent memory, that a migration program was necessary for White Australia's protection. Essentially, the policy represented an overt institutionalisation of discrimination, racism and xenophobia. Only Europeans, preferably Northern Europeans could now immigrate to Australia. The ethnocentric policy therefore implied that the values and beliefs of people with white skin were superior to those of non-whites.

It was assumed that the British Empire would continue its power indefinitely and that white supremacy would always be embedded as valid (Riley 2016).The policy was progressively dismantled between 1949 and 1973.

Historian Henry Reynolds (2003, p. 161) wrote:

> The White Australia policy came to be a source of international embarrassment, a political, moral and intellectual dead-end out of which the nation had with difficulty to negotiate itself while leaving a legacy of suspicion and distrust in the non-European would that continues to the present day.

Xenophobia fuelled the fear of invasion from Asia but there were tragic repercussions for those unwanted peoples already in Australia; Indigenous Australians and South Sea Islanders. The annual visit to Australia's north by the Macassans was banned in 1906. This decision resulted in severed kinship connections and lifelong friendships (Shellam et al. 2017). Some Indigenous Australians found themselves stranded in Indonesia. Many South Sea Islanders were deported resulting in broken marriages and the separation of extended families. The government did not show concern for these traumatic events. Hirst (2014, p.152) asks: "what made Australians who had little experience of non-Britishers and a good deal of hostility towards them, accept them into their society? The short answer is that the government told them they must". Calwell's appeal: "was not to the benevolence of Australians but to their self-interest, a much more secure basis for policy" (Hirst 2014, p.153).The ancient land of Australia had evolved into a new nation, a desired homogenous identity of 'the nation', one underpinned by xenophobia, racism and ethnocentricism.

NATIONALISM

Some historians argue that the true nationalism sentiment in Australia emerged in the ANZAC tradition after World War one (1914-1918).

Garton (2015, p.124) for example, argues that nationalism in Australia became curiously linked with loyalty to the Empire:

> While nationalism was the ideological glue that held settler societies together in the immediate post war years, preventing social and political disintegration, in Australia these nationalist discourses took on a peculiar character, at once proclaiming the virtues of veterans as founders of the nation while adopting a heightened sense of the importance of ties to the Empire. What emerged was a hybrid discourse that interwove nationalism and Empire loyalism.

The Australian nation today remains reluctant however to include and genuinely accept the first Australians. How is it that in the year 2017, 219 years post invasion, Australia is just coming to terms with the idea of a proposed referendum on the recognition of Aboriginal and Torres Strait Islander people in the Australian Constitution? I would argue that this necessary initiative is due to the entrenched xenophobia, ethnocentrism and racism within the Australian nation. Many Australians fear the outsider, the foreign and many Australians believe that the Australian way, the dominant culture is a superior one to others. This misbelief began from the early days of the colony and came with the newcomers (Plage et al. 2016). The Eurocentric perception of superiority however has ancient roots which run back to Europe which always situated itself apart from the East as its exotic other (Said 1978, 2001). The myth that Europe, Europeans and European ideas were not only superior but the whole of the Western world was also superior, infiltrated the new Australian psyche. It seemed that the Eastern world could be totally ignored or discounted as making any worthwhile contribution to humankind. Harding (2011, p.34) points out:

> Modern European sciences began to emerge in the 16th century. Yet some of the older traditions of China, India and other cultures in Asia and the Middle East were far more sophisticated than European ones until Europe's industrial revolution in the 19th century. It takes a lot of work to create and nourish such Eurocentric ignorance.

Most European Australians by 1900 believed that obtaining national greatness and cohesion was associated with being white and a member of the British race, a race which should not be contaminated by racial interbreeding but rather remain pure. In fact a kind of obsession with the concept of race existed in most western societies at the time. In terms of Indigenous Australians then, most European Australians held racist views towards the first peoples and this mindset was conveniently expanded to justify the dispossession of Indigenous Australians from their land. In fact, according to (Markus & Semyonov 2010, p.2) the dispossession of Indigenous Australians from their lands: "continued well into the twentieth century up until the 1950s and in some cases later." The following 1901 extract from the Bulletin (a prominent nationalistic magazine at that time) provides an example of public sentiment which included the fear of mixed race relations between Indigenous and white Australians:

> If Australia is to be a country fit for our children and their children and their children to live in, we must KEEP THE BREED PURE. The half-caste usually inherits the vices of both races and the virtues of neither. Do you want Australia to be a community of mongrels? (Broom, R 1994, p.93).

Indigenous Australians, although considered British subjects, were discriminated against by mainstream society across every Australian institution. As Kleist (2017, p.192) explains:

> No one experienced the ambivalence of belonging in Australia more than the Indigenous population…they were culturally, legally, and politically excluded until the second half of the twentieth century.

The 1967 referendum gave Australian Indigenous peoples political recognition but not social and cultural belonging (Gunstone 2017). The health system for example constituted an exclusion zone for the first people, their descendants and others considered 'non-white'. A white supremacy attitude prevailed, continued for decades and was extended to

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the provision or non-provision of medical care. The following is a stark example from Queensland in 1937:

> the committee cannot see its way clear to allow aboriginals and non-whites to be operated on in the theatre nor to receive any surgical after-treatment in the annex to the main building (Hospital committee at Normanton Qld. 1937 in May, 1988, p.180).

In 1975 the Racial Discrimination Act removed overt racial discrimination from Australian legislation but a residue was left in the treatment of Indigenous Australians and in immigration policies. Moreover, impossible to measure, covert racial discrimination towards Indigenous Australians and migrants remained to lurk in the minds of many white Australians.

Multiculturalism was introduced as a relatively new concept in the 1989 National Agenda for Multicultural Australia. Championed by Labour Prime Minister Paul Keating, Multiculturalism was touted as a vision for a better Australia and as the new way forward for the nation. It constituted a statement of policies and goals which were presented to the Australian Parliament and received bi-partisan support. The vision for a better Australia stated: "The National Agenda for a multicultural Australia represents a necessary attempt to modify Australia's institutional structures in the interests of the community as a whole. It presents a vision of the future and a framework of specific Commonwealth Government initiatives to help achieve it" (Australian Commonwealth Government 1989). Multiculturalism policy was developed around the three policy objectives of: social justice, the need to nurture a more efficient economy and the maintenance of cultural identity. The imagined Australian community was reframed by the Government but was not necessarily accepted by the established Australian community.

The policy, as explained by Plage et al. (2016, p.3) :

> Espoused the freedom to maintain distinct cultural heritage and practices, economic efficiency promoted the use of all Australians' skills and social justice incorporated equal opportunities regardless of individual background or ethnicity.

The concept and vision of multiculturalism in modern Australia can however be viewed as problematic as Pettman (1992, p.8) points out: " The multicultural model may obscure the power of dominant groups and see Australia as a mix of cultures and plurality of interests". Ultimately, the ideal nation state identity sought by Australia was challenged by the rhetoric of multiculturalism. As articulated by Brabazon (1998, p.60):

> Clearly, there are contradictions between nationalism and multiculturalism. A nation is built on the formation of a fixed, stable citizenry. Migrants will never slot into this nationalist narrative. Their divergent life histories always disrupt the singularity of the nation.

For example, In their 2000 study, Pakulski and Tranter (2000, pp. 217-218) found, eleven years post multiculturalism, that 'Ethno-nationalists' (those in the Australian population with neo-conservative attitudes) showed:

> Strong preferences for abandoning multiculturalism which is seen as potentially divisive and hindering social adaptation and that it is better if ethnic and racial groups 'blend' into the larger society and do not maintain their distinct traditions and customs, especially if this maintenance occurs with government assistance.

Many Australians remained fearful of the 'other' and protectionist particularly in terms of immigration posing a threat to Australian jobs and as a potential threat to the maintenance of 'Australian' culture. However, Australia still held a desire to cling to Britain and the Commonwealth, with a 1999 proposal to become a republic rejected via a referendum (Gunstone 2017).

Australia today remains: "A constitutional monarchy, although interference by the Queen in Australian, as in British politics is virtually unheard of" (Dowding & Martin 2017, p.60). Australia is often referred to as a young country, for example in the national anthem: "Australians all let us rejoice for we are young and free". This incongruent situation in mind, acclaimed Indigenous Opera singer Deborah Cheetham declined an invitation to sing the national anthem at the 2015 Australian Football League grand final and told the media:

> Let me be clear: it was an honour to be asked. The problem is, as an Indigenous leader I simply can no longer sing the words "we are young and free". For that matter, as an Australian with a strong desire to deepen our nation's understanding of identity and our place in the world, I believe we can and must do better (Australian Associated Press 2015).

This objection was also echoed in the behaviour of Indigenous boxer Anthony Mundine, who before his most recent fight (2017), refused to stand for the national anthem. The Australian community, while said to embrace 'fairness' for all, in reality, does not. Rather, the Australian nation is also representative of division and exclusion and 'fairness' is only the experience for some. Blackshaw (2010, p.151) succinctly explains:

> Community is always a double. In other words, all its warmth, charm and geniality, notwithstanding, there is much about community that is distinctly unsettling: if one side of its coin is inclusion and harmony, its companion side is always exclusion and oppression.

IMGs in Australia today do not necessarily experience 'fairness'. This thesis argues that they are othered simply because they are foreign. The original contribution to knowledge established by this thesis demonstrates that IMGs constitute an underclass within the elite profession of medicine. This chapter has established the development of their current positioning through time. An historical lens has taken the reader from the British invasion in 1788 and the arrival of the first IMGs; British naval surgeons, to the emergence of the

imagined Australian nation state of today. The original custodians of the land, Australia's Indigenous peoples became an ethnic minority in their own country. The scene for subsequent chapters has been set with the flagging of significant historical stages such as Federation, the White Australia Policy and nationalism through to post war displaced persons and multiculturalism. These aspects of Australian history have significantly influenced and contributed to the state of the nation today. The foundations of the intersecting oppressions of class, race and nation are found in Australia's past. History shows a fearful nation threatened by others and medical doctors trained overseas were no exception. IMGs were regarded with suspicion and their training and qualifications were questioned (as they are today).

This chapter has established the deliberate long standing discrimination of IMGs. This is evident in the policies related to the accreditation and registration of IMGs of today and the organisations tasked to administer them. The processes IMGs wishing to work in Australia must engage with are outlined in the following chapter. This enables the reader the opportunity to appreciate the numerous avenues available and the choices IMGs must make. It is argued that these bureaucratic initiatives are deeply entrenched within the dimensions of structural, hegemonic and interpersonal power.

CHAPTER THREE

POLICIES, PROCESSES, POPPYCOCK AND DIMENSIONS OF POWER:

STRUCTURAL, HEGEMONIC AND INTERPERSONAL

It seems to me that the real political task in a society such as ours is to criticise the working of institutions which appear to be both neutral and independent; to criticise them in such a manner that the political violence which has always exercised itself obscurely through them will be unmasked, so that one can fight them (Foucault in Rabinow, 1984, p.6).

You start to question whose problem is it? Surely the system cannot be this dysfunctional? The sad fact is it really is! (Dr Douglas, 2012, submission 111).

This chapter configures a framework for an exploration of power and relationships. Dimensions of Power are separated and unpacked into categories so that they can be explored in a structured and ordered way. Following the work of Patricia Hill-Collins, Intersecting oppressions can be organised through a matrix of domination which she explains as: "the overall social organisation within which intersecting oppressions, originate, develop and are contained" (Hill Collins, 2000, pp.228-229).

For this study, three categories are represented; Structural Power, Hegemonic Power and Interpersonal Power. Structural Power refers to the numerous entities that make up the health system and as a result, are sanctioned by the government to administer all aspects of health care in Australia. IMGs coming to Australia must engage with the health system as well as various other government departments and agencies. Secondly, Hegemonic Power probes the Australian medical profession specifically and its power, influence and

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control as gatekeepers to the health system. The third dimension of power is Interpersonal Power. This power category is concerned with the voices of IMGs and their relationships and discourses with the system and with the Australian medical profession. The Structural Power and Hegemonic Power dimensions have a mutually beneficial role in that they create and maintain the existing power relations. These power relations influence the strategies of control employed by the system to regulate IMGs.

This thesis endeavours to explore the link between macro analysis of the system and micro analysis of the individual narratives of IMG experiences. The contribution to knowledge advanced by this thesis is revealed through an analysis of the power differential and the position of IMGs. Relations of power and associated discourses are structured into Structural, Hegemonic and Interpersonal power domains to enable insight into how IMGs are positioned within Australia's medical culture.

Experiences of coming to Australia, working in Australia, surviving in Australia and the well-being of IMGs in Australia will be explored through the IMG voice, the reflection of lived experience. The reader will have the opportunity to gain an awareness of the experience from the very people whose lives are the experience. The complexity of the process journey will be revealed and the engagement of the doctors within numerous unfamiliar contexts and cultures explored. Ultimately, all relations between the IMG and life in Australia are to a greater or lesser extent mediated by the system. It is the system which has the power to dominate and control. IMG interactions with the deficit discourses of the system are couched in terms of power and oppression.

STRUCTURAL POWER: THE SYSTEM

The Australian health system is structured in a uniquely national configuration.

Helen Belcher (2014, p.367) suggests that "The Australian health care system can best be described as mixed." There is a distinct public and private sector with both sectors holding responsibility for the provision and delivery of health services to the Australian public. Interestingly, private practitioners practice their services in public health institutions. They receive payment via a fee-for-service or sessional basis which is funded by a combined contribution of payments from the individuals seeking their services, private health insurance providers and government funded Medicare payments.

The reality of lived experience for IMGs in Australia is controlled by numerous identities which take the form of agencies, professional bodies, government departments and the like. For example, The Medical Board of Australia oversees registration standards. English language tests are administered by several approved providers such as the International English Language Testing System (IELTS). The Australian Medical Council (AMC) controls written medical and clinical exams. Various Australian Medical Colleges have their education and training programs accredited by the AMC. The medical colleges, of which there are sixteen, regulate entry into the specialties. Medicare issues provider numbers while visas are the domain of the Department of Immigration and Border Protection. This complex bureaucracy, for the sake of simplicity, will be referred to throughout this thesis as the system. The system has evolved out of a perceived need to scrutinise, regulate and control IMGs. Over time, the system has managed to escape any major change which could undermine its dominant position and represents an ongoing and seemingly growing power structure. The establishment and maintenance of power by various social groups over others has been a phenomenon of intense interest to many scholars (such as Marx, Weber, Foucault, C. Wright-Mills) for many years. IMGs must undertake a process journey through the requirements of the system through which a power differential is operationalised.

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THE PROCESS JOURNEY THROUGH THE SYSTEM

The following information enables the reader of this research, to track the process IMGs undertake to begin work as a medical doctor in Australia and therefore gain an appreciation of what is expected of them. It is important to bear in mind here that if an IMG is unsuccessful at any step throughout the process journey the IMG is required to begin the process journey again from the start.

To gain full Australian medical registration, an IMG must undertake the following: obtain all required documentation for immigration, accreditation and registration purposes. A number of forms specific to the IMGs selected immigration, accreditation and registration pathway must be completed in the exact prescribed format and relevant application fees paid[10]. If any required documentation is not in English, they must arrange for its translation by an approved government certified interpreter. Documentation must be verified as stipulated in the requirements of the relevant organisation or agency. IMGs must also pass mandatory English language proficiency exams. If any of the steps required are not undertaken exactly as directed, extra costs will be involved and the application's progress delayed.

For example, according to the National Rural Health Alliance (2011, pp.12-13):

> If there is a document needing verification that is missing, the OTD will need to ensure that additional documents are signed by the same individual as previously. The complexity of the processes for the application to the AMC is illustrated by the fact that the 'Quick Guide' runs to 72 pages and an additional guide for specialists covers 42 pages.

Extensive requirements can result in lengthy delays in processing applications. This seems at odds with the immediate imperative to facilitate the movement of IMGs into areas

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[10] Fees payable to a specialist college may be as much as $8,000.00.

of need as quickly as possible. Initially, it is necessary to establish that IMGs, are not eligible for a Medicare provider number unless they work in a District of Workforce Shortage (DWS). This also applies to overseas graduates from Australian medical schools and Australian trained bonded doctors who agree to be bonded to practice for a period of time in a DWS. A DWS is an area deemed as having below average access to medical doctors. General Practice in inner metropolitan areas of Australian capital cities is classified as non DWS (apart from Darwin due to its ongoing doctor shortages and remoteness). The classification of areas as DWS was updated as part of the Rural Classification Reform and came into operation on the 10th of February 2016[11] (DoctorConnect, 2016).

The Australian Government, in response to doctor shortages in rural and remote areas of Australia has initiated an International Recruitment Strategy. According to the Australian Government Department of Health's DoctorConnect website (Commonwealth Department of Health 2016), the first step in the process for an IMG wanting to practice in Australia requires the applying doctor to obtain skills recognition. This is done by visiting the Australian Medical Council website (AMC) (2016) where the doctor needs to choose a registration pathway: competent authority, standard or specialist. The standard pathway can involve either AMC exams or workplace based assessment. The specialist assessment pathway leads to full comparability/area of need (AON). Area of Need classification is determined by state and territory health authorities (Medical Board of Australia 2016). In addition the doctor must have medical qualifications verified through primary source verification and meet English language standards. The AMC's role is to

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[11] As at 26 April 2017, the DWS areas have been updated at the DoctorConnect – Home page: http://www.doctorconect.gov.au/

assess the: "knowledge, clinical skills and professional attributes of IMGs" (Commonwealth Department of Health 2016). The AMC also assesses applications for recognition of medical specialities. There are two ways to progress identified here, depending on whether or not the doctor has a job. If the doctor already has a job he or she is required to apply to the Australian Health Practitioner Regulation Agency (AHPRA) (Australian Health Practitioner Regulation Agency 2016) in the relevant state or territory for registration. Applying doctors are advised that this application may include a Pre-Employment Structured Clinical Interview (PESCI) assessment of their clinical skills for the job. The next step is to make application to the Department of Immigration and Border Control for a visa and then relocate to Australia. The process of applying to practice medicine in Australia initially seems reasonably straight forward. The role of AHPRA, which is the regulation of Australia's health practitioners, is in partnership with and support of the Medical Board of Australia (MBA). The general public can access the AHPRA website for other information such as: to check if a medical practitioner is registered or to make a complaint. The MBA is the national board, while there are medical boards supporting the national board in each state and territory. According to the MBA website (2016), the state and territory boards each have several committees such as the: "Registrations committee, health committee, immediate action committee and notifications committee". Not only is the MBA responsible for regulating medical practitioners practising in Australia, which seems to be administered by the supporting body AHPRA, it is also charged with handling complaints, registration renewals and supervision guidelines. In addition the MBA approves accreditation standards of medical related courses of study and assesses IMGs who wish to practice (Medical Board of Australia 2016). (Rural Health Workforce Australia 2016) There seems to be overlap here with the AMC and the distinction between who does what becomes blurred. For example, I was informed on the AMC website (2016) that

English Language Proficiency proof is required by the MBA not the AMC. I was then directed by the MBA website to the AHPRA site for further information. Requirements and processes could easily become unclear for an IMG trying to identify a suitable route through the system.

Doctorconnect (2016) further advises that if the applying doctor does not have a job, he or she should contact a recruitment agency or a Rural Workforce Agency, there are rural workforce agencies across Australia.[12] The Rural Health Workforce Agency is a government funded initiative to help address the rural doctor shortage through the administration of the International Recruitment Strategy. The agencies can assist with immigration, employment, registration and orientation. In addition, they offer free recruitment services to rural and remote medical practices for: "the complex activities required to recruit an overseas trained doctor" (Rural Health Workforce Australia 2016). The AMC also affords applying General Practitioner IMGs or non-specialist hospital IMGs new to Australia, the opportunity to test their skills via a trial exam which can be undertaken online for a fee of $25.00. The exam consists of multiple choice questions apparently set at the level expected from an Australian trained graduating medical student (Australian Medical Council 2016). At this point, it is perhaps a good idea to return to the major task of an applying IMG, to obtain a visa and choose an appropriate pathway through an approved provider.

It seems that the applying IMG has several options regarding the most appropriate pathway and there are numerous visa categories[13] available to those wanting to live and

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[12] Health Networks NT, NSW Rural Doctors Network, Health Workforce Qld., Rural Workforce Agency Vic., Rural Doctors Workforce Agency (SA), Rural Recruitment Plus (TAS) and Rural Health West (WA).

work in Australia. Some IMGs find the task of selecting an appropriate visa category and/or pathway confusing and time consuming and as a result, engage the services of a migration agent or recruitment organisation to assist them. Pathway and visa choices constitute major decisions as these will determine the terms and conditions an IMG will be bound by in Australia. Doctors from New Zealand are in a unique position however, as most New Zealanders are granted a Special Category Visa (SCU). This visa, while a temporary visa, provides permanent resident status which allows holders to live and work in Australia for an indefinite period. Most other IMGs apply for the Temporary Work (Skilled) Visa (Subclass 457) this visa affords skilled workers the opportunity to work for an approved business for a maximum of four years (Australian Government Department of Immigration and Border Protection 2016). The potential employer is required to formally sponsor the doctor and to provide assurance to immigration authorities that it is unable to fill the position with an Australian citizen or permanent resident who has the necessary skills. The Subclass 457 visa allows an IMG to also bring eligible dependants who too can work or study in Australia. After coming to Australia under this visa, there are no limits on the number of times an IMG and dependants can travel in and out of the country. IMGs who arrived in Australia prior to 26 February 2001 may be able to apply for Australian citizenship however, if arrival was after 26 February 2001 permanent resident status may need to be achieved first (Australian Government Department of Immigration and Border Protection 2016). Assuming that all goes well for an IMG and a visa is granted from the Department of Immigration and Border Protection, the next complex task is to identify and apply for a pathway.

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[13] For further information regarding the full range of visas see the Department of Immigration and Border Protection at https://www.border.gov.au/trav/check-your-visa-and-work-entitlements and Immigrationdirect.com.au

DOWN THE GARDEN PATH

Before applying for admission to a pathway and seeking registration in any category, IMGs must have their primary sources verified via the approved AMC process. Verification of qualifications is mandated under the Health Practitioner Regulation National Law Act 2009 (Australian Medical Council 2016). From October 2015 The International Credentials Services of the Educational Commission for Foreign Medical Graduates (ECFMG's) Electronic portfolio of International Credentials (EPIC) conducts verification (Educational Commission for Foreign Medical Graduates 2016). The results are uploaded to the AMC's qualifications portal. The portal is used by the MBA for registration process and by the specialist colleges for assessment purposes. This initiative seems like a streamlining process. This may be however, a frustrating or even terminating experience for some IMGs as the AMC website (2016) provides a list of overseas institutions that are often slow to respond to the EICS request or unfortunately do not respond at all! If qualifications cannot be verified a doctor's application cannot proceed.

The MBA (Medical Board of Australia 2016) outlines the options for an IMG as Follows:

THE COMPETENT AUTHORITY PATHWAY

IMG applicants must have successfully completed a bachelor of Medicine and Surgery from an AMC and World Directory of Medical Schools (WDOMS) (Gordon 1980)approved institution in: the UK, Canada, the USA, New Zealand or Ireland (World Directory of Medical Schools 2016), (IMGs from other countries are excluded). If doctors meeting these requirements have also obtained employment, they may apply to the MBA for provisional registration. After satisfactory completion of twelve months (or a minimum of 47 weeks full time) of practice under supervision, IMGs in this pathway may become eligible to apply to the MBA for general registration. Eligibility for this pathway does not guarantee

an IMG smooth and timely progress to registration however, and some become so discouraged that they give up trying. In their submission to the 2012 Parliamentary Inquiry, the National Rural Health Alliance (2011, submission 113, p.11) gave the following example to the committee:

> Dr G is an Irish born and qualified GP with the appropriate qualifications to be categorised as eligible for mutual recognition by the RACGP. She therefore represents those OTDs with the easiest pathway to registration as she is substantially comparable to an Australian GP specialist. In early 2010 she moved to Australia with her husband who has a clinical fellowship in a large teaching hospital. She recently decided to start working as a GP, and was able to find a position in an outer metropolitan practice with District of Workforce Shortage (DWS) status. Although she already had the relevant visas to allow her to work in Australia, she was required to complete over twenty different forms, pay approximately $3,500 in various fees and comply with a variety of additional requirements. It has been five months since she first applied for the specialist pathway with the AMC and she is still not registered to practise.

Needless to say, the submission further notes that the doctor in question has stated that she will not be encouraging her colleagues and friends in Ireland to consider seeking work in Australia.

THE STANDARD PATHWAY

This pathway is suitable for IMGs who are not eligible for the Competent Authority Pathway or Specialist Pathway and are seeking general registration with the MBA. To be considered for this pathway however doctors need to apply directly to the AMC. This pathway requires the IMG to pass the AMC multiple choice and clinical exams. If both exams are passed prior to making application to the MBA for registration, the applicant can apply for limited registration. Most applicants are assessed through this method. There is also the option for Standard Pathway (workplace based assessment). In this case the doctor must pass the AMC multiple choice exam and have his or her clinical skills and

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knowledge assessed in the workplace. The IMG must complete twelve months of supervised practice or a minimum of forty seven weeks full time service in an approved position. The MBA (2016) notes that few IMGs are assessed this way as there are limited numbers of approved assessment programs (only 7 locations across Australia). If IMGs taking this pathway have passed the AMC multiple choice and clinical exams before beginning supervised practice, they may make application for provisional registration. IMGs may work under supervision in general practice positions or hospital positions. In addition, IMGs may be directed to undertake the Pre-Employment Structured Clinical Interview (PESCI) before applying for limited or provisional registration.

In an effort to be clearer regarding registration categories, they are summarised below from the MBA (2016):

SEEKING LIMITED REGISTRATION

Before applying for limited registration an IMG must have obtained an offer of employment and have passed the AMC multiple choice exam. The limited registration is linked to the position, for example, an IMG may be granted limited registration for postgraduate training or supervised practice. Limited registration may be granted for work if it is located in an Area of Need (AoN).

To clarify, Doctorconnect (2016) advise that an Area of Need (AoN) is determined by State or Territory governments for immigration and registration purposes as opposed to a District of Workforce Shortage (DWS) which is determined by the Department of Health for the purposes of access to Medicare. Doctorconnect (2016) further advises that an employer wishing to gain approval to employ an IMG, in most cases, will need to meet both AoN and DWS status.

PROVISIONAL REGISTRATION

To be considered for provisional registration an IMG must pass the AMC multiple choice and clinical exams (AMC certificate holders). Provisional registration requires the IMG to have obtained employment.

GENERAL REGISTRATION

IMGs on the Standard Pathway complete twelve months supervised practice (minimum of forty seven weeks full time service) in an approved position before they become eligible to apply for general registration.

ENGLISH LANGUAGE PROFICIENCY

The AMC (2016) advises IMGs to make arrangements to provide proof of English Language Proficiency (ELP) before applying to enter any assessment pathway. IMGs may also apply for an exemption from the ELP requirement. Of particular interest here is a statement from the MBA (2016, p.4): "The board reserves the right at any time to revoke an exemption and/or require an applicant to undertake a specified English language test". The board notes that the ELP standards were last reviewed 1st July 2015 and that review is undertaken at least every 3 years.

The specialist medical colleges offer various pathways for IMGs and once an IMG has moved through the other processes a specialist medical college needs to be selected for the IMG to progress through to full recognition in his or her speciality area of expertise. For example, the Doctorconnect website (2016) advises that the Australian College of Rural and Remote Medicine (ACRRM) has an IMG Program. The ACRRM website (2016) states that it is the only college in the world to offer a speciality in rural and remote medicine. ACRRM's program leads to general registration and a specialist pathway leads to

registration in a relevant speciality.

The AMC (2016) advises that specialist pathway recognition applications must go directly to one of the sixteen medical colleges. Following qualification verification from ECFMG's Electronic portfolio of international credentials, the applicant is directed to go online to the AMC to set up an AMC portfolio. The relevant college assesses the comparability of the applicant against what is expected for an Australian trained specialist in the same field of practice. Once all requirements have been satisfied and assessment successfully completed the IMG can apply for the pathway Specialist Recognition or Area of Need. The applicant must apply to the MBA for registration. The MBA (2016) advises that the colleges will assess IMGs as: Not Comparable or, Substantially Comparable or, Partially Comparable (there does not seem to be a Fully Comparable category) and that the IMG "may be required to undertake a period of peer review (oversight) which may involve completion of workplace based assessment or a period of supervised practice and further training, which may involve college assessment, including exams." The MBA (2016) confirms the requirements of the Specialist pathway – Area of Need (as at 1 October 2015), as a pathway which does not lead to specialist registration but the applicant can also apply for specialist pathway – specialist recognition if seeking specialist registration with the MBA. The IMG is able to complete the requirements for specialist recognition at the same time as working in an AoN. The IMG is assessed by the college for suitability to the position identified by the employer. The employer must demonstrate that the position cannot be filled and as a result, there is an "adverse impact on service delivery." (Medical Board of Australia 2016). The employer then selects a suitable AoN application to the position (the applicant must be eligible to apply to the MBA for limited Registration AoN).

It is beyond the scope of this doctoral dissertation to explore all possible pathways for

each speciality college. ACRRM's pathways represent a unique proposition. ACRRM is accredited by the AMC for the speciality of General Practice (dedicated to rural and remote practice). The ACRRM website (2016) notes that both the workplace based assessment and the competent authority programs offered by the college, closed in July 2014. These pathways now sit with the MBA in an effort to minimise duplication and work towards streamlining processes as recommended by the 2012 Parliamentary Inquiry Report. ACRRM provides the following options for IMGs:

STANDARD PATHWAY

This pathway is for a non-specialist IMG and leads to registration. ACRRM (2016) has AMC approval in each state and territory to conduct Pre employment structured clinical interview (PESCI) assessment. Applicants to the Standard Pathway are required to undertake a PESCI. If the IMG has successfully completed assessment, gained registration and completed twelve months of medical practice in Australia, he or she may be eligible to train for fellowship of ACRRM via the Independent Pathway.

INDEPENDENT PATHWAY

This pathway is solely owned and administered by the college. It is designed for experienced doctors who require "self-directed learning and flexibility" (ACRRM, 2016). IMGs are invited to apply after undertaking a process of recognition of prior learning (RPL).

SPECIALIST PATHWAY

An IMG may be eligible to obtain Fellowship of ACRRM (FACRRM) if he or she has college recognised General Practice specialist qualifications. The college states: "this pathway is a fair and equitable pathway for IMGs to achieve FACRRM specialist medical registration in Australia and vocational recognition" (ACRRM, 2016). Perhaps pathways

offered elsewhere do not offer a fair and equitable pathway?

Applicants must have skills and expertise that are considered substantially or partially comparable to those of an Australian trained Fellow of the college and have overseas general practice qualifications as identified in the college's codified list[14]. This pathway enables doctors to practice independently anywhere within Australia.

The above represents only a thumb nail sketch of the process journey through the system and all its possibilities. The devil seems to be in the detail because attached to all these processes are the micro interactions between IMGs and the system, the small steps which need to be taken between and through the broader framework presented here. How do they navigate their way within such a powerful structure with firmly institutionalised ways of doing business?

IMGs are individual actors, not a homogeneous group. Rather, they come from diverse cultural backgrounds and have a range of different life experiences, norms, values and aspirations. The IMG experience in the system is also an individual journey. Some IMGs seem to have a reasonable relationship with the system while others report their relationship as problematic, even horrendous. IMGs however share an occupation, they constitute a professional group, that of medical doctors. As a professional group they also share the fact that they obtained their basic medical training in a country other than Australia. As a group of overseas trained medical practitioners, IMGs have a dedicated group position in the system, that of the other, an inferior position assigned to them by the

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[14] The list mentions eligible awards and institutions from the following countries only: Belgium, Canada, Denmark, Hong Kong, Ireland, Netherlands, New Zealand, Norway, Singapore, South Africa, Sweden, UK and USA.

system. IMGs somehow, even though they are also medical doctors, do not quite belong in the Australian medical profession. Initially, their overseas qualifications are often presumed as lacking or deficient in some way and consequently, can be treated as inferior to those of Australian trained doctors. IMGs must prove themselves (in some cases continually) to the system. They are required to satisfy the system that they are comparable to Australian standards in order to be admitted to the Australian medical profession. However, even if an IMG is able to satisfy the numerous requirements of the system, he or she is not necessarily entitled to leave the other status group and become a fully-fledged member of the Australian trained medical doctor group. From the very beginning of the process journey the IMG/system relationship is couched in a 'deficit' discourse and this often continues throughout the process journey. According to the Australian Doctors Trained Overseas Association (ADTOA): …"the professional and personal lives of hard working IMG doctors are being destroyed by this dysfunctional and evil system. Rural and regional Australians are literally paying with their lives" (2012). Many remote, rural and regional Australian communities are left with inadequate provision of medical services due to a health workforce shortage. IMGs are recruited to fill the gaps but many experience difficulties associated with the system. IMGs like Australian trained doctors are medical professionals and one would think that everything possible would be put in place to expedite the establishment of IMGs in these needy locations.

Moreover, it becomes evident in the following chapter five, that the toxic culture within the medical profession in Australia does not always act honestly, in good faith, or put patients' interests first. Many medical professionals including IMGs experience harassment and bullying within Australia's medical culture. Not only do IMGs have to navigate their way through the organisations of the system and their processes, but the requirements can be different. Requirements for individual IMGs can be based on their particular speciality,

which country they are from and which visa they have. In addition, the processes are also influenced by the position they obtain and where in Australia the position is located.

The registration processes for IMGs wishing to practice in Australia is arduous and confusing. In fact, Harris (2011, p.1) from her research of the experiences of overseas trained doctors in Victorian hospitals came to the conclusion that: "for decades, overseas doctors have been faced with a registration system with as many twists and turns as a diseased vascular system." The final report from the Parliamentary Inquiry Committee (2012) into the registration process for IMGs indicates the state of affairs by its title: "Lost in the Labyrinth". The report also notes that while individual bodies within the system may be able to clearly detail their processes, when they combine to become the system as a whole it resembles "spaghetti" (2012, p.6). Psychiatrist Dr Llewellyn, medical manager of a regional health district referred to the registration process as: "bordering on what I see as criminal in its inefficiency" *(Hyland 2011)*.

From the moment an IMG makes application to come to Australia, he or she begins a long term relationship with the system. The system is not a seamless entity and it does not necessarily share information across its various stakeholders. The seeming constant struggle of many IMGs with the system appeared very early in this study. The system/IMG relations seemed to always have a far reaching presence. Before I began this research I did not know about this troublesome relationship and the power differentials within. I sensed there were some issues during my fieldwork but I was unaware of just how problematic and all-encompassing this relationship was for some IMGs. My first direct exposure to this came via a focus group participant who mentioned having to fight the system. The perceived need to fight the system became apparent throughout this study. The system is the vehicle for a powerful interest group, that of the medical profession. This

high status group is tasked by the government to direct and police the accepted level of medical care and the required health behaviours of the population. Moreover, they are the expert body with the knowledge to set the requirements for medical training. The qualifications of IMGs are measured against the Australian standards. This in itself is necessary to ensure that standards are met and maintained. However, power relations enter into the equation and in an effort to keep standards high the system has evolved into a cumbersome, over-zealous maze which only serves to divide medical practitioners into two groups: Australian trained and overseas trained. As a result, many IMGs become trapped and oppressed with some unable to practice medicine at all. The process journey for IMGs in Australia is one of the most difficult in the world. According to Stanley a director of a medical recruitment company quoted in an Age Newspaper article entitled: Foreign doctors' obstacle course 'a disgrace': "Other Western countries have complex and strict systems, but we (Australia) have the worst system for co-ordination, with a reputation for causing frustration that makes us look ridiculous" (*Hyland 2011*). Yet, Australia is experiencing a health workforce shortage and IMGs are needed to fill gaps, particularly in rural and remote areas. There seems to be a problem here and while aspects of this have been acknowledged by various governments, agencies and inquiries the problem remains largely unaddressed.

The power of the Australian medical profession cannot be underestimated as medical dominance has a gatekeeper role to the Australian health system. The high status profession of medicine is akin to a ruling class in the health system and is underpinned by a hierarchy of power, self-interest and authority.

HEGEMONIC NEGOTIATION: THE AUSTRALIAN MEDICAL PROFESSION

Hegemonic negotiation is activated in the Australian medical profession specifically and its

power, influence and control as gatekeepers to the health system. The concept of hegemony can be understood in terms of Marx's work on historical materialism where the ruling class (in this case the Australian medical profession) interests are represented as universal interests (in this case the interests of society as a whole). Globally, medicine dominates every aspect of health policy and health delivery (Germov 2005, 2014). In Australia too health policy and health delivery are the domain of the Australian medical profession. Western medical practice in Australia post the 1788 invasion was closely linked to the British practice of medicine. In fact, the Australian Medical Association (AMA) was not formed until 1962, before then, medical doctors in Australia were represented by the British Medical Association. Keleher (2016, p.397) argues that:

> Both organisations have actively worked to ensure that the State is removed from regulating the private practice of doctors apart from the funding of registration bodies. The medical profession has nurtured the State through sophisticated advocacy to ensure the institutionalisation of medical power.

The AMA is a powerful body and constitutes the primary professional body for the medical profession, it has a reported membership of approximately 27,000 (2015). There are also other bodies that represent medical doctors such as the Australian Doctors Trained Overseas Association (ADTOA) which gives advocacy and representation to IMGs however, it is not anywhere near as powerful as the AMA. The AMA: ..."actively lobbies governments, fiercely defends fee-for-service medicine and has a strong focus on industrial issues"(Keleher 2016, p.400).

Medical dominance has always operated to a degree in the Australian health context. The economy and the state play a role in the maintenance of medical dominance (Keleher 2016; Willis 2006). Governments support medical dominance because they are responsible for the health and welfare of the population; as a result, governments endorse

and value the expert knowledge and advice of the medical profession. The work of Foucault is particularly helpful in the analysis of medicine and associated issues as his approach is systematic and can be applied to medical institutions, to the body and to governmentality (Hodges et al. 2014; Turner 1995). Foucault's (1991, p. 102) development of what he terms 'governmentality' defines the structure and function of governments as:

> the ensemble formed by the institutions, procedures, analyses and reflections, the calculations and tactics that allow the exercise of this very specific albeit complex form of power, which has as its target population, as its principal form of knowledge political economy, and as its essential technical means apparatuses of security.

It was in the second half of the 18th century Foucault argued that politics and the focus of governments shifted from concerns of the individual to the needs and welfare of populations as a whole (Crampton & Elden 2016). Foucault explored relationships in society between discourses and power, according to Turner (1995, p.10) particularly in relation to medicine: "that is the development of alliances between discourse, practice and professional groups." Foucault's work is not only complex and open to many different interpretations but has also shifted over time (Gariepy 2016). Nevertheless as stated by Zamora (2016, p.2): "His ideas have been used in fields as diverse as history, philosophy, anthropology, political science, sociology, gender studies and post -colonial studies." Many of Foucault's classic works on key concepts such as 'power', 'discipline' and 'governmentality' are the focus of scholars today, McCall (2016, p.52) suggests: "as they attempt to make sense of our neoliberal present." Dawes (2016) while endorsing Foucault's works with the potential for deeper analysis of liberalism and neoliberalism, notes that scholars often do not explain the concept. In acknowledgement of that omission, it has been described as a 'new' capitalism or the global economy and its innate inequalities. Usually, explanations include factors such as: an onus on individual

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responsibility, privatisation, free trade and markets and the restriction of State intervention (Nguyen 2017). Dawes (2016, p.286) offers a broader description:

> Neoliberalism is seen as the reinvention of the classical liberal tradition, expanded to encompass the whole of human existence, whereby the market stands as the ultimate arbiter of truth, and where freedom is recoded to mean anything the market allows.

Foucault's critical attitude explored liberalism as a part of a form of complex government rationality and he believed it should be approached: "Neither as 'an ideal' that one should devote oneself to, nor as an 'ideology' that can simply be exposed and opposed" (Raffnsoe, Gudmand-Hoyer & Thaning 2016, p.290). For Foucault, the market became the point of reference for liberalism. According to Betta (2016), the free market, economic interest, and the self-regulating forces of the market became the substance of liberalism. For Foucault: "the liberal government and its capitalist system needed freedom. It consumed freedom, which means it must produce it, it must organise it" (Betta 2016, p.31-32). Lorenzini (2016, p.46), states that according to Foucault: "freedom is not a metaphysical concept: on the contrary, the exercise of freedom is always punctual and relative to a certain given configuration of power relations." The rise of clinical medicine was also of interest to Foucault.

In his work entitled: "The Birth of the Clinic" (2003) he explored the power and control of medicine, the development of the clinical gaze and how knowledge gains legitimisation (Hodges et al. 2014; McCall 2016). Foucault took a particular interest in psychology and psychiatry (which he considered a 'dubious science') (Powell 2015) and the distinction between the 'mad' and the 'sane' where, at a time when 'madness' and 'illness' were linked, he claimed that the 'sane' held moral control over the 'mad' (Ninnis 2016).

Foucault maintained that the human body itself represents a station for circulating relations

of power and that rule of the human body underpins professional regimes of power. Powell (2015, p.409) further argues: "Indeed, the success of modernity's domination over efficient bodies in industry, docile bodies in prisons, patient bodies in clinical research and regimented bodies in schools and residential centres attest to Foucault's thesis." Another two critical areas of Foucault's work embrace concerns of genealogy and the archives of knowledge.

Foucault was an advocate of the historical perspective of Genealogy which encourages investigation to assist critique of how the present has been crafted by the past, to reveal the relationship between knowledge, power and the human subject. Genealogy then, as advanced by Wang (2017, p.2):

> Seeks to illuminate the contingency of the taken for granted, to denaturalise what seems immutable, to destabilise seemingly natural categories as constructs and confines articulated by discourse, opening up new possibilities for the future.

Hand in hand with genealogy is Foucault's notion of an Archaeology of Knowledge. Archaeology seeks to investigate the history of the structures within society which have created and moulded the boundaries around ideas, knowledge and truth; subsequently revealing representations and discursive formations (Hanson & Ogunade 2016). Linked to historical notions of truth, knowledge, rationality and the need for contextualisation:

> Foucault's archaeology examined the conditions of emergence, how and why a given society/era recognises certain things as knowledge, how and why some procedures are considered rational and others not (Wang 2017, p.2).

As a result, if deemed irrational, individuals and groups may become marginalised or excluded. Foucault, was a supporter of marginalised groups and pro civil society, his term 'totalizing institutions' referred to the centralizing of power and he was interested in the effects that follow when totalizing institutions monopolise knowledge (Nica 2017; Villadsen

2016). For Raffnsoe, Gudmand-Hoyer & Thaning (2016), Foucault's investigations of knowledge and government have become reflected in today's working and private life, regardless of where an individual is situated in the social order; marginalised or at its centre.

Discursive and non-discursive practices create the agenda and exercise powerful influence. A discursively constituted effect of power becomes truth which subsequently grants legitimacy to specialised forms of knowledge, which then reinforce and reproduce power (Gordon 1980; Legg 2016). Moreover, Legg (2016, p.860) asserts that: "It is the command to tell and know the truth, that Foucault suggests, marks the intimate intrusion of governmentality into self-conduct." Over time, Foucault became increasingly interested in the self and interaction between the self and others. According to Depew (2016), Foucault noted that perhaps in the past he focussed too much on technologies of power and domination and not enough on technologies of individual domination and power relations. That is, the chosen action taken by an individual upon his or herself by way of the technologies of the self (Tazzioli 2016). In fact, Foucault claimed that: "the conduct of oneself is one of the best aids for coming to terms with the specificity of power relations" (Depew 2016, pp 28-29). Ultimately, for Foucault, the Platonic Model espouses that truth results from self-knowledge (Cohen 2017; Peters 2017). Explained by Depew (2016, p.28): "The relation between the reflexivity of the self, on the self, and the knowledge of the truth is established in the form of the already-there, and self-knowledge is arrived at in the element of identity." Foucauldian ideas, according to Zamora (2016, p.2) have become: "a central intellectual reference of our time." Hampton (2016, p.115), in discussion of the marginal role given to the humanist tradition within Foucault's work on power, suggests why:

In the decades since his death (1984), many of the great humanist themes: the ethics of governments, the spatial expansion of empire, the dynamics of migration and diaspora – have made their return. In a global culture, the intersection between ethical government, spatial practice, and the movement of populations persists as a post-antihumanist concern.

In a global culture, medical migration is a constant (Bonditti, Bigo & Gros 2017). IMGs continue to choose Australia as a preferred country in which to practice medicine. Once in Australia IMGs are confronted with a medical profession based on a hierarchy of power, authority and self-interest. The pursuit of self-interest is linked to the exercise of power as Depew (2016, p.26) confirms: "If an individual seeks to gain political power over others, one cannot transform one's privileges into political action on others, into rational action, if one is not concerned about oneself." Foucault's systematic approach applied to medical institutions, governmentality and the human body offers a useful lens through which to view medical dominance and the ramifications of its actions and behaviours. The historical perspective applied to the rise of the medical profession and the development of the supporting structures and process which underpin it are illuminated by Foucault's complimentary concepts of Genealogy and the Archaeology of Knowledge. Knowledge shapes action taken and power exercised which in turn, shape new knowledge and its assigned credibility. Over time legitimacy of what is truth is established.

Powell (2015, p.403) explains:

> Other interpretations are simultaneously discounted and delegitimised. The result is a view and mode of practice in which power and knowledge support each other. These domains not only sustain, for example, certain professional discourses, they mould what those professions might become.

The expert knowledge of the medical profession in Australia has been granted legitimacy by the government and as a result, assumes a powerful superior status over other health

professionals. The beginnings of the professions can be located as long ago as the 11th century when craftspeople (such as bakers and cobblers) of the same trade formed associations. These early associations are similar to modern associations today. According to Susskind & Susskind (2015, p.20):

> They came together to set standards, control competition, to look after the interests of their members and families, and to enjoy the prestige of being part of a group of recognised experts.

Contemporary professions developed especially in the 19th century with the rise of capitalism and other scholars of the time had varying perspectives on how to view the professions. For example, for Durkheim they were a vehicle for integration and regulation in modern society and constituted a move away from excessive individualism. Weber was able to include their rise in his ideas of class and market economy where there was increasing rationalisation and bureaucratisation in society. Functionalist, Talcott Parsons stressed the function of the professions as a positive for modern society in terms of the maintenance of social order. On the other hand, the professions and professionalism viewed from a conflict perspective represented vehicles for power, authority and control. "Since British colonisation, medicine in Australia has developed as a strong market-based industry" (Keleher 2016, p.397).

By 1880, Willis (1989, p.60) argues:

> Medicine had a high-status, reasonably politically effective vanguard elite who utilised their class positions and contacts in the political sphere to further the cause of the occupation as a whole (the external dynamic) while attempting to regulate and reform it from within (the internal dynamic).

Hegemonic masculinity is also found in the medical profession which is male-dominated despite the fact that the number of female graduates is now equal to males. According to the Australian Institute of Health and Welfare (2015), women constitute 38.6%, nearly two

in five of all doctors. The medical profession's population represents an ageing workforce however with the average age of male doctors at 48years and the average age of female doctors at 41years. Women are underrepresented in the surgical fields. Nevertheless, the Australian population endorse the medical profession to be the custodians of population health.

To return to the focus of this thesis: How are IMGs placed within the profession and what does the Australian trained medical profession and the system expect of them? Importantly why are they placed as they are; a professional underclass within an elite profession? Turner (1995, p.133) argues that professionalization itself can be regarded as a strategy of occupational control which "structures the relationship between experts, patrons and clients." (see Powell, 2015; Susskind & Susskind, 2015). In terms of IMGs, the system has developed a number of strategies for control which conspire to limit, regulate and exclude IMGs so that their marginalisation is maximised. Strategies of control include such measures as exams and fees.

STRATEGIES OF CONTROL – EXAMINATIONS

Australia has a long history of exclusionary practices and assessment methods directed towards overseas trained medical practitioners. For example, after the Second World War when displaced person medical doctors came to Australia hoping for a new life and the opportunity to utilise their medical skills, they were met with discriminatory policies and strategies. A shocking practice is mentioned by Iredale (2009, p.44): "Sydney University was notorious. It took 'refugee doctors' for retraining but right up till 1974 it only allowed eight to graduate each year. If more qualified, a ballot was held." Another illuminating example from much later in 1998 shows that inquiries are not able to make any real changing impact on the discriminatory practices associated with the medical profession.

Marked differences were found in the assessment of Australian medical students and AMC candidates. The NSW Committee for Review of Employment (1998) found that this impeded not only the chances of AMC candidates from obtaining the required standard but also their access to employment. The Committee recommended (1998) that: "to ensure procedural fairness and to avoid complaints of discrimination, the Australian Medical Council examinations be based on a clearly articulated curriculum" (Iredale 2009, p.46). Assessment within Australian medicine, while deemed essential in the interests of maintaining high standards, can become a vehicle for exclusion.

The system has medical sovereignty and consequentially can control the entry of overseas trained medical professionals into the Australian Health System via exams and assessments that are difficult to access, attract fees and have lengthy delays. Some IMGs do not pass both exams, for example a doctor may pass the AMC multiple choice exam but fail the clinical exam. As a result, some IMGs are required to re-sit exams sometimes many times. Robyn Iredale has worked on issues associated with IMGs for over thirty years and made a submission to the 2012 Parliamentary Inquiry, in her view:

> The AMC exams are an example of systemic discrimination where certain ethnic/linguistic (NESB) groups do not achieve pass rates comparable to ESB groups. In countries like the US, this would require the AMC to prove that the exams are not discriminatory. In Australia, however, differential rates are attributed to the lesser knowledge and skills of certain candidates (2012, submission 134, p.5).

Strategies for control are developed and operationalised as if IMGs represented an alternate form of health care professionals. The system underpinned by medical dominance seems to regard and treat IMGs in the same way as it does other allied health bodies, that is the need to control them, establish boundaries around them and do the utmost to if not exclude them, at least marginalise them (Twohig 2016). Could it be that

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IMGs are perceived by the system to constitute a type of alternative care or even competition? Perhaps the situation for IMGs can be seen in these terms:

> Professionalism restricts entry into the medical market place which is controlled by professional associations via a system of formal exams. Professional medicine attempts to regulate the market to prevent the introduction of alternative systems of care. These controls on entry bring about limitations on competition…There is little public regulation of prices and the supply of service because of the existence of medical dominance (Turner 1995, p.195).

Examinations carry with them a great deal of power, the power to grant acceptance and the power to fail (McCall 2016). For IMGs particularly, unsuccessful exam results can result in costly re-sit fees or even be career ending. Found in all mechanisms of discipline, Foucault described examinations as:

> A constantly repeated ritual of power. The examination combines the techniques of an observing hierarchy and those of a normalizing judgment. It is a normalizing gaze, a surveillance that makes it possible to qualify, to classify, and to punish. It establishes over individuals a visibility through which one differentiates them and judges them (Rabinow 1984, p.197).

Many IMGs find the examination preparation and access process a very stressful time particularly as so much is at stake; their capacity to work in their profession in a new country. Failure can result in loss of income, adverse impacts on family life and ongoing pressure. Exams constitute an exclusionary practice (those who pass and those who do not) this has a potentially disempowering influence on an IMG's self-esteem. For Schroder and Thompson (2015) the ethical dimension of exams and the relation to self is of particular concern. "The praxis of examination entails self-confrontation in the light of the uncertainty regarding that which is expected of the self." IMGs are already fully qualified medical practitioners and their demotion to something akin to student level must challenge their ability to retain their professional identity. A strong professional identity as a medical

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doctor will assist through the process journey but at the same time that identity is being eroded (Harris, A. & Guillemin 2015). IMGs receive a very clear message that they constitute an underclass. IMGs possess an occupational skill set if you like, and when that is questioned and tested it represents a threat to occupational identity. While some IMGs may be undertaking some medical work, at the same time, their knowledge and skills are under examination, as they continue to work, their ability to work is being questioned. Therefore IMGs may be able to utilise particular components of their occupational identity, by activation of parts of their "tool-kit": "but it is the "tool-kit" itself that constitutes the entirety of one's occupational identity" (McDonald 2013, p.242).   The maintenance of identity for IMGs also involves the ability to finance the assessment journey they are required to undertake. For example, there is a financial cost to undertake exam assessment; application to enter a particular pathway attracts a fee as does appeals, cancellations and incomplete documentation.

STRATEGIES OF CONTROL: FEES

IMGs must be financially able to meet the costs associated with the practice of medicine in Australia. This requirement would immediately disadvantage some IMGs particularly those who are unemployed and those who, due to the circumstances they have come from, may be financially vulnerable. Compulsory fees represent another strategy to exclude and marginalise IMGs from the Australian medical profession. The system has an extensive array of fees with each of the speciality colleges having its own fee schedule. It is beyond the scope of this thesis to list them all however perhaps the most complex and expensive of all fee structures belongs to the RACS (see appendix 2). This is not surprising as surgeons are at the top of the medical hierarchy. Currently, surgeons constitute the, "most prestigious current professional of all (Susskind & Susskind 2015, p.20). The following is

an example of fees required by the AMC (2016).

Table 3 AMC fees (as at 1 January 2016)

Assessment pathway application	$ 500.00
Incomplete documentation	130.00
Multiple choice exam	2,720.00
Cancellation	1,360.00
Clinical exam	3,530.00
Clinical exam - retest	2,000.00
Appeal fee	215.00
Workplace based assessment	650.00
Certificate – Competent Authority Pathway	300.00

Unemployed IMGs must fund their fees from accumulated savings. This would be near impossible for those IMGs coming from poorer backgrounds or for those fleeing hostile unsafe countries, such as some refugee doctors. For those IMGs who can finance the fee requirements their navigation through the process to registration may take several months to years. Harris and Guillemin (2015, p.164) suggest that medically unemployed doctors: "are on the medical periphery and become part of the medical underground." Some of the IMGs in this study had worked as pizza deliverers and taxi drivers (Pascoe 2011) to survive and support their families while waiting for processes to progress or in an effort to save to finance the next required fee. Rita's story is a case in point. In our interview Rita mentioned that her husband (also an IMG) was driving a taxi while trying to study for his exams. They both intended to practice medicine in Australia but due to the extensive processes and fees required, Rita was forced to make a difficult decision. Rita abandoned her desire to practice medicine and found employment as an assistant in a nursing home.

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Rita also managed to obtain some casual tutoring at the local university. There was sadness in her voice:

> We couldn't both do this it was too stressful on the family…my two little boys. I said you just study, no more taxis, and I will get a job. I wanted to maybe get into public health but they said I didn't have experience. It was a bit sad and friends and family they didn't understand…they said what are you doing! I had to see a Psychologist to help get through it (2011, interview 4).

Fees for profit have become a part of many aspects of modern society. Capitalism transformed and undermined traditional ideals and values. Profit became the primary motivation (Susskind & Susskind 2015). According to Blackshaw (2010, p.162):

> One of the major reasons why the *status quo* is maintained (and capitalism flourishes) is that it readily incorporates from dissenting movements those aspects which dovetail with its *modus operandi*; while being always successful in resisting the remainder.

Hegemonic power enables the medical profession to demand payment of fees for the privilege of seeking approval to practice medicine. Ultimately, if an IMG is unable to pay the nominated fees he or she cannot progress towards accreditation and registration.

IMGs continue to experience difficulties with the system's expectations. The following section reveals the voices of IMGs and their lived experience. Their voices share a myriad of rich very personal stories. The reader will gain an appreciation of what seems to be predominately a struggle with power; interpersonal power relations with the structural power of the system and the hegemonic power of the medical profession.

INTERPERSONAL POWER: IMG VOICES

In the context of interpersonal power, the following IMG experiences of the system are

shared through the voices of the data set (focus group, individual interviews, the submissions to the 2012 Parliamentary Inquiry and 2016 Senate Committee Inquiry). This representation of lived experience through powerful narratives richly allows the reader into the world of IMGs. The process journey for many IMGs can become a long term struggle which seems to resemble a 'them' and 'us' battle. Unfortunately some IMGs become defeated by the system and this position can be reflected in their inability to work in the capacity they desire, in their chosen profession, or the inability to work at all in their chosen profession, due to not meeting the requirements of the system. Subsequently, some IMGs experience adverse physical and or mental health issues. The story of Dr Douglas a Canadian Assistant Professor of Family Medicine and past head of Canada's largest obstetrics department is a case in point.

Dr Douglas secured a lecturing position in the Australian National University's (ANU) medical school. However, on arrival and much to her dismay, she discovered that while she was considered highly qualified to teach Australian medical students, she was considered not sufficiently qualified (after seventeen years of clinical practice in Canada) to gain full registration to practice medicine in Australia. Dr Douglas was confronted with a lengthy and costly process journey. Dr Douglas wrote to the 2012 Parliamentary Inquiry Committee:

> It isn't that any one event in itself is particularly shocking; it is the fact that the problems never seem to end, and just go on and on, to the point where you literally feel like you are losing your mind (2012, submission 111).

Dr Douglas was left feeling vulnerable and powerless. This eventually had an adverse impact on her mental health. Dr Douglas has been an outspoken representative for IMGs by her association with Australian Doctors Trained Overseas (ADTOS) and through her exposure in the media where she told of her struggles with the system. As a result, Dr

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Douglas told the 2012 inquiry that she has been contacted by over seventy overseas trained health professionals experiencing difficulties with the system. The majority were doctors but she was also approached by dentists, nurses, pharmacists, physiotherapists and a vet. This indicates that other professional groups with qualifications from overseas also attract intense scrutiny from a system. My concern for the possible alienation of IMGs in this study from the system and perhaps from Australia itself due to their struggles convinces me to view IMGs as a community. This is an attempt to assign the IMG narratives through the stories they share, a central agency in the research with credibility and solidarity as a professional, political group.

IMGs AS A PROFESSIONAL COMMUNITY

To further the agency of the IMG voice, I viewed them as a discrete community with professional solidarity. Following Anderson's idea of imagined community, IMGs can belong to their own community "because the members of even the smallest nation will never know most of their fellow-members, meet them, or even hear of them, yet in the minds of each lives the image of their communion" (Anderson, B 1983, p.15). Further, Anderson believes that "communities are to be distinguished, not by their falsity/genuineness, but by the style in which they are imagined" (p.6). In this sense IMGs can view themselves as part of an IMG community while perhaps feeling as if they are somewhat excluded from the nation as outsiders. The power to identify as part of the nation is never equally distributed among a nation's members (Carter, D 2006). In fact, IMGs are represented by their own associations, such as the Australian Doctors Trained Overseas Association (ADTOA)[15] and there are other discipline specific associations such

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[15] Australian Doctors Trained Overseas Association (ADTOA) http://adtoa.org.au. Overseas Trained Specialist Anaesthetists Network (OSTAN) http://otsan.org/

as the Overseas Trained Specialist Anaesthetists Network (OTSAN). One FGP in this study made a comment that indicated a sense of community among IMGs however, it also revealed vulnerability:

> We network and support each other and stick together when we can. It's the blind leading the blind (Pascoe, 2007).

A definition provided by Brint (2001, p.8) in his critique of Toennies' gemeinschaft, views community as a generic concept and defines communities as: "aggregates of people who share common activities and/or beliefs and who are bound together *principally* by relations of affect, loyalty, common values, and/or personal concern." The work of Patricia Hill-Collins is particularly useful here. In her presidential address of 2009 to the American Sociological Association she suggested the reframing of community as a political construct to advance new ways for investigating social inequalities. Community is either named as a political construct or implicated in political phenomena. Collins(2010) advocates for rethinking intersecting systems of power and activities considered political for exploring how the construct of community works within power relations. The communal solidarity of the Australian trained doctors' community may be based on fear. Following Bauman's ideas on liquid modern communities, Blackshaw (2010, p.154) points out that the dark side of community solidarity operates by:

> Subjecting the least powerful social actors in communities…to a form of symbolic violence, which not only legitimizes the systems of meaning constructed in the interests of the powerful, but also maintains extant structures of social inequality.

In the eyes of the system IMGs may, because of their lived experience be labelled as not up to the standard of Australian trained doctors but IMGs can however constitute a

community. The construct of community is an important tool in the organisation of power differentials between communities as well as a tool for use by people to challenge hierarchies. Underpinning the construct can be the idea of community as fundamental to group identification. If IMGs are viewed as a community this implies a sense of solidarity.

According to Collins (2010, p.11): "the construct of community catalyses strong, deep feelings that can move people to action. Community is not simply a cognitive construct; it is infused with emotions and value-laden meanings". There is a social justice narrative entwined throughout the data which highlights the struggle, frustration and debilitation of some IMGs in Australia. As a result the community construct is particularly relevant in this study. As Collins (2010, p.26) argues: "Community is a ubiquitous, versatile idea that can accommodate contradictory means and link thinking, feeling, and action in ways that make it especially useful for contemporary social justice initiatives". If IMGs wish to mobilise to become further empowered and take action it seems that the best way to facilitate that would be via a community of IMGs rather than via individual IMGs.

Hence, in this study, IMGs can be positioned as the other in terms of their relationship with the system, but at the same time, as a discrete professional community. The other category brings with it an assumed deficit or inadequacy model because they are medical practitioners from overseas. The system which evolved to regulate and control them has been assigned with the responsibility to establish the ability and credibility of the doctors. IMGs are required to demonstrate that they meet the mandatory standards to practice medicine in Australia. For many IMGs this is not an easy task, especially for those seeking to begin work in Australia as a specialist. Moreover, the stumbling blocks often invented by the system to discourage this are endemic. During a conversation with my informant regarding specialist entry she stated: "If they want to come in as specialists, they can

forget it" (personal communication). The underpinning rhetoric and justification for the extensive processes produced by the system always appears to be around maintaining the high standards that are expected in the Australian health system.

I pondered the unlikely notion that all the people in the rest of the world must receive health care at a lower standard than people in Australia. One would assume that the anatomy, and physiology, that is the science and scientific study of the human body would not differ from one country to another. Surely the humans needing medical attention in Australia are not vastly different to humans needing medical attention elsewhere in the world. Dr Gonzaga (2012, submission 25) raised this with the Parliamentary Inquiry (2012) particularly in relation to the competent authority pathway which can give some advanced standing for doctors from New Zealand, the United Kingdom, Canada, United States of America and Ireland. This initiative seems to serve to divide IMGs into first class IMGs and second class IMGs and could be perceived as a racist initiative.

> The Competent Authority Pathway gave rise to a query of what['s] so special about doctors trained in the USA, UK, Canada and NZ? Isn't [it] that medical knowledge is a universal thing, regardless of language, colour, country status, the biochemical principles, human anatomical landmarks, mode of action of medications, types of bacteria and viruses, etc. are all the same wherever you are on Earth ... Therefore there shouldn't have boundaries in categorising and assessing competency of an IMG regardless of country of origin (2012, submission 25).

The maintaining standards rhetoric seems a thinly veiled cover for the justification of such intense scrutiny and perhaps the potential for less scrutiny for IMGs from English speaking countries considered 'more compatible' to Australian ways. Dr Ahrens in his submission to the inquiry committee made clear his opinion of the maintaining standards rhetoric.

Dr Ahrens argued that it is really about controlling competition:

> This has nothing to do with keeping standards; it is a closed shop mentality…don't expect these professional bodies to change their ways without considerable pressure. Which other profession is still in the extraordinarily privileged position to control national and global competition? (2012, submission 66).

There is difference however in the 'how' of medical practice, in the procedures, processes, protocols, rules and regulations from one country to another.

The structure and agency relationship and associated discourses sit firmly entrenched within the boundaries of the system. The system communicates to IMGs via a deficit discourse which is a vehicle for power. In terms of this research relations of language and power are embodied in the discourses. These discourses and the associated practices of the many institutions which make up the system overtly and covertly control IMGs.

DISCOURSE AND POWER

Initially, to provide a foundation on which to build an understanding of the IMG process and how it is experienced, it is necessary to explore the key concept of discourse and the complexity of power relations between the system and IMGs. For Foucault (1991) additional structures determine language use such as historically-based combinations of various themes, concepts or problems. The language statements made around these structures become 'discursive formations'. A discourse becomes a collection of statements which are made by the same discursive formation. In this way, discourses frame understanding of identity and place in society and domination is constructed through discourses in particular social sites. Totalising discourses then refer to ways of thinking and acting which control and take over whole areas of human life (Foley, G 2000). For example, people's lives increasingly regulated by the practices and discourses of the

professions (such as medicine) in that the population's health behaviours have become dominated by medical directive.

Rabinow (1984, p.10) maintains that Foucault did not seek to isolate discourses from the surrounding social practices but rather his aim was to: " isolate techniques of power exactly in those places where this kind of analysis is rarely done". Foucault argued that it is more productive to explore the way power is constructed, than to identify the sources of domination and power. The construction of power in social institutions can be at the local or 'micro' level and be subtle and undetected. This secret, unconscious aspect of discourses means that people can participate in their own subjugation by adopting the rules of a discourse or by accepting something that is socially constructed as 'truth'. According to Foley (2000, p.290): "Often, even when people resist totalising discourses they do so in ways which do not challenge the power of the discourse to set the boundaries of thought… The bearers of the discourse generally do not recognise the totalising power of what they are transmitting and so are the unaware bearers of oppression." In terms of this research, IMGs have no choice but to accept the discourses as they find themselves in a particularly vulnerable position. The socially constructed 'truth' of their situation they must engage with as 'truth' because it is a construction which has power over them and they are not familiar with it. If an IMG does not accept and follow the rules he or she may be unable to get work as a doctor or at worst be deported from the country. For example, during the focus group one participant shared the experience of an IMG colleague who had a personality clash with his supervisor. This eventually resulted in the IMG being dismissed of his duties.

The IMG was not a permanent resident so was required to leave the country within 28 days:

> The very next thing we had was people coming to our house crying, the whole family and they couldn't go back to where they'd come from, they'd sold everything from where they'd come from and what do they do, how do they get another job? (Pascoe, 2007).

Similarly, an IMG who arrived in Australia from the Philippines in 2006 to take up work as a GP was deported. His anonymous story is one that highlights the amazing inflexibility of the system. The medical board advised the doctor in 2010 that despite being employed in a medical practice in an AON and ignoring the fact that he had completed, with results pending, the Practice Based Assessment (PBA) necessary for fellowship to the RACGP, he was to undergo the PESCI to renew his registration. Unfortunately he failed and was advised that he was not fit to practice. Despite protests, requests and supporting documents the medical board refused to renew his registration. On the 1st of July 2010 he was required to settle his affairs and return with his family to the Philippines. On the 8th of October 2010 he was informed that he had passed the PBA and was awarded fellowship to the RACGP in November 2010.

Sadly, this successful outcome would not count. He wished to return to Australia with his family but was regrettably informed that he must begin the whole process again from the very beginning including supplying documents already supplied previously. This bureaucratic life changing event has taken its toll on the doctor and his family:

> The income I have lost and the psychological challenge that my family and I had to go through is unquantifiable. If the medical board allowed me to renew my registration and allowed me to practice for another 4 months pending my PBA results then none of these would have happened (Anon 2012, submission 15).

Another focus group participant acknowledged the vulnerability particularly of new IMGs in terms of negotiating their work conditions:

> You subconsciously say yes to most of the things that they want you to do rather than what you want. It is because of that vulnerable situation that we are put into and that's one thing we should address. (FGP)

The agents of the discourses however (the people employed in the system's institutions) I am sure do not deliberately set out to oppress IMGs, as they are also following the rules set down for them. They could well be unaware therefore that they are bearers of oppression.

Ideally, for Foucault (in Ball1990, p.2):

> Domination must be struggled with locally, dominant discourses must be countered by insurgent discourses: The only way to eliminate the fascism in our heads: is to explore and build upon the open qualities of human discourse, and thereby intervene in the way in which knowledge is produced in particular situations.

The IMG/system relationship is characterised with systematic and sustained intervention. The discourses convey to IMGs that they constitute an inferior status. What is conveyed is essentially a deficit model. In the field of education for example, teachers are warned against perceptions of a student based on weakness (or deficit) rather than strength. If a student's weakness is the dominant influence on teacher perception, the teacher will tend to develop lower expectations of the student. The student may go on to develop a self-fulfilling prophecy (following an Interactionist perspective) where he or she tends to see the weakness as dominant too and behaves accordingly. If an IMG is in constant struggle with the system and interaction is difficult and even demeaning this will eventually impact on the IMG's concept of his or her self. The self is made up of an individual's thoughts and feelings and its construction is produced and influenced via interaction with others. A deficit ideology is at the core of the system/IMG interactions. The associated discourses establish, reflect and enforce deficit. Many IMGs in this study mention loss of confidence

and loss of self-esteem due to their experiences with the system. In our interview Colin shared an example from when he first arrived in Australia and attended an orientation session held in Brisbane:

> They went on and on about litigation, patients will sue you, you must be very careful. They made us feel like we don't know enough, and I got very nervous. For the first 3 months of work I lost my confidence even prescribing the most basic medication (2010, interview 2).

Gorski (2010, p.2) maintains the most devastating aspect of deficit thinking occurs: "when we mistake difference, particularly difference from ourselves, for deficit." For example, consider the standard English spoken in Australia, when exposed to a variation of that language or a different language altogether, it may be perceived as inferior or even deviant (Collins 1988). The deficit perspective at work is described by Gorski (2010, p.5) as a socialisation for complicity to train the mass consciousness to "pathologise" the disenfranchised:

> Once that scornful gaze down the power hierarchy is in place, so is established the justification for maintaining existing social, political and economic conditions…This process prepares individuals to comply with the dominant discourse—the deficit discourse—… But it also prepares us to enforce compliance by marginalizing counter-discourses.

In terms of this research, it is implied both overtly and covertly, sometimes subtly and sometimes blatantly, that IMGs may not meet the standards required for medical practice in Australia, simply because they are overseas trained. Harris (2009, p.2) in her ethnographic study of overseas doctors in Victorian hospitals, also found that: "too often… the overseas doctors' difference is regarded, however subtly, in a negative way." In addition the organisations within the system also convey a negative view of IMGs.

The House of Representatives Inquiry and subsequent report (2012) noted that while many rural and remote communities have welcomed IMGs as one of their own:

it is clear that whilst IMGs generally have very strong community support, they do not always receive the same level of support from the institutions and agencies that accredit and register them"… The Committee also receive [sic] approaches from a number of IMGs, who while keen to air their concerns informally, refused to make formal submission to the inquiry fearing negative consequences.

Moreover, the blatant exercise of power and intimidation by the system can be found in the fact that the report's forward also notes:

nearly one third of the IMGs who made submissions requested anonymity, citing fears that their chances of progressing through accreditation to registration would be compromised if it became known that they had commented publicly.

The fear of reprisal or penalty is not confined to IMGs. Interestingly, Knowles and Bannon (2015) also make mention in the expert advisory group draft report on discrimination, bullying and sexual harassment for the Royal Australian College of Surgeons that some potential research participants (Surgeons, trainees, consultants) were reluctant to take part in their research because of concerns for possible repercussions. Similarly, the 2016 Senate Inquiry experienced reluctance from some potential submitters towards speaking out.

If throughout the process journey an IMG receives negative messages and encounters negative interactions from the system to the extent that as a result, discourses culminate in fear, it may ultimately have adverse implications for his or her health and subsequent ability to practice medicine. In fact, in his submission to the inquiry Anaesthetist Dr Schoengen, due to his first-hand experience of the "humiliating and depressing process" to get his professional qualification recognised in Australia, no longer recommends Australia as a professional destination (2012, submission 150). Moreover, minority group doctors

generally can be vulnerable psychologically. From their 2013 National Mental Health Survey of Doctors and Medical Students, Beyond Blue concluded:

> minority groups such as overseas trained medical professionals, Indigenous doctors and students, and those working in rural and remote areas, where greater independence may be required with reduced access to support networks, have been identified as groups who may be particularly vulnerable to psychological distress (2013, p.7).

Many of the submissions to the 2012 Parliamentary Inquiry and the 2016 Senate Committee are based on seemingly ridiculous situations in which doctors have found themselves due to the inflexible and almost bloody minded approach by the system. For example, the case of Dr Thuryrajah, an IMG from Kashmir. Dr Thuryrajah was assessed, verified and granted provisional registration by the West Australian Medical Board on an annual basis and worked as a GP in an outer metropolitan area of Perth from 2004 to 2007. In 2008 new legislation required her to have her degree re-verified because she was trained overseas. Dr Thuryrajah was asked by the AMC to reapply for verification of her degree via the Educational Committee for Foreign Medical Graduates (ECFMG) which she did. The AMC and the ECFMG did not inform her of the progress and when she eventually got a response to her repeated inquiries she was told that they were waiting on the University of Kashmir. Dr Thuryrajah contacted Kashmir herself and was told that due to an arson attack student records prior to 1983 were destroyed. Dr Thuryrajah offered to submit a true certified copy to the university but this was declined. Apparently, the only option available to her was to post or personally present her original degree to the relevant university staff in Kashmir. Dr Thuryrajah was not confident to let her degree out of her possession due to unstable and corrupt conditions in Kashmir, and described Kashmir as a war zone. In fact the university's Vice-Chancellor was murdered in 1990. The Australian government at the time had issued travel warnings and Dr Thuryrajah decided to heed the

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warnings:

> I felt it would be a significant danger to my life and safety…I am now not employed in any capacity (2012, submission 102).

Another example, which caused one interview participant to express anger and frustration in relation to the system's requirements, came to light in our interview. Tania was informed that she would have to re-sit the English assessment. Tania protested as she had already passed this assessment but was told there was no other option. Almost in tears (and in perfect English I might add) Tania said:

> This is crazy. I have done this and was successful. I have been in Australia for another two years since that, how could my English be worse? Why don't they stop disrupting our lives! (2011, interview 7).

Julian, one of the interview participants mentioned a particularly annoying situation where various bodies within the system refuse to share information. He was frustrated and amazed by the red tape in Australia but resigned to the fact that compliance is the only way through the system:

> I needed some paperwork which I had to send for my initial registration. Now I needed it to be able to go to the exam with the RACGP and they actually refused to give, even a copy. I said "I need a copy of that paper." They said "We can't give you the original, you signed that, we keep that." I said "That's fine, I just need the copy. They only want the copy." It's a piece of paper I can only get from Europe again and they refused and they said "Look, we had a bad experience, blah, blah, blah, you could then copy it again and again and again, and it could go anywhere." And then I said "Look, if I get it from Europe, I could do the same as well. I could just copy it or change it or whatever." I really don't understand why they are so suspicious of OTDs generally. I think it is political…it's a kind of paranoia. I just have to get through it (2010, interview 1).

Dr Neelaprinyantha after searching for a training position throughout Australia was finally offered an honorary position by a Melbourne hospital. His delight was subsequently

dashed when, because he had not worked for one year, his registration and English language certificate had expired and as a result impacted his employment offer:

> It is indeed very unfair to deprive me of the honorary position obtained with great difficulty because of the expiry of the validity of my English Language certificate by not renewing my specific registration. I believed once the English qualification was accepted by the Registration Board it remains valid as long as I am resident in Australia i.e. in an English speaking environment! (2012, submission 153).

The forward of the Parliamentary Inquiry's report (2012) further notes: "The Committee also had to contend with issues of a sensitive nature which had evidently resulted in high levels of angst and personal distress for some IMGs." For example, Dr Lemieszek wrote to the inquiry committee detailing his experiences of bullying in a NSW hospital and as a result:

> I became very depressed and anxious. I could not sleep or eat and needed to take time off work for stress related reasons (2012, submission 118).

Similarly, Dr Douglas as a result of her seemingly endless struggle with the system's processes where she had to obtain a fellowship with the College of General Practitioners before she could register as a GP; but she could not get a fellowship until she was registered stated:

> I fell into a state of deep depression (2012, submission 111).

Dr Douglas obtained her medical qualifications in Canada, a competent authority pathway country. As a result, Dr Douglas should have gained greater recognition and easier access to registration in Australia. This was certainly not the case.

The 2016 Senate Community Affairs References Committee noted: "the large number of personal accounts from or on behalf of medical practitioners whose lives and careers had suffered" (2016, p.39). For example, Dr Fettke told the Senate Committee (2016, p.39) about the impact on himself and his family from having a vexatious complaint made against him and an investigation launched:

> It changes you. It becomes all-consuming. You lose sleep. My wife and I spend hours beyond normal work hours trying to sort this out. It has affected our children with a combination of anxiety, depression and becoming more introverted. What should be a pleasant experience of helping people is now something you question every day: 'Why do I keep doing this? (Committee Hansard,1 November 2016, p.21).

The medical complaints process which is handled by AHPRA has also become a tool for bullying and harassment. Professor Stokes discussed the additional impact on practitioners subjected to a vexatious complaint, sometimes leading to suicide:

> the significant unintended consequences of vexatious reporting, which causes practitioner illness, also causes severe financial hardship and, in a number of cases that we know about, has caused the suicide of very good doctors (Committee Hansard, November 2016, p.13).

The Australian Medical Students' Association submission to the 2016 Senate Committee informed the inquiry that bullying begins during medical training. The 2013 Beyond Blue survey found that " a fifth of medical students and almost a quarter of doctors reported thoughts of suicide over the preceding 12 months" (2016, submission, 10).

 IMG, Dr Lemieszek was subjected to appalling treatment by his supervisor. He informed the 2012 Inquiry that he reported his experiences of bullying to three different organisations and was strongly encouraged to solve it privately and file a grievance rather than a bullying report. Dr Lemieszek stated that his supervisor told him:

> We will keep you like a dog on a leash. If you are a good puppy we will extend your leash, if not we will tighten it (2012, submission 118).

On another occasion when Dr Lemieszek questioned the low marks he had been given in a supervisory report his supervisor informed him that the reason why was that:

> Top marks are reserved for the top 3% of best performers, and as you are overseas trained you cannot belong to this group (2012, submission 118).

Dr Lemieszek did report the bullying and was stunned to be advised that the same bullying supervisor he reported was nominated to investigate the allegations. He made the following analogy:

> I felt like a victim of rape asked to reconcile with the rapist (2012, submission 118).

Dr Lemieszek was told by the alleged bully that he had: "Dug a hole for himself." Eventually he resigned his job and as a result of his 'poor supervisory reports' the medical board imposed such strict conditions on Dr Lemieszek's registration that it made it almost impossible for him to find another position. During his efforts to find new employment, Dr Lemieszek was shocked to hear from a recruitment agency that his past supervisor had phoned the agency and instructed that Dr Lemieszek was not to be given any job. Baffled by this Dr Lemieszek stated:

> I have no idea why this man would go out of his way to track me down and sabotage my attempts to get a job (2012, submission 118).

Dr Lemieszek did find another position as a psychiatry trainee and at the time of writing was happy in his new location and felt lucky that his career was not totally ruined.

However, the fact remains that as Dr Lemieszek concludes:

> My experiences at the hospital and its aftermath has inflicted serious damage to my career. I was deprived the opportunity to work in my profession, despite passing all required exams. I lost 11 months of my professional life and about $70,000.00 in income (2012, submission 118).

These (2012) examples of IMG narratives all tell of adverse experiences in their interactions with the system. Examples from within medicine generally given to the 2016 Senate Committee highlight the toxic culture of medicine. How could interview participant, Tania's (2011, interview 7) English be worse two years after her successful English assessment? Why should it be necessary to place an expiry date on English language obtainment if the doctor (such as Dr. Neelaprinyantha, 2012, submission 153) has remained in Australia? The unnecessary stalemate experienced by Dr Thuryrajah (2012, submission 102) in relation to the re-verifying of her degree resulted in her being unable to work and the bureaucratic bungling experienced by Dr Douglas (2012, submission 111) was nothing short of ridiculous. Dr Lemieszek's (2012, submission 118) treatment was outrageous and unlawful. Surely Julian's (2010, interview 1) paperwork could be safely shared between two bodies in the system, located two blocks apart in the Brisbane CBD. The fact that significant numbers of medical doctors and students contemplate suicide (as reported to the 2016 Senate Committee) is shocking. Moreover, the use of the AHPRA complaints process as a tool for bullying and harassment via vexatious complaints against colleagues is unacceptable. Finally, a stark example, that of South African surgeon Dr. Damp (2012) a highly qualified General Surgeon who was appointed to the position of General Surgeon at a rural South Australian hospital. It was made clear to IMG, Dr Damp that he was not welcome in surgical ranks. Dr Damp was given registration status with the

South Australian Medical Board of a non-vocationally trained general practitioner pending assessment by the AMC. Imagine arriving to begin your new job in a rural South Australian hospital:

> I was met at the front door of the hospital by an Adelaide Professor of Surgery and informed that I was unwelcome in South Australia and should not consider travelling to Adelaide to partake in Surgical Departmental meetings, ward rounds etc., as general practitioners were not welcome at surgeons meetings (2012, submission 06).

Mechanisms were put in place to continually make it difficult if not impossible for Dr Damp to fulfil requirements. Post the Dr Patel scandal of 2005 and the panic which ensued, registration requirements were tightened and supposedly streamlined such as the introduction of a centralised national registration process which was previously the responsibility of individual states. This initiative has been problematic and seems to still be inefficient. The following is Dr Damp's summary of his experiences and the subsequent tragic outcomes. This is an appalling story which shows a chain of events that led to the destruction of not only his career but his physical and mental well-being:

> I believe that as an IMG I have been: Used as a political pawn; invited and then made unwelcome, having burnt my bridges; rendered financially vulnerable and therefore manipulated; rendered professionally insecure with no mechanism to prove my worth; subjected to an unsympathetic employer prepared to take advantage of my predicament; dealt with by a nameless and faceless system impervious to my suffering; forced to negotiate with a devious College which continuously moved the goal posts and subjected to bullying.
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> All the above resulted in my becoming initially hypertensive and then profoundly depressed and ultimately suicidal. I eventually sought professional help and have now withdrawn from many aspects of my former surgical practice. I will not return to my previous employment level (2012, submission 06).

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[16] In 2006 COAG agreed to establish a single national registration scheme for health professionals. During 2009-2010 the National Registration and Accreditation Scheme (NRAS) was operationalised across Australia (Parliamentary Inquiry Report 2012, p.9).

The final irony was experienced by Dr Damp after years battling the system. A slightly inebriated senior surgeon announced to him: "Look, I like you, but we will never accept you as a surgeon in South Australia" (2012, submission 6). Dr Damp's submission not only highlights the inefficient, unreasonable and exclusionary practices by the system but it also highlights the hierarchical structure of the medical system. Surgeons for example, apparently out rank general medical practitioners. Dr Damp and Dr Lemieszek reveal the bullying culture within the medical profession. During our interview Alex mentioned that he had been bullied by nurses, perhaps nursing staff are positioned above IMGs in the medical hierarchy:

> The nurses were bullies, they said I was rude to them and they talked about 'certain' doctors in front of me like I was not present. (I knew they were talking about me)…he's this and he's that and they laughed. I was very uncomfortable. In my culture we don't say please and thank you all the time...does that mean I'm rude? I was glad to leave that hospital and them (2012, interview 10).

There are many stories like these in the data, many casualties from the maze that is the process journey for IMGs in their quest for registration and many stories of Australian trained Medical doctors trapped within a toxic culture. It seems that on the one hand while Australia relies on IMGs, on the other hand Australia does everything it can to make it difficult for IMGs, why is this the case? Power relations are at play here, it is the immense hegemonic power of the medical system which creates and maintains these conditions. In Australia: "Medicine dominates the health division of labour economically, politically, socially and intellectually"(Willis 1989, p.2).

Dr Galak gave his opinion to the parliamentary inquiry committee:

> It is my opinion that the present and future shortage of doctors in Australia is an artificially maintained phenomenon, which is based on pecuniary considerations of incumbents. It is created by the legislatively protected monopoly of the medical market place. This monopoly of local graduates is enforced by the existing legislation and by the modus operandi of the registering authorities (2012, submission 31, p.2).

The data clearly indicates that the IMG experience in Australia is impacted by a group of interconnected systems of oppression that together form a single, historically created system with systemic power, that of the Australian Health System. Intersectionality is a particularly useful framework here as it not only seeks to critique the work of power but by exploring why the social world is structured the way it is the work of power is also confronted. Understanding of how power is operationalised and its impact has the potential for challenge and ultimately transformation (Hill Collins 2000). The following examples focus on how some IMGs view and experience the hegemonic power operationalised through strategies of control such as exams and fees:

At a public hearing conducted by the 2012 Parliamentary Inquiry, it was noted that an IMG had waited more than a year to even obtain a place in a clinical exam (Harris, A 2011). Dr Wenzel highlights the lengthy waiting time IMGs can experience:

> After passing the AMC MCQ examination, the average wait for a position in the clinical AMC examination is 18 (!) months which exacerbates doctors' "time out of clinical work". There are no explanations why some IMGs have to wait much longer than 18 months!!! It gets worse for IMGs who fail in their first attempt, they face a wait of about 22 months, in some cases even up to 3 years! The situation is compounded by the AMC conducing unlimited MCQ examinations locally and overseas at a time where they cannot provide AMC clinical examination positions within a reasonable time! (2012, submission 68, p.2).

In our interview, Alex expressed his opinion of exams for IMGs in Australia believing that

IMGs are given false information about the level required:

> They say they are at intern level but they are not, they are much harder than that. When too many of us start passing they make the exam even harder (2012, interview 10).

In Dr Galak's opinion, fees are very expensive and pose a particular difficulty for those IMGs who come from poor countries, while for the bureaucracy; fees represent a good source of earning:

> To get fully registered an OTD has to pay through the nose to sit exams and to prepare for them. Since most of the candidates are from poor countries - where would they get the money from? There is quite an industry based on such a necessity. Exams are hideously expensive. Every time there is a failure, it has to be repeated. Nice little earner (2012, submission 31 p.2).

Dr Ahrens after more than five years of exemplary service was suddenly required to sit an exam:

> The College and AOA (Australian Orthopaedic Association) have assessed my qualification and experience before I immigrated to Australia. They have found me suitably qualified and trained to work as an Orthopaedic surgeon in an AON position in X. Even though I have filled this position for more than five years and performed to the upmost satisfaction of my employing Health Service and to standards of the College, I am now compelled to verify my competency in an Exam usually taken at entry to the profession. This doesn't make any sense. I was allowed to perform thousands of operations and had in excess of ten thousand patient appointments. My surgical practice is audited, peer reviewed and surgical outcomes are documented, easily comparing to Australian and International standards. Why is it that now a different set of rules applies to grant me unconditional registration or at least a location specific, not time limited registration to continue my work in X? (2012, submission, 66).

Dr Bo Jin's clinical exam experience is almost unbelievable. It was a difficult exam experience anyway due to interruption and criticisms from examiners regarding his English but imagine Dr Bo Jin's surprise when his feedback letter arrived:

The female patient of my second long case was replaced by a male patient. I was really confused about a male patient who could have a past history of total hysterectomy and mastectomy. Perhaps it can only be diagnosed by Australian trained physician in Australia, who is also an examiner for the FRACP clinical examination (2012, submission 26).

During the focus group session the idea of IMGs constituting a source of cheap labour was raised. All participants seemed to agree with this. The comment below explains:

The greatest percentage of bulk billing doctors are IMGs. People who want to start their practices as bulk billing, they look for IMGs because they are cheap labour. We are treated indirectly in a way as cheap labour. We are not cheaper labour, we have good skills, broad-based skills (Pascoe 2007).

According to Dr Galak, the rates of pay for IMGs generally are maintained at the minimum. Is this a deliberate strategy to indeed treat IMGs as a source of cheap labour? Even more concerning, Dr Galak mentioned that an IMG who questions employment conditions can be easily dismissed based on alleged poor performance.

As a general rule OTDs are paid minimal allowed rates and, if this Doctor would ask for his or her pay to be on par with the accepted rates, or request a raise promised at the time of the beginning of the employment, the shortcomings of his/her care provision would be found and this OTD would be quietly dismissed (2012, submission 31 p.2).

A focus group participant (as mentioned in chapter 1), who had not taken any leave, alerted us to the fact that his working conditions constituted cheap labour. Finding himself in an exploitative workplace situation, this doctor worked very long hours for 4 years without any paid recreation leave. He indicated that he could not afford to take leave:

You have to do so many hours, see this many patients from this time to that time, and basically very little time is given for leave (I don't get paid for leave) or to refresh themselves. I burn out. I do 8.30 to 5.30 each day and half day Saturday for the whole year with six weeks leave. I have worked for 4 years and I haven't had any leave (Pascoe, 2007).

Another example of IMGs as cheap labour was offered by Surgeon Dr Damp working in a rural hospital. Dr Damp's account below not only reveals a cheap labour situation but also one of dishonesty on the part of a hospital to save money:

> The X Hospital management informed me that my registration status was immaterial to them as I would work exclusively as a general surgeon and also perform all the emergency orthopaedic surgery. I was on call twenty four out of every twenty eight days. My name did not however appear on the duty roster for twelve of those twenty four nights, thereby saving the hospital the standby allowance for 50% of my after hours' work…The Adelaide surgeons received eleven times the standby allowance for performing the same work as I did (2012, submission 06).

In my interview with Barry, he explained succinctly his perception of the situation as a whole and the fundamental basis for these inequitable, discriminatory and dishonest behaviours by workplaces:

> They know they need us to help out, there aren't enough doctors here. But they wish they didn't need us, that is the problem. They don't want us here so they try to make it as hard as they can for us. The government says we should come but they [Australian trained doctors] want to keep us out (2011, interview 6).

Dr Galak made comment as to the impossibility of fair appeal for IMGs seeking to report workplaces or to appeal decisions made by medical bodies within the system. In fact, Dr Galak believed that to appeal was a waste of time and money due to power, control and legal protection:

> The registering bodies or a body now, are not answerable to anyone with the political clout to change their decisions. The hypothetical possibility of going to the Administrative Appeals Tribunal or Human Rights Commission is useless because these organisations, having tackled Medical Boards before, learned the awesome power of the legal protection these registering bodies enjoy. Who would wish to squander limited resources on a hopeless quest? In the end OTDs are left unprotected (2012, submission 31).

Dr Douglas was optimistic enough to undertake the appeals process and mentioned that

the RACGP appeals guidelines state that an answer would be forthcoming within fourteen working days. It was actually nine months before Dr Douglas received communication from the college. The letter stated that a reconsideration of a decision was declined but she was welcome to apply for the second stage of appeal. Interestingly Dr Douglas received another letter to say that her file had been reviewed and there was no original application form, therefore, she had no basis for appeal. The letter stated:

> On consideration of the events it is clear that there was no valid application before the RACGP. There is therefore no decision which might attract the appeals process". Dr Douglas was mystified: It is difficult to understand how the board could have made a decision on my application if I had never filed an application (2012, submission 111).

Dr Bo Jin has become an Australian citizen and has lived in Australia for over twenty years. Despite also completing a PhD in Endocrinology through the University of Sydney and the Royal Prince Alfred Hospital he has been seeking registration since 1993. Due to the obvious errors associated with his clinical exam feedback letter with no result recorded Dr Bo Jin sought legal advice:

> I spent more than $15,000 for legal advice from two barristers. They advised me to give up, as it would cost a fortune. A solicitor from the college also advised me to do so (2012, submission 26).

Through the lived experiences of IMGs presented here a complex process journey is revealed. The structure of the system and its systemic power, and the hegemonic power of the Australian medical profession have a far reaching impact on IMGs, their careers, their families and their well-being. For some IMGs constant struggle with the system has defeated them and they experience serious adverse mental health issues. Kemper's work (2011) on the status-power theory of emotions defines the feelings associated with structural emotions. IMG lived experience of the system can be viewed in these terms, as

structural emotions mirror status/power outcomes associated with the interaction between various groups. Kemper (2011, p.236) argues that: "happiness indicates sufficient status, sadness indicates irremediably insufficient status, anger indicates status withdrawn or withheld undeservedly, and fear indicates the threat of power from other. Anticipatory emotions then arise such as optimism/pessimism or confidence/lack of confidence." This comes into play when an individual anticipates an interaction in an existing relationship or anticipates the first interaction in a new relationship context.

The contribution to knowledge advanced by this thesis is revealed through an analysis of the power differential and the position of IMGs. It is clear that the structural power of the system has been created, and continues to be maintained, with one of its objectives being; to tightly control the accreditation and registration of IMGs. Via a deficit discourse the qualifications of IMGs are rigorously questioned, assessed and tested. The hegemonic power of the Australian medical profession has enabled the concept of deficit to be firmly embedded in the system and its processes. The interpersonal power of IMGs is severely compromised as they are unable to successfully hold the system to account. IMGs are essentially dependent on the system to grant them the accreditation and registration that is mandatory for them to practice their profession. Relations of power and associated discourses have been explored through the Structural, Hegemonic and Interpersonal power domains to enable insight into how IMGs are positioned within Australia's medical culture. It is clear that IMGs constitute an underclass with an elite profession.

Chapter four explains the concept of medical dominance and explores how this has developed and changed over time. In addition, the major task of this thesis, which is to explore why medical dominance is created, mobilised and maintained is offered. The original contribution to knowledge advanced by this thesis is to seek to explain why IMGs

are positioned as an underclass within Australia's medical dominance. The evolvement of a toxic culture within Australian medicine is also revealed, a culture of bullying, sexual harassment and an uncompetitive, self-interest agenda.

CHAPTER FOUR

MEDICAL DOMINANCE AND THE CREATION OF TOXIC CULTURE

> A profession attains and maintains its position by virtue of the protection and patronage of some strategic elite segment of society which has been persuaded that there is some special value in its work. Its position is thus secured by the political and economic influence of the elite which sponsors it- an influence that drives competing occupations out of the same area of work, that discourages others by virtue of the competitive advantages conferred on the chosen occupation and that requires still others to be subordinated to the profession (Freidson 1970b, pp 72-73).

> Collectively, we must change the often toxic culture of medicine into a culture that promotes a nurturing and supportive approach to teaching and supervision. The goal should be to develop medical practices that facilitate well-being and quality of life, where sustainable medical careers can develop and better serve the community (Ward & Outram 2016, p.112).

The role of chapter four is to transport the reader to the application of power in this thesis. The origin of power, as it is manifested in the medical profession, is explored and the concept of medical dominance is explained and unpacked. Evan Willis' (1989) noteworthy and influential work in the area of medical dominance explores the division of labour in the health system particularly the influence of the state. Dominance is viewed as control over esoteric knowledge, or medical knowledge known only to the medical profession, which is maintained by the interface between the economy and the state. For Willis (1989), there are three levels of medical dominance: firstly over medicine's own work, secondly over the work of other health related practitioners and thirdly over society as a whole. Willis (1989, p.8) argues that: "Dominance at each level is represented by the concepts of autonomy, authority and medical sovereignty". It is important to note, that while medical dominance

prevails in Australia at the time of writing it has been challenged and as a result, changes shape to meet these challenges. The profession has been challenged on various levels from the increasingly aware internet patient to the increased public interest in alternate and complementary therapies.

The original contribution to knowledge made by this thesis is demonstrated in the questioning of how and why IMGs are placed within medical dominance and crucially to explore why medical dominance positions and continues to position IMGs as an underclass within an elite profession. The analysis of medical dominance must look at how it has come about and how it is reproduced over time. This thesis is primarily focussed on the position of IMGs and their relationship with the health system. The 'how' is an important part of analysis but equally important I believe is the 'why'. An exploration of the 'why' is a fundamental part of this thesis in the move towards understanding the position of IMGs in Australia. For Willis (1989, p.3) "occupational ideology legitimating autonomy" sets the terms for the health division of labour. Medicine has control over other health professions such as pharmacy, optometry and dentistry. This is an indirect control however, that is operationalised through strategies such as setting the legal boundaries of these occupations and a medical presence on their registration boards. My informant stated that the same medical hierarchy seem to circulate around the organisations within the system too and sit on each other's boards. Subsequently, their ongoing influence retains control of processes. Moreover, the medical profession has the power to exclude various health occupations by denying them official legitimacy and assigning them an 'alternate' status. How does the Australian public feel about this domination when it is clear that there is growing interest in complementary and alternate health therapies?

WHAT IS EXPECTED FROM THE MEDICAL PROFESSION?

The Australian public have, in good faith, entrusted the provision of appropriate medical services to the government and the medical profession. The Australian public should surely expect the profession to behave ethically and in the public's best interests. Medical practitioners are subject to a code of ethics. The Geneva Declaration or the Hippocratic Oath and the AMA[17] outline core elements to ethical practice for doctors. These include: respect patient confidentiality, do not harm or abuse patients, do not undertake work beyond level of competence and provide equal treatment of patients (Keleher 2016). Perhaps the Australian public assume that an unspoken deal or bargain has been struck with the medical profession in return for the public's trust and respect. After analysis of the professions and a study of the literature, Susskind & Susskind (2015, p. 22) suggest the following social contract:

> In acknowledgement of and in return for their expertise, experience, and judgement, which they are expected to apply in delivering affordable, accessible, up-to-date, reassuring, and reliable services, and on the understanding that they will curate and update their knowledge and methods, train their members, set and enforce standards for the quality of their work and that they will only admit appropriately qualified individuals into their ranks, and that they will always act honestly, in good faith, putting the interests of clients ahead of their own, we (society) place our trust in the professions in granting them exclusivity over a wide range of socially significant services and activities, by paying them a fair wage, by conferring upon them independence, autonomy, rights of self-determination, and by according them respect and status.

Elliot Freidson (1970a) deemed medicine as the archetype profession which should, as all professions, adopt the provision of strong ethical service. Conversely, the preceding IMG narratives indicate that many doctors from overseas have encountered particularly unethical behaviours and practices at the hands of the medical profession. Yet, the

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[17] The full Geneva Declaration: ama.com.au/media/ama-adopts-wma-declaration-geneva
The AMA Code of Ethics: atama.com.au/position-statement/ama-code-ethics-2004-editorially-revised-2006

profession is gifted with not only the trust of the general public but also the State. According to Willis et.al, (2016, p.6) in their discussion of the Australian health system and in this case particularly medicine:

> Trust is given to professionals by the State and the patient because it is assumed that they work in the interest of their patients with a high level of skill underpinned by a high level of education. This gives the profession considerable esteem in the eyes of patients.

It would appear that the proposed social contract above expects the system to assess the qualifications and skills of IMGs seeking to practice medicine in Australia. It is of course necessary to ensure that the standard of health care in Australia is maintained, therefore medical doctors with qualifications from overseas, wishing to practice medicine in Australia should be assessed, but how much assessment is adequate and for how long? Perhaps in the spirit of maintaining high standards IMGs are administered an assessment overdose. I argue that there is far more at stake here than assessment to ensure the high standards of Australia's health care system are maintained. Rather, while ensuring overseas medical qualifications meet Australian health standards is a necessary and noble exercise, this is not entirely the reason. The intense scrutiny and assessment of IMGs is also very much driven by jealousy, conflict of interests, commercial gains and market share. The data indicates that IMGs are often not afforded full admission to the medical profession even after years of exemplary practice in Australia. One IMG informed the 2012 Parliamentary Inquiry committee: "I have been in this country for twenty years, I am an Australian citizen but I will always be overseas trained" (2012, submission 26). After years of practice in this country, this doctor does not feel a 'genuine' part of the Australian medical profession. It is helpful to begin with an exploration of how the Australian medical profession managed to obtain the power it currently enjoys and waves over the heads of IMGs, other health professionals and the general public. An historical lens will provide the

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reader with an appreciation of the rise of the medical profession. The focus concern then is to trace how the Australian medical practitioner has obtained a powerful elite status and what has influenced and directed this over time. As Bacchi (2009, p.43) suggests: "In Genealogy, attention is directed to the power relations that allowed and allow particular problem representations to emerge and gain status". The medical profession in Australia, despite changing demands, manages to retain its elite status. Is this status earned or ascribed?

THE RISE OF THE MEDICAL PROFESSION

The 1870s is an effective starting point for an exploration of the rise of the medical practitioner in Australia. Pensabene (1980) specifically undertook a comprehensive study of the medical profession in Victoria but suggests, that the evolution of the medical profession was similar across Australia. The 1870s marked a change in the professional status of doctors. At the time, there were advances in medical science which initiated change in medical practice in the colony. Doctors were increasingly able to present themselves above alternate practitioner competitors. These practitioners included: "chemists, dentists, herbalists and medical clairvoyants. Under the Medical Practitioners Act of 1862 these practitioners could not adopt formal titles but were free to treat the sick for a fee" (Pensabene 1980, p.5). In contemporary Australia not only do medical doctors present themselves above alternate and complimentary health practitioners but they also have the power to contain them to the health care margins (Twohig 2016).

In 1867 chemists also gained registration. Many were British Pharmacists and members of the Pharmaceutical Society of Great Britain. Pharmacists posed the greatest competition to registered doctors and provided a valuable service at a low cost particularly in rural, remote and isolated towns where there was not a medical doctor. The Pharmacists

operated with more power than the Pharmacists we know today (some promoted their offering of doctoring and medication) but they were still classified as a para-medical service which relegated them as subordinate to the medical profession. They were however, not only authorised to prescribe medication, but if a doctor's script was incorrect and the doctor was uncontactable, the Pharmacist was expected to correct the script (see Lewis, 2014). Pharmacists were in direct competition with registered doctors not only because of their knowledge of diseases and drugs but also because, according to Pensabene (1980, p.9) they offered 'shop front' medical care:

> The chemist was the first source of medical care for the majority of individuals…the chemist was located close to the main sources of public transport and accessible to most people. In addition…large chemists provided mail ordering services, posting medicines to distant patients. The patient had only to consult the daily newspapers to ascertain the types of treatment obtainable through the mail.

Some of the medications sold by chemists made unbelievable curative claims and contained dangerous concoctions. For example, medicines advertised to cure impure blood related diseases such as cancer and 'nervous trouble' usually contained a substantial amount of gin. The medicine with the comforting name of 'Mrs Winslow's Soothing Syrup' was made to treat teething children and contained amongst other ingredients; morphine. A New South Wales Department of Health report found: "most patent medicines contained high quantities of opium, morphine or chloroform". Unregistered practitioners were also readily consulted by the public (Lewis 2014). This range of practitioners constituted a curious group and included, as identified by the 1881 Victorian census (Pensabene 1980, p. 7): "aurists and oculists, homeopaths, hydropathists, herbalists, medical galvanists, medical botanists, medical mesmerists, medical clairvoyants and psychopathists". Variations of these alternate practices are currently operating in Australia, such as medical herbalists and practitioners of

homeopathy.

As in the 1800s, many Australians, prefer to consult a chemist before seeking out the services of a medical practitioner. Consumers expect pharmacies to carry a stock of complementary products and: "75% of Australians have used them" (Carter, S 2016, p.380). The Australian medical profession however does not share the enthusiasm and actively works to discredit complementary and alternative medicine (CAM). Twohig (2016, p. 210) maintains: "Opposition still exists in sections of the medical profession, and is supported by the often-vitriolic attacks directed towards CAM". Many consider CAM pseudo-science and an example of opposition was demonstrated by the Friends of Science in Medicine's unsuccessful campaign to stop universities offering CAM courses. The practice of CAM tends to be absent in government policies and many practitioners are denied national registration (Twohig 2016).

However, according to the Australian Institute of Health and Welfare (AIHW) complementary and alternative health services have been marginally incorporated into the health system. For example, acupuncture when practiced by a medical practitioner can be eligible for a Medicare rebate. Acupuncture rebates such as these constituted:

> A total of 0.6 million claims… in 2004–05, attracting benefits paid of $20.0 million. Some private health ancillary insurance covers some of these services, such as those provided by naturopaths, osteopaths, chiropractors and acupuncturists. In the quarter ending September 2005 there were benefits paid for approximately 1.8 million chiropractic services, 0.5 million natural therapy services, 0.3 million acupuncture/acupressure services and 51,000 osteopathic services (Australian Institute of Health and Welfare 2006, p.395).

Australian Bureau of Statistics (ABS) figures show that while there has been a consistent

and considerable rise in the patronage of CAM it still occupies a marginalised health space: "People consulting a CAM professional increased by 51% in the 10 years to 2005. Almost 750,000 people had visited a CAM practitioner in a two week period and the number of people working as CAM professionals rose from 4,800 to 8,600 in the 10 years to 2006 (Australian Bureau of Statistics 2008b; Burnet 1939). There is still a xenophobic suspicion amongst the orthodox Australian medical profession around 'other' practitioners and this was also evident in the 1800s. Pensabene (1980, p.17) points out that prior to 1970 no doctor with Chinese qualifications was entitled to registration as a legally qualified practitioner. The case of Doctor Yee, highly proficient in acupuncture, is an example of early xenophobia. Doctor Yee met all requirements of the Medical Act and his qualifications were recognised by the Chinese government, he was the first Chinese doctor to apply for registration. European mistrust of Chinese medicine however prevented Yee from being registered. The medical board sought the opinion of the British Magistrate Legation in Peking, who advised that Doctor Yee had: "no knowledge of medicine or surgery other than that gained from Chinese works which are fearfully incorrect as might be expected in the case of people who protest against anatomy as mutilation." Pensabene (1980, p.17) also notes that there was no objection however to: "Yee and other Chinese doctors treating patients of their own nationality." Many Australians now embrace acupuncture as a treatment and there are many Australians who practice as acupuncturists.

The registered medical practitioner at this time however did not hold high status rather; the profession was plagued by adverse events, publicity and therefore community opinion (Lupton 1998b). There were reports of professional misconduct, botched operations and in-fighting, all of which newspapers at the time presented to the public. The public became increasingly sceptical of the medical profession. Pensabene (1980, p. 30) asserts:

"adverse publicity in newspapers further narrowed the boundaries between the alternative and registered doctors." Much of this was the result of the lack of a scientific body of medical knowledge around illness and disease. Therefore, the practice of medicine was perceived as mysterious and, in an environment of persistent health problems with seemingly no solution, the alternative practices flourished. Science came to the rescue of the failing medical doctor's reputation however, and medicine underwent a transformation. The years between 1870 and 1930, Burnett (1939, p.23) termed the "Golden Age." Advancements in medical science in turn made medical knowledge scientifically based and this increased public confidence. Pensabene (1980, p.33) argues: "control of this knowledge gave doctors a degree of power and influence unequalled in the past." Researchers such as Pasteur (vaccination, microbial fermentation, pasteurization) and Lister (antiseptic surgery) influenced the new modern medicine. There were two major breakthrough areas succinctly outlined by Pensabee (1980, p.33):

> First, medical care was based upon scientifically established theories of sickness and disease. For each disease a specific germ or virus was identified and medical care was directed towards neutralising the effects of the germ on the human body. Second, new theories of disease resulted in more effective methods of treatment. In surgery, anaesthetics and antiseptics altered the extent of surgical interference, and in medicine, new drugs, vaccines and antitoxins were introduced to combat infectious diseases.

The doctor's sensory impressions were now supported and complemented by numerical data and observations as evidence. " Later in the 19th century, hospitals, laboratories and universities finally came together to produce modern scientific medicine" (Lewis 2014, pp. S6-S7). It is here that the seeds of medical dominance as we know it today were sown. These pivotal breakthroughs saw the beginning of the rise of the medical profession. In various dimensions, the medical profession has since continued to be successful in maintaining its elite position within the class structure and the professional hierarchy by

control and regulation of access to health-care delivery (Turner 1995).

MEDICAL DOMINANCE

In his analysis of the professions, Johnson (1972, p.45) concluded: "the profession is a peculiar type of occupational control rather than an expression of the inherent nature of a particular occupation". Professionalization for the medical profession has facilitated supply of quality medical care to the public, but it has also increased the control of the profession over the medical market. The rise of the medical profession in Australia has not been without struggle however, and it has, on occasions had to battle with the State. Professional bodies such as the AMA and before its inception the British Medical Association (BMA) have always resisted State intervention and guarded their control of fee-for-service medicine. The AMA also exerts control over its own members (medical practitioners). Into the 20th century the AMA/BMA fiercely defended the right to private practice. Keleher (2016, p.397) suggests:

> So strong was the pressure on doctors from the BMA, that the doctors were reluctant to take on government salaried positions which were perceived as a challenge to the independence of the medical profession. Any increase in public provision was seen as a direct threat to private medicine.

The 1940s saw a battleground develop between the Chifley Labor Government and private medical interests. At this time in the United Kingdom there was talk of the development of a national health system. Doctors in Australia viewed this initiative as indicative of socialised medicine and through the BMA strongly protested against salaried medical positions. Protests intensified when the Chifley Government proposed the establishment of clinics staffed by salaried medical practitioners. Despite the failure of negotiations, the Queensland government set up a free public hospital service. The State and the medical profession have a relationship often filled with tensions. The RACGP (Royal Australian

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College of General Practitioners 2010) advises that:

> In Australia today, medical practitioners have high levels of clinical autonomy in decision-making that affects patient care. That is, they are free to make decisions, within the parameters of evidence-based care, that affect the clinical care they provide rather than having these decisions imposed upon them.

Due to the fact that the health of the population is of major concern to the State and the professional autonomy and independence enjoyed by the medical profession, it is essential that the State enters into negotiation with the medical profession regarding policies and initiatives that are likely to affect the practice of medicine. There are however, many stakeholders with vested interests in the health care system. Following Gray (2004), Krassnitzer and Willis (2016, p.19) categorise these interests: "Service providers are concerned with profit, income and clinical autonomy. Citizens are concerned with affordable access to quality services and Governments are concerned with ideology, electoral popularity and budgets". There is much at stake here as Health service provision is big business. In the years 2012-2013 health expenditure in Australia was in excess of $147 billion; $101 billion by governments and $46 billion by non-government entities (Australian Institute of Health and Welfare 2014g).There is also an institutional mix of decision making and shifts in the balance of power occur. A level of structural balance is held by various groups across the system (Tuohy 1999). Health provision and reform is moulded by the balance of power between three groups. For example:

> Power might reside in the government with its authority, or the professions (particularly medicine) with their highly sophisticated skills, or the private sector with its wealth. As a consequence, the patient is variously portrayed in health policy as a citizen of the State with the right to free health care, or as a patient to whom a doctor provides the best possible care, or as a consumer purchasing a health product in a competitive market (Willis, Reynolds & Keleher 2016, pp.7-8).

A tripartite model of power or a Montesquian model while utilised by some studies, has been extensively criticised. This model is not useful in the case of this thesis as it is too simplistic for institutional analysis in the modern state. It arose in the 17th and 18th centuries as a way to view the separation of powers (an objective of liberal constitutionalism). This was a time of resentment of controlling monarchies and a quest for fair and responsible government (see Cane, 2015). "These models do not provide a reliable guide for allocating institutional power. Also, they cannot account for modern state structures, especially the phenomenon of executive dominance and the emergence of the administrative state" (Carolan 2009, p.19).Initiatives for health reform are often the site for tense relations between the institutional mix.

The power differential of the medical profession shifts depending on the conditions of the proposed reform and always operates to maintain or further the interests of the profession. This may involve allowing some initiatives while negotiating to eliminate others. The introduction of Medicare in Australia in 1984 is a case in point. This was successfully introduced by the Hawke Labor Government, which at the time, did not have majority in the Senate or the Lower House. The Government was however, able to persuade and then secure the support of the Australian Democrats to endorse the adoption of Medicare. In addition, the Labor party was in power in four Australian States and these States were keen for the Medicare legislation to grant them public hospital funding. As a result, strong political numbers meant that the Liberal Party, the market (private health insurance providers), the medical profession and patient groups were not strong enough to resist the Medicare initiative. In this instance, the Federal Labor Government had the structural power to enact the legislation. This did not mean that the medical profession had lost

however and according to Willis et. al., (2016, p.8) the new arrangement suited the profession:

> the medical profession had become irritated by the way former Liberal Prime Minister Malcolm Fraser had incessantly changed the rules governing the previous public system, Medibank, particularly for those patients eligible for bulk-billing. Bulk-billing was seen as efficient by doctors because it guaranteed payment, so the AMA was not as opposed to Medicare as it had been to Medibank.

The adoption of Medicare afforded all Australians to access free medical care[18]. However, as pointed out by Duckett (2008), there are inequities in access to the system particularly in relation to socio-economic status. The Australian health sector, while at times subject to tense, political institutional negotiations remains one of at least a degree of medical dominance, which equates to medical sovereignty. That is:

> Medicine is dominant in relations between the health sector and the wider society; doctors are institutionalised experts on all matters relating to health. State patronage for other health occupations has been historically contingent upon medical approval or at least acquiescence. Registration has traditionally been on terms acceptable to medicine or not at all (Willis 1989, p.3).

The profession of medicine is not static however and change in, for example, the medical encounter has been noted by Dew et al (2016, p.8). In the late twentieth century, the medical encounter was hierarchical and paternalistic: "laden with power relations rooted in social class, gender and ethnic differences." The medical encounter today is less paternalistic and more participatory, where patients are expected to take more

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[18] Medicare is partly funded by the Medicare Levy which is paid by taxpayers and depends on income level. Low income earners are exempt. Public hospital treatment for Australians is free but a Medicare Levy surcharge also exists to encourage higher income earners to obtain private health insurance. This is a taxation penalty levelled at those higher income earners who do not have private health insurance.

responsibility for their own health. Their case study of the medical encounter (Dew, Scott & Kirkman 2016, p.11) however also revealed that:

> The culture of clinical encounters can lead to interactional submission on the part of the patient, and thus to de-legitimation of elements of patient concern that step outside a biomedical framework.

Some argue that there is more pluralism in health provision today. Coburn (2006) for example, believes that while medical dominance was pivotal to analysis in health sociology in the 1970s and 1980s, other actors such as the State, other health professions and drug companies are more visible and more powerful:

> The practical and dominant issues of the day have transformed. Major political battles today are over the form which a globally dominant capitalism is to take. These changes demand that we view medical power more in process terms rather than as an end state (Coburn, D. 2006, p.441).

Baer (2008, p.257) believes that medical dominance has been challenged over the past three decades by six social forces: The professionalization strategies of allied health professions; health has become a broader concept which emphasises prevention and community care; the state has put regulatory efforts in place to minimise costs and assess quality and effectiveness of delivery; Medicine has experienced a decline in authority as a result of media exposure of fraud and negligence; growing popularity and acceptance of alternative therapies and Increased concern for patient rights. Broom, A (2006) mentions an additional force: the internet-informed patient.

In their study of a clinic setting Long et al., (2006) found that emerging ways for hospital clinicians to work together were challenging professional hierarchies. However they also

assert that their results illustrate:

> the complexity and embeddedness of values of medical dominance in health workplace culture. While confirming that organisational and policy change on their own cannot shift deeply enculturated behaviours and norms (Long et al. 2006, p.507).

Perhaps in ways medical dominance has declined or is at least changing shape but I argue that in terms of the power to regulate and control IMGs, medical dominance can be expanded to include the unequal IMG/the system power relations. I concur with Broom (2006, p.496):

> Notions of medical power and dominance have been deployed as part of broader critiques of doctors' control (or influence) over their workplace practices, patients, healthcare rationing, medical training and professional regulation.

In recent decades, the rise of managerialism has posed a challenge to medical dominance. Aspects of managerialism have infiltrated into regulation of medical practice (Germov 2014). Increased bureaucratization and subsequent managerial strategies place doctors in a more controlled workplace. For example, Sociologist, George Ritzer (2008) used the term 'McDoctors' to describe 24 hour fast food type clinics. Working In these establishments, doctors experience monitoring, evaluation of work performance and less autonomy. Australia has seen a move towards more corporate style control of health service delivery in general practice, particularly since the 1990s. This type of clinical governance while generally accepted by the profession has not as Germov (2014, p.399) argues threatened autonomy:

> The influence of clinical governance was cushioned from severe medical resistance because the pursuit of accountability and evidence-based clinical practices were difficult to object to, and were ultimately promoted by some sections of the medical profession. …the existence of guidelines and protocols did not usurp or undermine the clinical autonomy of medical

practitioners.

More recent attempts to reform health care have been developed in the interest of overcoming duplication and fragmentation such as the move towards interprofessional practice (IPP) which is aimed at improving interprofessional collaboration. It is hoped that through education and practice as a health care team instead of independent professionals, will result in: "opportunities for a reduction in the number of tests ordered, time spent in patient assessment, and referrals (Willis, Reynolds & Keleher 2016, p.13). How much collaboration with others the medical profession is prepared to enact remains to be seen, as well as whether or not medicine positions itself to be the leader/dominant occupation in a collaborative context. The literature indicates that medicine would dominate.

Digital health technologies are working towards a more personalised style of medicine where eventually patients will have their treatment designed specifically for their needs. This will include devices that enable patients to measure their blood pressure or cholesterol. Medical practitioners can now access technology to enhance their practice and patient security. "E-health has seen widespread implementation of secure messaging between health professionals, diagnostic agencies and hospitals using electronic referral systems and electronic health records, which is critical for increasing the efficiency of general practice, and medicine more broadly" (Keleher 2016, p.406). Future advances in technology, present seemingly unlimited potential. For example, Susskind and Susskind (2015) suggest the possibility of 3D printing various body organs, perhaps the technology to print cells directly onto burns, or imagine personalised medicine to the point of scanning a patient's DNA. The question is, will new innovations and reforms still see the medical profession as overall experts and the leaders of new ways to practice medicine, in other

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words, will medical dominance still exist and where would IMGs be situated?

Medical dominance over the professional regulation of IMGs is the central concern here. How this control is operationalised is of particular interest. It is possible to identify three modes of domination with respect to allied occupations, namely subordination, limitation and exclusion (Turner 1995). IMGs in Australia are positioned as an underclass within the profession and experience subordination, limitation and exclusion as do allied health practitioners. The medical profession views these practitioners as the 'other'. Divisionary and exclusionary practices ensure that IMGs are positioned as the 'other' within the medical profession. The system also seeks to divide IMGs into two groups of 'other'. For example, [19]the competent authority pathway clearly promotes one group of IMGs as more desirable and suitable for work in Australia than others. Dr Wenzel (2012, submission 68, p.7) wrote to the 2012 Parliamentary Inquiry committee linking inferior treatment to the competent authority pathway:

> For decades the medical system has maintained a two-tier culture where OTDs are treated inferiorly to their Australian trained counterparts ... This dilemma has not been helped by AMC introducing the 'competent authority' pathway, psychologically perceived by majority of OTDs from the other countries that they are INCOMPETENT!

Autonomy for the medical profession is crucial in the maintenance of medical dominance. Autonomy ensures the profession an occupational monopoly that secures its dominant position in the division of labour. This in turn enables medicine to decide where others, such as allied health professionals, are positioned outside medicine, and the subordination of IMGs within medicine.

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[19] This pathway is only for IMGs from: The United States, United Kingdom, Ireland, New Zealand and Canada

Friedson (1970b, pp. 72-73) succinctly explains:

> A profession attains and maintains its position by virtue of the protection and patronage of some strategic elite segment of society which has been persuaded that there is some special value in its work. Its position is thus secured by the political and economic influence of the elite which sponsors it- an influence that drives competing occupations out of the same area of work, that discourages others by virtue of the competitive advantages conferred on the chosen occupation and that requires still others to be subordinated to the profession.

The shape of medical dominance and the position of IMGs within will be interesting to track as we move into a changing future. Susskind & Susskind (2015, p.303) point out that not only are the professions changing but the future forecast indicates an incremental transformation: …"we foresee that, in the end, the traditional professions will be dismantled, leaving most (but not all) professionals to be replaced by less expert people and high-performing systems." All is not well within the Australian medical profession however. Alarmingly, the profession has a very dark side, a toxic professional culture. Perhaps medicine holds within, the seeds for its own destruction.

THE TOXIC UNDERBELLY OF MEDICINE IN AUSTRALIA

Bullying treatment (such as the stark examples from the voices in chapter three) is not just reserved for IMGs. A bullying culture is endemic within the medical profession and can also be directed at colleagues at the same level, junior doctors and medical students who are Australian trained. Reports of sexism and sexual harassment also join the toxic mix. During 2015 especially, numerous adverse reports around medicine's endemic, unsavoury culture surfaced in the Australian media.

The ABC's 4 corners presented by Kerry O'Brien aired a confronting program on the 25th May 2015 entitled At Their Mercy. Reporters Quentin McDermott and Karen Michelmore

reported: "A toxic culture of belittling, bullying and bastardisation is poisoning the lives of young trainee doctors in some of our major teaching hospitals" (2015). The program revealed first-hand accounts from young doctors trapped in an "entrenched cycle of abuse where teaching by humiliation is routine." Further, sexual harassment and sexism is also a part of the toxic culture. The story of Surgeon Caroline Tan is a case in point. Dr Tan refused the sexual advances of her supervisor and complained. As a result her career in public hospitals has been impacted: "I find that doors are closed to me that would otherwise be open to other people, so I've suffered enormous detriment." Another trainee surgeon told the Sydney Morning Herald: "Sexism in surgery humiliates me every day" (Medew, Hatch & Lillebuen 2015). The ABC program also highlighted a chilling realisation from a young doctor which indicates that bullying behaviour becomes a part of medical students' socialisation: "In one moment I could just see how this all happens. Someone bullied him, he bullied someone else, and now it's my turn." Then Australian Medical students' Association (AMSA) president James Lawler received a flood of reports concerning sexual harassment and bullying following the ABC program. He told Campus Review (2015) that four medical students had suicided that year. Feeling powerless he made an emotional plea to doctors to take a stand against these practices: "It can't be my job or the job of my junior peers at the bottom of the food chain to speak up because the hierarchy is too high and too strong."

In 2016, Elise Buisson, then current President of AMSA, described to the 2016 Senate committee one example of sexual harassment experienced by a female medical trainee:

> A student reported to me that they were sitting in surgical grand rounds, so that is when all the surgeons in the hospital come together and have an educational meeting. Someone presents some research to them. A trainee doctor stood up, gave an absolutely outstanding presentation—they had put a lot of work into it—and a quite established male surgeon was very loudly

interrupting her as she went on, saying, 'My, my, my! Haven't they let you out of the kitchen a lot this month!' and various other statements about her being female … He laughed, and everyone laughed, and the head of surgery at a medical school in that city was sitting in the room and did nothing, as did everybody else (2016, submission 10).

Sexism appears to be systemic especially within the surgical fields and within hospital contexts. Perhaps female medical trainees are discouraged from entering the surgical fields particularly in the light of the entrenched culture. As at 2015:

Only 10% of surgeons in Australia are female. Less than 3% of female doctors are surgeons and less than 1% of all doctors are female surgeons. Among surgical specialities, women are most highly represented in paediatric surgery (29%) and least highly represented in orthopaedic surgery (3%) (Walton 2015, p.168).

There is also a hierarchy within medicine, where Surgeons occupy top spot and General Practitioners the bottom. Further, within the field of surgery itself, some specialist practitioners such as Neurosurgeons and Heart Surgeons are viewed as out ranking General Surgeons, who occupy the bottom rung of the surgical profession ladder. In her article entitled "Royal Australasian College of Surgeons revelations: Patients complicit in promoting surgeons' God complex," Harriet Alexander (2015), wonders if the Australian public has, unintentionally assigned surgeons a deity status:

For every surgeon who has a God complex, there is a bevy of complicit patients. Nobody wants to know that the hero who saved their life in the operating theatre has a less than angelic personality. Yet the Royal Australasian College of Surgeons has discovered its ranks are riddled with bullies, creeps and bigots.

Following a string of complaints, The Royal Australasian College of Surgeons sought the advice of an expert panel. The draft report produced by the panel was scathing about the

current state of affairs and delivered a stern warning to the profession about the future. The report found:

> Nearly 50% of College Fellows, trainees and international medical graduates report being subjected to discrimination, bullying or sexual harassment. It is inconceivable that anyone finds this acceptable or contests the seriousness and spread of these problems.
>
> The status quo will not serve the future. Individually and collectively, College Fellows must recognise and commit to closing the gap between how it has been, and how it must become (Knowles, R & Bannon 2015, p.3).

High profile Neurosurgeon and brain cancer specialist, Dr Charlie Teo has been particularly outspoken about the state of affairs in the surgical field. Dr Teo, is the son of Chinese-Singaporean parents (his father an IMG) who migrated to Australia. Dr Teo has not shied away from sharing his own personal experiences and views via the media. These have often been honest and confronting such as the suicide of a colleague following years of bullying. Dr Teo has upset many of his colleagues and as a result, some have been quick to criticise him. Charlie Teo has been referred to as reckless and accused of giving false hopes to his patients. Dr Teo tells it like it is and many fellow surgeons do not like that. On 7th September 2016 Dr Teo appeared on the ABC program: "Anh's Brush with Fame" (Teo 2015b) and while having his portrait painted, revealed a truth that takes the concept of professional solidarity to a shocking level. It seems that some surgeons will even deny a patient treatment to protect their professional standing and reputation. Dr. Teo is a pioneer in minimally invasive surgical techniques for brain cancer and takes on cases other surgeons deem inoperable. Charlie Teo, by his own admission, acknowledges that brain surgery is the world's hardest sub speciality in medicine, and in Australia, he is the best.

The following is his account of a colleague's visit to his office:

> I've had a doctor come to my office and tell me…and this is a surgeon I have a lot of respect for, he was asked by my colleagues to come and speak to

me. He sat down and said: "Charlie you've got to stop doing this, you're really pissing a lot of people off." I said stop doing what? He said: "Stop operating on patients that others have called inoperable." And I go: hang on do you want me to say that a tumour is inoperable even though I think I can take it out? He said: "yeah". And I said OK, look at this X-ray, look at that tumour, do you think you can take that out. He said: "yeah of course I can." I go, well that patient has been told that's inoperable, so you want me now to call up that mother and say that that tumour is inoperable and I'm going to let your child die. And he goes: "yes I do that every day." Every day he lies so he doesn't piss off his colleagues and he doesn't give second opinions that are different to someone else's opinion. I've saved thousands of lives because I've operated on people who have been told their tumours are inoperable and they weren't[20].

It is difficult to accept that not only do bullying behaviours actually exist within the medical profession but that they would go to this extent. It seems that some colleagues will in fact go to any lengths to protect their self-interest. It is useful here to take a closer look into the full experience of an IMG surgeon, Dr Richard Emery. This story also reveals entrenched unprofessional and insidious behaviours and the ramifications of those behaviours, come to the surface in Dr Richard Emery's lived experience and subsequently, those around him. Relentless attacks by a few jealous, vindictive fellow surgeons on his professional practice led to Dr Emery becoming deeply depressed, contemplating suicide and ultimately leaving Australia. Dr Emery's (2015) case was the subject of a special report covered by the ABC's Lateline program. On the 3rd September 2015, hosted by Tony Jones, the program began with a disturbing question:

> Tonight, a story that raises some serious issues for the medical profession. Does the system of self-regulation overseeing surgeons in Australia work and is that system open to abuse?

Reporter Steve Cannane (2015) brought to life the disturbing chain of events in Dr Richard

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[20] The full episode of Anh's Brush with Fame can be seen on: iview.abc.net.au/programs.anhs-brush-with-fame/

Emery's case. In the program's introduction Cannane stated:

> Tonight for the first time, Richard Emery and other doctors speak out about the culture inside the medical profession and how a group of senior surgeons in North Queensland was able to prevent him from making a living in Australia.

The following presents extracts from the program's transcript. Answering the call for the need of a spinal surgeon by the Townsville hospital in North Queensland Australia, Dr Richard Emery arrived from France in 2003 to begin work. All was reasonably uneventful until, after five years, he announced that he was moving into private practice, therefore posing a threat to the livelihoods of those surgeons already in private practice. At that time, he received a hostile phone call from Dr Eric Guazzo, a local surgeon who was then president of the Neurosurgical Society of Australasia. Dr Guazzo (2015) informed spinal surgeon Dr Emery: "If you move to private practice, you won't be able to pay for surgery in no time. So go back to France." Cannane (2015) reported that apparently, Dr Guazzo had no recollection of any such conversation with Dr Emery. Nevertheless, Dr Emery went ahead with his move into private practice. As a result, three months later, saw the beginning of numerous anonymous complaints. These led to audits of Dr Emery's work.

Dr John Stokes, the former Director of Medical Services at the Mater Hospital in Townsville confided to Cannane (2015) that: "One surgeon told me directly in private that I should run him out of town". Jealousy of Dr Emery's clinical skills and advanced expertise as well as the need to guard self-interest was at the heart of the fictitious complaints.

 As consultant in the rehabilitation centre, Roger Watson confirmed to Cannane (2015) :

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"He was doing things twice as fast and procedures the others couldn't do and they got terribly jealous." Former Medical Services Director, John Stokes outlined to Steve Cannane (2015) the scope of the complaints made against Dr Emery:

> There were complaints about his blood transfusion rate and we audited that and it was normal… There were complaints about his use of item numbers and we audited that and it was no more abnormal than other surgeons use. There were complaints about his complication rate, so we audited a year of his surgery.

The results of the audits showed nothing out of the ordinary. However, this did not mark the end of the campaign by his colleagues in their attempts to discredit Dr Emery and inevitably force him out of perceived competition. Cannane (2015) reported that a further complaint was made and the result saw Dr Emery reduced to conditional registration:

> After Richard Emery had passed these audits, another surgeon made a complaint about him to AHPRA, the national body that regulates all health practitioners. That meant another audit and being placed on conditional registration.

According to Cannane (2015) Dr Emery then took the initiative to engage Dr Rob Kuru and Dr Bryan Ashman to conduct an independent review of 18 months' worth of his operations. Dr Kuru, also a spinal surgeon explained to Cannane:

> The colleagues locally felt that he wasn't or that they weren't experienced enough to comment on the type of work he was doing.

Richard Emery arranged for the review to be undertaken by surgeons who did a similar kind of work. The review by Drs. Kuru and Ashman did not find an unusually high amount of complications with Dr Emery's work.

In fact, Dr Kuru (2015) told reporter Cannane:

> The data that Richard supplied to us when we reviewed the types of procedures that he was doing, they were appropriate for someone doing

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complex spinal reconstructive practice and the complication rate, we found, was in published and acceptable limits if you're doing that kind of work.

This positive outcome in Dr Emery's favour however, did not serve the interests of the surgeons plotting against him. The surgeons used a presentation made to them in 2014 by Dr Emery as part of a standard peer review process, to initiate yet another complaint against him. Dr Emery presented the results of his operations carried out over the previous six months period. Yet, neither Dr John Stokes nor Dr Richard Emery, recall any major criticisms made by the surgeons who attended the presentation. Steve Cannane (2015) asked Dr Stokes about Dr Emery's presentation: "So Richard Emery's presentation did it have an unusually high complication rate attached to what he was saying"? Dr Stokes replied: "No. In my view, it didn't and that's supported by the view of the two AHPRA supervisors who had both seen the audit before." After Dr Emery's presentation to his colleagues, nine surgeons (including Dr Guazzo) signed a letter of complaint (one surgeon abstained). However, only five of the signatory surgeons were at Dr Emery's presentation. The Lateline program obtained a copy of the letter, and according to reporter Cannane (2015) it said, in part:

> We all feel that Dr Richard Emery's rate of major clinical complication was well above what would be acceptable surgical practice. As a craft group we have had ongoing concerns with regards to Dr Emery's practice, but the latest audit presentation is deemed unacceptable by us."

Not surprisingly, Steve Cannane (2015) noted that: "Dr Eric Guazzo would not speak with Lateline on camera, nor would any of the other eight surgeons who signed this letter of complaint." Also noted, is the disgust and disappointment felt by Dr Emery in that four of his colleagues would criticise his work without even attending his presentation. Dr Stokes (2015) believes the sham audit process was deliberately used to target and discredit Dr Emery, and commented to Steve Cannane:

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He wasn't given a fair hearing. He wasn't given help, which you expect out of audit. In fact, the audit that was finally done was used against him in what's called - the term a sham audit, where audit is used to harm a person. The intention of medical audit is to improve care and this wasn't used in an attempt to improve care.

Unfortunately for Dr Emery, his surgical colleagues withdrew their support. This action meant that Dr Emery could not operate and therefore not practice. Dr Stokes (2015) told Cannane: "so it's an easy thing for doctors to do, to withdraw support and put a person in a regional centre at great risk". This situation placed Dr Stokes in an impossible position and despite the fact that he was appalled by the unethical treatment of Dr Emery, he was forced to: "tell Richard Emery that without the support of his peers, he could no longer operate at the Mater Hospital" (Stokes, 2015).

Steve Cannane (2015) revealed that Lateline also obtained an independent assessment of Dr Emery's credentialing. The assessment was written for the Mater Hospital by Dr John Quinn, a principal advisor to the Council of the Royal Australasian College of Surgeons. Instead of criticising the practice of Dr Emery, the report by Dr Quinn, was highly critical of Dr Emery's colleagues. Communicated in the Lateline program via a male voiceover, Dr Quinn's (2015) report stated:

To undertake, assess and monitor spinal surgery at Mater Hospital Townsville requires cooperation, collegiality, peer support and professionalism from all those performing such surgery. Regrettably, these qualities seem to be lacking at your hospital at this time ... This seems to be personality driven more so than scientifically or surgically driven.

As for Dr Richard Emery, by March of 2014 he had become suicidal. After numerous complaints, sham audits, constant requirements to prove himself and his practice only to have restrictions placed on his practice, and now, without the support of colleagues, his

livelihood and career was being taken away from him. Steve Cannane (2015) reported: "He headed to the top of Castle Hill, and in his words, was ready to jump." What came next in the program was the following poignant quote from Steve Cannane's (2015) interview with Celine Emery, Dr Richard Emery's wife. Unnerved by her husband's text message, Celine Emery knew something was wrong.

> One day I came home and I got a text message saying, "Take care of the kids." And I thought he was gone for a run. And when I got the message, I understood straight away that he had gone somewhere. I knew he was running up Castle Hill from time to time and I really hoped that he was up there, I really did. Otherwise I'd - yeah. So I drove up there and couldn't see him, I drove up and up and I - and I thought it was a question of time. I kept calling him. He wouldn't answer. And I was really hoping it wasn't gonna be too late. And I found him. I found him and thank God, he was just sitting, sitting. And I told him, I said, It's all OK. We'll just go back home. Just go back home and everything will be fine".

Dr Emery and his Australian family returned to successful practice in France. Dr Emery has been able to get on with his life after his appalling treatment in Australia. However, there remains collateral damage fallout for colleagues who supported him (such as Dr John Stokes) and for his patients who missed out on his advanced surgical skill back in Australia. For example, Dr Emery's patient Michael Johnston, who, due to a rare condition, has a spine that cannot support him sufficiently. After previous operations that had failed, Richard Emery offered to repair the damage for free. Johnson (2015) told Cannane that Dr Emery said: "I tell you what, I'm going to perform the surgery for you free of charge. This is my Christmas present to you. No expenses." Steve Cannane (2015) reported that unfortunately: "Michael Johnson was about to be operated on in March last year (2014) when Richard Emery's privileges were taken away."

Johnson (2015) shared his experience:

> It was devastating, beyond belief. I'd waited 17 years to get my life back. We were two months away from it happening and it was taken from me. We were basically the carnage. We were just left behind. And it's not necessary. And

nobody seems to care. Richard's the only one that cares.

There have been repercussions for former colleague of Dr Emery's and medical services director, Dr John Stokes. Dr Stokes (2015) believes he has been targeted for reporting unfair process and has been virtually punished for speaking out in support of Dr Emery. He told Steve Cannane:

> In that same year, I was notified to AHPRA vexatiously on two occasions. There is almost certainly a link somewhere in that. I've had a good, long practice in medicine without any complaints about me. And I suspect there was some ulterior motive of stopping me being director of medical services.

Dr John Stokes was badly injured in a cycling accident that killed his friend. The accident was cited in a notification against him. Cannane (2015) stated: "So they even tried to allege that you were brain damaged, didn't they"? Dr Stokes (2015) replied:

> Yes. That was the most hurtful thing of all. A good friend of mine died, who I tried to resuscitate at the roadside. And I survived with major injury, but she died, unfortunately. And that was used against me to claim that I was mentally incompetent and should be deregistered.

Since the (2015) Lateline interview, John Stokes has been subjected to a further complaint, this time made to the Minister for Health. Steve Cannane (2015) raised the concerns of local Liberal National Member of Parliament, Warren Entsch who: "says he's appalled by what's happened in Richard Emery's case and wants the complaints process-overhauled".

Warren Entsch, was a member of the 2012 parliamentary inquiry committee. Many of the submissions from the 2012 parliamentary inquiry and the 2016 Senate Committee Report form a part of the data set for this doctoral thesis. It is noted below that there has not yet been a government response to the 45 recommendations[21] of the report

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[21] The Recommendations from the "Lost in the Labyrinth" Report can be assessed at: http://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_

produced by the 2012 inquiry; "Lost in the Labyrinth." Warren Entsch (2015) expressed

concerns in this regard in 2014. He explained to Steve Cannane:

> Unfortunately, I really got - I got no real response, you know, other than say that my concerns had been acknowledged. Now that was in 2014. Since that time, I've written again, I've sent that letter to the new minister, Susan Ley, and I've asked her to actually focus on this. First of all, we do need to get a response to those 45 recommendations[22], and secondly, I was hoping that we could've kept Dr Emery in Australia.

Steve Cannane (2015) asked Dr John Stokes: "Is that fair, that you can have your fate in

the hands of people who potentially are competitors"? To which Dr Stokes (2015) replied:

"That's not natural justice".

Not only was Dr Emery's career adversely impacted, he was also forced to move back to

France. The impact on his mental health, family, supporting colleagues and patients is

immeasurable and ongoing. The toxic culture associated with hospital culture and

particularly surgeons is apparently of grave concern for the Royal Australasian College of

Surgeons. The college has accepted all recommendations made by the Knowles and

Bannon report (2015) and has embarked on a three year campaign entitled: "Lets operate

with respect"[23]. The role of the campaign is to raise awareness of an action plan entitled:

Committees?url = haa/overseasdoctors/report.htm

[22] I contacted the Department of the House of Representatives on 27th June 2016 re a government response to the 45 recommendations. The report was tabled on 19 March 2012. It is expected that governments respond within 6 months. The email reply stated: …"You may feel free to contact the Health Minister or the Department of Health for a response noting also that a number of the recommendations are directed at the AMC(an independent national standards body).

[23] The Royal Australasian College of Surgeons explanation of the campaign initiative includes comments from various surgeons. These can be viewed at Youtube.com/watch?v=ahy_nWVpfOU&feature=youtu.be

"Building respect, improving patient safety" which has three areas of focus: "Culture Management and Leadership, Improving Surgical Education and Strengthening Complaints" (Royal Australasian College of Surgeons 2016). This seems a rather protracted response, in that it will take three years just to raise awareness of an action plan. This current toxic culture is not a new development or a shocking surprise. The College acknowledges on its web page, that bullying is not confined to surgeons; it extends across the health sector:

> Bullying is a real problem for our profession, like it is in the rest of the health sector. Almost half of us have seen it or felt it. Now is the time to build respect and improve patient safety in surgery. We have to deal with discrimination, bullying and sexual harassment (Royal Australasian College of Surgeons, 2016).

The 2016 Senate Community Affairs References Committee on Medical complaints process in Australia report raised vexatious complaints and the adequacy of AHPRA to adequately deal with them as a key issue. There was evidence that the complaints process had become a vehicle for vexatious complaints and therefore a tool of bullying and harassment. The committee report (2016, pp 21-22) stated:

> The committee recognises that vexatious complaints are not always readily apparent, but is not convinced that AHPRA's processes are adequate for the purpose of identifying complaints made vexatiously. In particular submitters allege that notifications were lodged against them in response to their own complaints of bullying and harassment.

The pursuit of self-interest, often underpins vexatious complaints. Dr Don Kane, Chair of the advocacy group Health Practitioners Australia Reform Association (HPARA), informed the Senate committee that this is a significant problem for medical practitioners:

> These people [those making vexatious complaints] are misusing AHPRA for their own personal reasons. It is very rare, if ever, that AHPRA have taken

action against people who have lodged vexatious claims. There is an absolute abuse of the mandatory notification process. It was put in there in the guise of being in the public interest, but really it is in the interests of the people making the complaint (2016, p.22).

The lengthy delay in dealing with complaints was also noted with the average age of open notification, currently at 137 days (2016, p.24). Dr Fettke made the following statement to the Senate committee about his personal experience of the complaints process.

The AHPRA process has shifting goalposts for those under investigation. You answer one allegation and another one surfaces. Trying to defend one's position without knowing the evidence and its accuracy makes for a star chamber circus (2016, p.26).

Moreover, bullying within medicine is not unique to Australia, it is found in other countries too. Medical schools in the United States for example, have been described as carrying out institutional abuse through soul crushing boot camps[24]. It is suggested that medical students graduate from US medical schools with Post Traumatic Stress Disorder which has been caused by their training. The findings of a study investigating burnout among medical students in the US, showed that while students may develop resilience to traumatic events such as patient suffering and death: "students exposed to personal mistreatment and poor role modelling by their superiors did not demonstrate resilience but instead showed higher depression and stress (Cook, Arora & Rasinski 2014, p.752). Further exploration of bullying behaviours within medical schools based in other countries is beyond the scope of this thesis but I suspect that this could be endemic in the profession on a global scale. This is indicated by another US study on medical students which undertook a systemic review and meta-analysis on the prevalence of harassment

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[24] The situation in the United States can be viewed in: "100% of medical students report abuse" https://www.youtube.com/watch?v=3G6zgGIPgc and "Why doctors kill themselves" https://www.youtube.com/watch?v=qyVA+Z9VZ4Q

and discrimination. The study highlights the extent of the problem: "Findings emphasise how common this problem is in medical training programs around the world" (Fnais, Soobiah & Chen 2014, p.821).The media has provided extensive coverage of the most recent developments regarding the toxic culture of medicine in Australia. While it is well known that some media thrives on sensationalism, it is difficult to take anything away from the stark reality of the voices who speak of lived experience.

MEDICINE IN THE MEDIA

The media and other impacted individuals via television, radio, newspapers, You Tube videos and other social network platforms have been quick to share the 2015 complaints and their views with the public. In her discussion of problem representations Bacchi (2009, p.242) acknowledges the media as a significant political influence and force in how issues are viewed: "they play a significant role in governing co-constituting problem representations and influencing citizen subjectivities." Reporting by the media can be very powerful in its construction of current affairs. For example, the analysis of newspaper reporting of the Dr Haneef case carried out by Ewart and Posetti (2008, p.13). The study concluded that in a climate of 'war on terror', border security and national security: "An over-emphasis on crime and security can overshadow significant human/civil rights issues and effectively bury the lead." The work of Lupton (1998b) and Lupton & McLean(1998) examines the role of the media in the portrayal of the medical profession specifically and subsequent professional image and status. The medical profession of course needs to be represented in positive terms to confirm the continuation of the profession's high status position. In addition, patients need to maintain their trust and faith in the biomedical model and the professionals who practice it. Following discourse analysis of media headlines, Lupton and Mclean(1998, p. 956) found: …"doctors and the medical practice are the

source of competing and diverse representations. While medicine may be portrayed as a fraught, conflictual and politicised profession in this forum, it is also represented as offering considerable benefits to patients." Comprehensive and frequent media attention of the Australian medical profession brings a personal and professional focus to media coverage. Germov (2014, p.345) argues that ..."the fact that they are subject to such great mass media interest also cements their position as an elite group enjoying cultural and social authority." Media stories with photographs presented the archetypal male medical practitioner and depending on the positive or negative content of the story, were portrayed as either demons in cases such as fraud and malpractice or angels in cases of healing and medical breakthroughs (Lupton & McLean 1998).

The most recent media attention, again regarding the RACS, demonstrates the particular plight of IMG surgeons who are from competent authority pathway countries[25]. This pathway while appearing to favour IMGs from deemed more 'acceptable' countries does not necessarily mean a more streamlined pathway to recognition. In her article of the 22nd September 2016, Julie Medew (2016) of the Sydney Morning Herald revealed another two concerning experiences, that of: London trained plastic surgeon, Patrick Tansley and American trained ear, nose and throat surgeon Dr. P. (unwilling to supply his name for fear of repercussions). Medew (2016) suggests that the RACS is "controlling the borders to keep out highly trained surgeons from abroad." Dr P experienced bullying, harassment and discrimination while attempting to have his skills recognised, while Dr Tansley claims that deliberate delays in his assessment proves making it nearly impossible for him to achieve fellowship within the mandatory 4 year period. Dr Seneviratne, a colleague of Dr Tansley's, made comment on his experience: "At each turn there has been an act of

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[25] Also, see the experiences of Dr Douglas, Canadian trained family physician in chapter 4

retribution that comes with the process…It has been almost child-like in its transparency." The Knowles and Bannon (2015) report commissioned by the RACS, called for increased transparency in the RACS' processes. This highlights an intriguing irony. Ultimately it is the media's role to inform the general public and in addition, it can also become a source of data for research. Workplace bullying for example is a key concern in the field of Human Resources. In their recent exploration of workplace bullying in the media, Ramsay, Branch and Ewart, (2016, p.87) note the importance of a well-informed public with a view to enact positive social change:

> Bullying is carried out by people (not entities), and it is only people who can devise policies and procedures and enact behavioural norms within contexts and processes that can encourage or could reduce bullying.

Perhaps initiatives to reduce bullying within medicine on an individual level could begin where the behaviour begins, by a move to involve engaging and listening to medical students (Sklar 2017). When the voices of those who have suffered at the hands of some misguided individuals within the profession, in the health system, or in various associated bodies speak, it is a powerful voice. While medical students are encouraged to report unprofessional behaviours in the workplace and are able to access information on how to do so, such as the General Practice Registrars Australia web site (2017), they tend not to. This body also provides advice on how to be a supportive bystander for someone else who is being bullied. It is difficult to marry the 'social contract' proposed by Susskind and Susskind (2015) to the behaviours exhibited by sectors of the medical profession. It seems that the profession does not fulfil all the obligations associated with their suggested end of the bargain.

This chapter has explored the application of power and its origins in the medical profession beginning with the rise of medicine itself in Australia from the 1870s. Medical Dominance

exists firstly over medicine's own work, secondly over the work of other health sector practitioners and thirdly over society as a whole. Medical dominance is firmly entrenched in the Australian Health System where medical practitioners are institutionalised experts on all matters related to the health of the Australian public. It is of a dynamic nature however and must adapt to constant challenges to retain its position. The relationships medicine has with the state and economy as well as complementary and alternative practitioners have been noted. The original contribution to knowledge made by this thesis is demonstrated in the questioning of how IMGs are placed within medical dominance and crucially, why medical dominance positions and continues to position IMGs as an underclass within an elite profession. The medical profession has the power to exclude various health occupations by denying them official legitimacy and assigning them an 'alternate' status. This chapter has argued that the position of IMGs within the medical profession and therefore within medical dominance is akin to an 'alternate' status; an underclass.

A major concern is that the Australian medical profession, a profession with considerable power, is imploding from within through a festering, toxic culture. This culture, as shared by the voices here, seems to hold even more power than the profession itself; that is the power to destroy the careers and sometimes lives of its members. Not only the careers of its members are impacted however, sometimes this toxic waste spills over into the public, the lived experience of patients. Medical practitioners every day make decisions that have the potential to give or take life. In this chapter the reader has been exposed to appalling examples of jealousy, self-interest and deliberate, dishonest attempts to discredit colleagues. Bullying, sexual harassment and other unsavoury behaviours have been aired particularly in relation to hospital cultures and specifically the surgical specialities. How do IMGs negotiate their way through this powerful yet less than desirable context? The

following chapter attempts to answer the fundamental question: What is the problem with IMGs represented to be and what are the potential silences in the representations of difference?

CHAPTER FIVE

THE REPRESENTATION OF IMGS AS PROBLEMATIC?

> Australia is the 'lucky country' which still resonates in the minds and the actions of many people here and worldwide. 'Australia' is the land beyond the border (the place that exploited peoples try to reach, and older Australians are nostalgic about)… Australia continues to be perceived from outside as a relatively safe haven (Tulloch & Lupton 2003, p.41).

> The unfortunate person who émigré is the one who is blamed most of the time. Despite great cultural, religious, familial and national bonds he often has little choice but to leave. With this in mind he moves to the land of milk and honey where he has always the feeling of being a foreigner (Malekpour et al. 2009, p.281).

This chapter begins analysis, given the current context for IMGs in Australia. What is going on and how can it be explained? The contribution to knowledge made in this thesis is an investigation into the positioning of IMGs within Australia's medical culture. Analysis of why IMGs are positioned as an underclass within the elite profession of medicine requires closer questioning of problem representations. What is the problem with IMGs represented to be? Does the ongoing positioning of IMGs constitute a wicked problem, one that is highly resistant to a solution? IMGs as a community attract an enormous amount of attention and they are the subject of intense scrutiny. In fact, a whole organisational network has grown and evolved around the perceived need to regulate and control IMGs. This chapter is underpinned by an investigation into problem representations and the teasing out of any associated silences. Initially it is useful to briefly look at the positioning of IMGs globally and the associated ethical issues.

IMGS GLOBAL REPRESENTATION: AN ETHICAL PROBLEM?

The international migration of the workforce has become a part of the globalisation movement, which in itself, has become the focus of much discussion and analysis. Migration across the world has been enabled by changes after the Second World War and increasingly since the emergence of the World Wide Web. Today there is a climate of vast international exchange between nation states from ideas and technologies to goods and services and, subsequently, the international migration of the workforce (Toader & Sfetcu 2013). The World Bank (2011) reported Australia as having 3.3 physicians per 1,000 head of population. Australia has always to some degree been reliant on IMGs to fill medical workforce gaps. In rural and remote areas IMGs comprise over 40% of the medical workforce (House of Representatives Standing Committee on Health and Ageing 2012). The US, UK and Canada have also historically required IMGs to assist when there are shortages in the medical workforce. IMGs constitute approximately 25% of Canada's physicians (Walsh, A et al. 2011). In the US IMGs make up 23% of physicians (Hoekje 2007, p.327). In the UK 36.6% of physicians were overseas trained (Campbell et al. 2015). More recently other countries such as South Africa, Thailand and Singapore have sought out IMGs. In some instances IMGs are deliberately recruited or they are enticed via immigration programs (Iredale 2009).

The supply of medical doctors varies significantly around the world. For example, in 2011 a wealthy country such as Monaco, had 7.1 physicians per 1,000 and a stable European country such as Austria had 4.8 physicians per 1,000 (The World Bank 2011). Whereas a country with economic difficulties such as Romania, faced an acute deficit of physicians with coverage of only 1.9 physicians per 1,000 (Toader & Sfetcu 2013, p.126). The UK comes in at 2.8 practicing doctors per 1,000. This number is below the European average (3.4) despite initiatives to recruit more IMGs to the UK. The UK falls below countries such as: Italy, Spain, Germany and France. Laura Donnelly, Health Editor for the UK Telegraph

(2014) noted that around 500 Accident and Emergency doctors trained in the UK have chosen to come to Australia to practice.

What's the problem? Many argue that there is an ethical problem here, with relatively wealthy developed countries enticing doctors and other health professionals away from less wealthy developing countries. This can have severe adverse repercussions, for example, in Sub-Saharan Africa where the World Health Organisation (WHO) (2016a) noted that:

> Shortages of physicians and nurses jeopardise health system advances in many low-middle income countries. Sub-Saharan Africa has only 2 doctors…per 10,000 people compared with around thirty doctors in high-income countries. Meanwhile rural to urban migration of health professionals continues to increase practitioner shortages in rural areas where the need is the greatest.

In addition, more developed countries lure doctors from other more developed countries. For example, the Royal College of Surgeons in Ireland names Australia as a popular destination for Irish trained physicians:

> Only one third of foreign doctors planned to remain in Ireland and the longer the time Irish trained doctors spend abroad, the less likely they are to return to Ireland. Australia is one of the most popular destination countries (World Health Organisation 2016b).

Interestingly in some countries, it is considered a good move for the highly educated, including medical doctors to leave the country of their training to work elsewhere in the world. This is the case in Iran which, with 20% of highly educated individuals choosing to live abroad, has the highest rate of brain drain in the world.

> Despite improvement in gross domestic product there is unsatisfactory resource allocation for the most educated. The host country provides

graduates with all their basic needs as well as offering a chance to fulfil some of the higher-level needs in Maslow's hierarchy[26]. As a consequence, migration is commonly seen as admirable by the elites of society, at least in Iran (Malekpour et al. 2009, p.281).

Source countries have invested heavily in the training of their medical practitioners with the impetus on increasing the numbers of physicians to serve the health needs of their population. The qualified medical practitioner is a valuable resource which is then highly sought after by other countries experiencing a health workforce shortage. Understandably, some countries appear to be more attractive places to live and work than others, after all medical practitioners are also human beings with likes, dislikes, preferences and career aspirations. This presents an ethical dilemma, while developed host countries are effectively poaching medical practitioners often from countries with poorer health populations and of greater need, doctors should be free to migrate to any country of their choice anywhere in the world. Medical doctors also have human rights. Some host countries undertake to not receive workers from underdeveloped source countries, but this is difficult to police. The World Health Organisation (2011) in order to provide a global response to health workforce migration concerns, introduced the code of global practice on the international recruitment of health personnel. The code, while discouraging active recruitment of health practitioners from developing countries with critical shortages of health personnel, encourages collaboration between destination and source countries. Circulation migration is endorsed enabling the transfer of skills and knowledge to the benefit of both countries. This is underpinned by the principle of mutuality of benefits. The code (World Health Organisation 2011, p.2) encourages Member States (of which

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[26] Maslow (1943) developed a hierarchy of needs pyramid model where he argued that human beings require basic needs such as food, water, shelter and safety before they can progress to higher levels of needs such as love and self-esteem and eventually self-actualisation.

Australia is one) to: "provide technical assistance and financial support to developing countries or countries with economies in transition that are experiencing a critical health workforce shortage."

Perhaps mandatory compensation of some kind should be provided from the host country to the source country. A compensation initiative would be inherently difficult to operationalise and would require a distinctive styled approach. In his possible compensation discussion, Smith (2008, p.8) maintains: "It would require a high level of international cooperation between countries with inherent competition with fiscal and ethical agendas which would make harmonisation difficult to achieve." Nevertheless, the fundamental question remains as, Iredale (2009, p.42) notes:

> Discussions about compensation are not popular with receiving countries but the question remains of whether it is ethical to use the skilled human resources of struggling nations without somehow paying them back.

Some IMGs migrate for adventure and opportunity while others migrate for further training. Some IMGs migrate from countries that are unsafe due to political upheaval and war. Some IMGs find themselves in a desperate situation forcing them to flee as refugees.

WHY DO IMGS MIGRATE?

Health care workers migrate for a number of reasons. Some IMGs are refugees desperately fleeing war torn countries. Some IMGs are able to migrate before a refugee situation occurs and are partially motivated by the possibility that their home country is descending into a dangerous state. Some IMGs want to travel and work abroad to experience a new country, one which is also in need of doctors. Most of the participants in this study were motivated by the need for relative safety and good education options for their children. To raise their children in an English speaking country was important and

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viewed as enabling better life opportunities. Some IMGs had more lucrative positions elsewhere but decided to migrate to Australia because they considered their country of residence unsafe. Those IMGs who come from areas of conflict often have to leave everything behind and are unable to return to their country of origin. For example, Dr Munjed Al Muderis, a surgeon, fled Iraq due to an impossible situation. Dr Al Muderis, writes in his book: Walking Free (Al Muderis & Weaver 2014) that while at work in a Bagdad hospital, he was instructed by Military Police to remove the ears from three busloads of Army deserters. His supervisor was executed on the spot, in front of his surgical team, for refusing to do this. Dr Al Muderis, determined not to compromise his principles, managed to escape and hid for hours in a female toilet within the hospital. Eventually, he found his way safely out of Iraq and into the hands of Indonesian people smugglers who facilitated his arrival in Australia and subsequent relocation to the now closed, Curtin Detention Centre. The situation was so dire he did not have plans to come to Australia; indeed he did not have any plans at all. To flee to safety and avoid execution was the only motivation. Dr Al Muderis believes that if he ever returned to Iraq he would be executed immediately.

Unless source countries can offer safety, stability, good education and lifestyle opportunities, the migration of medical doctors from developing countries to developed countries will be ongoing (Malekpour et al. 2009).The desire for safety in terms of a safe environment and the subsequent feeling of safety for themselves and their families was an important motivator to come to Australia for the majority of participants in this study. Life in Australia was perceived as a lifestyle free from circumstances and events which were considered unsafe. In contrast however, interview participant Julian (2010, interview 1) commented: "If things don't go well here for any reason, we'll just go home." Julian was from a relatively safe European country and was not motivated to come to Australia by the

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need for safety at all, rather for the opportunity of adventure and to work abroad.

RISK FOR THE SAKE OF POSSIBLE SAFETY

Situations of political unrest and control, military coup, war and violence were mentioned by participating voices in this thesis as constituting unsafe conditions in which to live and work. Consequently these situations led IMGs to leave their country of origin. Colin (2010, interview 2) was motivated by continuing political unrest: "There were on-going political problems so we decided to come here." Similarly, Andrew (2011, interview 5) experienced political unrest but was also concerned about his country's isolation from western societies, he commented: "Primarily because of the political issues in my country. We were isolated from the Western community. We wanted our son to have advantage also by education in English." Shaun (2012, interview 8) sought a feeling of freedom from the political situation in his country and had the advantage of knowing others already in Australia: "Mostly because of the political situation in my country and because I already knew people who came here. We wanted a better lifestyle, a brighter future… to feel free." Nancy's (2011, interview 3) concern for safety and fear of becoming trapped in an unstable country motivated her to come to Australia. Nancy stated: "There was a military coup in my country and continued unrest. We thought it was best to leave while we still could in case things got worse. I did not want us to be trapped unable to leave. The place was not safe". At the time of our interview, Nancy felt that her country had changed forever and she did not feel safe to return there for any length of time: "I don't think we'll ever go back to live now, just short visits. I can't trust the way of life there any more, it can change to dangerous at any time" (2011, interview 3). Despite a higher status lifestyle for medical doctors in South Africa, Tania (2011, interview 7) was more concerned about the welfare of her children and their safety from violence: "We came to Australia from South Africa

where we were treated very well indeed, much better than Australia but South Africa is a very unsafe country where there is a lot of blood-shed and in my view not suitable for children." The decision to relocate yourself and your family to another country is not one taken lightly. There are many things to consider and the decision itself may be perceived as an exercise in risk taking.

If the current environment is unsafe and therefore perceived also as a risky environment in which to live and work, similarly the decision to leave for another environment must also involve risk. Perhaps for some IMGs the risks associated with remaining in the current unsafe situation far out-weigh the potential risks involved in moving to another country. Of course, there is difference in the level or degree of risk an individual can experience. In Australia, things perceived as risky may be perceived as not the least bit risky by individuals involved in life-threatening environments in other countries. Tulloch and Lupton (2003) explore what is termed a 'risk society' and 'risk modernity' and how they are experienced in everyday life. Relative to an individual's situation, risks may influence physical well-being, emotions, cultural identity, economic and social status, relationships and psychological state. Due to their severity however, some stressors can be universally accepted as constituting absolute crisis situations such as war (Walsh, J 2008). Risks such as war or persecution can be classified as uncontrollable by an individual due to the actions of others which cannot be controlled. In these circumstances, the individual is powerless and while unable to enact change may be able to undertake risk behaviours.

Tulloch and Lupton (2003, pp41-42) argue: "In the case of migrants to a country like Australia, these risks will be mingled and articulated in complex geographical-biographical and social ways… The risk actor emerging from these discourses in many ways

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approximates the fearful and rationally reflexive subject who is both highly aware of the pervasiveness of risks and seeks control over them." In some cases voluntary risk taking can be perceived as positive particularly if for example, it is somehow related to personal improvement, or perhaps financial gain. Even the automatically activated psychological mechanisms possessed by humans can have a high level of flexibility. Unlike the fixed action patterns of nonhuman animals, humans may be more inclined to activate psychological mechanisms in certain situations in response to regulatory information. Functional flexibility can be more strongly activated when assessing regulatory information in relation to benefits which promise to outweigh costs (Park & Buunk 2011; Walsh, J 2008). Park and Buunk (2011, p.14-15) suggest that: "…such regulatory information may lie in individuals' external environments; such as threatening situations as well as within individuals; such as a chronically fearful personality." The participants in this study who voluntarily chose to relocate to Australia for safety reasons prioritised their personal safety and that of their families above other aspects of life in their country of origin. An anticipated life without war, political unrest and violence where one could feel safe and guarantee the relative safety of one's family was obviously perceived as worth any other risk which may be associated with moving to a new country. In addition to a new safe environment, perhaps life in Australia would present other potential gains in the quality of life experience. "Here another version of the reflexive actor in response to risk emerges, an actor who may well be somewhat frightened of the outcome of risk-taking but is also willing to take some risks because of possible benefits" (Tulloch & Lupton 2003, p.37). Bauman (2013, p.4) argues however that: "Security and freedom are two equally precious and coveted values which could be better or worse balanced, but hardly ever fully reconciled and without friction." Medical doctors seeking safety in Australia is not a recent event, historically medical professionals have fled unsafe situations and come to Australia for a

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new life.

For example, medical doctors were amongst those who were rendered Displaced Persons after the Second World War (discussed in chapter two). In 1947 the International Refugee Organisation estimated that refugee doctors from post-war Europe in Australia numbered around two and a half thousand. By 1949, this number increased to nearly three thousand (Kunz 1975, p.7). Much later, a questionnaire administered by Kidd and Braun (1992) from the Department of Community Medicine at Monash University investigated the experiences of overseas trained medical doctors in Australia. 192 doctors responded to their question: Reasons for migrating to Australia. Kidd and Braun (1992, p.19) found that:

> 27 (15 percent) of those doctors had migrated because of political or religious difficulties or persecution in their country of origin, and 17 (9 percent) had migrated for the safety of themselves or their family.

They also noted that these doctors had not migrated under refugee status. However, 39 (19 per cent) of the 201 overseas trained doctors who responded to the question asking under which scheme had they migrated to Australia, stated that they had migrated as refugees (Kidd, M & Braun 1992, p.11) . Even though the IMGs in this study who came to Australia seeking safety came from locations perceived as unsafe, they did not come as refugees. The IMGs in this study seemed to have other avenues for migration to Australia. As previously outlined, Australia is actively recruiting IMGs from around the globe due to a health professional workforce shortage. It was somewhat surprising then when Colin (2010, interview 2) from this study revealed his inability to obtain an offer of interest from a prospective employer. Although Colin was initially unable to find employment as a medical doctor in Australia, due to his existing skills he was accepted into an Australian university and was subsequently able to obtain a visa to undertake post-graduate studies. Not to be deterred, Colin (2010, interview 2) was determined he was coming to Australia, one way or

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another and stated: **"**I sent over 100 CVs to places in Australia and not one response at all. So, I applied for Post-Graduate studies in Melbourne; a Master's in Public Health. I was working on this for 1 year and then they offered me a job, they said you can work here as a doctor, so I said fine." Similarly, both Rita (2011, interview 4) and Alex (2012, interview 10) were able to take advantage of the existing immigration agreement between New Zealand and Australia. However, they left an unsafe source country of origin to migrate to New Zealand in the first instance. Rita (2011, interview 4) explained: "There was an agreement between Australia and NZ, where NZ citizens could become permanent residents of Australia automatically. As soon as we got NZ passports we moved to Australia for better opportunities."

The majority of Australia's permanent immigrants without visas are New Zealanders who arrive under The Trans-Tasman Travel Arrangement. This arrangement, which is often influenced by existing economic conditions, allows for unrestricted movement by Australians and New Zealanders between the two countries (Castles et al. 1998, pp.12-13). Schotel (2012, pp.22-23) argues that all contemporary immigration policies are motivated by some or all of the following considerations: "National security, public health, national economy, social and cultural cohesion, balanced national demographics and rewarding favoured national and penalizing unfriendly states." Authorities often use more relaxed (e.g. waivers) or strict visa/admission requirements to express the quality of the relationship with a foreign country.

The participants in this study who felt unsafe in their country of origin were empowered enough to organise other alternatives to refugee status (although they may have been entitled to refugee status) to come to Australia. As medical doctors they were well-educated, financially able and highly skilled in an area of workforce need. These qualities

allowed them to take some control over their unsafe situation and make arrangements and changes towards a safer future, they also belonged to a sought after group by Australia, that of health professionals.

One would assume that in an ideal world a safe environment and subsequently the feeling of being safe would constitute a basic human right. What exactly are human rights and how are they enacted? For Bauman (2013, p.76) human rights have to be collectively won:

> It is the nature of 'human rights' that although they are meant to be enjoyed *separately* (they mean, after all, the entitlement to have one's own difference recognised and so to remain different without fear of reprimand or punishment), they have to be fought for and won *collectively*, and only *collectively* may they be granted.

For those peoples around the world who are not empowered to take control of their situation and leave unsafe environments, Australia has undertaken to accept a quota of refugees.

REFUGEES AND HUMAN RIGHTS

Australia has an official Humanitarian Program based on the United Nations definition. Refugee immigrants include people from other countries seeking protection from persecution. Special Humanitarian arrivals can come to Australia to seek escape from discrimination deemed to constitute the significant violation of human rights. There is also a Special Assistance Category which permits entry to other overseas people in particularly vulnerable situations, who have close family or community ties with Australia.

In the interests of human rights, humanitarian refugees may be entitled to seek refuge in Australia however the number allowed each year is uncertain and depends upon the policy stance of the current Commonwealth government. For example, in 2012, the Gillard labour

government announced an intention to increase Australia's yearly humanitarian intake from 13,750 to 20,000 and to 27,000 within five years. The then Opposition Leader Tony Abbott however stated that if elected, his government would cut the humanitarian refugee intake by 6,000 (Australian Associated Australian Associated Press 2012). In 2015, the current Turnbull liberal government adopted the 2012 figure of 13,750 with an additional one off intake of 12,000 extra refugees from the current conflict in Syria and Iraq (Anderson, S 2016). Phillips (2015; Phillips, J, Klapdor & Simon-Davies 2010) states in a Parliamentary research paper series that: "Since 1945, when the first federal immigration portfolio was established to administer Australia's post-war migration program, over 8000,000 refugees and displaced persons have settled in Australia." From 1788 until today however, Australia does not generally have a good human rights record, for example: historically since 1788, the chronic neglect of the rights of Indigenous Australians and currently in 2016, the off shore detention of asylum seekers (including children).

The whole concept of exactly what are basic human rights and whether they are the same internationally is problematic. For example, as Schech and Haggis (2000, p.156) point out:

> Universal application ignores the fact that rights are based on cultural traditions and may vary from society to society. Human rights tend to focus on the individual…this artificially separates individuals from their communities…. Moreover the focus on the individual fails to recognise the common oppression which large groups of individuals experience in many societies.

Moreover, Bauman (2013, p.5), reminds that: "We cannot be human without both security and freedom; but we cannot have both at the same time and both in quantities which we find fully satisfactory." In the aftermath of the Second World War, human rights were very much at the forefront of thinking as much of the world was in crisis. The United Nations (UN) was established and The Universal Declaration of Human Rights was proclaimed by

the General Assembly of the UN in 1948. Unfortunately as Scheck and Haggis (2000, p.158) note, despite the fact that member countries of the UN were pledged to "save succeeding generations from the scourge of war" … and "to reaffirm faith in fundamental human rights" people continued to suffer and currently still suffer the effects of war and human rights violations around the world. Despite the fact that Governments and people acknowledge in principle that human rights should be observed, at the same time human rights continue to be abused across the globe.

The Universal Declaration of Human Rights clearly advocates that human rights are universally fundamental for all peoples. For example, the first Article of the declaration states that: "All human beings are born free and equal in dignity and rights…" Article two states that: "Everyone is entitled to all the rights and freedoms set forth in this declaration." Finally, Article three asserts that: "Everyone has the right to life, liberty and security of person" (United Nations 1948). It seems that while the establishment and enforcement of human rights and other aspects of quality of life are largely the responsibility of governments, other forces conspire to hinder this. Schech and Haggis (2000, p.186) in their discussion of human rights argue that:

> While the state retains the key responsibility for ensuring that all human rights are observed, the deconstruction of state boundaries through global currency, trade, capital, and labour flows undermines the state's ability, even if it wanted, to ensure its citizens' social and economic needs are met and to regulate violence.

For the participants in this study who fled unsafe environments, the ramifications of their experiences may have impacted on both mind and body before their arrival in Australia. Post- migration difficulties can be assigned to three groups: "socioeconomic stressors, social and interpersonal stressors, and stressors related to the asylum process and immigration policies" (Li, Liddell & Nickerson 2016, p.1). Feeling unsafe is liable to raise

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the stress levels of an individual and IMGs are no exception.

SAFETY AND PSYCHOLOGICAL STRESS

Humans have a number of psychological mechanisms for the avoidance of stressors. For Walsh (2008, p.159) psychological stress can be categorised as "*harm:* a damaging event has occurred; *threat:* the perception of potential harm; and *challenge:* while this can constitute a positive opportunity, if it is perceived as a negative, it can be seen as a cause for alarm and require the mobilisation of struggle against a perceived obstacle". People may also experience traumatic stress which can be triggered by natural events such as a cyclone or by technological events such as a war environment which was the case for many participants in this study. Interestingly, cultural difference can be seen in psychological traits and associated behaviour. This is either because: "…similar psychological mechanisms are evoked differently in different regions or because different cultural norms are transmitted in different locales" (Walsh, J 2008, p.27) . Whereas in the case of infants where responses to threatening situations can be readily observed, if adults feel their safety is threatened, they have often been taught (perhaps a cultural norm) to try to hide the response which makes stressful reactions more difficult to observe.

Feelings and emotions 'motivate' or move us. The holistic connection of mind/body is complex and psychological and physiological responses can be closely connected. Feelings can produce somatic expressions. For example, a response to the feeling of fear may be the expression of increased heart rate however, there is much more involved. As Freund (1998, p.275) explains: "somatic expressions, … may 'feed-back' to influence mood and feeling and are whole complexes and configurations of hormonal, neurological and muscular activity." Emotions can be neutralized or appear to be neutralized. In his discussion of the aesthetics of emotion, Cupchik (2016, p.xv) suggests:

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Emotions are *emergent phenomenon* that develop from the background of bodily states in evocative situations and are neutralized again with time (at least on the surface) or through efforts at self-regulation.

Perhaps arriving in Australia, already having experienced significant stress could be compounded by the necessity for vulnerable IMGs to place their careers at the mercy of the Australian health system. The impact on their careers can be enormous to the point of an IMG having no career at all, joining the ranks of the medical unemployed. In their recent review of research into post-migration stress and psychological disorders, Li, Liddell and Nickerson (2016, p.3) found that:

Across studies refugees who are more highly education and had higher economic status pre-displacement show poorer mental health outcomes after settlement. This may be due to the greater loss of socioeconomic status experienced upon resettlement which can contribute to settlement stress.

Gaining qualification accreditation and subsequent registration to practice medicine in Australia is a complex process (as evidenced in chapter 3). Iredale, (2009, p.33) argues that the questioning of IMGs' knowledge and skills from a source country by another host country has a historical background:

Variously attributed to the non-transferability of qualifications and skills due to: different medical regimes; styles of patient care; types of drug usage and levels of technology; lack of knowledge about the quality of training in source countries; judgements about inferior training in source countries; absence of adequate language skills in the language of the destination country; and discrimination and xenophobia based on race and or gender. The outcome has sometimes been the unfair treatment of overseas trained medical practitioners by some countries in denying them access to the profession, confining their practice to certain disadvantaged areas and/or impeding their progress or career advancement once in the medical workforce.

It seems that IMGs are indeed perceived as problematic and there are several parts to the representation of the problem. The confirmation that there are problems is firstly found in the various inquiries held over time which have been tasked to investigate and make

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recommendations in relation to aspects of IMG/the System relations and associated policies and processes. The inquiries have all arisen out of ongoing perceived problems and, interestingly, the subsequent recommendations made, repeatedly mention terms such as: accountability, transparency, efficiency and unfairness.

INQUIRIES, INQUIRIES AND REQUESTS FOR MORE

Inquiries related to IMGs have been occurring for decades some have not specifically focused on IMGs but are often the subject of organisations and processes that impact on IMGs and their professional practice. The Clarke Inquiry (Law Council of Australia 2008) for example, was set up specifically to examine the circumstances surrounding the charging and detention of Dr Haneef, an IMG suspected of links to terrorism. Inquiries usually conclude with recommendations and those involved, are encouraged to consider and implement the recommendations. There is no structure or over-arching body in place to enforce compliance. One notable exception to this however, occurred in 2003 when the Australian Competition and Consumer Commission (ACCC) imposed twenty one conditions on the RACS's accreditation processes (Iredale 2009). This was the result of a two year investigation into unfair restriction to fellowship. It is beyond the scope of this thesis to delve deeply into every inquiry; however the following are some of the more notable investigations.

The Fry Committee set up in 1982, is an extensive 2 volume report that examines conditions around all overseas qualifications (including medicine). Particularly relevant recommendations in terms of medicine include that: "A formal appeal system constitute an integral part of every assessment procedure…and an examination of both portability of qualifications between States and the discriminatory nature of current reciprocity arrangements" (1982, p. 7-8). At this time assessment of qualifications was State based.

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Subsequent relevant inquiries include: The National Population Council (1988), the NSW Committee of Inquiry (1989) and the Human Rights and Equal Opportunity Commission's report (1991) entitled: The Experience of Overseas Medical Practitioners in Australia: An Analysis in the Light of the Racial Discrimination Act 1975. The Committee of Inquiry into Medical Education and the Medical Workforce (Committee of Inquiry into Medical Education and Medical Workforce 1988) (sometimes referred to as the Doherty report) was partially initiated by complaints from the AMA that there were too many IMGs coming to Australia. The climate at the time was one of concern regarding: over-servicing in metropolitan areas, the threat of competition and a Medicare explosion. The report resulted in a reduction of medical student places and a reduced intake into the RACGP (Iredale 2009). In 2004 the Australian Competition and Consumer Commission (ACCC) jointly with the Australian Health Workforce Officials Committee (AHWOC) (2005) reviewed the selection, training and accreditation arrangements of all specialist colleges. The 2005 report recommended: further consideration of the recognition of prior overseas training and greater transparency of assessment criteria. Also in 2005 the Productivity Commission and The Australian Health Workforce Advisory Committee (2005) tabled a report on the Australian Health workforce to the Council of Australian Governments (COAG). The report's terms of reference included a concern with all major health professions but it was noted that the accreditation and registration for medical doctors was overly complex. An inquiry, also relevant but more so to the representation of IMGs as problematic occurred in 2008. The Law Council of Australia (2008) conducted an inquiry into the case of IMG, Dr Muhamed Haneef. Arrested in 2007 and detained for 12 days before being charged, Dr Haneef was accused of providing a subscriber information module (SIM) card to a terrorist organisation in the UK and his 457 visa was revoked (see

Clarke Inquiry[27], 2008, (Ewart, J & Posetti 2008). There was extensive media coverage of the story at the time and Dr Haneef, also a Muslim, was demonised. This linked IMGs to terrorism a connection easily made by the Australian public in conjunction with the anti-terrorism, national security rhetoric championed by the Howard Government at the time. Dr Haneef, (now without a visa) returned home to India to await legal processes in preference to now being accommodated in community-based immigration detention. The charge was eventually withdrawn due to a lack of evidence and Dr Haneef's visa was reinstated by the full bench of the Australian Federal Court. The Commonwealth Government awarded Dr Haneef compensation of an undisclosed amount (Ewart, J. 2012). In 2011, The Parliament of Australia Senate Finance and Public Administration References Committee investigated the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA) (2011), a relatively new body at the time. It was noted that AHPRA's poor administration of registration processes had effected recruitment of overseas trained health practitioners. The results of what was referred to as 'teething' problems included: prolonged timeframes, provision of inaccurate advice and lost documentation. The Expert Advisory Group on discrimination, bullying and sexual harassment in their draft 2015 report to the Royal Australian College of Surgeons concluded that gender inequality was a central concern. The report recommended increased transparency, independent scrutiny and external accountability to be fully incorporated into the college's operation (Knowles, R & Bannon 2015). The Parliamentary Inquiry (2012, p. x), the submissions to which form part of the data set for this thesis, begins its report: "Lost in the Labyrinth" with the disturbing comment below. This clearly shows, that a significant number of IMGs have become intimidated by the System:

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[27] The Hon. Mr. Clarke QC, 16 May 2008, Clarke Inquiry into the Case of Dr Mohamed Haneef https://www.lawcouncil.asn.au/lawcouncil/images/LCA-PDF/a-z-docs/

> One third of IMGs who made submissions requested anonymity for fear of public comment jeopardising their chances of accreditation and registration. Some only aired concerns informally and refused to make formal submissions fearing negative consequences.

It was felt that IMGs, while generally having community support from those they serve, do not necessarily receive the same level of support from the institutions and agencies that accredit and register them (2012, Foreword). The System was found lacking in efficiency and accountability with IMGs having little confidence in it. In addition, IMGs were faced with duplication and administration hurdles and subjected to discrimination and anti-competitive practices. It was noted that these have impacted the success of some IMGs in registration for practice in their chosen speciality. The committee recommended that red tape be reduced while ensuring maintenance of high standards (House of Representatives Standing Committee on Health and Ageing 2012). In 2013, The Victorian government also held an inquiry into the performance of AHPRA (2014). The subsequent 2014 report by the Legal and Social Issues Legislation Committee of the Victorian Parliament, investigated the authority for effectiveness, efficiency and fairness. The subsequent AHPRA (2014) media release states that "AHPRA engaged fully with the committee during the inquiry and welcomes its calls for increased: transparency, accountability and reporting to parliament". AHPRA (2014)also welcomed a stipulated forthcoming independent three year review. However, seemingly resistant to change, AHPRA also stated: "We advised the Committee that we would be concerned about the risks of making any substantial changes to the way we work in Victoria…" Further subsequent requests for investigation have been made. In 2015 Neurosurgeon Dr Charlie Teo, called for a Royal Commission into the bullying behaviours of surgeons and also in 2015, South Australian Senator, Nick Xenophon along with Victorian Senator John Madigan called for a Senate Inquiry into medical complaints. In a 2016 press release from Senator Xenophon's office, Senator Madigan stated:

"Despite denials by AHPRA, I know of at least seven doctors in Australia who have been hounded from work through bullying and harassment by AHPRA." (Xenophon 2016). These inquiry requests resulted in the most recent inquiry that of the 2016 Senate Community Affairs References Committee entitled: "Medical Complaints Process in Australia." Senators Xenophon and Madigan were inquiry members. The subsequent recommendations of the inquiry were directed to all parties with the responsibility for addressing bullying in the medical profession; governments, hospitals, speciality colleges and universities[28]. The parties are requested to: "commit to ongoing and sustained action and resources to eliminate these behaviours" (Senate Committee 2016, p.x.). AHPRA and its processes attracted considerable attention from the committee from lengthy delays in dealing with complaints to inadequate guidelines. Professor Stokes (2016, p.13) commented to the Senate Committee (2016) on AHPRA's guidelines: "The guidelines from AHPRA are extremely loose. You could drive a truck through them." Similarly, as was the case for the 2012 Parliamentary Inquiry, many of the submissions made to the 2016 Senate Committee, were either marked confidential and therefore unable to be accessed or marked name withheld. The Committee determined that submissions from individual medical practitioners or their family members which contained detailed personal accounts would be accepted in confidence. Most submissions were individual cases, and the risk of possible repercussions for speaking out, were taken into consideration.

Another inquiry has been recommended by the 2016 Senate Committee to focus specifically on issues around the need to review the handling of medical complaints,

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[28] The recommendations of the 2016 Senate Community Affairs References Committee Medical Complaints Process in Australia can be viewed at:
http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/ Community Affairs/Medical Complaints

patient safety and the National Law. I suspect that there will be further issues raised and requests for investigation made into the future. Whether or not these eventuate into actual inquiries or whether they resolve any of the issues raised remains to be seen. What is clear however, is that there are numerous 'problems' within and associated with Australia's medical culture and IMGs seem to be portrayed as 'problematic'. This thesis suggests that the current positioning of IMGs in Australia's medical culture and the system which has evolved to maintain that position has in itself become a wicked problem. That is why the situation will continue in its current vein despite all manner of inquiries into structures, practices, policies and procedures. What exactly is a wicked problem?

> A wicked problem is a complex policy problem highly resistant to resolution. They challenge our governance structures, our skills base and our organisational capacity (Australian Public Service Commission 2007, p.iii).

The concept of a wicked problem was originally introduced in 1973 by urban planners Rittel and Webber from the University of California, Berkeley USA. The concern at the time was centred on systems design at a micro level. Since then, through subsequent literature, the wicked problem concept has been extended to broader economic and social policy concerns. The government is well aware of wicked problems and is constantly attempting to deal with them. Australian Public Service Commissioner Lynelle Briggs wrote in 2007 that many of the most difficult challenges in policy for the Australian Public Service (APS) involved tackling wicked problems. Wicked problems are characterised by:

> Social complexity, they cross the boundaries of APS agencies and cross jurisdictional boundaries. Stakeholders and experts often disagree about the exact nature and causes of the problems and not surprisingly they disagree about the best way to tackle them (Australian Public Service Commission 2007, p.35).

The innovative work of Carol Bacchi (2009) brings fresh perceptions to the wicked problem

debate and advocates a post structural approach to policy which asks: 'what's the problem represented to be'. Bacchi's critical rather than descriptive form of analysis argues that: "We need to study problematisations through analysing the problem representations they contain rather than problems" (2009, p. xiii). Briggs (2007) maintains that wicked problems go beyond the capacity of any one organisation to understand and address, and they almost never sit within the responsibility of any one organisation. Examples of wicked problems in Australia range from chronic policy failure in addressing Indigenous disadvantage to the challenges of climate change and land degradation to the alarming increase of obesity within the population. In their discussion of wicked problems from a national perspective, Newman and Head (2017, p.40), point out that: "the very fact that the concept of wicked problems has caught the attention of public policy scholars signifies that there is some belief that potential remedies exist." Wicked problems however are complex and according to Lavery, (2016, p.1): "Every wicked problem is essentially unique and every wicked problem can be considered a symptom of another problem." These problems tend to be multi-causal; have multiple interdependencies and even conflicts within the wicked problem itself. As a result, wicked problems can be difficult to clearly define as they are usually unstable and can be evolving at the same time as policy makers are endeavouring to deal with the policy problem.

In terms of IMGs and the system, there are two key characteristics that are fundamental to the concept of a wicked problem in this context. Firstly, the power differential sits at the heart of the wicked problem. Professor Nancy Roberts (2000) in her discussion on wicked problems argues that the key consideration when tackling the problem is how power is dispersed among the stakeholders. Most of the literature supports a collaborative approach to the problem (Innes & Booher 2016; Newman & Head 2017; Waddock 2013), however other approaches may be more effective, such as an authoritative strategy. The

authoritative stance requires a particular group or individual to tackle the problem-solving process while others agree to abide by the result of the deliberations. It is necessary then, for other stakeholders to not only agree to the transfer of power to the individual or group appointed but also abide by the decisions taken. The selection of the individual or group appointed may be based on organisational position in the hierarchy, knowledge and expertise, level of information or coercive power.

The second fundamental characteristic in the IMG/system context is the need for behavioural change. A key component of the resolution of many wicked problems involves the accomplishment of sustained behavioural change. It seems unlikely that significant change will occur in Australia's medical culture in the foreseeable future. It is clear that the process journey to accreditation and registration for IMGs is overly complex and the associated administration is cumbersome and repetitive. Despite ongoing adjustments to aspects of the system, subsequent inquiries and investigations consistently identify inefficiencies. The numerous bodies involved their entrenched hierarchical structures, and underlying ethos of maintaining high standards of health care in Australia, make major behavioural change seem unlikely. Stakeholders may not be willing to relinquish or change their power status and may not be willing to change their approach. Moreover, a culture of bullying and sexual harassment, particularly within Australian hospitals in the surgical specialities has been raised and led to a RACS report (Knowles, R & Bannon 2015). One has to ask the question though: is an inquiry sufficient to instigate major behavioural change amongst surgeons? One would assume that these behaviours have been operating for a long period of time and as such become a part of the organisational culture of the specialities. Further, inquiries do not have significant power, they only highlight issues and problems and make recommendations for potential changes. Perhaps there is an authoritative, powerful overarching organisational layer missing in the system, or is it far

more complex and perhaps too complex to fully address. In his project entitled; "Towards a New Sustainable Business Model for Energy Companies", Waddell (2016, p.443) provides a discussion on wicked problems and advocates for a societal change system framework, he argues that: "There is a need for an agent with system legitimacy, power, and competency to nurture and when appropriate, push change initiatives to address…needs for a robust, coherent set of actions." However, in the context of Australia's medical culture which is already comprised of numerous agencies, the how of problem representation in this instance is more useful in the explanation of IMGs' positioning. Their representation has ramifications for how they are perceived and how they perceive themselves:

> How the 'problem' is represented or constituted, matters. This is because the way in which the 'problem' is represented carries all sorts of implications for how the issue is thought about and for how the people involved are treated, and are evoked to think about themselves (Bacchi 2009, p.1)

Bacchi's (2009) analysis framework of interrelated questions guides the analysis of the representation of the problems associated with the positioning of IMGs within Australia's medical culture. Bacchi's (2009, p.xi) suggestion for how to study problematisations is to:

> open them up for analysis by identifying the implied problem – what is seen as in need of fixing – from the plan of action that is proposed. This characterisation of the 'problem' is the place to start in order to understand how an issue is being understood.

Due to the nature of this study and what the voices revealed, it seems that much of what would constitute a wicked problem is indeed too broad, too entrenched, too stakeholder heavy and overall too complex to attract the ultimate goal of solving the problem. This is evidenced by the persistent problems found by the succession of various inquiries. The ultimate question then is: How can a wicked problem be tackled where there is a recalcitrant power base such as medicine, which is government sanctioned, that sets the

terms, processes and restrictions to further its own agenda? Carol Bacchi's (2009) work: 'What's the Problem Represented to be approach (WPR)' is particularly relevant here. This is because the appraoch advocates a paradigm shift from a problem solving focus to a problem questioning approach. In the case of this doctoral thesis then, it seems that the Terms of Reference given by the government to the 2012 Parliamentary Inquiry is an enlightening place to begin. The Terms of Reference established by the then Minister for Health and Ageing, the Hon Nicola Roxon MP and referred to the House of Representatives standing Committee on Health and Ageing reflect the concerns or problems as they were perceived at that time. The voices from IMGs and other interested parties were collected by the Inquiry committee and constituted the state of affairs. The resulting report: "Lost in the Labyrinth" and its recommendations reflect the voices in association with the terms of reference below:

Recognising the vital role of colleges in setting and maintaining high standards for the registration of overseas trained doctors (OTDs), the Committee will:

- Explore current administrative processes and accountability measures to determine if there are ways OTDs could better understand colleges' assessment processes, appeal mechanisms could be clarified, and the community better understand and accept registration decisions;

- Report on the support programs available through the Commonwealth and State and Territory governments, professional organisations and colleges to assist OTDs to meet registration requirements, and provide suggestions for the enhancement and integration of these programs; and

- Suggest ways to remove impediments and promote pathways for OTDs to achieve full Australian qualification, particularly in regional areas, without lowering the necessary standards required by colleges and regulatory bodies (House of Representatives Standing Committee on Health and Ageing 2012).

At the outset it is interesting to note that the Minister was very careful to acknowledge the two seemingly most important aspects of the overarching knowledge/power nexus: those

of the role of the colleges and the need to maintain high standards.

The terms of reference given to the committee implied and set the tone for how the colleges, IMGs and the general public were viewed by the government. The terms constituted a deficit discourse which immediately established the Australian medical profession and the system as a ruling class while IMGs and the general public were relegated to an under-class or 'other' status. The colleges were given the respectful acknowledgement they expect as the privileged custodians of things medical and the assurance and confirmation of their superiority. It was assumed that IMGs and the general public were perhaps unable to understand the processes involved and the decisions which were made, therefore they needed a dumbed down or more simplified version they could understand. In addition, IMGs required assistance to meet registration requirements as they did not have full Australian qualifications which are superior to any other medical qualification obtained elsewhere. Finally, the standards set by the colleges must not be lowered to accommodate IMGs into the Australian system.

Discourse, in this case a deficit discourse which marginalises IMGs also informs our thinking. The medical dominance discourse which resonates from the above terms of reference leaves no doubt about the power and control held over IMGs and the general public by the Australian medical profession. Kovach (2005), highlights the link made between discourse and marginalisation:

> the dominant society's usage of language to silence the voices of those who are marginally located… is the tool by which a meta-narrative of "truth" and "normalcy" is perpetually reproduced. In centres of knowledge production… the language becomes powerful and pervasive (Kovach, 2005 p.25)

The health system and medical dominance represents itself as normative and truthful as well as the custodians of medical knowledge and this is reproduced in the deficit discourse

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assigned to IMGs. The 2012 Inquiry terms of reference is a clear example.

In contrast to the 2012 Inquiry terms of reference, are the terms of reference given the 2016 Senate Inquiry. On 2 February 2016, the Senate referred the medical complaints process in Australia to the Community Affairs References Committee for inquiry and report, with the following terms of reference:

- the prevalence of bullying and harassment in Australia's medical profession;

- any barriers, whether real or perceived, to medical practitioners reporting bullying and harassment;

- the roles of the Medical Board of Australia, the Australian Health Practitioners Regulation Agency and other relevant organisations in managing investigations into the professional conduct (including allegations of bullying and harassment), performance or health of a registered medical practitioner or student;

- the operation of the Health Practitioners Regulation National Law Act 2009 (the National Law), particularly as it relates to the complaints handling process;

- whether the National Registration and Accreditation Scheme, established under the National Law, results in better health outcomes for patients, and supports a world-class standard of medical care in Australia;

- the benefits of 'benchmarking' complaints about complication rates of particular medical practitioners against complication rates for the same procedure against other similarly qualified and experienced medical practitioners when assessing complaints;

- the desirability of requiring complainants to sign a declaration that their complaint is being made in good faith.

These terms of reference are not specifically directed at the investigation of issues concerning IMGs. As a result, there is not a dominant deficit discourse evident. While there is acknowledgement that the complaints process needs to be examined and that it must be

checked against Australia's world class standard of health care there is an absence of a paternalistic tone and language. Also acknowledged is that Australia's medical profession does have a bullying and harassment culture by the need to investigate its prevalence. Submissions made to the Senate Inquiry (2016) from various bodies within the health system overwhelmingly claimed that their organisations take a zero tolerance stance on bullying and harassment (for example, the AMA submission 9, p.1).

The WPR approach (Bacchi 2009, p.2) suggests that analysis take place with a focus on the following six questions. These questions, when considered systematically, guide an integrated analysis which highlights the ways political subjects can be conceptualised.

What is the problem represented to be in policy?

IMGs have been problematized, firstly because their medical qualifications are not Australian and we need to maintain the high standards of medical practice expected in this country. Secondly, this rhetoric runs through the policies and processes developed to address perceived deficiencies which could potentially undermine Australia's high standards.

What assumptions underlie this representation of the policy?

It is assumed that IMGs possess inferior qualifications and poor English language skills. In addition, they are not familiar with how we practice medicine in Australia. However, some IMGs are somewhat more acceptable than others. IMGs from the English speaking countries of: The US and UK, Canada, New Zealand and Ireland are deemed more competent than IMGs from elsewhere; perhaps the Australian public is more likely to trust a native English language speaker. These privileged IMGs are still not totally up to Australian standards however and must undertake further training and supervision in

Australia.

How has this representation of the problem come about?

As shown in chapter two, Australia has a long history of ethnocentricism, xenophobia and racism which persists today. As a result, 'others' are often perceived as foreign, suspicious or of less worth. The Australian way, our norms and values are assumed to be superior to others and amongst the best in the world, medicine is no exception. These social constructions are deeply entrenched in the fabric of Australian society and are not only reinforced and perpetuated in the socialisation of our citizens but also institutionalised, enshrined by laws governing our institutions.

What is left unproblematic in the problem representation? Where are the silences? Can the problem be thought about differently?

The fundamental need for IMGs particularly in rural and remote areas of Australia appears to be on the one hand unproblematic, it is a fact that Australia currently does not have enough doctors. On the other hand however, it is perceived as problematic that past government decisions have led to the shortage of Australian trained medical practitioners (such as cutting medical school places) this was negligent on the government's part. The silences lie in the toxic culture found within medicine itself, not only the treatment of IMGs but also the treatment of Australian medicine's own. Medicine's toxic culture, evidenced by bullying, sexual harassment, Jealousy, self-interest and a preoccupation of market share has been showcased by the media. It has been revealed via the voices shared in this thesis that in some instances medical professionals (especially surgeons) will go to any lengths to drive competition away. Dr Emery's experience in North Queensland is a case in point. These behaviours specifically, were not aired as a concern in the inquiry terms of reference therefore rendering them as unproblematic. Post the 2012 inquiry

however, medicine's toxic culture has emerged as no longer a silence but rather the elephant in the room. Moreover, recently the problem representations of Australia's medical culture have come out of the silence to the forefront of scrutiny. There is no real problem with IMGs as such. Rather, the problems lie with the injustices and inefficiencies in the system's dealings with IMGs.

What effects are produced by this representation of the problem?

IMGs continue to be represented as a problem. This problem representation legitimises the over-zealous interrogation of IMG credentials. As a result, some IMGs suffer gross injustices at the hands of the system as evidenced by many of the voices embedded throughout this thesis. Some IMGs experience unskilled employment or unemployment. In addition, some IMGs experience adverse health issues due to bullying, exclusion and the inability to fulfil career aspirations. Also impacted by this problem representation is the self-esteem of IMGs and how they are viewed by the Australian public. Bacchi (2009, p.189) argues:

> Members of outgroups-those located outside influence and recognition-are constructed as, in some way, lesser than the unspoken norm. Representation of the 'problem' sometimes produces a low sense of self-worth in victims of discrimination and contributes to the public impression of them as inferior.

How/where has this representation of the problem been produced, disseminated and defended? How could it be questioned?

The representation of IMGs as the problem has been produced over a long period of time (as documented in chapter three). The problem representation has been extensively disseminated through the media. The drawn out case of Dr Patel is a useful and interesting example in that, somewhat surprisingly, the medical profession eventually

closed ranks and came to the rescue of an IMG. Perhaps this defence was motivated mostly by maintaining the reputation of surgeons. The following extract from an article in the Courier Mail at the time read:

> Patel was charged with multiple patient deaths in 2006; found guilty in a 14-week Supreme Court trial in March 2010, before having the convictions sensationally quashed by the High Court in August 2012.With a bill for taxpayers topping $13 million - $9.7 million in special compensation paid to almost 300 victims plus $3.5 million in legal and other costs - Mr Moynihan QC said the complexity of the case, the defence's success with medical experts in court and cost outweighed the public interest in continuing. After eight years and $13 million, the state's top prosecutor has admitted the Crown failed to successfully prosecute Jayant Patel because it couldn't beat the medical experts the surgeon's defence arrayed against them. The decision to drop the charges sparked victim fury and set off a political storm (Keim et al. 2013).

The Patel saga was active in the media for years. Panic ensued in relation to overseas medical qualifications and standards. Many of the processes in place today for the accreditation and registration of IMGs in Australia were influenced by the Dr Patel scandal. At the time there was a warning climate around careful scrutiny and increased vetting. Dr Patel, an IMG born in India, had arrived from practice in the US and because of this fact alone was, not thoroughly checked. It was discovered that Dr Patel lied in his CV and that he had been sighted for negligence in the US. The fallout influenced IMG/community relations. As mentioned in the introduction to this thesis, the Dr Patel case sparked my interest in the experiences of IMGs in Australia. During our focus group session there was discussion around Dr Patel and it was suggested that the case had put IMG/community relations back twenty years (Pascoe 2007).

The defence has always been linked to maintaining Australia's high standard of health care. Medical dominance can be seen in a gatekeeping role to protect the Australian public from 'suspect' IMGs. However, silently and simultaneously medical dominance is also

protecting livelihoods from competitive IMGs, often via uncompetitive behaviours (Parliamentary Inquiry, 2016).

Certainly, the wicked problem concept continues to surface within policies and as a result, processes. Why are wicked problems increasingly recognised? Briggs (2007, pp. 6-7), advances some contributions while acknowledging that these only begin to scratch the surface. They include: the expansion of democracy and of market economies. Globalisation, travel and social exchanges may have highlighted value differences, weakened traditional authority and control mechanisms. In addition, technological and information revolutions enable more people to become active participants in problem-solving and as a result, increase the complexity of the process. Information revolutions also increase the expectations of citizens for higher standards of living and therefore expectations that government should take responsibility for managing a greater range of complex problems.

IMGs do not constitute a problem, but are viewed as problematic in terms of their qualifications. In the interests of maintaining Australia's high standards, IMG qualifications are found to be, at best, comparable only to some degree to Australian medical qualifications. Why does the problematizing of IMG qualifications exist? What is the origin for such assumption? The underpinning influences of problem representations are unpacked in the following chapter. This will unveil the Australian ideologies that conspire to relegate IMGs to an underclass within an elite profession. The contribution to knowledge offered by this thesis explores the why associated with the positioning of IMGs within Australia's medical culture. The positioning of IMGs globally and the associated ethical dilemmas have been discussed including refugees and human rights, particularly the human right to feel safe. The reader has been able to gain an appreciation of from where

and under what conditions some IMGs have come to Australia. The concept of wicked problems and particularly the: What's the problem represented to be approach has been introduced as a useful framework for analysis in this context. Analysis continues in the following chapter where intersecting inequalities are explored.

CHAPTER SIX

IMGS AND INTERSECTING INEQUALITIES: CLASS, RACE AND NATION

> Attending to the perspectives and experiences of those who do not have power to make their voices heard is undeniably an important step for understanding social inequality. Indeed, these groups are often the objects of political debates, rather than participation subjects of democratic politics, and stereotypes about them are rife (Choo & Ferree 2010, p.137).

> However and wherever this production started, it continues, in old and new forms, with old and new aims, using old and new infrastructural supports. It takes a lot of work to produce race, class and gender, which indicates a deliberateness to the enterprise (Ken 2008, p.158).

This chapter argues that the intersecting inequalities of class, race and nation help to explain why IMGs are positioned as an underclass within Australia's medical culture. Through the analytic tool of intersectionality, inequitable power relations are viewed as intersecting oppressions which conspire together to produce forms of discrimination. What is intersectionality? In the words of prominent Intersectionality scholars, Hill Collins and Bilge (2016, p.2), intersectionality is succinctly explained:

> When it comes to social inequality, people's lives and the organization of power in a given society are better understood as being shaped not by a single axis of social division, be it race or gender or class, but by many axes that work together and influence each other. Intersectionality as an analytic tool gives people better access to the complexity of the world and of themselves.

The original contribution to knowledge offered by this thesis unpacks an analysis of

intersecting inequalities and their roles which weave their way through Australian society and its institutions to influence the positioning of IMGs. Through the analysis journey it becomes clear that Australia's medical culture has been and continues to be influenced by deeply entrenched norms, assumptions, values and beliefs. The task here is to explore the social relations (structure and agency) between and within the fields/occupation of medicine in Australia particularly in relation to the IMG community and the Australian trained medical community. Following Hills-Collins (2010), analysis is framed by presenting IMGs as an occupational community; as a community construct. The doctors share the same occupation/profession but IMGs are singled out as different, as the 'other'. Therefore, IMGs and Australian trained medical graduates are also separate communities. While the profession is considered elite there are 'double standards' at work. IMGs constitute oppressed elite, in that they become an underclass while still remaining medical professionals. Analysis through class, race and nation explores the root causes which underlie the 'double standards' rationale and advance an explanation for why this exists. Many Intersectionality scholars include gender in their studies. I have deliberately left gender, as a specific intersecting inequality, out of this analysis. I acknowledge the importance of gender analysis, but in this case, I did not want to divide the IMG community on a gender basis nor in any way further disempower the IMG community, preferring to keep their solidarity as purely a professional community. As Sefa Dei (2008, p. 81) notes:

> It is indeed crucial and strategic that in intersectional discursive politics we look for a common lens of identity construction which allows multiple parties to join in a community of shared purpose.

Further, a thorough analysis of gender as an intersecting inequality is beyond the scope of this thesis. It is class, race and nation that most effectively aid in the 'why' analysis of the position of IMGs. Initially, the analysis tool of intersectionality will be defined followed by an

exploration of the complex expressions of inequality. Class, race and nation have been discussed historically (since the 1788 invasion) in chapter three. The role of this chapter then, is to investigate more recent and ongoing examples of what has become the Australian nation: the prejudices, the exclusions, the violations of human rights, in other words, the more ugly side of the land of milk and honey. For these reveal the environment for the socialisation of Australia's citizens and the impetus of Australia's governments, laws and institutions.

INTERSECTIONALITY AS AN ANALYTIC TOOL

Intersectionality was conceived by Black feminist, Kimberle` Crenshaw, a critical race scholar (1989) and followed by Patricia Hill Collins (1990). These feminists were particularly interested in the multiple oppressions experienced by women of colour in the United States. Since then, Intersectionality has become central to many feminist works. It is essentially a tool for the analysis of the ways hierarchies are constructed and intersect allowing some groups to have privilege over other groups. The categories advanced here: class, race and nation do not have rigid boundaries however and the struggles and injustices within are not confined; intersectionality is a flexible theoretical framework. According to Lutz et. al. (2011, p.132): "different forms of social inequality, oppression and discrimination interact and overlap in multidimensional ways. That is, the categories are co-constitutive and synergistic; no category has a single, fixed meaning." This structure can be viewed as "web-like" (Fraser & Taylor 2016).

The foundations of analysis have been set down in preceding chapters four and five where the investigation of power practices via the study of processes and systems and the creation of systemic power have been explored. How this power is created, recreated and maintained in this study is via relations between the health system (the controlling medical

bureaucracy) and the 'other' (IMGs: oppressed elite). Interlocking systems of oppression are part of a single, historically created system. Against a back ground of institutional power, a deliberate exclusion via tactics of roadblocks, lengthy delays and other strategies for control, make the process to full medical registration for IMGs as difficult as possible. This thesis is also a political critique of the social world which includes the relationship between power and knowledge and the experiences of marginalised voices, those shared with the reader from the lived experience of IMGs. The work of an Intersectionality approach endeavours to confront power. The fundamental focus which underpins this thesis seeks to move to empowerment linked to analysis of power relations and the ongoing acknowledgement of systemic oppressions. Following Brown and Strega (2005, p.10):

> By centering questions of whose interests are served not only by research products but also in research processes, it challenges existing relations of dominance and subordination and offers a basis for political action.

Unjust power relations and how they are created and maintained have been the focus for many scholars. Historically, classical theorists such as Marx and Weber, followed by Foucault have been interested in the analysis of the relationship between the social system (structures, institutions, historical processes) and the social actor (discourses, actions, and meanings) and the organisation of knowledge and power. Foucauldian archaeology (1972) for example, seeks to unearth assumed thought. Bacchi (2009, p. 5) argues that: "this kind of analysis includes a search for deep-seated cultural values – a kind of social unconscious – that underpins a problem representation." Power relations in Australia underpin the focus of this doctoral thesis.

From a Peace Studies perspective, the concept of violence in power relations is useful in the case of the IMG experience in Australia, in particular their interaction with aspects of

the system, which in itself is a manifestation of Australian 'normalcy'. The work of Savitch (1975) in terms of systemic bias and the work of Galtung (1970) in terms of structural violence, as well as his concept of cultural violence (1990) provides a helpful way to view how IMGs are situated and how power relations and the associated discourses are structurally entrenched in Australian society.

Structural violence can be seen as violence built into the social order. In his development of this concept, Galtung (1990) expanded his ideas to cultural violence. This perception of violence consists of " any aspect of a culture that can be used to legitimize violence in its direct or structured form" (p.291). For example, distinct from direct violence and the violence built into the structure of society, symbolic violence built into a society's culture does not wound or kill but can be used to legitimize either or both. In addition, Eckermann et.al. (2006, p.64) introduced the idea of systemic frustration of aspirations which maintains that:

> the predominant social order denies one category of persons access to the prerequisites of effective participation in a system developed and controlled by powerful interest groups…further, it is argued, the controlling groups generally define legitimate pathways to effective participation in order to maintain their own power.

Many of the voices in this study had their aspirations eroded or destroyed by the system. In the quest to confront power and the agents who enact it, it is also necessary to consider IMG agency within intersecting oppressions. Black feminist thought offers an invaluable contribution to intersectionality and research concerning the marginalised. The work of Patricia Hill Collins for example, advocates the significance of knowledge in a politics of empowerment and argues that Black feminist thought requires a paradigm shift in the analysis of unjust power relations: "By embracing a paradigm of intersecting oppressions of race, class, gender, sexuality and nation, as well as Black women's individual and

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collective agency within them" (Hill Collins 2000, p.273). While intersectionality is strongly connected with women and gender studies it is not confined there, rather it has become multi-disciplinary and usefully utilised in varied studies that seek to explore power relations. Intersectionality has become a strong vehicle for critical inquiry and praxis (Hill Collins & Bilge 2016).

To assist in the investigation of power in this thesis it is necessary to explore the influences which underpin Australian society that in turn contribute to the formation of ideas and their execution through the fabric of individuals, institutions and governments. I argue that the intersecting oppressions of class, race and nation are the best way to view and therefore begin to understand why IMGs are positioned as an underclass within Australia's medical culture. This thesis is essentially a search for the 'why' of IMG positioning as the 'how' has already been revealed in terms of medical dominance (see Willis, 1989). However, Bacchi (2009, p.5) suggests: "The question becomes not why something happens but how is it possible for something to happen." This is a valid point and I note that perhaps the whole 'how' has not been considered. Perhaps the 'why' analysis offered here will actually complete the 'how'.

CLASS, RACE & NATION AS INTERSECTING OPPRESSIONS

Intersectionality is a flexible framework and intersecting oppressions overlap. Therefore, the discussion offered here will reflect the connectedness of the intersections. Initially though it is important to note the interpretation dilemmas of the term inequality and the somewhat problematic oppressed and oppressor binary. The term equality has taken on the general meaning of treating all people in the same way and the term equal opportunity is now the dominant equality discourse in Western industrialised countries. This implies that individuals should have the same chance to pursue opportunities and have equal

access to opportunities. This sits on specific meanings of inequality. However, Bacchi (2009, p.180) argues that: "No term is more contested than inequality. It plays a key role in Western public policy, policy affected by Western laws and Western precedents by a set of binaries: equality/difference, sameness/difference, equal treatment/different treatment, equal opportunity/equal results or outcomes." Australia prides itself on being a country where equal opportunity is almost a given. In reality, however this is not the case, racial inequality for example is clearly evident in Indigenous Australian communities.

In addition, the discourse of intersections can pose intellectual dangers in terms of the oppressor and oppressed status. In his discussion of race, difference and the discourse of intersectionality, Sefa Dei (2008, p.85) notes:

> Sources of identity complicate our understanding of oppressions beyond the oppressed/oppressor binary. Context, location and historical specificities themselves add complexity not only to our analysis of the intersectional and/or interlocking nature of oppressions, but also to essentialist claims.

Australia, as context and location has indeed specific historical archaeology that is not only complex but often incongruent with the Australian image portrayed to the rest of the world. Australia is an imagined society and nation and there are generalised 'truths' as well as contestation and conflict over what constitutes the Australian nation (Plage et al. 2016). Is Australia a fair and just egalitarian society or is it exclusionary and racist? Is Australia multicultural, or British/Western, or a second America? Is it an old or a young country? Essentially, as White (1997, p.13) suggests:

> 'Australia' exists pre-eminently as an idea. While it has a real existence as a geographical space with defined boundaries, and as a political entity, a nation-state organised for the pursuit of political power. 'Australia' for the most part is something we carry around in our heads.

The political climate in Australia is a useful place to begin discussion around the intersections of class, race and nation and the positioning of IMGs. Governments pass legislation of ideas and processes into laws, and subsequently into institutional structures. The voters of the nation, Australia's citizens, elect the government. The government and the Australian voters should provide an image of what Australia stands for or hopes to stand for. A particularly interesting politician of recent times is Pauline Hanson and her right wing, conservative platform One Nation Party. Hanson declares that 'political correctness' threatens Australia's identity. The policies developed by this party and the fact that people vote for them demonstrates that a significant number of Australians hold racist and xenophobic views as well as an ethnocentric view of what constitutes the nation Australia.

THE RISE AND FALL AND RESURRECTION OF HANSON: 'I AM FED UP!'

On the 10th of November 2016, Pauline Hanson shared a bottle of champagne on the front lawns of Parliament House in Canberra with her colleagues in celebration of Donald Trump's election to the presidency of the United States, which he intends to: 'make great again.' Hanson (2016) explained:

> Why I'm celebrating is that I can see that people ... around the world are saying, 'We've had enough of the establishment,' she said. Give people the power back to have their own democracy. I think Donald Trump will bring that to America and I can see in Donald Trump a lot of me and what I stand for in Australia. I think it's great (Le Messurier 2016).

In 1996 Pauline Hanson, fish and chip shop owner, came out of political obscurity into the public spotlight and was unexpectedly elected to the House of Representatives as an independent. Her beliefs and ideas shocked 'fair' minded Australians and unearthed some others who secretly agreed with her xenophobic and racist statements giving them a

chance to 'come out'. The media capitalised on her ignorance and ill-informed opinions.

Initially it was Asians which Hanson demonised the most, claiming that Australia would be

swamped by them. Indigenous Australians also came under fire. Referring to Indigenous

Australians in her maiden speech to Federal Parliament in September 1996, she ignorantly

stated:

> I am fed up with being told, 'This is our land'. Well, where the hell do I go? I
> was born here, and so were my parents and children. I will work beside
> anyone and they will be my equal but I draw the line when told I must pay
> and continue paying for something that happened over 200 years ago. Like
> most Australians, I worked for my land; no-one gave it to me (Museum
> Victoria, 1996).

Hanson also mentioned that she was tired of Aboriginal people being presented as the

most disadvantaged group in Australia. In the 1998 federal election, Hanson lost her seat

but assured Australia that she would be back. She contested several state and federal

elections as an Independent and then re-joined One Nation in 2013 and again became

leader. Throughout her political career Hanson has singled out many groups of people for

undeserving criticism, such as claims that Africans come to Australia spreading disease,

she was referring to HIV Aids (Museum Victoria 1996). Currently, Pauline Hanson is more

focussed on the demonisation of Muslims. In 2016 after a successful campaign entitled:

'Fed Up', Hanson was back, this time elected as a Queensland Senator. In her Maiden

Speech, during which senators from the Greens party walked out in protest, she predicted:

> Have no doubt that we will be living under sharia law and treated as second-
> class citizens with second-class rights if we keep heading down the path with
> the attitude, 'She'll be right, mate'…Therefore, I call for stopping further
> Muslim immigration and banning the burqa…(Sydney Morning Herald 2016).

The policies of the One Nation Party (2016) which now has four senators in the 45th

parliament, include the desire to abolish multiculturalism and the Racial Discrimination Act,

promote assimilation, nationalism, loyalty and pride in being Australian. The party also wishes to withdraw from United Nations treaties on migration and refugees that conflict with our sovereign rights and laws (One Nation Party, 2016).

It has been a long journey for Hanson, in 2003 a Brisbane Court found her guilty of electoral fraud which was, subsequently overturned by a Queensland Court of Appeal. However, she spent the eleven weeks prior to the appeal being heard, in prison. From her first appearance in Canberra in 1997 until today she has continued her populist public commentary and received a growing level of support. Pauline Hanson is not alone.

'LOVE TRUMPS HATE' AND 'THE EUROPEAN UNION HAS FAILED US ALL'

The election of Donald Trump in the United States in 2016 is indicative of an ailing economy, high unemployment and an angry working class backlash. Like Pauline Hanson, Donald Trump's proposed policies range from ambitious and naïve, to exclusionary and racist, to outrageous and include: The proposed construction of a wall along the Mexican border and to detain and then deport all illegal immigrants. As long as the threat of Islamic State (ISIS) persists, Trump vows to stop Muslim immigration into the US, he also intends to increase defence spending. As a seemingly true champion of the working class, Trump aims to create a dynamic booming economy that will create 25 million jobs over the next decade especially in construction and steel manufacturing via an ambitious increase in spending on infrastructure. Trump promises to cut individual and corporate taxes while endeavouring to reduce or eliminate most deductions and loopholes available to the very rich (Poliplatform 2016). These policy initiatives may seem like salvation for a weary section of the American public however, some policies may cause adverse reactions from other countries.

As Phillips (2016) warns in his Guardian article about the possible tit-for-tat ramifications of Trump's proposed 45% tariff on Chinese imports:

> A batch of Boeing orders will be replaced by Airbus. US auto and iPhone sales in China will suffer a setback, and US soybean and maize imports will be halted. China can also limit the number of Chinese students studying in the US.

Many Americans were shocked with the election result and there have been protests across the country with 'not my president' placards a dominant image. In an opinion piece, Ernst (2016) identified Trump supporters and a desire to go back to past 'better' times: "what differentiates Trump's supporters is their resentment towards immigrants, African Americans and feminists – anyone who challenges the hierarchies that reigned back when America was great."

Similarly, the political right has been at work in the UK with the successful vote for Britain to leave the European Union (Brexit) in 2016. The desire to return to a past which is perceived as somehow a time when a nation was 'great' resonates in this context. In a news article entitled who is UKIP Leader Nigel Farage?, Chang (2016) writes of a nostalgic great nation sentiment:

> His straight-talking, man-on-the-street style resonates with many older, white, blue collar voters and is reminiscent of a bygone era when the economy felt stronger, immigration was lower and Britain was great.

Nigel Farage, a former Conservative, left the party in 1992 when Britain signed the Maastricht Treaty. The treaty led to the formation of the European Union (EU) and the creation of the Euro currency. Although Farage was not part of the official 'leave campaign' he was an enthusiastic and tireless campaigner and his party: United Kingdom Independence Party (UKIP) which he founded in 1993 had a mandate to move Britain

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away from Europe. During the leave campaign, Farage toured nationwide in the 'battle bus'. The UKIP has become a force in British politics even though the party only has one Member of Parliament in the House of Commons and despite former Prime Minister David Cameron's opinion of the party as: "fruitcakes, loonies and closet racists"(Chang 2016). Farage has never been able to secure a seat in the UK Parliament but in 1999 successfully gained a seat in the European Parliament. The impetus to leave the EU was also closely linked to immigration and Farage made no secret of his xenophobic views. The UKIP poster entitled: "Breaking Point The EU Has Failed Us All" featured the image of a long queue of migrants entering Europe in 2015. This initiative attracted many critics and he was accused of promoting racist and xenophobic views (Armstrong & Britton 2016). Farage has publicly backed Australia's tough immigration policy, stating: "If you have an Australian style points system and you control the quantity and quality of who comes, you know, people will sign up for that" (Chang 2016). This statement echoes the now infamous statement made by former Australian Liberal Prime Minister, John Howard who announced in 2001, during the election campaign that: "we will decide who comes to this country and the circumstances in which they come" (Maley 2016, p.676). Indigenous Australians could well have echoed similar sentiments in 1788.

As in the US against the election of Trump, there have been protests across Britain against the vote to leave the EU. Nigel Farage has already met with Trump, the first UK politician to do so and Trump has indicated that he will seek advice from Farage. Writing for the Huffington Post, Demianyk (2016) reports that Farage told Fox News in the US that: "the only people resisting Brexit and a Donald Trump presidency are full-time professional protesters who didn't vote in the first place because they can't get out of bed." There are some common threads here which link the current political climates in Australia, the US and the UK: concerns regarding the economy, immigration, the maintenance of national

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identity and a nostalgic return to 'greatness'. The desire for a return to the nostalgic nationalistic notion of a past greatness is not convincing. As Blackshaw (2010, p.39) points out: "Liquid modern community today might come with its own uplifting messages, but the shame is that it is hardly ever convincing. A kind of grand narrative of community." It seems that there is also a commonality of the element of 'surprise' associated with the resurgence of the One Nation Party in Australia, Brexit in Britain and the unpredicted election of Donald Trump over seemingly 'sure thing' candidate Hilary Clinton in the US. This state of affairs has been succinctly described by Paul Oosting, Director of Getup! Australia:[29]

> Brexit, Trump, and on our own shores, the resurgence of One Nation. There's a growing nexus between economic disadvantage and racially motivated resentment that is overwhelming all political expectations. There has been an abject failure of progressives both here and abroad to understand this, let alone counter it. And when right-wing demagogues tap this pulsing vein of resentment, we've mocked it as an ignorant fringe or dismissed it as isolated extremism.

A shift towards the political right has been building but despite its visibility, it seems that it was not taken seriously enough. In the US the election of Donald Trump confirms that a ground swell presumed, to perhaps, become reasonably popular with a disgruntled section of the community arose with enough power and numbers, to take the white house. Donald Trump was not viewed as a 'real' threat and now that it has happened there is dismay amongst many. In the UK many did not think that Brexit would actually take place, a close vote was predicted at worst. Now that it has happened, many are calling for another vote. In terms of Australia, Pauline Hanson's One Nation Party is in an early re-emergence

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[29] "Getup is an independent left movement to build a progressive Australia and bring participation back into our democracy". The core values of this organisation are around social justice, economic fairness and environmental sustainability: **www.youtube.com/user/getupaustralia**, **https://wwwgetup.org.au**

phase. However, if the likes of Trump and Brexit have managed to succeed against the majority of thought, then Hanson's potential should not be discounted. A resurgence of anti-immigration sentiment not just in Australia but also in the United States and the United Kingdom will perhaps extend to other countries and be reflected in the election of more right-wing governments. What does this mean for IMGs in Australia, or wishing to come to Australia? The original contribution to knowledge made by this thesis offers an explanation for the positioning of IMGs as an underclass within the elite profession of Medicine. A growing anti-immigration position may further impact on the conditions surrounding the immigration of IMGs as well as the willingness of the Australian public and the Australian medical profession to accept them. The Australian medical profession has been noted for its self-interest and uncompetitive behaviour with some professionals feeling the need to 'protect' their turf from outsiders. The political, economic and social climate around an anti-immigration stance is already seen in the current Liberal government via Australia's adoption of a tough protection of sovereign borders initiative. Clearly there is currently a conservative political shift occurring and this is not a new phenomenon.

WHAT HAPPENED?

This western world current political phenomenon has some predictability around it and the populist conservative politics cannot be dismissed. Stuart Hall in 1979 analysed a shift to the right in the UK and noted that the right has been a contender since the late 1960s. In fact, economic and structural industrial vulnerability in the UK emerged after the post war boom. What are the conditions necessary to bring about such a political shift? Hall (1979, p.14) argues that: "This is a matter of a set of discontinuous but related histories, rather than neat, corresponding movements." Additionally, these histories are evasive and difficult to analyse. This may be because the left attempts to analyse from within rational,

respectable and well-known positions which are now inadequate for analysis. Fundamentally, the right is what it is because the left is what it is. This presents itself as a constant class struggle. Hall (1979, p.15) suggests:

> What shifts them is not "thoughts" but a particular practice of class struggle: ideological and political class struggle. What makes these representations popular is that they have a purchase on practice, they shape it, they are written into its materiality. What constitutes them as a danger is that they change the nature of the terrain itself on which struggles of different kinds are taking place; and they have pertinent effects on these struggles.

Communities may become disenchanted and disengage. Commenting on the 'liquid' stage of modernity and individualisation, Zygmunt Bauman (2013, p.86) sheds light on community disengagement:

> The perception of injustice and of the grievances it triggers, like so much else in the times of disengagement which define the 'liquid' stage of modernity, has undergone a process of *individualisation.* Troubles are supposed to be suffered and coped with alone and are singularly unfit for cumulation into a community of interests which seeks collective solutions to individual troubles*.*

Guy Standing (2011) presents the notion of a new class, a dangerous class. The Precariat is a class in the making and constitutes a frustrated and angry socio-economic group living with insecurity and without agency. It is not yet a class-for-itself but can be likened to the proletariat or a working class (following Marx). Their precariousness however, is being normalised in globalised labour markets and as suggested by Redhead (2015, pp.10-11):

> We have moved, unerringly from cosmopolis to claustropolis, though, of course, never completely, and only in a roundabout way. Uneven development is always with us, as is reproletarianisation. The narrow theoretical ledge from which to view this new claustropolitanism passing by at the speed of light seems more precarious by the minute, but finding space on it is a necessary condition for survival.

The nationalist ideal therefore, of countries returning to or retaining 'greatness' as

espoused by Hanson, Farage and Trump is not possible. Standing (2011, p. 7) suggests: "Perhaps the reality is that we need a new vocabulary, one reflecting class relations in the global market system of the twenty-first century." The Precariat instead, has a 'truncated status' in that while it has class characteristics:

> It has none of the social contract relationships of the proletariat…it also has a peculiar status position, in not mapping neatly onto high-status professional or middle-status craft occupations (Standing 2011, p.8).

Status is often related to an individual's occupation, but this is problematic as within an occupation there can be: "divisions and hierarchies that involve very different statuses"(Standing 2011, p.8). The positioning of IMGs within Australia's medical culture is indicative of this context. IMGs while medical professionals do not hold the same status as their Australian trained medical colleagues. The IMG community then is a separate division with lower status. It is also clear that there is a hierarchy within medicine itself: with General Practitioners at the bottom and Surgeons at the top and again within the surgical specialities: with General Surgeons occupying the bottom position and Neurosurgeons at the top.

Any worker can become a member of the Precariat due to changed circumstances or choice. Migrants however, are particularly vulnerable, especially in wealthy countries. A central key to the right shift in politics in Australia, the US and the UK is immigration. Migrants are demonised in public discourse; a most common concern is the belief that migrants take local jobs. The response by governments is often to enact stricter controls around migration but this global problem is more related to an evolving and growing flexible labour market rather than migrant workers. Real permanent jobs and careers are in decline while there is an increasing casualisation of the workforce. The result is a lack of

job/income security leading to underemployment or unemployment. Australia's immigration policies have a long history of xenophobic responses to outsiders and seem to have become more extreme over time. Hand in hand with the perception that migrants take jobs, is a kind of paranoia that Australia will be overwhelmed with a flood of migrants, refugees and asylum seekers, particularly those who come via boats. This is not the case as Maley (2016, p.672) clearly demonstrates, arguing that: …"even if all unauthorised boat arrivals over the last forty years were to be seated in the Melbourne Cricket Ground over a quarter of the seats would remain vacant." In fact, boat arrivals in 2013 only constituted 0.89 persons per thousand of the Australian population (Australian Bureau of Statistics 2013)

AUSTRALIA'S BOAT PEOPLE PARANOIA

Unjustified hostility towards migrants is not confined to Australia. There are growing tensions around the world. Standing (2011, p.114) mentioned a 2009 poll conducted in the US, UK and six countries within Europe. The UK was the most anti migrants, where 60% believed they took local jobs as compared to the US showing 42%. Subsequent polls conducted in 2010 revealed that attitudes towards migrants had deteriorated across all the countries polled. Currently, Europe is facing a migration crisis, on a scale not seen since the Second World War. Large numbers of people are fleeing from the Middle East and Africa. In Syria for example, where there is terrorist activity, extreme violence and infrastructure collapse, 12 million people are left in need of humanitarian aid, while 4 million people have managed to escape elsewhere (Brannan et al. 2016). Many people have no choice but to escape via boats and the most popular route from Turkey to the Greek Islands is perilous. Unfortunately, many desperate people have drowned. The ones who survive are likely to find themselves in hastily constructed, inadequate and

overcrowded refugee camps in Europe. Brannan et al., (2016) while noting that the exact scale of loss of life is difficult to assess, highlight the dire situation:

> The UN High Commissioner for Refugees (UNHCR) estimates over 590,000 people have arrived in Europe by sea this year. The countries at the forefront are Greece and Italy, these countries which were never designed for such high level of migration, are inadequate.

Australia has continually implemented harsh measures to restrict and discourage boat people and the people smugglers who organise their sometimes treacherous voyages. Both the Labor Party and the Liberal Party have introduced various exclusionary policies since 1989. Labor governments in the 1990s introduced mandatory detention for boat people and repeatedly attempted to reduce their legal entitlements. Labor also initiated the Pacific and PNG (Papua New Guinea) Solutions in 2001. John Howard's Liberal-National coalition government continued in this manner particularly after the rise of Pauline Hanson's One Nation Party. In late 2007, Labor returned to power and resolved to dismantle the PNG solution but due to an increase in boat arrivals, reintroduced it in 2013.

Throughout the 2000s, as Glynn (2016, p.3) notes:

> Australia drew on its economic advantages to tempt various Pacific island nations, and more recently Cambodia, to house and resettle boat people in exchange for valuable aid and investment.

The Cambodian attempt was outrageously expensive and unsuccessful. In his opinion piece, Riley (2016) reports: "The government spent $55 million to transfer five refugees to Cambodia. Only two remained for any length of time, and the Cambodian government admitted that its government "does not have the social programs to support them." The current 'solution' (to what exactly, I am not entirely sure) in Australia, is Operation Sovereign Borders. This title is not surprising however, as Immigration overall is handled

by the Department of Immigration and Border Protection. However, from 2007 until September 2013 the responsible Department was called The Department of Immigration and Citizenship which was preceded by the Department of Immigration and Multicultural Affairs. Perhaps the departmental name changes indicate a shift in Australia's stance regarding immigration, from suspicion and caution to a paranoidal focus on exclusion to facilitate protection. To protect Australia from what, perhaps a mass invasion from China? No, to 'protect' Australia from fellow human beings who are in crisis and inviting them to settle and make a new life. Instead, our response to these people is to make sure they do not set foot on Australian soil. Numerous discriminatory legislations has been introduced by various governments over time to achieve the desired exclusion, while too numerous to mention all, the following is just one example from 2001 outlined by Glynn (2016, pp. 128-129):

> one privative clause was designed to ensure that a decision to reject an asylum seeker's application for refugee status could not 'be challenged, appealed against, reviewed, quashed or called in question in any court'. This followed several previous Australian governments' ineffective attempts to reduce the influence of NGOs and lawyers representing asylum seekers. In Ruddock's[30] words, this hard-line political response would ensure that 'unauthorised arrivals do not achieve their goal of reaching Australian soil; there is no automatic access to Australian residency; [and,] there is no access to the judicial system.

Currently, Australia still sends asylum seekers to Manus Island in PNG and the pacific island of Nauru. According to Operation Sovereign Borders, in September 2016 there were 873 asylum seekers on Manus Island and 396 on Nauru (Australian Government Department of Immigration and Border Protection 2016). Government policy, according to Riley (2016) is based on disproportionate fear, in that if the Government reconsiders and

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[30] Phillip Ruddock was Australia's Attorney General in 2001

agrees to resettle asylum seekers in Australia people smuggling via boat will escalate. Riley (2016) argues that:

> this is very unlikely. Given the manifest immediate harm to refugees and asylum seekers on Nauru and Manus Island, it is worth risking the resumption of boat arrivals to solve the humanitarian crisis on our doorstep that is entirely of Australia's making.

The government's rationale and the rhetoric around its Border Protection approach has been the demonisation of people smugglers and the responsibility to do our humanitarian best by discouraging them. A tough stance was espoused as a life-saving initiative which would ultimately prevent the drowning of boat people trying to reach Australia. In a recent joint press conference (2016) with Peter Dutton the Minister for Immigration and Border Protection, Prime Minister Turnbull stated that the government was locked in: a "battle of wills with criminal gangs of people smugglers. You should not underestimate the scale of the threat. These people smugglers are the worst criminals imaginable." The latest policy initiative of the Turnbull Liberal government proposed in October 2016, is the strongest most exclusionary initiative to-date. The government announced that any asylum seekers including all those detained on Manus Island and Nauru at any time since the last half of 2013 will never be accepted to enter Australia on temporary or permanent visas (including tourist visas). The reality of this announcement will result in family trauma, as noted by Riley (2016):

> This will prevent asylum seekers who have family in Australia from ever meeting them in Australia. We know anecdotally that there are asylum seekers and refugees on Nauru and Manus Island in this position. Indeed, it is common for refugees to follow the same path to protection as family members who had earlier fled persecution.

In addition, this will prevent asylum seekers from perhaps re-entering Australia years after

their detention to undertake studies or to conduct business. The impetus for this policy again is based on a xenophobic fear that somehow asylum seekers denied access will return from a country where they have been resettled and try again. Minister Dutton in Tom McIlroy's article in the Age (2016) is quoted:

> What we don't want is if someone is to go to a third country, that they apply for a tourist visa or some other way to circumvent what the government's policy intent is by coming back to Australia from that third country.

What is this group of Australian politicians really afraid of? What justifies such extreme measures? Boat arrivals since 1998 have increasingly been depicted as some kind of 'national emergency.' Firstly, asylum seekers coming via boat have been portrayed as illegal 'queue jumpers.' Maley (2016, p. 673) argues:

> This is an entirely spurious claim: it is not an offence under any Australian law to seek to enter the country without a visa and internationally there is no 'queue' for refugees to 'jump', given that resettlement programmes do not offer a place in a queue but a ticket in a lottery.

This term and the rhetoric around it, while created by bureaucrats, managed to gain significant support from the general public. Secondly, as mentioned earlier, the justification for deterring boat arrivals is portrayed as a humanitarian stance which will ultimately save lives that otherwise would be lost at sea. This is not convincing either and appears to be not only a thin veil for xenophobia and racism but also ethnocentric views around superiority, requiring paternalistic initiatives.

Maley (2016, p.674) places the stance into perspective and maintains that:

> This is once again a suspect line of argument at multiple levels. It has overtones of the 'whiteman's burden': that the kind of people who board boats could not possibly be capable of thinking for themselves, and therefore need others to do their thinking for them. It does not explain why causes of mortality such as the road toll, which routinely produces more than 1000 deaths a year in Australia, have led to virtually no public emoting by political leaders.

If Australia was to act genuinely humanely it would consider the source causes of refugee movements and realise that if the route to Australia is a 'closed' one, then this simply forces people fleeing to find another route, perhaps one that is even more dangerous than the route by sea to Australia (Donini, Monsutti & Scalettaris 2016). Perhaps Australians are not really concerned for the safety of refugees, preferring not to welcome refugees at all.

F*** OFF WE'RE FULL[31]

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[31] "Show your Aussie Pride with this classic T-shirt design. Made of 100% cotton, this shirt would make the perfect Christmas gift for the patriotic Australian in your household". AUD $22.70 accessed 14/12/2016
https://teespring.com/shop/australiana#pid=2&cid=2397&sid=front

When I first saw the above T-shirt worn by a middle aged man in a local supermarket, I was shocked. Overtly xenophobic and racist, seemingly unafraid of possible reaction, he went about his shopping. Unfortunately, I saw this same T-shirt several times on different individuals (all males) on different occasions. Through its persistent anti asylum seeker/refugee rhetoric, the government has been able to influence the thoughts of many Australian citizens and now with the 2016 approach has sent a very clear message to the world. Riley (2016) sums up the message:

> The government's message to people who might subsequently attempt to get to Australia is loud and clear: you are not welcome, you will not be resettled in Australia, you will spend many years in remote locations that will lead many of you to develop serious mental illness, and many of you will commit suicide or self-harm. We cannot guarantee your safety at these locations. You risk being murdered or sexually assaulted. Things will be so bad that many of you will choose to return to your country of origin, where you fear persecution, rather than tolerate these conditions.

It is clear that Australia does not readily welcome the 'other' and is a xenophobic, fearful nation. Immigration however has been central in the Australian population from the 19th century and a part of the ideal of a white Australian nation populated with British people. Although, small numbers of other Europeans were tolerated on the basis that they would assimilate into the mainstream population, but: 'coloured' immigration was almost completely excluded" (Carter, D 2006 p.329). After the Second World War the mass immigration program to boost the population increased the pool of potential migrants and, this began to transform the ethnic and cultural composition of Australia. By the 1970s the result was a change in immigration policy and therefore a transformation of Australia as now a 'multicultural' nation.

However, increased levels of immigrants from Asia in the 1970s and 1980s brought about

fresh fears of change and particularly a perceived threat to stability and social cohesion.

Carter (2006, p.329) concludes:

> It is clear that large-scale immigration has had profound social and cultural effects on Australian society. The voices of anxiety and reaction are responding to real social change, both in Australia and globally (as are the advocates of ever larger immigration intakes). …racial categories remain powerful in mainstream conceptions of the Australian nation, no less so for no longer being named or understood as racial.

The asylum seekers of today, those in concentration camp conditions on Manus Island and Narau, are the scapegoats for a renewed and backdated vigour of government attention and punishment. The extent to which the current Australian government will go in its excessive nationalist quest in the recent push to further alienate asylum seekers and refugees from Australia beggars belief. My sentiments are aligned with Riley's (2016, p.6):

> Since October 2013, nearly 2500 asylum seekers have had to suffer for the Australian government to send this message. Does it really need to add to the list of detriments that asylum seekers will never enter Australia in any capacity for the rest of their lives? Where does it end?

This is the Australian nation IMGs come to, the nation they wish to live and work in, sharing their much needed professional skills. It is this nation which bestows inequality upon them via the system and their positioning to an underclass within Australia's medical culture. For IMGs this is an Australia that sends very mixed messages, one that this country represents an egalitarian society with a 'fair go' for all as opposed to one that marginalizes and excludes certain groups of people who are othered (Plage et al. 2016). The Australian nation and its nationalist stance is clearly an intersecting oppression for IMGs. Intertwined with nation is race which has been at the heart of the country since the 1788 invasion by the British. The creation of the 'new' Australian nation required the dispossession of Australia's Indigenous peoples and they were systematically excluded.

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Vehicles for exclusion included their physical confinement to reserves and missions. They were assigned a separate and inferior legal status and cultural and psychological exclusion (Reid, Taylor & Hayes 2016). "This exclusion was through, an extraordinary forgetfulness, a voluntary amnesia which rendered them invisible within the nation" (Stanner 1969). Pettman (1992. p.7) states:

> The new nation had a class structure and race, cultural and gender relations that reflected the dominant groups and their interests, and the society was stratified in terms of race, ethnicity, gender and class.

Racism towards Indigenous Australians is still very much embedded and institutionalized within the structure of society and in the minds of many Australians. For example, the journal reflection made by a Bachelor of Education student in Merridy Malin's (1997, p.49) study of an Anti-Racism Teacher Education Program. The student's reflection concludes with:

> Where would the Aboriginal be now if the British didn't settle here? They wouldn't be as well off as they are now would they? Sure they would have the land but nothing else. No money, alcohol, cars and tobacco just to name a few. They would have none of this.

Another example, in a similar vein, was published online in 2000. It was circulated by students at several universities in Australia (including the one at which I was employed) in 2002.

Entitled "Australian Apology to the Aboriginals," it lists several 'apologies' including:

> We feel that we must apologise for building hundreds of homes for you, which you have vandalised and destroyed. We apologise for giving you doctors and free medical care which allowed you to survive and multiply so that you can demand apologies. We apologise for giving you law and order, which has helped prevent you from slaughtering one another. We humbly beg your forgiveness for all these sins and are happy to take back all the above and return you to the paradise of the outback whenever you are ready.32

Many Australians openly express racist, xenophobic and ethnocentric views but insist that those views are not. One notable example came from an Australian Prime Minister. In 1997 The Howard Government was presented with the Bringing Them Home Report (Human Rights and Equal Opportunities Commission 1997). The report detailed many oral histories of Indigenous Australians who were forcibly removed from their families as children (often referred to as the Stolen Generations). The report recommended that Australian governments publicly apologise for the past harmful policies. The response of the Howard Government was to reject and dispute the report. In fact, the past practices by governments was defended and justified by the Howard Government as 'doing the right thing'. Hocking (2010, p.57) describes the feeling at the time:

> This attitude fed the racism of many Australians who agreed with John Howard. Without even perhaps reading at least one of the oral histories contained in the report or perhaps without any understanding of the racist policy which led to this particular part of our shared history.

It was not until February 2008 that a national apology was made by the newly elected

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32 The full 'apology' can be accessed at Australia's e-journal of social and political debate (Post and Reposte by Tim Dunlop 19 April 2000) http://onlineopinion.com.au?view.asp?article=107g page=2

Labor Prime Minister Kevin Rudd. Moreover, in 2009, the Rudd government finally endorsed the United Nations Declaration on the Rights of Indigenous Peoples. Until this time Australia was opposed to the declaration and abstained from voting. The previous Howard government failed to sincerely recognise the rights of Australia's Indigenous peoples, much of this stance was based on fear. The government and wider community feared that perhaps Traditional law could challenge National law and clear the way for Indigenous Australians to make claims.

WE'RE NOT RACISTS! BUT…

The Australian national ideology is founded on 'whiteness', obtaining it, keeping it and perpetuating it. In fact, the first legislation to come from the new Federation Parliament in 1901 led to the White Australia Policy, which was in place until the 1960s (Hirst 2014). Ironically, the country was full of black Australians, another marker of the invisibility of Indigenous Australians, and also a chosen ignorance to the invisibility of a social reality. Colour can in fact bring a hypervisibility to certain groups. Eloquently explained by Sefa Dei (2008, p.83):

> Social identities morph into complex configurations. Through time human societies have morphed into configurations. Identities are historically contingent and specific…While identities are fluid, we must also recognise the "permanence" – as in its longstanding evocation – of skin colour as a salient marker of identity through time, history and space. It is in this understanding that we herald the power of race in intersectional analyses…the significance of colour in the mind of the racist cannot be dismissed.

I am a fair skinned Indigenous Australian and I distinctly remember a friend of my white adopted parents reminding me that I am one of the lucky ones because I do not have to be Indigenous. I think he somehow was trying to comfort me about my heritage and offer me hope. He was unable to comprehend that I am proud of my heritage. Rather, he advised

that I should keep that "under my hat". The white/black binary opposition has ancient roots. 'Blackness' and 'whiteness' are embedded in medieval European Christian texts, for example. Whiteness was seen as an important part of Christian identity, a colour of salvation and goodness while blackness was the colour of hell and evil (Ken 2008).

Whiteness is more than identity. Following Frankenberg (1993), whiteness is discourse, structure and location. Power and privilege play a central role in how whiteness works. Colour and racial/ethnic origins can be applied to whites and blacks. The difference is that for blacks the application has resulted in profound outcomes of loss, whereas for whites it has meant privilege. In addition, privilege for the West. As Moreton-Robinson an Indigenous academic explains (2004, p.75):

> Because in the West whiteness defines itself as the norm…in this way whiteness is constitutive of the epistemology of the West; it is an invisible regime of power that secures hegemony through discourse and has material effects in everyday life.

Indigenous disadvantage in Australia has become in itself a wicked problem, as despite numerous efforts by governments to be seen to be 'doing something' disadvantage has not been addressed. I would argue that this is because governments are not willing to hand over real power and opportunity to Indigenous communities, particularly full, equal access to the economy. Moreover, the Australian nation would not allow governments to do so. Therefore, the state of affairs remains as it is with no real long term solution possible. At the core here is racism, an ethnocentric white supremacy and xenophobia fuelled by entrenched negative stereotypes and ideological/political baggage. In terms of IMGs in Australia, those with dark skin can be viewed as carrying a double burden or layer of difference; firstly, because they belong to an underclass within the medical profession and secondly because they are black. During conversations with interview participants in

this study some shared perceptions of a black/white binary lived experience. In our interview, when I asked Colin (2010, Interview 2) how his wife had settled in to Australia, he expressed concern for her loneliness. Colin's wife was a high school teacher but her qualifications were not accepted in Australia. Colin stated: "people here won't talk to her." I asked him why he thought that was the case, and he replied: "because she is black skinned I suppose." Shaun (2012, Interview 8) considered himself, in some ways, fortunate: "Well, I have an accent but at least I'm not black." Whereas, Gary (2012, Interview 9) considered himself more fortunate, and stated with a knowing smile: "I don't have black skin and not a really strong accent, so I go under that radar. I think my patients get surprised when they ask me where I'm from."

This leads to a questioning of identity, and in terms of the IMG community particularly, professional identity. IMGs come to Australia with the professional identity of Medical Doctor but almost immediately, the processes and discourses of the system begin to erode that identity, constantly calling it into question.

IMGs AND PROFESSIONAL IDENTITY

The intersecting expressions of class, race and nation in the representation of IMG experience in Australia impact on their professional and personal identity. Intersectionality aims to connect identity with other forms of difference. Sefa Dei (2008, p.85) argues:

> Critical anti-racist work, whether pursued as part of intersectional or interlocking analyses, calls for subverting the dominance meanings (meta-narratives) surrounding the use of…categories. We do so by recognising the distinction between the 'metaphor' and the 'real' and how, for some bodies, the permanence of these categories are refracted in the daily experiences.

In their fascinating research into the use of space by medically unemployed IMGs in Victorian hospitals, Harris and Guillemin (2015) reveal an adaptive culture which has

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evolved out of need and agency. A kind of medical underground for IMGs exists in the margins outside of clinical activity but within the hospital environment. These IMGs as a professional community try to keep their identity as medical doctors while striving to study for registration assessments and have contact with other IMG community members. The most popular "congregational nodes" within the hospital were usually, the library, cafeteria and tutorial room. The scene is poignantly described (Harris, A. & Guillemin 2015, p.168):

> Amongst the textbooks and teaching models, the IMGs had a heightened sense of medical identity. Alongside other IMGs, they could try to survive the tediousness of study and efface the loneliness of life in textbooks. At the same time the skeletons and anatomical dummies with their organs fitting neatly together, the ordered filing systems and carefully delineated places and times of study, reiterated forms of control; these paralleled the regulating principles of the registration process the IMGs were enmeshed in, the place mirroring their position in the hierarchy. IMGs were delineated in this place from the staff 'with passes'; they were grouped with students, also on the medical periphery, and allowed access only to distinguished areas at designated times.

The hospital was symbolic of a medical identity for IMGs, a connection to their study days as medical students and while perhaps a source of empowerment in terms of solidarity as a community, very much reflecting back to them their status, as an underclass within Australia's medical culture.

The intersecting oppressions of inequality: class, race and nation all conspire to subjugate IMGs to an underclass within Australia's medical culture. The original contribution to knowledge offered by this thesis moves towards an explanation of why IMGs are positioned as such. The Australian nation has a long history of xenophobia where the other is viewed not only with suspicion and fear but as inferior. Racism also lurks in every fibre of the growth of the 'new' nation from 1788 to today. It is evidenced by the adoption of the White Australia Policy in 1901 to the current chronic failure of governments to address Indigenous Australian disadvantage. Whiteness is the epistemology of Western

democracies and the associated norms, values and beliefs have been enshrined in laws rendering exclusionary ideas and actions institutionalised into Australian society and into the structures and operations of Australian institutions. Hence, it follows that the various bodies constructed to regulate and manage IMGs and their entry into medical practice in Australia reek of and reflect: class, race and nation. IMGs find themselves positioned within these disempowering oppressive intersections which are interconnected and fluid. This chapter has explored the paradigm of intersectionality and its potential to confront inequitable power relations. Australia's immigration policies have been exposed as exclusionary and inhumane. They continue to grow more so with every development in the asylum seeker/refugee saga. They are underpinned by Australia's obsession for whiteness and fear of the foreign other, xenophobia. The government has succeeded in demonising those who are the most vulnerable and needy who try to come to our shores. There is a western world political shift as seen in the rise of the One Nation Party in Australia as well as the election of Donald Trump to the US presidency and the UK vote to leave the EU (Brexit). These results represent an angry working class backlash often seen in ailing economies with high unemployment. This political phenomenon has been explored for common concerns, that of perceived job loss due to immigration and the resurgence of nationalism. As a result, these political times also represent a concern for IMGs and global medical migration.

The following concluding discussion in this thesis, brings together themes and thoughts. The future and what it could look like is also advanced, but it is the future that always holds some mysteries and surprises and I am sure Medicine in Australia will be no exception. What is known thus far in this journey however is that all is not well in the land of milk and honey. The original contribution to knowledge offered by this thesis is clearly the exploration of the positioning of IMGs as an underclass within Australia's medical

dominance. What is not known is whether or not with the changing nature of medical dominance, the continued advancement of technology and constant questioning via numerous inquiries, the positioning of IMGs will transform into something other than it currently is.

CONCLUSION: WHERE TO FROM HERE? TRANSFORMATION OR A

VERY WICKED PROBLEM

The planet does not need more successful people. The planet desperately needs more peacemakers, healers, restorers, storytellers and lovers of all kinds (Dalai Lama).

The emphasis on consumerism and managerialism has legitimized and advanced the individual pursuit of material self-interest and the standardization of professional work which are the very vices for which professions have been criticized, preserving form without spirit (Freidson 2001, p.181).

Critical researchers view reality as both objective and subjective: objective in terms of the real forces that impinge on the lives of groups and individuals, and subjective in terms of the various individual and group interpretations of these forces and the experiences they engender (Brown & Strega, 2005, p. 9).

This thesis is essentially underpinned by an exploration of the power structures which infiltrate the experiences of IMGs in Australia. Analysis has not produced a 'truth', rather following Foucault (1981) this thesis has searched for the processes which assign 'truth' to some forms of discourse above other forms of discourse. The Australian Health System and Medical Dominance assign a deficit discourse and inferior status to IMGs. The IMG voice is relegated to an underclass within medicine. Power struggles however can be the source of transformation. Drawing on the work of Hook (2001), Macias (2015, p.238) in her discussion on Foucault's work points out:

Illuminating moments in which power struggles determine how discourse evolves normative discourses experience moments of weakness, uncertainty, and rearticulation present important transformative possibilities, because it is in these moments that we see that things do not have to be the way they are.

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Foucault stressed the need to develop a sceptical attitude and a critical understanding of power and how it works as well as a need to: "know how and to what extent it might be possible to think differently, instead of legitimating what is already known" (Foucault 1985, p. 9). It appears however, that not enough is known about the medical profession, aspects of how it operates and perhaps how to transform it. Decades of inquiries and subsequent recommendations have not addressed many fundamental and concerning issues such as bullying and harassment.

The Senate Community Affairs References Committee (2016, p.66) Recommendation 6 4.37 proposes that another new inquiry be established. This time, the suggested terms of reference for further inquiry are focussed on aspects of the National Law and whether or not changes are needed to adequately deal with medical complaints. The impetus for this recommendation has obviously been driven by the surge of complaints linked to bullying within the medical profession and their very public airing. It is also evident that there is concern for perhaps unlawful or inadequate legal processes and patient safety, which in itself, has legal implications. Also of concern is the impact that bullying and harassment may have on patient safety. The Senate Committee (2016, p.33) noted that:

> Bullying and harassment, identified as a prevalent issue in the medical profession, is not currently considered to have a substantial impact on patient safety. The committee is of the view that the entire medical profession needs to, as a matter of priority, recognise this significant impact.

The Health Care Consumers' Association (HCCA) (2016, submission 16, p.11) drew the committee's attention to research which shows increasing clear evidence that medical workplaces where bullying and harassment are present also represent unsafe places for patients. The HCCA referred to current research from the United States:

Intimidating and disruptive behaviours can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments.

Within the medical profession, there is general recognition that bullying and harassment is a significant problem. For example, the AMA (2016, submission 9, p.1) sums up succinctly the contributing factors to the current culture within medicine:

The hierarchical nature of medicine, gender and cultural stereotypes, power imbalance inherent in medical training, and the competitive nature of practice and training has engendered a culture of bullying and harassment that has, over time, become pervasive and institutionalised in some areas of medicine.

This state of affairs is certainly indicated by other inquiries, the voices from this study, complaints and media coverage. How many inquiries are necessary to establish that the entire profession, from the training of medical students within universities and on placement (referred to in submission 10, 2016 as a "pedagogy of humiliation"), to the questionable practice of some high ranking senior surgeons, requires an extensive shakeup? Ward and Outram (2016, p.112) call for collective change to develop a culture: "where sustainable medical careers can develop and better serve the community. How much change do inquiries actually instigate?

Sometimes the result of inquiry recommendations manifest in changes but are they helpful or far reaching enough? In her journal article, Dr. Douglas (2008, p.36) argues that in terms of IMGs: "In some ways the attempt to establish fairer and more flexible accreditation and registration standards for IMGs will make the situation even more complex." It has been established that the accreditation and registration processes required of IMGs are already overly complex, such as the 2012 Parliamentary Inquiry Report which likened the processes to a "bowl of spaghetti" (2012, p.6). The question of

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whether or not Royal Commissions, inquiries and the like constitute truly beneficial change agents is not a new one. Burton and Carlen (1979, p.7) critique the history of inquiries and official discourse around law and order maintaining that in the nineteenth century inquiries often arose in response to social crisis. In contemporary society however, with the rise of capitalism, the importance of inquiries has declined:

> They can be seen as tactical devices to defray government activity, to postpone legislative or other action while simultaneously demonstrating that particular problems are under administrative review and control…moreover the recommendations of a report (when not 'white-washes'), being advisory, can be and frequently are ignored.

Inquiries take time and as a result have the potential to soothe the public and issues of concern while waiting for subsequent reports. This in turn, can temporarily alleviate the pressure on governments and stall a response. For example, the government has yet to respond to the 2012 Inquiry report: "Lost in the Labyrinth." It must be disheartening for those IMGs who made submissions to the inquiry to be still waiting for a response, perhaps there will be no response.

It is argued here, that the power of the medical profession, which gives it medical dominance status, is flawed. The weaknesses exposed within medicine, and its well established toxic culture, have accelerated to the extent that power has failed, medicine is imploding from within. The original contribution to knowledge made by this thesis establishes the positioning of IMGs within Australia's medical culture. IMGs as a professional community within Australia's medical dominance constitute an underclass within an elite profession. The thesis has extended beyond the explanation of 'how' medical dominance is created, perpetuated and retained (see Willis 1989, 2006) to the explanation of 'why' medical dominance is created, perpetuated and retained. The 'why'

has played a fundamental part in thesis construction, it was the 'why' that led me to continually question and search for the reasons, interests and agendas which underpin and explain the positioning of IMGs.

This doctoral dissertation constitutes an exploration of the experiences of IMGs in Australia. As explained in the introduction, it was initially inspired by the Dr Patel tragedy of 2005 at the Bundaberg hospital in Queensland. This incident trigged what Dr Haikerwal (a past president of the AMA) called: "Medical Racism" (Haikerwal 2005). Dr Patel was of Indian descent and as a result of his malpractice and fraud, other doctors of Indian appearance especially, were on the receiving end of abuse from the general public. Acutely aware of racism in this country, I was again intrigued by its insidious ability to lurk covertly under the surface of society always present always threatening, but silent. Then, an incident or turn of events releases the beast and it erupts overtly to the surface in all its ugliness. Other IMGs also began to experience a public backlash and a 'panic' ensued calling into question the equivalence of IMG medical qualifications to those of Australian trained doctors. The government was of course expected to respond to these concerns as were the medical bureaucracy and as a result, there was a renewed, more intense focus on the qualifications, assessment and recruitment procedures of overseas trained medical professionals entering Australia. Australia's long history of xenophobia also came to the surface to fuel the fire with suspicion of the 'other'. The rhetoric of: we must maintain Australia's high standards of health delivery became the dominant discourse. The partner of racism and xenophobia, ethnocentricism joined in and superiority (underpinned by whiteness) completed the package. Subsequently, the response implied that Australian trained medical doctors were superior, because the standard of their training is amongst the best in the world. The health care available in Australia is second to none. Therefore, to maintain that high standard we must stringently screen medical doctors from overseas

because they are foreign and their qualifications are inferior to Australian qualifications. Dr Patel came to Australia from working in the United States and was found to have been disciplined there, which of course, he did not mention in his CV. The reaction to his malpractice in Australia therefore was one of alarm that this medical practitioner's credentials and record of practice in the US was not sufficiently and thoroughly checked, enabling him to secure employment and practice in Australia. In this climate, my journey began and I sought out IMG voices to gain a sense of how they might be feeling, how they experience Australia, what might be the challenges and rewards of medical practice in a new country. Where and how was I to find IMG voices?

The journey to find the voices and the associated methodological choices has been detailed in Chapter one. At the outset, it was crucial for me to declare my position as an Indigenous Australian as well as a researcher, to validate myself and my location within the research process itself. I am a Pintubi, Aranda, Arrente, Bundjalung woman and I came to the research with my own collection of experiences and feelings, which construct the many epistemological lenses I look through. From an Indigenous perspective my declaration makes me accountable for my position in the participation of knowledge creation.

A social justice, anti-oppressive stance was the best approach to take in this qualitative research study as I sought to interpret the meaning of the social reality and lived experience of IMGs as a professional community. The recruitment of participants and data collection, particularly in terms of individual interviews was a lengthy process mostly due to the nature of the cohort: a time poor, stressed group of medical professionals often guarded against an outsider and wary of possible repercussions for 'speaking out'. Once I had established a couple of contacts, then recruitment was best facilitated via snowball

sampling, one interviewee recommending another. Why would the sharing of your experiences in Australia, with a researcher, present a problem? Many IMGs have a problematic relationship with the system, the place where they are judged and assessed, and it may not be in ones best interests to draw attention to the inefficiencies of or difficulties with the system. I realised from my field work prior to data collection, that the system played a part in the IMG experience but I did not realise how all-encompassing and powerful the system was until the voices began to show me. I have described the system as the elephant in the room. Once its enormity and power was exposed its presence invaded the research space and seemed to be connected in some way to every aspect of the construction of IMG lived experience. The focus group participants, the interview participants and those IMGs and others who participated through submissions to the 2012 Parliamentary Inquiry and to the 2016 Senate Community Affairs References Committee provided me with a rich data set. These gifts enabled me to tell their story as best I could, within the limits of a doctoral dissertation. Their stories were further enhanced by voices resonating from other literature. During the last year of the development of this thesis the experiences of IMGs, Australian trained medical doctors and medical students have surfaced into the light via the media. As a result, the culture within medicine itself has been put under the microscope. I have found the stories, at times confronting, shocking and many reveal serious violation of human rights. A toxic culture within the medical profession itself spewed out into the public forum. The highly respected elite and powerful profession of medicine was rife with bullying and sexual harassment (Cannane & Sherden 2015). The surgical fields were identified as the most septic with outrageous examples of lying, fraud, bullying and victimisation towards others to guard self-interest and market share. The extent to which some surgeons were prepared to go was criminal such as the virtual running out of town of the, by then, suicidal French surgeon Dr Richard Emery who was

the victim of false complaints and sham audits (Emery 2015). Then, there was Neurosurgeon; Dr Charlie Teo's revelation that surgical colleagues (guarding their reputations) were not performing operations they should, sometimes resulting in loss of life, and were reluctant to disagree with another colleague's opinion (Australian Broadcasting Commission 2016). It seemed that my journey to explore the experiences of IMGs had morphed into a Pandora's Box. The experiences of IMGs highlighted a problematic relationship with the health system and with Australian trained doctors. In addition, the medical profession itself was problematic.

A social justice research agenda was adopted to maximise representation of the voices while exposing the power structures which oppress them. Intersectionality offered an emancipatory, anti-oppressive analytic tool for the exploration of intersecting social phenomena (Hill Collins & Bilge 2016) and was therefore the best way to organise and explain the experiences of IMGs in Australia. Theories around social justice explore both social reality and the possibility for social justice (Strega 2015). However, I felt constricted by the academic norms in terms of how a thesis should look, in other words what is 'good' research and how it should be structured in the eyes of the academy. I was to become a committed social justice worker, armed with advice from Potts and Brown (2015, p.37):

> You will encounter these discourses, and it will be up to you to understand the deep positivist and neoliberal epistemological roots they extend from. You will need to see how these discourses will try to construct and constrain your work. And, most importantly, you will need to know how to engage anti-oppressive practices to try and produce social justice outcomes despite the constraints.

The academy reflects a Western standard because Whiteness is the epistemology of the West (Moreton-Robinson, 2004). I was uncomfortable, particularly with how the voice would be presented, in 'the data chapter.' Inside, I screamed: "No, this is not

representative of the voice; I want the voice as part of the ongoing conversation of the thesis not marginalised to its own chapter, tied down and then silenced." Following the academy's standard social science model, I would have left out many voices simply because they did not make comments on the decided three or so themes. A multi-disciplinary approach allowed for a more equitable representation of the voice. This thesis has therefore challenged the academy and invited the voice to be a part of an ongoing conversation woven throughout rather than being marginalised to one space. In this sense, the thesis has been decolonised. The work of Leslie Brown and Susan Strega (2005; 2015) was supportive of my ideas and encouraged me to stand up for different ways of knowing and story-telling. I am a story-teller, I needed to tell the IMG story from the voices I had been gifted. The voices are not mine, I am not entitled to confine them and leave many out. Brown and Strega (2005, p.2) see research as resistance and the intention is:

> to make space and take space for marginalized researchers and ideas. We push the edges of academic acceptability not because we want to be accepted within the academy but in order to transform it.

In fact, Strega (2015, p.144), referring especially to academic institutions points out that: "Historical and critical analysis of the role of research in marginalized lives makes us aware that these institutions are also deeply implicated in maintaining and rationalizing inequities." Through the processes of field work, the data collection and the emerging media content, analysis with social justice at its heart, was fuelled by constant questioning, reflexivity and comprehensively revisiting the data.

Power emerged as the first major player, firstly the power invested in and exercised through the health system with the medical profession as gatekeepers. Secondly, the concept of Medical dominance and how it works to maintain the power of the medical

profession, thoroughly theorised by Even Willis (1989, 2006) was illuminating and assisted with conceptualising structures and power relationships. To gain further understanding, an historical lens was required to aid in understanding the present following C. Wright Mills (1959) the study required history and biography.

THE FIRST IMGs

In chapter two the first IMGs in Australia were introduced as British naval surgeons, nine of whom arrived via the first fleet in 1788, and doctor explorers who accompanied expeditions to map the Australian coast. What these adventurers came to was an ancient land populated with many Indigenous nations and languages (Foley, D 2008). The invaders had no idea of the complex social systems they were displacing and quickly dismissed the black people they saw as heathens and savages (Hirst 2014). Post British invasion, this ancient land began to take a different shape with the marginalisation of the traditional peoples, massacres, and progressive dispossession from their land (Breen, S 2008). Through the process of colonisation Indigenous Australians became regarded as and subsequently oppressed by a race category. They were classified within that category on the basis of full bloods or various levels of mixed blood (Hirst 2014; Kidd, R 2008). Although Australia's new population was a motley crew of convicts and military personnel, white supremacy reigned. 1788 marked the beginning of the Australia we know today, a xenophobic, ethnocentric and racist country. Evidence of this can be found in the current Turnbull Government's: Operation Sovereign Borders initiative (Department of Immigration and Border Protection 2016). Australians are fearful and suspicious of the other, tend to believe that our way of life, norms and values are superior to those of others and prefer to keep Indigenous Australians and other undesirable races as invisible as possible because we want to be a country populated by white, English speaking citizens who have British

ancestry. Chapter two documents a number of blights on Australia's 'goodness' over time such as the White Australia Policy which was trumpeted in conjunction with the establishment of the great nation state Australia at Federation in 1901 (Gunstone 2017). This blatantly racist policy institutionalised racism and made it very clear to the world that the vision for the new nation was a white one. Australia's non-acceptance of overseas medical qualifications first arose when doctors arrived from Europe as Displaced Persons after the Second World War (Iredale 2009; Kunz 1975). There is an interesting connection here in that Australia's population at the time needed boosting and immigration was being championed as a means to do this. This initiative arose out of a xenophobic fear that Australia, with a small population, could be invaded from the North by hordes of Asians (Hirst 2014). The connection here is echoed in Australia today, in that we need to boost the medical workforce, particularly in rural and remote areas, by actively recruiting health professionals from overseas. When they come however, the standard of their qualifications is assumed deficient. They are subjected to over-zealous assessment or banished to the medical unemployed. Chapter two sets the scene for today's landscape, demonstrating the development over time of the foundations for a xenophobic, ethnocentric and racist Australia. Grigg and Manderson (2016, p.13) in their paper tracing the development of the Australian Racism Acceptance, and Cultural-Ethnocentrism scale (RACES) confirm that:

> Racism is a significant challenge in contemporary Australian society due to the potential and significant negative impact on a range of health, social, psychological, and economic outcomes of the diverse racial, ethnic, cultural, and religious groups within Australia.

Similarly, the National Mental Health Survey of Doctors and Medical Students conducted by Beyond Blue (2013) found that IMGs identified and reported racism as a source of work

related stress. In addition, Knowles and Bannon (2015, p.4) found that twenty seven percent of IMGs reported racial discrimination. In their submission to the 2016 Senate Community Affairs References Committee Inquiry, the Australian Indigenous Doctors' Association (AIDA) (2016, submission 8) reported that Indigenous Australian medical doctors experience racial discrimination during their training and subsequent practice:

> To date, most of the reports AIDA received from its members in regards to bullying and harassment have focussed on racist behaviour and attitudes of colleagues or systemic racism embedded in the institutions they work in and under (AIDA, 2016, submission 8, p.2).

The white Australia policy was abolished in the 1960s by the Whitlam Labor Government (Hirst 2014) and gave way to multiculturalism. Abolishing, or for that matter, introducing policy does not ensure that the minds and behaviours of the general public and institutions are instantaneously reformed, this is evidenced above. Moreover, multiculturalism sent a message that Australians embrace cultural diversity. I am sure Pauline Hanson and One Nation voters would not necessarily agree. Multiculturalism was a project to reimagine a national identity, one that would accommodate migrants from different backgrounds. Australians however, perhaps just tolerated multiculturalism, rather than genuinely accepted it (Plage et al. 2016). An historical perspective explored, it was necessary to turn focus back to the power structures of today with the knowledge of some of the contributing factors to their creation. In chapter three the structure and play of power in IMG relations with the health system and the Australian medical profession were unpacked, essentially, a macro analysis of the system and micro analysis of the individual narratives of IMG experiences.

POWER DIMENSIONS

Foucault's extensive work on power and knowledge was helpful here to provide clarity to

what was unfolding. Foucault (1997) believed that by understanding how power works as an instrument of discourse, we can in turn, uncover how human life is situated within discourse and then how, as a result, discourse rules and governs humans (Wang 2017) The power differential and power struggles at the sight of the power/knowledge nexus became a major focus as IMG narratives revealed their experiences. Power struggles establish the meaning in discourse and the resulting effect of power, that which becomes regarded as truth. In her discussion of Foucault's work, Macias (2015, pp.238-239) emphasises the: "Need to pay attention to the conditions that make truth a product of discourse and power. The power struggles to grant some statements more validity than others." The positioning of IMGs as an underclass within the elite profession of medicine is embedded in a deficit discourse which communicates to IMGs a perceived inferiority of their qualifications and skills.

Following Patricia Hill-Collins (2000), relations were presented in terms of a Matrix of Domination. Relations of power and associated discourses are structured into Structural, Hegemonic and Interpersonal power domains to enable insight into how IMGs are positioned within Australia's medical culture. **Structural power** is represented by the system and its many agencies as well as the numerous processes IMGs are required to negotiate. From obtaining the most suitable visa, gaining accreditation and registration to finding employment, all processes involve IMG/system interaction. The confusing array of pathway choices for IMGs has been outlined, as well as the racist initiative of the competent authority pathway, an option available only to IMGs from selected countries. **Hegemonic Power** refers to the Australian medical profession specifically and its power, influence and control as gatekeepers to the health system. The third dimension of power is **Interpersonal Power**. This power category is concerned with the voices of IMGs and their relationships and discourses with the system and with the Australian medical profession.

The reality of lived experience for IMGs in Australia is controlled by numerous identities which take the form of agencies, professional bodies, government departments and the like. For example, The Medical Board of Australia is responsible for medical registration. English language tests are administered by several approved providers such as the International English Language Testing System (IELTS). The Australian Medical Council (AMC) controls written medical and clinical exams. Various Australian Medical Colleges have their education and training programs accredited by the AMC. The medical colleges, of which there are sixteen, regulate entry into the specialties. Medicare issues provider numbers while visas are the responsibility of the Department of Immigration and Border Protection (Harris, A 2009). Through this complex bureaucracy of structural power IMGs are classified, regulated, managed and controlled as the other; medical doctors trained overseas. The hegemonic positioning of the medical profession as gatekeepers to the structural power of the system cements together a mutually beneficial power alliance. Hegemonic power allows the medical profession to maintain a self -interest agenda which drives the need to 'other' IMGs, rather than the espoused rhetoric of the need to maintain high standards. The structural power/hegemonic power alliance is a long standing relationship (by 1880) as argued by Willis (1989, p.60):

> Medicine had a high-status, reasonably politically effective vanguard elite who utilised their class positions and contacts in the political sphere to further the cause of the occupation as a whole.

The interpersonal power dimension in the matrix of domination draws the voice into the conversation, what is revealed is predominantly a power struggle; interpersonal power relations with the structural power of the system and the hegemonic power of the medical profession. IMG's share their rich narratives of lived experience and the reader is able to gain an appreciation of the gamut of emotions and experiences revealed. Among them

there is distress and frustration, career aspirations ruined and an adverse impact on mental and physical health. In fact, the mental health of doctors generally has been a concern for some time. A key finding of the 2013 survey into the mental health of medical doctors in Australia revealed that: "Doctors reported substantially higher rates of psychological distress and attempted suicide compared to both the Australian population and other Australian professions" (Beyond Blue, 2013, p.2). IMGs carry additional stress due to the extra demands the system requires of them, because they are not Australian trained.

Various strategies of control and vehicles for exclusion are mentioned such as examinations and fees. Foucault, viewed exams as a "power ritual" (Rabinow 1984, p.197). Failure at exams denies IMGs access to progression through the required processes; in addition if an IMG is not financially able he or she may not be able to sit exams at all. Progression through the system attracts a myriad of fees; an IMG must be able to finance these. If an IMG is unemployed without reasonable savings, he or she is not only significantly disadvantaged but excluded. The considerable hegemonic power held by the Australian medical profession is extended and developed into chapter four where the concept of medical dominance and Australia's medical culture is the focus of discussion.

MEDICAL DOMINANCE AND TOXIC TALES

The concept of medical dominance equates to a control of esoteric knowledge which is maintained by the interface between the economy and the state. Interested in the division of labour in the health system, the work of Evan Willis (1989) mapped the parameters of medical dominance to extend to: dominance over the practice of medicine, over the work of other health care providers and over society. Medical dominance enables the exclusion

of complementary and alternate health therapies. Despite the growing popularity of these therapies medical dominance ensures that they remain marginalised (Twohig 2016). Firstly, the rise of the profession of medicine from the 1870s when medicine attained scientific status is explored to put context around the development of medical dominance and how it has changed over time.

Currently, medical dominance is being challenged from various quarters and is changing shape to accommodate itself within changing health care delivery practice (Coburn, D. 2006; Germov 2014; Willis 2006). For example, since the 1990s a more corporate style of control of health service delivery has developed in general practice. There is an increased focus on managerialism, regulation of work practices and accountability. A major change agent has been the growth of digital health technologies and there have been changes in the doctor/patient relationship (Duckett 2008; Willis, Reynolds & Keleher 2016). For example, the internet has transformed access to general medical advice and information for patients, while doctors now expect patients to take more responsibility for their own health. Ultimately, despite challenges and the need to give concessions here and there, medical dominance is still alive and well. The medical profession however, is sometimes at odds with the State. Germov (2014, p.399) views the current changes as a battle with the State:

> Clinical governance heralds an era where the performance of individual doctors and hospitals can potentially be publicly comparable in terms of cost, timeliness, and clinical standards of effective treatment outcomes. It is an attempt by the state to exercise control over the medical profession at the clinical level-the last bastion of medical dominance.

Currently in Australia, there are three major power players in health: the Government which holds the authority, medicine which has the professional knowledge and clinical skills and the private sector where wealth is situated (Willis, Reynolds & Keleher 2016).

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Medicine's power therefore remains immense, simply because it holds the status of institutionalised expert, the keeper of knowledge that the other players do not have. Against this backdrop however, the reader has the opportunity to learn about the ugly side of medicine, the institutionalised expert with a great deal of power, status and respect has been tarnished and the reputation of medicine is called into question. During 2015, numerous adverse reports around medicine's endemic, unsavoury culture surfaced in the Australian media. Some of the voices from the stories shared with the media were invited to join the IMGs voices already shared from the data set of this thesis (the focus group, individual interviews, the 2012 Parliamentary Inquiry and the 2016 Senate Community Affairs References Committee) because they are also voices in crisis, from within a profession in crisis. The voices from the media too had some shocking and disturbing stories to share. These included a plea from the then Australian Medical Students' Association president, James Lawler (Campus Review, 2015) following four medical student suicides in the first half of 2015. Lawler appealed to senior medical practitioners to step up and stop bullying behaviours. In its investigation into the mental health of doctors, Beyond Blue, (2013 p.5) established that: "Medical students reported high rates of general and specific distress in comparison to the general population. In addition to bullying, the ABC's *4 Corners* program presented by Kerry O'Brien on the 25th May 2015 reported claims that belittling and bastardisation were: "poisoning the lives of young trainee doctors in teaching hospitals" McDermott and Michelmore (2015). Reports of sexism and sexual harassment were rife, particularly in the surgical fields and again particularly within hospitals. A young female trainee surgeon commented that because she had refused the sexual advances of her supervisor her career was now over. It was also mentioned that to report incidents ultimately resulted in career suicide (Knowles, R & Bannon 2015). Another mentioned that in the workplace, she suffered humiliation every day. There are many

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examples of sexism directed towards women within medicine. Often these examples involved women being relegated to the domestic stereotypes associated with the kitchen/grocery domain or to the sexual body image/fertility domain. For example, two specific episodes of blatant sexism and harassment were offered to the RACS expert panel by female trainee surgeons. The first was a demeaning comment made by a male senior surgeon to a female trainee who thought she was going to be invited to assist him in surgery: "Why don't you just go and do the grocery shopping…or you can join us in theatre – not to do anything, just for eye candy." Another female trainee surgeon seeking a job stated: "I was told I would only be considered for the job if I had my tubes tied" (Knowles, R & Bannon 2015, p.12). The Royal Australasian College of Surgeons appointed expert advisory panel's subsequent report found that:

> Nearly 50% of College Fellows, trainees and international medical graduates report being subjected to discrimination, bullying or sexual harassment. It is inconceivable that anyone finds this acceptable or contests the seriousness and spread of these problems (Knowles and Bannon, 2015 p.3).

It is not surprising then, that a profession with an established toxic culture has no qualms in positioning IMGs as an underclass and also subjecting them to aspects of toxicity. These startling findings beg the question of possible retaliation. As discriminatory, bullying and sexual harassment behaviours are against the law; it could be only a matter of time before legal action such as a class action is instigated against the RACS, other medical speciality colleges or individual medical practitioners. Has the medical profession/Australian community relationship been damaged? I argue it has. While the medical profession may possess considerable power and status it has also shown the weakness within, the outcome of a weak professional culture one of bullying, sexual harassment and self-interest is instead, power failure.

IMGs are often viewed as some kind of a problem or at least problematic, yet they have come to Australia to assist with a problem, that of a health workforce shortage. Chapter five suggests an analysis of why IMGs are positioned as an underclass within an elite profession. This requires closer questioning of problem representations and the teasing out of any associated silences. Initially, a global representation of IMGs is investigated as in today's world there is a climate of vast international exchange between nations; from ideas and technologies to goods and services. As a result, there is an international migration of the workforce (Toader & Sfetcu 2013). The medical profession is no exception and the supply of medical doctors varies around the world.

MIGRATION AS AN ETHICAL DILEMMA

Medical doctors are a valuable resource, highly sought after by countries experiencing a health workforce shortage (such as Australia). Countries in need of more medical doctors actively recruit them from elsewhere. However, there is concern associated with wealthy, developed countries 'poaching' doctors from poor, underdeveloped countries (OECD 2015). The source country has invested in the training of medical personnel in an effort to increase their numbers, only to have them take their skills to practice in another country. This practice is not confined to poor source countries supplying wealthier host countries however and developed countries also lure doctors from other developed countries. There are two dilemmas here, firstly the freedom of doctors and secondly the idea of compensation. The free movement of human beings is considered a basic human right and therefore regardless of where they have trained, medical doctors are human beings and should be free to migrate to any country of their choice anywhere in the world. This leaves the source country without those medical doctors. The question then becomes: should the host country somehow compensate the source country? Out of concern, the

World Health Organisation (WHO) (2011) proposed a code of global practice which encourages collaboration between destination and source countries via a skills transfer of knowledge to benefit both countries. Some developed countries have undertaken to cease recruitment of IMGs from underdeveloped countries. The issue of compensation is a difficult one to establish and would possibly need a country by country approach. It has been noted (Dwyer 2007; Iredale 2009; Smith, SD 2008) that host countries are reluctant to undertake compensation discussions. Why do IMGs decide to migrate?

RISK TAKING FOR SAFETY

Again in chapter four, the voices join the conversation and explain their reasons for coming to Australia. They share their need to feel safe for themselves and their families as well as the perceived opportunities offered in Australia. Linked to these desires is discussion around safety and psychological stress, with some IMGs arriving in Australia already psychologically vulnerable due to their traumatic experiences of war, political uncertainty and persecution (Kahn, Chikkatagaiah & Shafiullah 2015). Human rights and refugees are also explored and the problematic representation of IMGs. In chapter five, the wicked problem concept (a problem which is highly resistant to a solution) and problem representation presents a framework for useful exploration and clarification by employing Bacchi's (2009): "What's the problem represented to be approach." Following Bacchi's (2009) six question model systematically, it is argued that there is no real problem with IMGs; rather the problems lie with the injustices and inefficiencies in the system's dealings with IMGs. The silences have been in medicine's toxic culture, now thoroughly exposed. Bacchi (2009) advocates a paradigm shift from a problem solving focus to a problem questioning approach. This allows space for consideration of the problem fallout, the possible impact on those involved:

How the 'problem' is represented or constituted, matters. This is because the way in which the 'problem' is represented carries all sorts of implications for how the issue is thought about and for how the people involved are treated, and are evoked to think about themselves (Bacchi 2009, p.1).

IMGs are met with a deficit discourse from the moment they attempt to come to Australia, immediately they are in a position of constantly having to prove themselves, the standard of their qualifications and the competency of their clinical skills. At the same time, many who have difficulties with accreditation and registration are faced with the challenge of retaining their dignity, self-esteem and medical identity.

In chapter six, I argue that the analytic tool of Intersectionality represents an effective multi-disciplinary vehicle for critical inquiry and praxis as the approach seeks to confront unjust power relations (Hill Collins & Bilge 2016; Hill Collins & Solomos 2010). Particularly suited for analysis in this research study, Intersectionality is fluid in that the intersecting oppressions of class, race and nation are not fixed, rather they weave their way within and through each other. In order to empower IMGs with a sense of solidarity and shared purpose (Sefa Dei 2008) they are represented as a community construct, that is a professional community that shares an occupation (Hill Collins 2010). I did not want to disempower the IMG community by separating out divisions from within such as gender and ethnicity (while many Intersectionality studies use these categories and they are very important). IMGs have enough to contend with in Australia; therefore, I sought to facilitate solidarity in IMG agency. The system with which the IMG community must engage represents a manifestation of Australian 'normalcy'. Entrenched within the system and operationalised via its discourses and structures is structural violence and systemic bias (Galtung 1990) coupled with a systemic frustration of aspirations (Eckermann et al. 2006). The current political climate begins discussion around the intersecting inequalities of class, race and nation and their influence on the positioning of IMGs. The political climate

provides a feel for how Australian citizens are voting and as a result how governments are reflecting the will of the people by passing legislation of ideas, policies and processes into laws, and subsequently into institutional structures. These laws and institutions are the sites of struggle for IMGs and provide a picture of the Australian nation and what it stands for. Recently however, there is shift to a political right wing conservative stance which is represented in Australia, the United States and the United Kingdom. There are common threads which link the shifts that have been brought about by an angry voter backlash. There is also a commonality of the element of surprise in these results. Concerns around the economy, immigration and jobs, the maintenance of national identity and a nostalgic return to 'greatness' are all central to political movement in Australia, the US and the UK. This sentiment is indicative to a common reluctance to embrace the transformations associated with modern life, as outlined by Blackshaw (2010, p.146):

> The two concepts of nostalgia and community are indelibly connected as they simultaneously evoke the idea of a past that is committed to memory on the basis of both enchantment and appetite…in this coming together of community and nostalgia, there is a strong connection between the themes of loss, longing, regret and suffering.

The vote in the UK to leave the European Union (Brexit) shocked many. A champion of the leave vote, Nigel Farage, expressed nostalgic great nation sentiment (Chang 2016). Farage has openly been accused of racist and xenophobic views (Armstrong & Britton 2016) and publicly backed Australia's tough immigration policy (Chang 2016). Similarly, the election of Donald Trump to the presidency of the US stunned many around the world. Trump has promised to fix an ailing US economy by 'making America great again.' For Trump, tight restrictions, or in some cases bans on immigration (particularly Muslims) will help bring back jobs and safety for Americans. One of his election promises was to construct a wall between Mexico and the US (Ernst 2016). In Australia, Pauline Hanson's

One Nation Party has re-emerged as a viable option for voters and was even preferenced by the Liberal Party in a recent West Australian election. Hanson expressed her delight at the Brexit vote and Trump's election, she tweeted: "We've had Brexit, and that's happened, and now America – good on you guys, you got it right. I'm so happy that Donald Trump is there[33]. Hanson, a nationalist advocate, has been outspoken over several years expressing racist, xenophobic and ethnocentric views. She has demonised Australia's Indigenous peoples, Asians and now Muslims. Hanson has warned that unless Australia stops Muslim immigration and bans the burqa, Australians will find themselves living under Sharia law (One Nation Party 2016). This political climate is likely to spread and it is an uncomfortable time for immigration, including IMGs currently in Australia, and those who desire to come to Australia. The right wing political phenomenon is not new and emerges as the result of constant class struggle: the right wing side of politics is what it is because the left wing side of politics is what it is (Hall 1979). The Precariat class advanced by Standing (2011) offers a possible profile for those who become disenfranchised in society. The Precariat is a frustrated and angry group without agency or security. Their precarious position, due to increasing casualization of the workforce and decline in full time jobs and careers has become normalised in globalised labour markets. Many IMGs find themselves in similar circumstances while they await the system's decision on accreditation and registration. Some join the ranks of the medical unemployed, driving taxis and delivering pizza. Chapter six concludes with a discussion around Australia's immigration stance and racism. IMGs receive mixed messages, Australia can be espoused as a free egalitarian society, where there is a 'fair go' for all (Plage et al. 2016). Simultaneously, Australia in reality offers only a 'fair go' for some. Demonstrated

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[33] http://www.news.com.au/...senator-pauline-hanson-makes-toasts-donald-trump
ABC/TwitterSource: accessed 10 November 2016.

throughout this thesis is Australia's long history of racism, xenophobia and ethnocentricism. Currently, around the world there is an immigration crisis, the like of which has not been seen since World War 2, and as a result, there are growing tensions. People are fleeing from war, poverty and persecution especially from the Middle East and Africa. Many of these people are seeking asylum from countries without the infrastructure to accommodate refugees, and many of these people have no choice but to embark on perilous sea voyages (Brannan et al. 2016). Tragically, there have been many drownings. I argue that Australia has developed paranoia around people fleeing to Australia via boat and has gone to great lengths to ensure that these people do not set foot on Australian soil. Australian Detention Centres located on the Pacific island of Nauru and Manus Island in Papua New Guinea have become the 'new home' for refugees and asylum seekers while they await acceptance and resettlement (Maley 2016). These locations have been described as constituting concentration camps. The rhetoric around stopping people smugglers bringing desperate people in often unsafe boats is presented as humanitarian concern due to lives lost at sea, but the conditions provided for these people in the detention centres are not humane. In its most extreme display of xenophobic policy yet, the Australian government has determined that detainees on the Islands at any time since the 2nd half of 2013 will never be accepted in Australia under any circumstances (not even as a tourist) for the rest of their lives (Riley 2016). There is a fear that once a detainee is resettled in another country he or she may again attempt to come to Australia. Australia seems determined to evade the humanitarian crisis on its door step and sends a message to the world that asylum seekers and refugees are not welcome. In their discussion on neoliberalism and nationalism in Australia, Lueck, Due and Augoustinos (2015, p.612) note that:

Assylum seekers are frequently politicized in media discourses, that is,

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presented within the framework of politics rather than for instance, human rights, and that this includes little self-representation or humanization.

Racism is often a partner of xenophobia and from 1788; racism has been manifested in Australian society based on an ethnocentric perception of racial superiority. The British invasion of 1788 resulted in the decimation of the first peoples' knowledges, cultures and traditions which were deemed inferior. The participation of Indigenous Australians in Australian society is still steeped in a western discourse which positions the first peoples within a 'race' social construct (Foley, D 2008). Colour and racial/ethnic origins can be assigned to both white and black people. However the outcome is very different, for blacks there are disadvantages, but for whites the outcome is privilege because whiteness is the way of the West (Moreton-Robinson 2004). Chapter six has unpacked examples of racism at work in Australian society. Some IMGs have shared their perceptions of the black/white binary and the outcome for IMGs with black skin is perhaps a double or extra burden of difference. From the very beginnings of the 'new' nation, Australia has strived for a white nation (for example, the White Australia Policy of 1901). Discussion highlights whiteness as power and privilege, whiteness is the normative epistemology. A blatant, ongoing example of institutionalised racism in Australia is Indigenous Australian disadvantage and the chronic policy failure to address it. This has, in itself become a wicked problem with no solution in sight. IMGs and Indigenous Australian medical doctors experience racism in daily life and in workplaces and was identified to the 2016 Senate Community Affairs References Committee on Medical Complaints process in Australia as a source of workplace stress. Racism is institutionalised and anti-immigration sentiment comes directly from the government. In fact, at the time of writing (2017), the Prime Minister has proposed changes to section 18C of the Racial Discrimination Act. Chanel 9 digital news has reported that following approval at a joint party room meeting, the race-hate laws will be

watered down in the interests of freedom of speech. "Offend, insult and humiliate" will be replaced by "harass and intimidate" making racial discrimination claims harder to prove. The Shadow Attorney General, Mark Dreyfus commented that: "Every single ethnic community in Australia has been betrayed by this government[34]." Currently, Indigenous Australians are not included in the Australian constitution and the government is stalling on the idea of a referendum for our inclusion. There is a tension between the rejection of Indigenous sovereignty by Australian governments and Indigenous Australians claim that sovereignty has never been surrendered (Gunstone 2007). A no vote in a referendum would be disastrous for Australia.

What do IMGs make of these mixed messages? Australia is experiencing a health workforce shortage and IMGs are encouraged to bring their experience and skills to Australia, but what kind of country is Australia? The Australian nation appears to be at odds with itself, on the one hand there is the image of a 'fair go for all', an egalitarian land of milk and honey. On the other hand there is the image of a nation which excludes Indigenous Australians and tolerates the fact that many Indigenous Australians live in third world conditions and experience the poorest health of any group in the country. However, the majority of the Australian population enjoy a first world health system (Reid, Taylor and Hayes, 2016). In addition, Australia's anti-immigration stance is the toughest in the world and sends a clear message that people fleeing dire circumstances are not welcome (Riley 2016). Moreover, IMGs who come to Australia must deal with a dysfunctional system and endure the toxic culture of the medical profession. Australia is clearly not the country it imagines itself to be.

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[34] Proposed Changes to the Racial Discrimination Act Met with Mixed Response (9 digital Pty. Ltd. 2017 with AAP) http://www.9news.com.au/national/2017/03/21/11/32 accessed 22 March 2017.

Where are IMGs positioned in Australia? IMGs are positioned as an underclass within an elite profession. Despite numerous inquiries which acknowledge the shortcomings of the system and its processes, the difficulties faced by many IMGs persist.

LET'S HAVE ANOTHER INQUIRY

The evidence that generally a wicked problem exists within the system and medicine's culture however, is the string of inquiries. For decades, all manner of inquiries related to IMGs, medical workforce supply, assessment processes and complaints associated with medicine and the like have been undertaken. No real solutions have come out of these. Issues are exposed; subsequent recommendations are made but very little if anything really changes. Susskind and Susskind (2015, p.37) clarify the context:

> When confronted with the criticisms and challenges…a common response of professionals (and their representative bodies) is to address each alleged shortcoming in turn and to suggest small modifications. The mindset here is to repair the traditional way of working.

An examination of these inquiries reveals a repetitive discourse around recommendations, with terms such as: accountability, transparency and efficiency strongly featured. There are possible new inquiries on the horizon too as suggested in recommendation six of the 2016 Senate Community Affairs References Committee Inquiry[35]. The committee suggests a further inquiry into the medical complaints process and the National Law. What will become of these remains to be seen, what does remain however, is the ongoing difficulties experienced by IMGs in their dealings with the system and the toxic culture within Australian medicine. I argue that the powerful medical profession has succumbed to the

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[35] The Senate Committee Report (2016, p.47) notes that as at November 2016 the Government has still not responded to the 2012 Inquiry report: "Lost in the Labyrinth".

weakness within and as a result there is power failure. The profession is in breach of its service to the community. Therefore, I argue that the toxic culture of medicine and the associated totally unacceptable behaviours render the social contract broken; medicine is in breach of contract.

A BREACH OF SOCIAL CONTRACT

After a toxic culture is unearthed, how is it addressed? Can it be managed and eliminated? Does a toxic culture represent a wicked problem, one that is highly resistant to a solution? When the voices of those who have suffered at the hands of some misguided individuals within the profession, or at the hands of the health system, or at the hands of various associated bodies speak, it is a powerful voice. It is difficult to marry the 'social contract' proposed by Susskind and Susskind (2015) (also see Sen, 2010) to the behaviours exhibited by sectors of the medical profession. It seems that the profession does not fulfil all the obligations associated with their suggested end of the bargain.

The Australian public did not agree in good faith for medical professionals to look after their own interests first and foremost, nor did they agree for the esteemed profession to produce bullying, sexual harassment and unlawful practices which in some cases have led to victims taking their lives. The Australian public deserve better as do those who have suffered and continue to suffer. The medical students trained in a bullying culture, through "pedagogy of humiliation" (AMSA 2016 Submission 10, p.6) did not enter university with the intent to become the next generation of bullies. The IMGs who have been denied the opportunity to utilise their skills and those who have been forced to compromise those skills in order to gain some employment, are innocent victims. Where are these IMGs and how do they retain their agency and medical identity as fully qualified medical doctors? The study by Harris and Guillemin (2015, p.169) established that IMGs working to obtain

registration constitute a medical underground and enterprisingly utilise peripheral spaces within a hospital to maintain and strengthen identity:

> One group of IMGs gathered regularly in this cafeteria on Sundays to study for the written exam, amidst containers of homemade cake and photocopied papers. Dr Rudi van Aarde, a clinically retired IMG who had worked for 30 years as a general practitioner in Johannesburg and still attended the Sunday session, spoke about the members of this group. He talked about the leader of the group who had worked in Kuwait, Egypt, London, Ireland, Scandinavia and New Zealand before coming to Australia. He talked about the German psychiatrist, the Indian oncologist and an Eritrean general practitioner, a paediatric surgeon who was working as a hospital cleaner, another working as a nurse. He said that there was an Afghani cardiologist there too and a doctor working as a night watchman. Many IMGs in this group were a lot older than those on the wards; they were rich with years of previous clinical experience. The Sunday group was struggling to pass a written medical exam modelled on that given to final year medical students in Australia. Many of these IMGs were in a holding pattern, waiting and hoping to find a place in the Australian medical profession.

These IMGs struggle to retain a community solidarity which affirms their identity as medical practitioners. Some may succeed and become registered medical practitioners in Australia with employment in their chosen speciality and some may not. What will medicine itself become in a changing future?

WHAT OF THE FUTURE?

Susskind & Susskind (2015) have predicted that technological advances will transform the professions, including medicine well into the future. They do explain however that there will be resistance such as old entrenched ideas will be hard to abandon, an attachment to the way we always do things and perhaps a stubbornness to accept that another way could be better. The medical profession could well suffer from what they call 'technological myopia':

A tendency to underestimate the potential of tomorrow's applications by evaluating them in terms of today's enabling technologies….this is the inability of a sceptic, because of the shortcoming of current technology, to concede that future systems may be radically more powerful than those of today (Susskind & Susskind, 2015, p.44).

Is this in fact the road to a kind of technological determinism, a world of unfeeling machines, robots, devices? Where is the human? Humans make choices and decisions based on knowledge of what should be done in a set of circumstances, machines cannot. Humans feel emotions and pain machines do not. Important conversations need to take place around not only the advantages of technological determinism but also the disadvantages. In terms of medical care for example, who could be marginalised or even excluded? Individually, perhaps the poor, the elderly, those with impairments would be disadvantaged. In terms of communities, perhaps rural or remote communities and Indigenous communities would be disadvantaged. Some of these communities may have no, limited or unreliable internet access.

However, perhaps Artificial Intelligence (AI) holds the key to a marriage between humanness and technology. The academic community has expressed warning about the potential dangers of AI, but also highlight the potential benefits. Speaking at the opening of the Leverhulme Centre for the Future of Intelligence (LCFI) at Cambridge University, Professor Stephen Hawking (2016) noted that AI could be the best or worst thing to happen to humanity:

Perhaps with the tools of this new technological revolution, we will be able to undo some of the damage done to the natural world by the last one – industrialisation. And surely we will aim to finally eradicate disease and poverty (Hern 2016).

A world without disease and poverty would certainly be a challenge to the medical profession. We do not know exactly where the world is heading but we do know that the

world will continue to be heading forward with great change. Could technological change push medical dominance to the point where it no longer exists? Or conversely, could medical dominance become even more powerful, further empowered with the assistance of new technologies? Could the position of IMGs as an underclass within an elite profession become empowered by technological change and take on another status? However, Friedson (1994) reminds that while there is even greater, continuing change ahead, self-interest is a human trait and will remain. The negatives of medical dominance will only be stifled if it is liberated from material self-interest. Given the existing circumstances, this seems highly unlikely for this powerful profession. In fact, Baudrillard (2010b, p.17) suggests that power has to be eliminated altogether, where both sovereign and subject reject domination: "It is power itself that has to be abolished - and not just in refusal *to be dominated*, which is the essence of all traditional struggles, but equally and as violently in the refusal to *dominate."* The power differential within medicine in Australia however, appears fixed at this time. The work of Nobel prize winner Amartya Sen around social justice and reason places the role of institutions as instrumental in the pursuit of justice. He argues that institutional involvement allows for the possibility of several different reasonable stances or positions. However, what is certain is that: "at a particular time not everyone is willing to undertake such scrutiny." Reasoned justice is often avoided by: "placid guardians of order and justice" (Sen 2010, p.7). For Sullivan (2016, p.1) "Social justice demands equity in health capability more than equal access to health services." Ultimately it is fundamental for the population to feel empowered to manage its health and have confidence in health services and in the professionals who work in them. Perhaps an optimal/maximal approach has potential? According to Sen (2016, p.1):

> Critical sound reasoning can lead us to a partial ordering yielding a maximal
> alternative that is not optimal.

The voices gifted to this thesis have spoken out about their experiences and observations. From these narratives it seems that the medical profession and the toxic culture within is underpinned and influenced by several negative factors: the profession is hierarchically structured and entrenched with gender and cultural stereotypes. There is a power imbalance and competitive nature embedded in medical training and medical practice. As a result, there is an environment conducive to negative behaviours.

Has the nation lost all sense of humanness, the ability to tap into an empathy, concern and caring for others? Human qualities, a sense of what is right, a social responsibility, seem to be fading. Surely, the moral and the material are inextricably linked:

> And, as such, [we] must recognise love as an essential ingredient of a just society…love is a political principle through which we struggle to create mutually life-enhancing opportunities for all people. It is grounded in the mutuality and interdependence of our human existence-that which we share, as much as that which we do not. This is a love nurtured by the act of relationship itself. It cultivates relationships with the freedom to be at one's best without undue fear. Such an emancipatory love allows us to realize our nature in a way that allows others to do so as well. Inherent in such a love is the understanding that we are not at liberty to be violent, authoritarian, or self-seeking (Darder & Miron 2006; Denzin & Lincoln 2008, p.152).

I have been left disturbed by the toxic culture within medicine itself and by what is happening in the nation of Australia. This nation recruits IMGs to serve our health workforce needs and then treats them shabbily. Australia has a border protection agenda that is xenophobic in the extreme and Indigenous Australians are subjected to institutionalised racism (Gunstone 2017). The intersecting inequalities of class, race and nation in Australia conspire to relegate IMGs to an underclass within the Australian medical profession.

Medicine is a demanding, stressful profession which carries enormous pressures and responsibilities. Doctors often have the responsibility of life and death decisions in their

hands. Many doctors are hard-working, decent human beings but clearly some are not. Bullying behaviours cannot be tolerated as a rite of passage into medicine. From the anti-oppressive theoretical perspective and social justice imperative of this thesis: Please, no more lives torn apart.

The original contribution to knowledge made by this thesis clearly demonstrates the positioning of IMGs as an underclass within the elite profession of medicine in Australia. Why IMGs are positioned as such is advanced, adding to the existing literature around medical dominance. The ground-breaking work of Willis (1989) began the research to explain how medical dominance is established and maintained, much scholarship has followed (Coburn, D. 2006; Coburn, D. & Willis 2000; Germov 2014; Keleher 2016; Willis 2006) and within that scholarship medical dominance has been found to be accommodating change while retaining its position. The gap in the literature which this thesis has now consolidated is two-fold. Firstly, the positioning of IMGs specifically within medical dominance as a discrete community of medical practitioners ascribed a lower class status. Secondly, the question of why IMGs have come to be positioned as an underclass within an elite profession has been explored. I believe the current circumstances surrounding IMGs and Australia's medical culture constitute a wicked problem. Significant change in attitudes and values on the part of resistant individuals and organisations are unlikely and further, how major change could be successfully brought about is unclear. What is clear however is that medicine in Australia is imploding due to a power failure brought about by itself.

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APPENDIX 1

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

2012, *INQUIRY INTO REGISRATION PROCESSES AND SUPPORT FOR OVERSEAS*

TRAINED DOCTORS, **THE PARLIAMENT OF THE COMMONWEALTH OF**

AUSTRALIA, CANBERRA

	SUBMISSION
Dr Ahrens	66
Dr Anon	15
Australian Medical Council	42
Dr Bo Jin	26
Dr Damp	6
Dr Douglas	111
Dr Galak	31
Dr Gonzaga	25
Dr Iredale	134
Dr Lemieszek	118
National Rural Health Alliance	113
Dr Neelaprinyantha	153
Dr Schoengen	150

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THE SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE 2016, *MEDICAL COMPLAINTS PROCESS IN AUSTRALIA*, CANBERRA

APPENDIX 2

Royal Australasian College of Surgeons – Fees 2016: IMGs

Specialist Assessment Fee	9,504.00
Supervision/oversight Fee-onsite	7,620.00
Supervision/oversight Fee-remote	21,750.00
Document Assessment Fee – College Endorsement for AoN	1,425.00
Document Assessment Fee – AoN subsequent to Specialist Assessment	1,425.00
IMG Administration Fee	940.00
Short Term Specified Training Position Application Fee	1,140.00
EXAMINATIONS:	
Clinical Exam Fee	2,170.00
Fellowship Exam Fee	7,850.00
Generic Surgical Science Exam Fee	3,780.00
Speciality Surgical Science Exam Fee	1,890.00

Health Workforce
Queensland

Chris Mitchell
CEO
cmitchell@healthworkforce.com.au

6th June, 2007

Vicki Pascoe
Lecturer
Nulloo Yumbah: Indigenous Learning, Spirituality and Research Centre
Central Queensland University
Rockhampton Mail Centre,
Rockhampton Qld 4702

Dear Vicki,

In response to your letter and your email on Monday, 4th June, 2007, I wish to advise that Health Workforce Queensland is pleased to support your PhD research looking at the experiences of OTDs in rural and remote Queensland Communities.

Health Workforce Queensland will provide a link on our website that will encourage OTD's to access a brief description of your research and your contact details with the view to participation in a one to one semi structured interview with yourself.

We fully endorse the view that OTD's and GPs in general are not in favour of written circulated questionnaires as the generally held view is that there is very rarely any end result.

We wish you well in this research work and look forward to the release of your findings at the conclusion of this study.

Please do not hesitate to contact us, if we can further assist you in any way.

Yours sincerely,
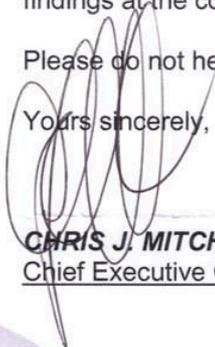
CHRIS J. MITCHELL
Chief Executive Officer.

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