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Le bon médecin pour l'emploi : comment les diplômés en médecine migrants accèdent à l'emploi en Australie

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Résumé de l'article

Les médecins qualifiés migrants doivent faire face à un processus complexe pour avoir accès à un emploi dans leur société d'accueil, où les systèmes d'accréditation et d'inscription leur sont présentés comme des preuves standardisées de compétence. À ce jour, les recherches à ce sujet ont tendance à se concentrer sur les problèmes d'ordre organisationnel, politique, économique et éthique plutôt que sur la façon dont chaque individu est confronté au parcours vers l'emploi, puis de la façon dont il y fait face. Cet article souhaite pallier ce manque en s'appuyant sur des entrevues ethnographiques réalisées auprès de médecins migrants étudiant et travaillant en Australie. Le parcours vers l'emploi semble requérir de la part du médecin un investissement significatif d'un point de vue financier, personnel, professionnel et émotionnel. Cet article s'intéresse à la créativité et à l'effort social et émotionnel dont ces médecins font preuve durant ce processus ainsi qu'aux conséquences de celui-ci sur la définition même du professionnel de la santé dans un contexte d'accroissement global de la mobilité de la main-d'oeuvre.

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The Right Doctor for the Job: International Medical Graduates Negotiating Pathways to Employment in Australia

Le bon médecin pour l'emploi : comment les diplômés en médecine migrants accèdent à l'emploi en Australie

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ABSTRACT ■ Skilled medical migrants must negotiate complex pathways to local employment in their new home countries. Accreditation and registration systems are promoted as standardized assessments of competence. To date, literature on this topic has tended to focus on organizational, political, economic and ethical issues, rather than how individuals encounter and subsequently negotiate employment pathways. We help address this gap by drawing on ethnographic interviews with migrant doctors studying and working in Australia. We find that negotiating employment pathways is a process entailing significant financial, personal, professional and emotional investment on the doctors' behalf. We discuss the creativity and social and emotional labour entailed and the consequences of this on what it means to be a healthcare professional in the midst of increasing global worker mobility.

RÉSUMÉ ■ Les médecins qualifiés migrants doivent faire face à un processus complexe pour avoir accès à un emploi dans leur société d'accueil, où les systèmes d'accréditation et d'inscription leur sont présentés comme des preuves standardisées de compétence. À ce jour, les recherches à ce sujet ont tendance à se concentrer sur les problèmes d'ordre organisationnel, politique, économique et éthique plutôt que sur la façon dont chaque individu est confronté au parcours vers l'emploi, puis de la façon dont il y fait face. Cet article souhaite pallier ce manque en s'appuyant sur des entrevues ethnographiques réalisées auprès de médecins migrants étudiant et tra-

vaillant en Australie. Le parcours vers l'emploi semble requérir de la part du médecin un investissement significatif d'un point de vue financier, personnel, professionnel et émotionnel. Cet article s'intéresse à la créativité et à l'effort social et émotionnel dont ces médecins font preuve durant ce processus ainsi qu'aux conséquences de celui-ci sur la définition même du professionnel de la santé dans un contexte d'accroissement global de la mobilité de la main-d'œuvre.

KEYWORDS ■ Skilled immigration, medical accreditation, health professionals, recognition, qualitative research.

MOTS CLÉS ■ Immigrant qualifié, accréditation médicale, professionnel de la santé, reconnaissance, recherche qualitative.

Introduction

Dr. Hamid Reza Salimian is perplexed. He has been in Australia for one year and still does not have a job. Hamid left Tehran with recommendations from his professors, a host of papers published in highly regarded journals and a thirst for a well-regarded medical career outside his politically tumultuous home country. He thought it would be easy to find work as a doctor in Australia. Yet, here he was, spending his days studying in hospital and university libraries. He had arrived with dreams of pursuing a career in gynaecology like his esteemed father. Now though, he would be happy to settle for any job, anywhere. Hamid quickly passed his English language exam, then the Australian Medical Council (AMC) written (theoretical) exam, but it took a long time to be granted a seat in the AMC clinical (practical) exam. He waited, practising his exam techniques with other overseas doctors in the meantime. Finally, he was allocated a place to sit the clinical exam, but he did not pass the required number of stations. On his second attempt, months later, he passed the exam easily, proudly confirming his sense of competence as a doctor. Yet, he still could not find work in the city hospitals or in the discipline he desired, a key stepping stone in enabling him to undertake the year of required supervised practice to complete his registration. Hamid was considering two options and could not decide which to pursue. However, he knew he had to change his plans in order to work as a doctor in Australia – he was either going to have to move to a rural location in another state, where jobs were more plentiful, or he was considering taking some of the psychiatry night shifts in the outer-metropolitan hospitals which he had heard were readily on offer to overseas doctors. Neither option was what Hamid had imagined when he moved from Tehran to Melbourne. He had

come to build upon his blossoming medical career in a metropolitan city in a country that seemed to be calling out for doctors.

In recent years, Australia, like other countries such as Canada, the United Kingdom (UK), the United States of America (USA) and New Zealand, has been experiencing a medical workforce shortage. As part of a broader strategy to attract skilled migrants to areas of workforce shortage (Almeida *et al.* 2015) and to fill the gaps, these countries have relied on international medical graduates (IMGs), or doctors who have received their medical qualifications "elsewhere." In the UK for example, more than a third of registered doctors have obtained their qualifications outside the UK, a number which has risen since 2014 (Kehoe *et al.* 2016). This statistic is higher in countries such as Australia where 42.9% of doctors are migrants, as well as Canada (35.1%), Ireland (35.3%) and New Zealand (46.9%) (World Health Organization [WHO] 2014). The movement of doctors around the world is an ethically and politically charged situation. From an international public health perspective, migrating doctors are viewed as one of the primary factors exacerbating crumbling healthcare systems in many resource-poor regions of the world. The WHO declared in their 2006 World Health Report that healthcare worker migration was one of the most significant health issues of contemporary times, with proceeding reports (WHO 2014) reiterating the ongoing importance of this issue.

Not only are countries with fewer resources losing doctors, putting a strain on existing healthcare services but the doctors who move to the resource-rich mentioned above are also experiencing difficulties and hardships in regards to gaining employment. In Australia, this situation has received public and political attention in recent decades, and inquiries into how the employment of migrant doctors can be improved are ongoing. For example, in 2011, the Australian Federal Government conducted a lengthy inquiry that received more than 200 submissions (over half of these from IMGs) and heard evidence in 22 public hearings around Australia from numerous representatives of organizations involved in the assessment, registration and employment of IMGs, as well as from the IMGs themselves. The result of this inquiry was a series of recommendations published in March 2012 (House of Representatives 2012). While our analysis does not consider this inquiry, our paper raises many problematic aspects of the employment process which were also highlighted in these governmental proceedings. Voices continue to be raised in defence of the importance of the overseas medical workforce for the Australian healthcare system (e.g. Shrivastava 2016), yet doctors continue to have to negotiate very complex pathways to employment. This article documents the stories of doctors who faced this situation in Australia in

2007. However, still to this day, the accreditation and registration systems continually change and the argument that doctors need to become the "right doctor for the job" remains ever relevant.

Each country has their own pathways to employment for IMGs, usually involving multiple types of validation of qualifications, assessments of language and medical expertise, registration by medical boards, and interviews. The IMGs find out about these pathways through official websites of the AMC and Australian government (such as DoctorConnect), through information evenings in Australian capital cities where these and other organizations are represented, and through the IMGs' own informal networks, within and beyond Australia (Harris 2010). These pathways are officially promoted as standardized processes designed to assess the competence of IMGs to work in that country. In ensuring the competence of IMGs to practise, accreditation, registration and other employment procedures aim to protect the safety of the population and reinforce public trust in the medical system.

In many countries, the accreditation, registration and employment of IMGs is thoroughly intertwined and connected, sometimes loosely, to migration processes. This is an ever-changing process, with adaptations and revisions occurring on a regular basis. In order to avoid confusion in the article, we refer to this thoroughly intertwined process of accreditation, registration and employment, as the "pathways to employment," or "employment pathways." These are pathways which have understandably often been described as "complex" by different stakeholders (Douglas 2008: 29). The pathways are riddled with acronyms and different entry and exit points. Although it is widely agreed by all involved that these pathways are indeed complex, complexity is also arguably used by some stakeholders to abdicate from taking responsibility in simplifying this process.

With some exceptions (e.g. Blain *et al.* 2017), the literature on this topic to date has tended to focus on organizational, political, economic and ethical issues, rather than how individuals encounter and, subsequently, negotiate employment pathways. This article offers critical insights into the employment pathways for skilled migrants in receiving countries by focusing on the practices employed by the migrant medical professionals to navigate the system. Scholars have studied the underutilization of skilled migrants in Australia from the perspective of employees or employers (Almeida *et al.* 2015; Almeida *et al.* 2012), or barriers to employment (Zulauf 1999; Kamimura *et al.* 2017), and gatekeeping (Salaff *et al.* 2002). Here we focus on the creative practices of doctors who adjust to the dynamic, supposedly standardized, accreditation and registration system for employment. We consider standards as the normative rules

which specify who can work as a doctor in Australia, which is considered to equate to "medical competence."

We theoretically frame our analysis of becoming the "right doctor for the job" by drawing upon a classic Science and Technology Studies (STS) book, *The right tools for the job*, in which Clarke and Fujimura (1992) critically engage with the notion of rightness in terms of the "tool" and "the job." They argued that notions of "'rightness' can vary across time, space, problem, discipline, and participants" (Clarke & Fujimura 1992: 6). We extend this beyond the right tools and right jobs to the "right doctor." Using Clarke and Fujimura's framework helps us to understand that the different ways that IMGs have been defined and classified is socially, politically and historically contingent. In Harris (2013), we have shown what is at stake in the use of these different classifications of IMGs. Just as the "right doctor" is made to be flexible, the job is similarly made pliable. Government bodies adapt employment requirements to fill gaps according to areas of workforce shortage. At the same time, IMGs need to be flexible to fit the job, for example by modifying their career goals and searching for job opportunities in locations or specialities which are not necessarily desirable to them. In this article, we show that the rightness of the doctor for the job is situationally constructed and circumstantial – historically and locally specific. We explore the shifting meanings of rightness, where rightness is not exclusively the outcome of rational planning and standards, but is contingent on historical and social conditions (Clarke & Fujimura 1992: 21).

We build on Clarke and Fujimura's work to examine the adjustments that doctors needed to make to become the right doctor for the job, adding a new theoretical perspective to the literature on skilled migration that predominantly draws from human capital theoretical frameworks (Almeida *et al.* 2012). We conceive of these adjustments as a constant response from the doctors to their new environments, including registration processes, exam formats, paperwork procedures, patients, other hospital staff, and instruments (Harris 2010). Importantly, adjustment lies not only in practices themselves, but in the responsiveness of practices to the surrounding ecological conditions, which are never the same from one moment to the next (Ingold 2000: 353). For the IMGs, this meant a constantly moving arrangement of assessments, and bureaucratic processes, a situationally and temporally contingent set of standards. Unlike many studies that focus on the difficulties that migrants face in seeking employment, this article focuses on their creative strategies to gain employment, creative strategies that are not without consequences.

Situating our article geographically and temporally on the situation for IMGs in Australia in the early twenty-first century, we explore the

practical strategies of migrant doctors based on ethnographic interviews. First, we argue that the standards which are claimed to be embedded in the employment pathways for IMGs are historically and locally contingent, correlating with the findings of others who have studied different time periods in the history of medical immigration to Australia (Groutsis 2006; Iredale 2009; Kunz 1975). We further argue that doctors find creative ways to adjust to these dynamic and ever-changing "standards." This adjustment does not happen effortlessly. For doctors, such as Hamid, adapting to become the right doctor for the job required significant financial, personal and emotional investment. This has consequences of flexible notions of rightness upon healthcare systems and upon our understandings of what it means to be a doctor.

This is an article about doctors, but it tells a story which could easily apply to many other healthcare professionals including, for example, veterinarians, dentists, nurses, pharmacists or psychologists (Connell 2008) and others in the "protected professions" (Salaff *et al.* 2002) migrating somewhere outside their country of birth and/or training and having to negotiate complicated employment pathways which claim to be standardized processes. Medical migration is a topic which has received considerable attention from academic researchers, governments and organizations such as the WHO (Packer *et al.* 2007). It is often assumed that the border barriers for medical migration are actively lowered and that it is easier for doctors to move across borders because of the internationalization of credentials, free trade agreements and other factors facilitating global migration (Packer *et al.* 2007). IMGs, however, experience many barriers to employment (Kamimura *et al.* 2017). Sociologists such as Shuval and Bernstein (1997) and anthropologists such as Blain *et al.* (2017) have shown that not only do pathways differ for doctors from different backgrounds, but also that medical migration can have negative impacts for doctors, such as on their sense of professional identity. We contribute to these insights by looking at the social and emotional toll upon doctors trying to meet Australian standards, to become the "right doctor for the job."

Background

The details of the policies and history of medical migration in Australia are complicated, as in many other countries, and we offer a brief summary here in order to set the background for the rest of the paper. In the era of early colonization, all medical practitioners in Australia were IMGs, predominantly from Ireland and the UK. These doctors were able to find work easily. It was not until the outbreak of war in Europe in the

1930s, and the influx of refugee doctors that accompanied this historical event, that the medical profession in Australia started to develop stricter rules (Kunz 1975: 23). Two employment pathways were implemented – one for doctors with qualifications from British, Irish and New Zealand universities, or Commonwealth universities in Africa, Asia or America, and another for other European countries, predominantly Eastern. The Commonwealth doctors were accepted into Australian employment without question, whilst doctors educated outside the Commonwealth had to fully requalify at an Australian medical school (*ibid.*: 52). The only European doctors who were able to practise in Australia were those willing to work in "fringe areas" such as in rural settings, in Papua New Guinea, or on ships bound for Antarctica. To work in Australian cities, the right doctor was deemed to be from the Commonwealth, whilst the right doctor in these fringe areas could be qualified elsewhere. Many of the European doctors reported feeling humiliated by this process (*ibid.*).

Since that time, the Australian medical profession has played a significant role in vetting IMGs for the sake of public safety. In Australia, doctors are employed in both public and private roles and settings, both of which require registration and accreditation. In regards to both contexts, Australian governments have worked together with the medical profession to shape the employment process according to workforce needs. In the 1980s, IMGs were restricted from entering Australia, based on the premise that future doctor-to-population ratios were going to be too high (Birrell 2004). With the Australian population rapidly expanding in the late 1990s, the restrictions on medical employment became evident in falling doctor-to-patient ratios. An ageing population, decreased working hours and a local graduate preference for inner-city hospitals exacerbated the severe workforce shortages in health care in rural and outer-metropolitan areas. The Australian government and medical bodies were forced to increase the number of IMGs allowed to work in Australia to fill gaps in general practice and in outer-metropolitan public hospitals (Hawthorne *et al.* 2003). Suddenly jobs were available to IMGs, with governments and medical organizations shifting the rules according to their perceived needs.

By 2007, at the time of our empirical research, to be able to work in Australia, IMGs had to have fulfilled the requirements of the Australian accreditation and registration system. IMGs could take a number of different pathways to employment, which were largely contingent upon their immigration status (or visa), country of training, specialty or the job location. As others have also argued (Groutsis 2006; Iredale 2009; Kunz 1975), this system was highly contingent. Depending on their visas, IMGs faced two different employment paths: Doctors who were on

temporary visas were only eligible to work in areas of significant workforce shortage (Australian Government 2007). To work in these areas, temporary resident doctors did not have to sit a medical exam (the AMC exam) and could proceed directly into medical practice (Hawthorne *et al.* 2003: 7). On the other hand, doctors who had permanent visas who wished to practise unconditionally in general medicine (non-specialist) in Australia had to pass the AMC examinations, both written and clinical, and satisfactorily complete a year of supervised training in an accredited hospital in order to receive registration (AMC 2008). In sum, depending on their visa, doctors willing to work as generalists had two very different pathways to employment.

The pathway to employment for specialists also depended on whether they were on temporary or permanent resident visas, with concessions made for temporary resident specialists willing to work in areas of workforce shortage. Overseas trained specialists wanting to work unconditionally had to undertake a specialist accreditation process that was separate from the AMC exam. As part of this process, overseas specialists were initially assessed by the relevant specialist college. If the college deemed that the doctor was comparable to local graduates, they were given restricted registration for up to two years to complete supervised specialist practice. If the college deemed that they required further training, doctors needed to go through the AMC examination pathway (*ibid.*). The specialist pathway was contingent on which specialty the IMG was hoping to pursue. Each specialist college set their own requirements. For example, overseas specialists wishing to continue working in dermatology were required to go through the full local examination process, while psychiatrists wishing to practise in their field only had to pass an oral examination. Generally, specialties experiencing workforce shortages often had more lenient assessment requirements. For example, in emergency medicine and rehabilitation, doctors only had to sit parts of the exam, whilst highly competitive specialties such as ophthalmology required doctors to start the assessment process from the beginning (*ibid.*).

Methodology

Interviews were conducted as part of a larger ethnography examining the experiences of IMGs studying and working in three outer-metropolitan hospitals in Victoria, Australia. At the time of the study, in 2007, Victoria was one of the three most popular migration destinations for doctors in Australia (Hawthorne *et al.* 2007: 22). A large number of IMGs in Victoria were studying and working at the three research field sites. Ethnographic

fieldwork was conducted over a 12-month period. The fieldwork comprised of observation, informal interviews, as well as 13 more structured interviews with IMGs. In this article we focus on the interview material, which helps us to explore the ways in which IMGs navigated their pathways to employment through their own narratives, although this discussion is greatly informed by the ethnographic participant observation conducted. In other work from this ethnographic project, we have examined themes of marginalization, adjustment, classification and transition (Harris 2013, 2010).

IMGs who participated in the interviews were recruited as part of the ethnographic study. Potential participants were initially recruited through an invitation from the hospitals' Director of Clinical Training, and remaining participants were recruited during fieldwork or through snowball techniques. As the fieldwork progressed and themes started to arise, doctors were approached directly for participation, with the premise that their stories could enrich emerging ideas. For example, migrant doctors at varying stages of employment were sought out. No participants withdrew from the study. Ethics approval was obtained from both the hospitals' and the University's human research ethics committees and participants gave informed consent to participate. Throughout the article, pseudonyms are used to refer to the study participants.

While many informal interviews were conducted as part of the study, more structured interviews of approximately one hour's duration were conducted with 13 IMGs. Interviewees were chosen because they had become key participants, either through the amount of time spent with them or through a certain level of insight they had into their practice. The doctors ranged in levels of experience, age, gender, nationality and specialities. All of these interviews and conversations took place in English, which is the second or third language for many of the doctors interrogated. Interview questions were based on analysis of early fieldwork material and comprised topics such as early experiences in Australia, how doctors navigated finding work in Australia and their reflections on practice in the field site hospitals. Interviews were digitally recorded and transcribed verbatim.

All fieldwork data, interview transcripts and documents were analyzed thematically. Our analysis was informed by national and State orientation guidelines for IMGs, local and national newspaper articles, and public policy documents from national and Victorian government as well as medical organizations. At each stage of analysis, initial theories were generated and these were continually checked against the data. In the following pages, we present the findings of this analysis.

A Flexible Doctor

The ever-changing employment pathways outlined earlier in our article aim to provide required medical services, while ensuring that doctors are channelled into hospitals and clinics where they are needed and maintaining public confidence in IMGs. They are claimed to be standardized processes of assessment (AMC 2008; MBA 2010). Underlying this, however, is a socially constructed idea of "rightness," where the "right doctor" and the "right job" are not fixed but change according to various stakeholder agendas.

Participants in our study put considerable work into negotiating these supposedly standardized employment pathways and adapting to what was required. For example, IMGs became skilled at demonstrating and performing their "patient-centeredness" in their assessments, which they learned was a necessary skill for passing the exam. Polite questions for patients were rehearsed, unfamiliar situations such as "breaking bad news" were memorized, and the inclusion of families and other colleagues in decision-making were emphasized during role-plays. These were all considered attributes of the right doctor, fit to work in Australia. The IMGs knew that failure to demonstrate "appropriate" interpersonal skills could equate to failing the exam. Although the clinical exam was presented by the AMC as a standardized assessment of knowledge, IMGs quickly learned that you had to present as the "right doctor" to pass. But did this mean that you were a "good" doctor? Dr. Mladen Mück, a middle-aged Bosnian obstetrician in the hospital, described two of his registrars (doctors training for specialization) and their different assessment pathways:

> *Like Intaj – I should tell you that her performance is not bad but close to bad – it's unskilled – and they test her and she passes – and they don't ask how she is to work with … this paperwork is what she concentrated on instead of her work. I tell you it's so difficult to find that balance when you are an overseas doctor – like Dumitru, he worked very hard to prove he was skilled – but when they decided to give the job, what happens? Dumitru doesn't get the job and Intaj does – or more that Intaj gets the job in the city and Dumitru gets put out even further. Dumitru is knocking his head.*

IMGs also needed to be flexible in how they responded to the changes in incentives or disincentives for practice in Australia, as evidenced in the following section of the interview with Dr. Yang Fuquan, a middle-aged general practitioner (family doctor), who was not practising in Australia at the time of his interview:

> *I went to China and come back [to Australia] and my friends give me the federal government advertisement, for overseas doctors. And I decided just to ah, change my plan, my original plan, I had to change it, otherwise, the*

> *situation might change again because 16 years ago there were too many doctors, now there is not enough doctors, if I miss that, say four or five years, they might say too many doctors again, until the next sixteen years* (laughter), *or maybe it will never happen again? So, I decided, just get this opportunity first … Some stage in 2005 my friend, actually my sister's university classmate, said at the time she can work in a remote area, she said they really need doctors – even tried to go back to China to recruit doctors, then my sister's friend said, quickly pass the MCQs* [multiple choice questions] *and then you can get a job here. I said OK, so I finish in 2006 March, and then I rang her, and she said it is too late, the situation has changed, now you need to pass the MCQs and have experience, or you pass the clinical as well, and I thought OK, things keep changing, we can't change the thing or but we can try to adapt, so I try to pass clinical and yeah I believe that things come up from time to time as long as you are ready.*

Doctors were constantly working out how they could secure visas, use their visas and change temporary visas into permanent visas. They were continually trying to determine the best pathway towards employment. However, these opportunities were transient, and passing the necessary assessments at one point in time did not mean you were the right doctor for the job at another point in time. Dr. Yang Fuquan's story highlights the temporal nature of this process and the efforts that the doctors put into meeting the standards, always having to be ready to adjust. These adjustments were not just required to obtain a job, but also to keep it. Dr. Mladen Mück, who was introduced earlier in the article, explained how he remained in obstetric practice by working within the system and being flexible with where he worked:

> *In terms of assessment with the college* [Obstetrics and Gynaecology] *I was assessed close to Australian consultants* [meaning he almost but did not fully meet local "standards"] *and I needed to achieve the fellowship, of full recognition – the condition was to pass my membership exam and spend two years of advanced training and unfortunately, I continued to work full time. I was good in that field but I could not manage to achieve that goal you know, to pass the exam in that period of time required. That's the reason why five years after working as a senior registrar at Hospital Y* [an inner-city hospital] *I needed to change the hospital and come, actually I came to Hospital X and to work in what we called, a hospital in an Area of Need, and that's the reason I continue here. It's my fourth year in Hospital X.*

Because Dr. Mladen Mück did not pass the specialist exam in the time required, he was no longer considered the right doctor for the job in the inner-city hospital. There was another way of practising in obstetrics, however, and that was to work in an Area of Need, on temporary registration. He was willing to work in an outer-metropolitan hospital

where there was significant workforce shortage in his discipline, and the malleable rules enabled this. Other doctors discussed flexibility in their own career ambitions, working jobs of workforce shortage as a short-term measure. This was particularly evident in an interview with Dr. Farokh Mostofi, a young Iranian doctor who was working as a junior (internal) medical resident in the hospital when interviewed:

> *I don't look at what I am doing as a medical career – just a job, just like a casual job. There is not much difference between working psychiatric night shifts and working in Coles-Safeway* [a supermarket]*! You know. There is not much scientific job here ... Yeah, my expectations were really high for Australia but I don't think that I can reach that point at this stage. It is really unlikely for me now to reach for example, to start my career in dermatology. Or something like that, so, I prefer to stay in nephrology. Which was actually my first priority before, but it is not really a good choice when you are just limited to choose between just one or two fields of medicine. You don't feel really good. But anyway, I see people who have come here earlier, and they could not work where they wanted to – so I cannot see a bright future here as what I had been expected. But anyway, I will try my best – that's all I can do.*

Dr. Mostofi was flexible with his career ambitions so that he could work as a doctor in Australia. He recognized that the pathway to work in his specialty of choice was more difficult than those of other specialties. He made compromises in his goals, and this did not "feel really good." As we discuss in the next section, there are serious consequences in these continual requirements to adapt.

Whilst we have focused on IMGs who were flexible in regards to their assessments, work locations and career ambitions, not all doctors were prepared to sacrifice what was needed to become the "right doctor" in Australia. Dr. Saimon Ambi, a middle-aged cardiologist on an occupational visa from a large cardiac hospital in Malaysia, quickly worked out that his chances of being employed on a long-term basis in Australia were slim. He said that he found the local surgeons very protective of their group and "didn't want to share a piece of the cake," adding that:

> *I did entertain the thought [to stay] but I thought it would be very difficult – for surgery it would be difficult. If I got a post as a consultant, the pay would be a lot better but if I got a post as a registrar it would not be ... In Adelaide for example there are only three cardiothoracic surgeons and only four posts for registrars ... I have a good post back home – to migrate here, it's too uncertain.*

Dr. Saimon Ambi recognized that within his specialty, the standards shifted to protect local graduates. He wanted to avoid the uncertainty that many doctors experienced in their negotiations of becoming the

right doctor for the job; with these adjustments came serious personal and emotional sacrifice.

The Consequences of Becoming the Right Doctor

The IMGs in our study had already met standards elsewhere, and been deemed competent to practise in their country of training. They embarked on the employment process in Australia, presuming that the system was about assessing their competence in a standardized way. Yet, they soon became embroiled in a process that was much more about whether they were the right doctor for the job. For many IMGs, what first appeared to them to be a straightforward accreditation and registration system ended in tortuous pathways, with choice over their own medical careers being taken out of their hands. Dr. Dumitru Bara, the young though slightly jaded obstetrics registrar from Romania, articulated his frustration about having to negotiate this system:

> *Medicine here is now five years – no longer six. It keeps changing – very weird. Who knows how many they need? No one knows the demographics… Australia had this policy of No, no, no, yes, yes, yes – don't let them in, oops, some need AMC, no AMC. There's a lot of crap going around – it's not a present that they give and then take – it's not something that I've begged for.*

Most IMGs arrived in Australia with the understanding that they were needed for work, and that having completed the requirements, they could work where they liked, in the discipline of their choice. They soon realized that these jobs were not everywhere, but only in some places. Rightness was situationally contingent upon political intentions, local doctor preferences, population statistics, IMGs' countries of origin and visa status, the specialty pathways and other factors.

As a consequence, IMGs became unsettled, confused and angry. These sentiments were also expressed in over 100 submissions from IMGs and statements made in the 22 public hearings conducted as part of the 2011 Australian government inquiry into the registration system. These doctors, just like our research participants, felt they were forced to narrow their career ambitions, against their will. Doctors also had to deal with the lack of security in their positions. Dr. Mladen Mück ended up working in an Area of Need position on temporary registration, lacking any job security. He felt anxious about studying for the AMC exams and the possibilities of only being accredited to be a general practitioner (GP) if he passed. He remained in his temporary position, without promotion or possibility of private practice, supervising locally qualified registrars who would go on to become consultants:

> *In my case it is now nine years with temporary registration – temporary registration for nine years is just a joke … but I don't think that the future is sort of – that I can be relaxed at all, from year to year. You are just waiting for the new contract, the new registration. Overseas trained consultants just can't fit into two categories, GP or fellow of the college. It is unfair of them to say you are OK to work as an obstetrician here but not here. What does this say about my capabilities and competence as a doctor? The problem is that you can't be psychologically settled … At the moment, I have an approval as an obstetrician to work in an Area of Need … my boss said that it would be easier to show that I am going to go down the GP pathway. I can do my job, I can do this 100%, but to work in Australia you need to have medical registration … they wanted to force me to be a GP, but I am an obstetrician!*

While the notion of work flexibility has been widely studied and criticized (Håkansson & Isidorsson 2012), flexibility is often seen as a virtue in the organization of medical work. For example, "doctoring," or tinkering of medical practices, which remains flexible with respect to working with patients (Mol 2008), colleagues (Hindmarsh & Pilnick 2007) and bodies (Pope 2002; Zetka 2003) is valued. But is flexibility in medicine always best? We have shown that continual adjustments and contingency can take its toll on individuals negotiating a supposedly standardized medical accreditation system. Being flexible gives IMGs greater chances of employment, but it also means emotional distress, discarded dreams and precarious futures. Claims of standardization meant that the doctors assumed that passing each step should ensure employment. When they realized that this was not always the case, this had serious consequences on the morale of doctors both working in the system and working towards employment. Some doctors will never be flexible enough, and will spend years in libraries and tutorial rooms. These doctors are "stuck" – to use Ghassan Hage's (2008) terminology in his essay on "waiting" – having left a country they cannot return to, and not able to work in a profession in which they have invested much time, skill and sense of identity. Many of these doctors will wait; wait for their credentials to be certified, wait for an examination place, wait on the phone for answers to their questions, and then, wait for those opportunities that come up "from time to time," frustrated yet resigned to the process.

Discussion

In this article we have shown that the IMGs we studied were constantly working at being the right doctor for the job. Like others (Groutsis 2006, 2003; Kunz 1975), we believe that standards of competence of IMGs are not as consistent as they claim to be and that claims of standardization

are not solid, but rather are dynamic in that they are situationally and temporally dependent. IMGs arrive in Australia expecting to have their medical competence affirmed after completing the accreditation process. After passing the Australian exams, they expect that this affirmation of their quality as a doctor will enable them to work as a medical practitioner in Australia. Instead, like Dr. Hamid Reza Salimian discovered, there are many other aspects to their registration and employment, and IMGs needed to be assessed as the "right doctor for the job." Not all IMGs who passed the exams were deemed to be employable as doctors in Australia. Employment was based on a situated notion of "rightness." The "right doctor" became a list of characteristics that shifted, temporally and spatially, according to workforce needs. One of Blain (2016) and colleagues' participants made a similar point when she said that she had "*the right skin colour and the right accent*" (author's italics).

As Kofman and Raghuram (2005) argue, definitions and understandings of skills are reworked in the context of migration. For the IMGS, the "right doctor" became a flexible term used differently by the various stakeholders. The stakeholders in this case included the Australian government, medical organizations, medical practitioner boards, workplaces, the public and the IMGs themselves. What was considered the "right doctor" was contingent on where doctors were needed at given points of time, on ensuring that public confidence in IMGs was maintained, and upholding professional boundaries, while still providing a medical service. It was not the case that an eventual and agreed-upon "right doctor" emerged during the course of the research; rather our findings highlight the continuing negotiations between the notions of rightness between the doctor, the job and what they are expected to do.

Clarke and Fujimura's (1992) "right tools for the job" concept is useful in reminding us that the classification of IMGs, medical accreditation systems and how we understand medical competence are all constructions or, more specifically, co-constructions; they are given meaning through the network of relations in which they operate. This highlights that these elements are not fixed, but instead are malleable and contingent. Despite the expectations of the IMGs that by following a designated path this would lead to their registration, what they faced in practice was far from their expectations. The benefit of the "right tools for the job" framework is its focus on the processes involved, in this case the processes of negotiating, mediating, tinkering and reimagining. By focusing on the processes, we come to understand how Australian medical registration is experienced by IMGs, a perspective that would not be possible by just focusing on the registration system itself.

We have contributed to the skilled migration literature with a study of the adjustment practises of individuals negotiating such a contingent registration system, focusing on the creativity and social and emotional labour entailed in this process. Although our case study is Australian, and limited to a specific period in time, we suggest that this is not just a local issue. Other countries are also facing similar medical workforce shortages and, in turning to IMGs as a potential solution, have had to deal with similar accreditation and registration issues. With more than 200 million people estimated to be working outside their countries of birth (Williams & Baláž 2008: 5), this is indeed an issue relevant for many workplaces. Nor are the findings of this study limited temporally, to the time period discussed. New changes in the Australian pathways to employment for IMGs in Australia since our study demonstrates there remains a continual appeal to "standards," despite structuring different tracks for those deemed the "right kind of doctor" for the job (i.e. those more "similar" to Australian graduates).

We are not advocating for abandoning standards. Ensuring that all doctors, local or international, are accredited and registered is of vital importance for public safety and confidence in maintaining an efficient medical system. We are, however, also wary of celebrating flexibility in this context. The flexibility that we have documented in this article, found in the ways doctors sought to be the right doctor for the job, certainly help address the staffing of a national health care system. However, as we have argued, this flexibility and contingency have significant consequences. This is important because it has real implications for the doctors themselves, the health care systems, the way we understand medical competence and how we entrust the doctors managing our health care.

First, there were professional, financial, personal and emotional costs for the IMGs; they left their countries of origin in the belief that they would be able to work in their destination country as medical practitioners in their chosen specialty. To leave your home country and loved ones, to find you have to retrain in a new system and to start anew after already being deemed "competent" elsewhere, is a serious commitment. Years of having to constantly adapt to new sets of rules without seemingly ever reaching your goal presents huge personal burdens, and the waste of professional skills and lost aspirations is demoralizing.

Second, there are consequences for the hospitals and clinics which have trained IMGs prior to their migration, particularly those countries which are not resource-rich. As previously mentioned, discussion of the negative consequences of health care worker migration on these health care systems and social infrastructures more broadly is beyond the scope of this article, but it is certainly significant.

Third, it is important to consider the consequences of flexibility on how we understand medical competence. As Dr. Mladen Mück stated, what does it mean to say that a doctor is "OK to work here but not here"? The contingent nature of rightness has consequences on our perceptions of medical competence. Notions of rightness help to shape what kinds of medical practitioner is valued and where, and this has consequences on the kind of care which is provided and how that is perceived by health care recipients. What do our accreditation, registration and employment systems say about the kinds of health care practitioners that we value? By looking closely at the adjustments that skilled migrants make to standards, researchers can learn more about the details of locality which are taken for granted by those dwelling in familiar environments. Further consideration also needs to be given to "rightness" and the problematic assumption that cultural congruency between migrant physician and migrant patient leads to better health care delivery (Organisation for Economic Co-Operation and Development 2007: 199; Shuval & Bernstein 1997: 130).

Finally, there is the issue of societal trust in IMGs. In Australia, as elsewhere, there have been a number of incidents where societal trust in IMGs has been eroded due to malpractice (Wijesinha 2005). There is a need to regain and maintain trust in IMGs in order for the appropriate medical services to be provided. Like others (Blain *et al.* 2017), we believe that one solution to this problem will involve greater transparency of the registration process, so that IMGs are forewarned of the system they are entering and the employment procedures. The responsibility for this needs to be shared by migration agents, recruiters, governments, medical organizations and employers. We acknowledge that migrants will pursue any pathway potentially leading to employment with the hope that the difficulties faced by others will not happen to them. Nonetheless, we advocate for clarity in regards to the processes of employment so that migrants' expectations can be realistic and somewhat tempered.

Conclusion

Our focus on the employment pathways for IMGs in Australia has shown a highly contingent process, with serious consequences for the doctors negotiating these pathways. The ways in which individuals negotiate the dynamicism of standards has received little critical attention in the skilled migration literature; however, it is an area worthy of further examination. Professional mobility in medicine and other health-care professions will continue, requiring countries, organizations and workplaces to continually address issues of accreditation, registration and standardization. More research is required to examine how individuals negotiate these

standards in other health-care professions and skilled migrants, and whether flexibility is something to be celebrated or whether, in these cases, it is also accompanied with potentially damaging consequences. Tensions will always exist between flexibility and standards, and an examination of how this plays out in different settings will undoubtedly continue to be a fertile area of research.

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