The Implications of Being an International Medical Graduate (IMG) in Canadian Society: A Qualitative Study of Foreign-Trained Physicians' Resettlement, Sense of Identity and Health Status

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Submitted in partial fulfillment of the requirements for the degree Master of Arts in Applied Health Sciences

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Abstract

This qualitative research study used grounded theory methodology to explore the settlement experiences and changes in professional identity, self esteem and health status of foreign-trained physicians (FTPs) who resettled in Canada and were not able to practice their profession. Seventeen foreign-trained physicians completed a pre-survey and rated their health status, quality of life, self esteem and stress before and after coming to Canada. They also rated changes in their experiences of violence and trauma, inclusion and belonging, and racism and discrimination. Eight FTPs from the survey sample were interviewed in semi-structured qualitative interviews to explore their experiences with the loss of their professional medical identities and attempts to regain them during resettlement.

This study found that without their medical license and identity, this group of FTPs could not fully restore their professional, social, and economic status and this affected their self esteem and health status. The core theme of the loss of professional identity and attempts to regain it while being underemployed were connected with the multifaceted challenges of resettlement which created experiences of lowered self-esteem, and increased stress, anxiety and depression. They identified the re-licensing process (cost, time, energy, few residency positions, and low success rate) as the major barrier to a full and successful settlement and re-establishment of their identities.

Grounded research was used to develop General Resettlement Process Model and a Physician Re-licensing Model outlining the tasks and steps for the successful general resettlement of all newcomers to Canada with additional process steps to be accomplished by foreign-trained physicians. Maslow’s Theory of Needs was expanded to include the re-establishment of professional identity for this group to re-establish levels of safety, security, belonging, self-esteem and self-actualization.

Foreign-trained physicians had established prior professional medical identities, self-esteem, recognition, social status, purpose and meaning and bring needed human capital and skills to Canada. However, without identifying and addressing the barriers to their full inclusion in Canadian society, the health of this population may deteriorate and the health system of the host country may miss out on their needed contributions.
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I offer this Master Thesis to the young and optimistic pediatricians, public health physicians and general practice physicians who truly believe that they can add to positive changes in the world and decrease social disparities, wherever they have the opportunity to practice.

December, 2007
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Glossary of terms

There is a list of key terms, and working definitions related to this study. Definitions were drawn from the literature and relevant reports and sources.

Determinants of health

Mark Lalonde, Canadian Minister of Health in 1974, outlined four determinants of health for Canadians: human biology; the environment; lifestyle (behaviors and risk factors); and health care organization including alternative health care (Lalonde, 1974). More recently, psycho-social factors, such as gender and ethnicity have also been integrated in those determinants of health. The study of population health has developed a more extensive list of determinants of health that can include the following: income, employment and working conditions; education; the physical environment; housing; social support networks; biology and genetics; personal health practices and lifestyle behaviours; coping skills; healthy child development; and health services (WHO, 2003, Health Canada, 2004).

Ethnic identity

Ethnic identity is the set of values, goals, beliefs, and attitudes shared by individuals who are in the same group and that differentiate them from other social groups. In the final stage of accomplishment, ethnic identity is typified by one’s own ethnicity (Utsey, Chae, Brown & Kelly, 2002). Ethnic identity is a complex cluster of characteristics which identify individuals as belonging to a specific group. It involves self-identification as a group member, and the experience of shared feelings, thoughts, and practices within that group. Ethics, attitudes and manners influence the life of individuals, and their
interactions with other groups, to form an image and opinion from the whole society (Negy, Shreve, Jensen, & Uddin, 2003).

**Foreign-trained physician**

For the purposes of this study the term foreign-trained physicians (FTPs) will be used to refer those participants who participated in the study and who had received their training, medical licenses and certifications in other countries outside of Canada. In the literature and in the Ontario licensing process, they are also referred to as internationally-trained physicians or International Medical Graduates (IMG’s).

**Health**

Health is a multifaceted resource and state resulting from interrelations between the individual and the environment. The World Health Organization (WHO, 1998) has defined health in a wider socio-ecological sense. “Health is the ability to identify and realize aspirations, to satisfy needs, and to change or cope with the environment of living. Health is therefore a resource for everyday life, not the objective of living. Health is a positive concept, emphasizing social and personal resources, as well as physical capacities” (National Forum on Health in Canada, 1997). From this broad concept of health, the measures of health include the factors and the determinants which play a positive role in the experiences of life, and which their absence could interfere with an individual’s or group’s health status.

**Health promotion**

Health promotion is defined as “the process of enabling people to increase control over and to improve their health” (National Forum on Health, 1997). According to O’Donnell (2002) health promotion is the science and art of helping people change their
lifestyle to move toward a state of optimal health. It is the process of advocating health to enhance the probability that persons (individual, family, and community); private stakeholders (professional and business); and public agencies (federal, state, and local government) support positive health practices to become a societal norm.

Health status

Health status is a broad conceptual approach that has many dimensions including emotional, physical, psychological, spiritual, and social factors, and can be operationalized through one’s subjective assessment of overall health status (Haveman-Nies, de Groot, & Van Staven, 2003).

Human capital

Human capital refers to individual skills and abilities such as language skills, skills education, and the labor market experience of utilizing these talents. Many social and political factors impede the development of personal human capital assets and the use of professional skills, as well as the maximization of personal abilities which can contribute to a reduction in the overall social capital that is essential to a nation’s future (The State University of New York, 2004).

Immigration

See migration.

Identity theory

Identity theory has to do with how one identifies and views self. One’s identity is constructed by many elements and may include one’s social identity through association and belongingness to social groups. One’s identify may be made up of familial identity;
ethnic identity; cultural identity; age identity; professional identity; occupational identity; and institutional or organizational identity (Cote & Schwartz, 2002).

**Lifestyle**

Lifestyle “involves aspects of an individual’s behavior and surroundings that they control; although it takes into account that behavior is influenced by the social and physical environment. A healthy lifestyle incorporates elements of social responsibility, as well as individual responsibility, and can be defined as comprised of patterns of health-related behaviours, values, and attitudes adapted by groups of individuals in response to their social, cultural and economic environment” (Ministry of Health, 1987). Lifestyle behaviours include; dietary habits; the use of alcohol or drugs; physical activity; supporting an environment for maintaining and improving mental health; preventing injuries; preventing family violence; avoiding smoking; and maintaining healthy sexuality (Health Canada, 2004).

**Migration**

Migration is the movement of people from one area to another for varying periods of time (World Health Organization, 2003). Immigration is the process of coming to live in a country that is not your own. Emigration is the movement or departure from one country to live in another country.

**Newcomers**

Newcomers is a term used in the study to include all people who have left their own country and are resettling in Canada. The term newcomer includes all those who enter through immigration and sponsorship processes, and those who enter as refugees seeking asylum. Newcomer, as defined in this study refers to a person who has arrived in Canada
from another country and usually includes those who enter as refugees or immigrants within their first 10 years of settling in Canada.

**Professional identity**

Professional identity is made up of the acquired specific knowledge and skills required to claim the professional role, the social status associated with the identity, and the assimilation of those values, feelings and thoughts. This social learning process has been defined as professional socialization (McGowen & Hart, 1990). Professional identity is defined by one’s identification with a particular profession and its ethics, norms, standards, practices, training, education and body of knowledge; and the sense of security and belonging that is bestowed by such associations. It is a dynamic process and has to be frequently strengthened and renovated through “work practices and strategies of control, use of specific language and public representations of this image” (Shuval, 2000). According to this author, “The most urgent and profoundly felt need of an immigrant is to re-establish a meaningful sense of identity of which the professional component is the major element” (Shuval, 2000, p.192).

**Quality of life**

According to The National Forum on Health (1997) quality of life in the health sense, refers to the measurement of the health status of an individual and may include domains of health perceptions, functional status, cognitive function, pain, impairments or symptoms, and opportunity influenced by disease, injury, treatment, or policy.

The World Health Organization Group (1998) suggested that *quality of life* is an individual’s perception of their position in life that is measured in the context of the
culture and value system in which they live and in relation to their goals, expectations, standards, and concerns.

Refugees

Convention Refugees are “persons who flee because of fear of persecution based on race, religion, nationality, social group, political opinion or armed conflict, and lack a durable solution” (US Committee for Refugees, 2004). According to Citizenship and Immigration Canada (2007) a Convention Refugee is a person who is outside her or his home country or the country where he or she normally lives, and who cannot return because of a well-founded fear of persecution based on: race, religion, political opinion, nationality or membership in a particular social group, such as women or people of a particular sexual orientation. A person in need of protection is a person in Canada who is afraid to return to her or his home country or the country where the person normally lives, because of: a risk of torture; a risk to life; or a risk of cruel and unusual treatment and punishment. Internally displaced, or internal refugees share many characteristics with emigrating refugees, but are legally different because they remain inside their own country despite fleeing persecution (US Committee for Refugees, 2004).

Canada recognizes two types of refugees: resettled refugees who have been sponsored by the government of Canada or by a private group; and people who make their way to Canada and the situation they are fleeing and apply for asylum (Citizenship and immigration, Canada, 2003)
Resettlement

Resettlement is the process through which an immigrant or refugee takes up residence in a new country and finds housing, income, employment, education, health services, and support within a community and begins the process of building a new life.

Self-esteem

Self-esteem was defined by Osborne (1997) as a “relatively permanent positive or negative feeling about self that may become more or less positive or negative as individuals encounter and interpret their successes and failures in their daily lives” (in Winstock & Enosh, 2004, p. 5). Rosenberg (1995) defined self-image as “an attitude towards an object [the self], [that] includes facts, opinions and values with regard to the self, as well as favorable and unfavorable orientation towards the self.” This author did not distinguish between self-image and self-esteem, and used both terms in his work as meaning the same.

This study will use the definition: “self-esteem is a basic single characteristic represented by a qualitative, subjective judgment of the self, ranging from positive to negative, albeit slightly changing across different contexts” (Winstok & Enosh, 2004).

Self-reported health status

Self-reported health status is the perception of well-being by the individual (Shah, 1998). Miilunpalo et al (1997) defined health status as “the subjective health assessment which reflects a person’s integrated perception of health, including its biological, psychological and social dimensions, that is inaccessible to any external observer.”
**Sense of identity**

A sense of identity is the overall sense of self and may be influenced by age, ethnicity, occupation, profession, place, race, culture, social position and social context.

**Social capital**

Social capital refers to “the features of social organization such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit” (Putnam, 1995, p. 66).

**Social identity**

Social identity is understood as identity that is rooted in group interrelationships. Brewer (2001) described social identity as being person-based, relational and group-based. Individuals work hard to accomplish and to keep a positive social identity which increases their self-esteem and self verification. Helpful feedback between individuals of the same group and significant external groups often result in the development of a positive social identity (Brown, 2000).

Social identity is defined by Tajfel and Turner (1979) as formed in group interrelationships which have three central ideas: categorization, identification and comparison. In their view, people are categorized in order to identify the social environment; individuals are identified with groups that they recognize themselves to belong to; and people are compared to in a positive self conception which is a part of a standard psychological performance.

**Stress**

Stress refers to the psychological or physiological unbalance triggered by some change experience. Life events such as migration, unemployment, cultural impact,
identity loss and decreased self-esteem, often are related to depression and anxiety which expose individuals to negative health effects. Social support and personal coping style often influence the individual’s responses to distressing events (Shah, 1998).
CHAPTER 1.0 INTRODUCTION

All immigrant and refugee newcomers to Canada are challenged by the resettlement process and are engaged in establishing housing, income, employment, language proficiency, health services, and social and community networks in a new country. For foreign-trained physicians (FTPs), to successfully restore their professional status and identity after migrating to a new society is considered to be at the core of their settlement process (Bernstein, 2000). According to Bernstein (2000), the re-establishment of a physician’s professional identity not only provides income and employment, but also plays a fundamental role in the maintenance of self-esteem and self-identity. Not to be able to re-establish a physician’s professional identity as part of the resettlement process, therefore could potentially have detrimental effects on their sense of identity, health and self-esteem.

The professional identity of physicians is shaped not only by personal, societal and cultural forces, but also by the strict and hierarchical institutions of medical schools which socialize and encourage medical students to embrace and perpetuate firmly outlined identities (Kaiser, 2002). As a result, more than for other professional newcomer groups who are new to Canada, a physician’s professional status and work function are often more prominent in their social hierarchy, and this has a potential to reinforce their positive self identity, if it is available to them (Bernstein, 2000).

Identity development for the medical professional is further defined by the established societal norms and structures that determine who decides who is a professional and who is not. In a societal context, we observe, act and make sense of our actions, our achievements and who we are (Miller, 1998). Identity development is accomplished within the specific social, cultural and institutional contexts within which we live.
This study investigated the settlement experiences and health status of foreign-trained physicians who had immigrated to Canada, and who were presently not able to practice their profession. Resettling in a new country without being able to claim the prior attained professional identity and social status involves great change. Those experiences and the impact of those changes are worthy of investigation. According to the Association of International Physicians and Surgeons of Ontario (AIPSO, 2003), in 2002 there were 1067 foreign-trained physicians who were registered members living in Ontario still attempting to seek their license.

Canadian immigration procedures are used to screen out those who are sick or unfit for acceptance into Canada. Pre-characteristics of immigrants, such as their education, language proficiency and job skills often facilitate the immigration and resettlement process. Physicians who are accepted into Canada through the immigration process are pre-screened for basic health, education and English proficiency, but their prior medical certification to practice is not accepted. Physicians can also enter Canada through the process as refugees seeking asylum.

Foreign-trained physicians resettling in a new country are challenged, not only to survive and settle in the new environment, but also to cope within a new culture while trying to re-establish their professional credentials and identity and meet local requirements for licensing. The health of foreign-trained physicians is shaped by many factors including: living conditions and the environment; demographic and genetic characteristics; present and past experiences of stress; lifestyle; experiences of discrimination and violence; employment and income; and a multitude of other psycho-social-biological factors (Hyman, 2001). These factors all interact and have an effect on individuals, their families and their health in their
new life circumstances. Social determinants of health such as housing, education, relationships, employment, and income have been found to be associated with the overall health status of the individual (Statistics Canada, 2004). Socio-economic and socio-demographic differences often have an effect on self-reported physical and mental health (Hyman, 2001).

Losing the sense of identity attached to being a medical physician causes intense changes in the lives of foreign-trained physicians. Comparing their lives before they emigrated and were a licensed physician and after settling in the new country without being a physician could disclose new facts, relationships, and variations on their health related to those changes. The changes in professional identity and employment status and their resultant impact on other life changes, self-esteem and health status were of particular interest in this inquiry.

Migration and acculturation processes alone are often stressful. If they are also accompanied by insufficient social support, and the inability to be able to work or to re-establish a personal or professional sense of positive identity, an individual’s health status may be negatively affected. It has been found that the health status of the immigrant population deteriorates over the first five years post-entry to Canada. This trend has been referred to as the “immigrant health effect” (Hyman, 2001).

The health of newcomers has been studied primarily through the use of quantitative population health surveys. These surveys are generally cross-sectional and have not been used to study changes over time. They also have not yielded information about the factors or experiences that may be having an influence on their health. Hyman (2001) suggested that quantitative and qualitative methods used together may be a more appropriate approach for
data compilation to study the complexities and magnitude of health behaviors and dilemma in the newcomer population. To understand this phenomenon further, a mixed methodology of qualitative and quantitative research was indicated to explore the dynamics, experiences and variables at work in the resettlement period. There may be strong influences in operation or significant points of helpful intervention or support indicated in the resettlement process if we understand what factors and experiences may be operating within this phenomenon. Such research could also provide information related specifically to the health status of specific newcomer sub-populations. An understanding of their past lives and present lives, and their health behaviors and health influencers are essential. Such information may help to develop future strategies that could have a positive impact on foreign-trained physicians who bring such rich new potential contributions to Canada.

This study was framed within a grounded theory approach. The systematic, constant, and comparative data analysis of grounded theory was chosen for its potential to disclose new facts and new processes to potentially explore and explain what has been experienced, what has been observed, and what has occurred (Patton, 2002). The focus of the study was on a sample of newcomer foreign-trained physicians who presently were unable to practice medicine in Ontario, Canada and who desired to be able to practice in their profession.

Each year, the number of displaced persons worldwide increases, often due to wars and political changes. Harassment and violence have caused citizens from many countries to flee within their borders, or outside their nations as refugees to seek new lands where they can rebuild their lives. In addition, because of political instability, environmental catastrophes, genocide, and increased crime in countries where impoverishment has caused hopelessness and homelessness, citizens often leave their countries and emigrate to more
developed countries. In addition, many people migrate worldwide to seek new opportunities, to unite with families and to seek new experiences. Foreign-trained physicians come as refugees and immigrants to Canada and have a variety of reasons for leaving their countries.

Foreign-trained physicians, who migrate to Canada, not only share some common experiences related to the loss of professional status and employment, but each of them also carry their unique history of prior circumstances and culture to the new country. Milne (2003) described their experiences in this way:

There are as many stories as there are international medical graduates (IMGs). Dr. Luis Monterrosa, a pediatrician who fled Colombia with his family, is sweating night and day to become a doctor in Canada. He works nights at a factory in Guelph, Ontario, days as a medical research volunteer in Hamilton, and evenings at an intensive English course. Dr. Slobodan Lemez, a family physician who left Bosnia for Toronto with nothing but two suitcases, has passed all the Canadian medical exams but may never get his license. With four mouths to feed, he can’t take a year off from paid work to do residency training. Dr. Chafic Farhat, a well respected thoracic surgeon in Sao Paulo, Brazil, for 30 years, now runs a pizza restaurant in Fredericton, N.B. (p. 28).

Exploring the experiences of newcomer physicians, and attempting to understand the complexity of their lives are essential research endeavours to help explain how those factors effect health status and successful resettlement. Investigating how a sample of foreign-trained physicians self-report and interpret their own current health status, its modifications and outcomes in the course of the resettlement process in the new environment could help to identify the main health determinants that may have a significant impact on their lives. Refugee and immigrant re-settlement takes place through distinct processes and at particular moments in societal, institutional and individual lives.

Many citizens of the world have experienced the trauma of violence and war, poverty and social exclusion, and the lack of employment and educational opportunities before they emigrate. They could also have experienced a good life, and a high level of employment,
education, social connections, social status and overall health. They flee or migrate to another country to follow their dreams, in the hopes of survival, and to build a better life. Newcomers who have had success with education and employment in their countries of origin, and a decent relative standard of living there, often leave out of a desire for change, to seek an improved quality of life, to reunite with family or to flee persecution and political upheaval. Newcomers transplanted in a new country are challenged, not only to survive in the new environment, but also to cope with a new culture while trying to maintain their health and to making a living. However, the relationships between immigration to Canada, poverty and health have not been well established in the research.

The relationships between immigration, relocation, resettlement and health are unclear, when indirect social determinants of health such as income, housing and employment are included (Hyman, 2003). Hyman also indicated that further research is needed to clarify the relationship between social support and immigrant health status, as well as the apparent underutilization of foreign-trained professionals in health services.

Work satisfaction, mood, self-assessed health, and self-esteem were analyzed by Shuval (2000) at three stages after newcomer trained-physicians’ immigrated to Israel. The research indicated a relationship between a sense of identity, the profession, and the ability to be able to work in the medical career and profession:

The most urgent and profoundly felt need of an immigrant is to reestablish a meaningful sense of identity of which the professional component is a major element (Shuval, 2000, p. 192).

...success in resuming one’s former occupation after migrating to a new society is a key determinant of overall adjustment and well-being (Bernstein, 2002, p. 183).
1.1 Purpose statement and research questions

The purpose of this present study was to gain a deeper understanding of the resettlement processes and experiences of foreign-trained physicians in Canada, particularly the loss of professional identity and how these impact on their overall sense of identity, self-esteem and health status. This study examined the newcomer foreign-trained physician’s social, physical, and psychological experiences in the old and new environment, and the impact of the resettlement process on their sense of identity, self-esteem and health status. This study, besides researching and describing how these physicians experienced the resettlement process, examined the context of the participants’ lives prior to leaving their own country, reasons for emigrating, current experiences with the determinants of health, and their experiences with studying and re-licensing to restore their professional identity.

Through semi-structured qualitative interviews, and participant information surveys with foreign-trained physicians in Ontario, Canada this study explored the following research questions pertaining to foreign-trained physicians who cannot practice in Canada:

1. What impact does having to work outside of the medical profession have on the resettlement process, sense of identity and health status of foreign-trained physicians?

2. How important is professional identity in the overall sense of identity of foreign-trained physicians who presently cannot practice in Canada?

3. What other factors such as prior violence and trauma, the settlement process and stress had on their sense of identity and health status?

4. What are the main barriers, facilitating factors and supports that effect re-settlement health status and the re-establishment of professional identity?
Although this study was not primarily about the policies and processes related to newcomer professionals and foreign-trained physicians in Canada, the findings could contribute to the development of further research, improved services related to resettlement support, and improved processes for the re-establishment of foreign-trained physician licensing and professional status. The findings have relevance for improving the integration of such precious human capital and available talent and skills for the benefit of individuals and potentially to make more primary health care delivery resources available to Canadian communities. The overall community social capital could be increased positively with the civic participation and inclusion of newcomer physicians into Canadian society.
CHAPTER 2.0  LITERATURE REVIEW

The literature review was conducted to guide the research design, the choice of methodology and to identify the key areas of inquiry for this study. The experience of foreign-trained physicians and their loss of professional identity is an under examined area in the literature and the study of this experience has potential implications for the successful resettlement, re-licensing, self-esteem and health of this population.

A literature review of relevant research, statistics, government reports, and databases was conducted relevant to the study and is summarized in sections. Relevant theories and frameworks used in associated research were explored and summarized. The literature on newcomers to Canada yielded helpful statistics, studies and information related to newcomers in general and to foreign-trained physicians in particular regarding their health determinants, resettlement, employment, labour force participation, licensing and re-establishment of professional identities. Finally, a section of the literature review is dedicated to a review of methodologies and approaches used to date to study newcomers and FTPs. The literature review of research methods utilized in prior studies related to this inquiry had implications for the selection of research methodologies and data collection approaches relevant to this study. Mixed research methods and the use of triangulation in analysis from the examples of previous studies helped to strengthen this study, based on the assertion that every method has its limitations and several sources of information would be beneficial (Patton, 2002).
2.1 Theories and frameworks to guide the research

Several concepts and theoretical frameworks were reviewed for this study: identity theory; institutional theory; acculturation theory; Maslow's hierarchy of needs theory; social capital theory, and human capital theory. Many of these theories were found to have some relevance to aspects of foreign-trained physicians' lives that would be explored in this study. The concepts reviewed in the literature primarily had to do with the development of personal, professional, relational, group-based and institutional identity; the development of self-esteem, self-actualization and needs satisfaction; and the acculturation, integration and inclusion of social and human capital in a society.

*Identity theory* is a broad concept that has to do with how one identifies and views self. One's identity is constructed by many elements and may include one's social identity through association and belongingness to social groups. One's identity may be made up of familial identity; ethnic identity; cultural identity; age identity; professional identity; occupational identity; and institutional or organizational identity (Cote & Schwartz, 2002).

Cote's (1966) explanation of *identity capital theory* suggests that persons are motivated to empower and invest in their uniqueness based on the assumption that future dividends will be harvested as a result. In Western developed countries, individuals are stimulated to invest in and to widen their identity. Identity capital, in this instance is seen as the personal and suitable resources that individuals use to handle the challenges of living and to deal with the barriers of the modern world (Cote, 1966).

According to Brewer (2001), our social identity signifies the individual's true acceptance of the rules, hopes and models related to specific social roles to the point that
they become features of the individuals themselves. The individual identifies himself or herself into a distinct position relative to others and the wider social organization. He outlined 3 types of social identities; person-based social identities; relational social identities; and group-based social identities. *Person-based social identities* refer to the description of social identities established in the individual self concept. Those concepts are understood to be specifically influenced by the attachment to definite social groups in which socialization experiences are shared as the result of the former chosen membership. *Relational social identities* are defined as mutually supportive in the sense that the features and evident behaviors depend on other partners' attitudes in the relationship. *Relational social identities* refer to the influence on the self-concept of the social rules related to being engaged in specific interactive social roles and positions. Specific interpersonal relationships have an influence on how that role is accomplished. *Group-based social identities* refer to the insights and perspectives of self as a central or identical part of a larger group or social unit (Brewer, 2001).

Stets and Burke (2003) state that *identity theory* involves an individual having control of their behaviours in a manner that is consistent with their goal identity. This "goal state" or ideal state provides *identity standards* to strive toward. Individual identities interact with one another and the resources which maintain individuals are manipulated, transformed, and transferred to seek this ideal goal state (Burke, 2004). Burke’s *identity control theory* suggests that identities manage significance and resources by taking the perceptions of their identities in an event into a configuration with related levels of their established identity standard (Burke, 2004). The author states that identities work into the existing social framework, but the nature of the connections are still
unclear. He suggests further investigation is needed in the areas of identity standards; the relationships between the perceived inputs of identity; the significant values in the condition and the identity standard; and the condition that stimulate identity development.

According to Burke and Cast (2002):

Identity theory focuses on the degree to which individuals are able to achieve a match between an identity goal or 'ideal' (the identity standard) and perceptions of the environment or the 'actual' performance of the self ... a focus on the degree to which successes match pretensions. Therefore self-esteem can be thought of as a direct outcome of successful self-verification (p. 1044).

Burke and Cast (2002) stated that identity is a series of senses formed as the result of the interactions between feelings, perceptions and hopes of an individual in the social environment. The authors suggest that the verification of an identity creates a sense of expertise and merit, thus improving self-esteem. A lack of self-verification decreases self-esteem. Self-esteem which derived from this positive self-verification identity process acts to protect individuals against stress.

As such, self-esteem may work as a type of 'social lubricant' helping individuals deal with various stressors or 'bumps along the road' thereby allowing them to function meaningfully and effectively from day to day in the roles and social structures within which they exist. (Burke & Cast, 2002, p.1042).

Personal identification with other persons who present similarities has been found to contribute to the definition of self. Ethier and Deaux (1994) reviewed the theories related to social identity developed by Tajfel (1981) and Turner (1987), in which group interrelationships allows individuals to achieve positive effects on behavior such as inclusiveness, social influence, and uniqueness. Social identity is defined by Tajfel and Turner (1979) as group interrelationships which have three central ideas: categorization, identification and comparison. According to the Australian National University, School of Psychology, Faculty of Science (2006) people are categorized in order to identify their
social environment. Individuals are identified with groups that they recognize themselves to belong to.

_institutional theory_ and _organizational theory_ refer to the affiliation and inclusion people have with their institutions, especially educational, professional and employment institutions. Organizational culture, norms, structures, communications and practices help to socialize and to define the individuals who are associated with them. The medical institutions, hospitals, businesses and the actual work tasks and products of work become a part of an individual's sense of personal identity and guide the performance and behaviours of individuals and even of the society at large.

_Kaiser (2002)_ described the strength of affiliation cultivated in medical institutions for physicians through the norms, training, titles and hierarchical structures of the medical profession. _Bernstein (2000)_ wrote about the strength of this affiliation with the medical institutions and how important it was for physicians to reclaim this. _Kirpal (2004)_ examined the professional and work identities of nurses including the identification with work structures and environments and the development of internal and individual self-definitions. _Oleson (2001)_ examined aspects of professional identity theory and the lifelong learning, qualifying and socializing process in several professional and semi-professional fields including nursing, social work and engineering.

_Salaff and Greve (2003)_ applied the theories of human capital and institutional theory to explain why the job status of immigrants, for the most part declined after immigrating. Human capital models explain most career progress in China and in that country their career progress is based on skills, abilities, education and credentials. Human capital theories can help to identify the structural obstacles and barriers to success.
that are particular to those in controlled professions, especially for women in Canada. Structural facilitators or barriers explain why immigrants’ precedent professional paths are poorly recognized, or are often obstructed in the new environment. English proficiency often helps skilled immigrants to get good jobs. Otherwise, skilled immigrants are not recognized as competent professionals. Institutional theory helps to explain the evolution of professional careers and the strong bonds of affiliation of their members. Prior achievements in careers endorse specific competences, but those milestones are not broadly accepted when brought to a new country (Salaff & Greve, 2003).

Acculturation is a social process that occurs when newcomers come in contact with individuals of the host cultural society with different backgrounds and establish an active and prolonged relationship with each other. According to Berry (2005), a potential for conflict is established and both groups compromise to reach supportive effects to adjust themselves (Berry, 2005). Acculturation theory had its basis in anthropology and has being used in sociological analysis previously labeled as “integration theory” (Berry, 2001). Acculturation theory is the phenomena that results from the interaction between groups of individuals from diverse cultures. Cultural models of either or both groups change through continuous contact in this multifaceted social process (Rudmin, 2003). Acculturation as a multidimensional process described by Birman, Trickett and Vinokurov (2002) to include three diverse facets of acculturation experiences: language proficiency; behavioral involvement; and identification.

Newcomers bring with them unique former identities and cope with the new society to adapt those identities to the new influences based on social cognition which creates
new guidelines for their behavior and lifestyle. Immigrants have less political influence, and usually are often discriminated against by the prevailing group. Those attitudes by the host society can retract the acceptance of the new country and social identity, and as a consequence may interfere negatively in the acculturation of newcomers (Padilha & Perez, 2003).

*Maslow's needs theory* (1970) is established on a hierarchy of needs. According to this theoretical framework, human beings have different levels of needs which motivate them. The theory is built upon the belief that as lower needs are completed and gratified individuals move to satisfy higher level needs. Maslow believed that people lean toward growth, and love, and that violence happens when human needs are frustrated. Maslow also proposed that people are intrinsically trustworthy, self-protective and self-governing. Maslow's theory outlined five levels of needs: physiological needs (food); safety needs (security); love and belongingness need; esteem needs (self esteem and recognition from others); and the need for self actualization (the desire to maximize their potential in many aspects). Maslow's theory posits that if individuals do not have their needs fulfilled, they could have their health status negatively affected. His theory of motivation is based on the hierarchy of needs, whereby a self-actualizing healthy personality emerges when need is satisfied.
Several writers have critiqued and developed Maslow's theory further. Sirgy (1986) developed a quality-of-life theory based on the progressive satisfaction of needs theory as proposed by Maslow. Heylighten (1992) critiqued Maslow's theory and suggested that it did not offer a fully developed description of self-actualization. He stated that “self-actualization signifies that these potentialities of the self are made actual, are actualized in a continuous process of unfolding” (p.41). Heylighten provided a reconstruction of the theory to include a cognitive-systemic framework that further developed self-actualization competence and resourcefulness. Heylighten states, “Self-actualization is redefined as the perceived competence to satisfy these basic needs in due time” (p.41).

*Social capital theory* relates to the trust and relationships among individuals and the social links of reciprocity, participation, and networking that develop from this (Putnam, 2000). Social capital refers to that civic virtue, and the resultant community engagement that is most influential when mutual social networks are built with shared values and
behaviors. “A society of many virtuous but isolated individuals is not necessarily rich in social capital” (Putnam, 2000, p. 19). Social capital, according to the World Bank (2004) includes the social and political environments which shape the social framework and allow the development of a specific society. This definition includes the most complex social organizations as part of the social capital of a society such as government agencies, educational institutions, political administration, civil and political freedoms, and the court system. Social capital also is described as the bridges needed to link the diverse social sets related to religion, ethnicity, gender, socio-economic status, and professional identity, into a sense of community belonging (Putman, 2000).

Social capital recognizes the capacity that groups have to truly operate in their collective interest. Social capital therefore, is a property and asset of human societies. “Social capital is not just the sum of institutions which underpin a society- it is the glue that holds all together” (Putnam, 2000, p. 288). Social capital is measured by the levels of trust, belonging, networking, civil participation, reciprocity, and effective action in a community (World Bank, 2006, p.1).

The social capital literature (Putnam, 2000) identified how social capital is a factor for citizens to be able to solve common problems together and to try to benefit all members through the sharing of civic responsibilities. Social capital is the networking mechanism by which society develops smoothly, with inclusive beneficial behaviours, compliance, and participation to that builds collective worth and reduces costs.

The networks that constitute social capital also serve as conduits for the flow of helpful information that facilitates achieving our goals ...Social capital also operates through psychological and biological processes to improve individual's lives. Mounting evidence suggests that people whose lives are rich in social capital cope better with traumas and fight illness more effectively....Community connectedness is not just about warm fuzzy tales of civic triumph. In measurable
and well-documented ways, social capital makes an enormous difference to our lives (Putnam, 2000, p. 288).

Social capital has been seen as a resource and a determinant of health, and its connection to health was discussed by Kemenade (2002). This author identified socio-economic inequality as an indirect and direct health determinant affecting mortality. The frustration and feelings regarding the perception of a low standard of one's own social condition was discussed in a Health Canada report (1999).

Social cohesion is an aspect of social capital and can be a health resource that allows individuals to enlarge their shared values, decreasing the differences in wealth and income in the same social group (Kemenade, 2002). Membership in professional organizations, such as the American Medical Association was identified by Putnam (1995, in Kemenade, 2002) as an indicator of health. According to Liang (1994) in a study of 6 immigrant groups in the United States, social contact and social capital are important in the process of naturalization.

*Human capital theory* involves the skills, knowledge, talents, expertise and abilities that each person possesses and how these talents are collectively acknowledged and included in a society. Human capital concepts suggest a relationship between education and employment and that this knowledge could be conducive to planning for the financial advantages of individuals and societies. Human capital theory is often attached to the study of market trends and opportunities and this makes it difficult to fully address any underemployment or unemployment dilemma as a result.

The current employment situation entails an enormous waste of resources and an unacceptable level of human suffering. It has led to growing social exclusion, rising inequality between and within nations, and a host of social ills. It is thus both morally unacceptable and economically irrational. (Michael Hansenne, Director-General, International Labor Office, 1995, p. 93).
Human capital theory assumes that, if skilled workers do not get good jobs, it is often a consequence of the employer's lack of information about what skills and abilities immigrants bring. Institutions need to recognize and decrease the barriers that obstruct the inclusion of the human capital of newcomers and increase the overall social capital available to the society. The study concluded that institutional theory is more broadly pertinent than human capital theory to explain the damage related to loss of job status in the samples examined. The findings concluded that former physicians had the most trouble of all groups to find high status and income jobs in Canada (Salaff & Greve, 2003).

Salaff and Greve (2003) examined social capital, human capital, institutional theories and strategies that could assist skilled, recently immigrated Chinese professionals to transition into jobs and careers in Toronto, Canada. Those in the research sample experienced unemployment and an accompanying decline in status and earnings compared to their previous careers before immigration. Men and women could not easily transfer their credentials between the Chinese and the Canadian labor markets. Women fared the worst in the transference of credentials and getting work within areas of their educational expertise (Salaff & Greve, 2003).

2. 2 Foreign-trained physicians' professional identity and licensing

Immigrants to Canada generally have been found to be more educated than their Canadian-born counterparts because a majority of them enter Canada as skilled workers. In fact, the number of recent immigrants possessing university degrees (24% of the men and 19% of the women) has been found to be higher than Canadian-born residents (13% and 12% respectively) (Hyman, 2003). Most newcomers (70%) indicated that finding any
job was their first challenge, followed by having difficulties with the transferability of overseas qualifications and language obstacles (Statistics Canada, 2003). Foreign diplomas and educational certifications are often not recognized, nor are previous work experiences, even though those attainments helped to score points in the immigration process. Documents verifying experiences and credentials are often not available, or not easily understood or transferable. For skilled workers who are newcomers, loss of investments, reduction in income, inability to speak the host language, and experiences of racism and discrimination, have been reported as factors that add to the feelings of disappointment and stress which follow their relocation to Canada.

In Canada, few newcomer foreign-trained physicians actually ever get licensed to practice medicine in Canada (Taggart, 2003). Shuval (2000) concluded that the willpower to re-establish a professional identity is a major driving force among immigrant physicians. The author found that the structural elements protecting the interests of existing groups in the host society often trigger a vast array of psycho-social-biological and personal responses, along with the obvious socio-economic losses experienced by foreign-trained physicians and their families (Shuval, 2000).

Even though Canada had received 58,320 skilled workers with university degrees in 1998, of the total of 174,000 immigrants, the unemployment rate of newcomer professionals was found to be more than three times the Ontario provincial rate each year. Only 24% of skilled workers were employed in their chosen and trained profession (Calleja, 2000). The now-defunct Canadian Labour Force Development Board, a national advocacy group, stated that Canada would spend nearly 1 billion dollars to educate the newcomers who came in to the country between 1992 and 1997 (Calleja, 2000).
The immigrant population has been found to have lower income levels than the general Canadian population (Hyman, 2003). The associations between poverty and health have been well established (World Bank, 2004). Resettlement stress has been linked with the emergence of many diseases such as tuberculosis in the early years after arrival in Canada, mental health problems, hypertension, and diabetes (Hyman, 2003). Health risk behaviors such as smoking, obesity, and drinking have been indicated to negatively affect the newcomer population in Canada.

Professional identity in the medical profession was examined by Kaiser (2002). The author analyzed the impact of the cultural forces which strengthen the construct of a physician's identity. Medical schools are communities that encourage medical students to assume a strict and powerful identity that is highly associated with their profession. Although newcomers cannot practice in Canada and are not referred to as physicians, their medical professional identity is still strongly attached to their sense of self worth and personal and professional identity (Kaiser, 2002).

Professional identity was defined by Miller (1998) as a fluid identity process through which a group of specific stakeholders develop a common identity within a society. This identity has both internal characteristics such as self worth and self definition and external characteristics such as status, positions and recognition. According to this author, this professional identity changes and adapts to the society in the same way that societies adapt to new cultures and environments.

A study conducted by Bernstein (2000) on immigrant physicians in Israel concluded that the personal establishment of a positive professional identity is fundamental to a newcomer physician's psychosocial well-being, and the author states:
Studies of immigrants have consistently provided support for the theory of occupational status persistence, which hypothesizes that success in resuming one's former occupation after migrating to a new society is a key determinant of overall adjustment and well being. Occupational continuity is important, not only because it provides the immigrant with an income, but also because it also gives him or her an anchor to preserve his or her self-identity during a period of uprootedness, when there is a need to deal with a wide range of physical, social, and psychological stressors (Bernstein, 2000, p.184).

The Bernstein (2000) study concluded that immigrant physicians who were successful in getting their licenses and acquired jobs in their profession had higher scores in work satisfaction, mood, self assessed health, self-esteem, and general satisfaction with living in Israel. Addressing the needs of physicians right at the point of entry to the new country was found to result in most of the 333 immigrant physicians in the study to be employed after 3 years of resettling in Israel and to account for the personal well-being of the physicians to be reported as improving.

For International Medical Graduates (IMGs), to be successful, they are required not only to pass all the exams in effective French or English, but they also need a solid flow of money, infinite tolerance, and determination to surpass the barriers en route (Milne, 2003). They often have their needs and hopes frustrated when they try to restore their professional life. The IMG licensing process is a long, exhaustive, and expensive process which requires patience, persistence, and the dedication of a lot of time. The process of re-licensing, as it is presently established in Canada, may be a source of stress and act as a negative determinant of health (Statistics Canada, 2003).

Milne (2003) stated that dealing with a new language, and preparing for the licensing examinations is a huge challenge for IMGs. The examination includes both practical and clinical questions related to the new cultural context, and provides a difficult ladder to climb. Most IMGs have to work in unskilled jobs to survive, and to
provide for themselves and their families, leaving little time to dedicate to the intensive study required. Most of the newcomer physicians who cannot practice in Canada have to start from the first step on the ladder of the IMG licensing process. They need to study, take exams, seek residencies and approved clinical experiences, and they might never reach the top. They also often struggle to surpass other daily barriers of racism, isolation, discrimination, and depression that can be frequent experiences for immigrants and refugees. Foreign-trained physicians, while trying to meet their physiological needs, employment and housing needs are challenged even after they pass all the examinations to compete for a residency program spot to gain one of the few 200 positions offered by the Province of Ontario (Milne, 2003). It could take several years to be accepted into a residency

In the last three decades, Canada has offered alternatively a 15 point system for the immigration of foreign doctors that allows more possibilities to be accepted into the country. The IMG Routes to Licensure in Ontario (2006) outlines the process for foreign-trained physicians who would like to emigrate to Canada, and the process for those who are already living in Canada. Before this, little information, or inconsistent information was available.

The immigration history of IMG's to Canada and the history of the Canadian Health Care System and policies affect the present realities and the political implications of being a foreign-trained physician in Canada. Much of the historical information regarding physicians was reviewed by Burke (1996). After the Canadian government created a universal health insurance system in the 1960s, tension between the medical professionals, government, and politicians increased. Medical professionals and their professional bodies
repeatedly argued that the government interferes in their autonomy. There appears to be a steady pressure between the medical associations, the public, and government that continues into recent times (Burke, 1996). This tension has also impacted on changes related to the support for foreign-trained physicians and their licensing process in Canada.

Robert Evans in 1976 (in Grant & Oertel, 1997) reasoned that the health care system in Canada called for control increasing costs. He argued that the main difficulty was the excessive number of available physicians, which he suggested might expand service utilization, and therefore, might increase overall costs. This period resulted in the closing of three medical schools, and increased the number of intermediate level practitioners. Some Canadian physicians emigrated to the United States as a result. The powerful lobbying of physician associations created a stressful relationship between the government and Canadian physicians. This conflict also resulted in more difficulties in the process for International Medical Graduates (IMGs) to practice in Canada. Evans further stated: “restriction of immigrants is probably the only feasible second best approach.” After 20 years of a stable number of physicians, Canada is experiencing the possibility of a critical shortage of physicians, not only in rural areas but also in total number. This may be the result of the emigration of Canadian physicians to the United States (US), the aging and retirement of a large number of physicians, and the barriers in place that make it difficult for foreign-trained physicians to be able to be licensed in Canada in a reasonable timeframe. It is estimated that 10-11% of Canadian doctors emigrated to the US (Grant & Oertel, 1997).

The idea of importing International Medical Graduates (IMGs) as needed human capital because of the high costs of training Canadian medical practitioners and the
increased need for primary care physicians has often been poorly accepted. After the Hall Commission of 1964 predicted the physician shortage, the Canadian immigration point system designated 15 points for medical professionals entering Canada. In 1975, alterations in the “point system” for physician immigration consigned no points for medical professionals. The obstacles faced by IMG’s were compared to a defensive tax:

They tend to limit a country’s access to lower-cost supply, reduce domestic competition, raise the income of domestic suppliers, and impose higher costs on consumers. This welfare loss is accompanied by a substantial income transfer from the public to private practitioners in the form of subsidies to medical education (Grant & Oertel, 1997, p. 164).

Grant and Oertel (1997) concluded that the loss in economic welfare to Canada because of these obstacles was substantial enough to deserve an investigation of the barriers and official recognition processes.

The acceptance of IMG credentialing in Canada is controlled by federal policy resolutions and provincial licensing processes. Canadian health planners have often put forth the idea that IMGs could adequately fill Canadian healthcare needs. Currently, the necessity of the IMG’s to be able to practice tends to be as strong again as it was in 1969 when the IMGs made up 24% of the total physicians in Canada. However, the present supports and processes do not facilitate the inclusion of similar numbers.

The IMG Ontario process to license foreign-trained physicians in Canada starts with writing the Medical Council of Canada Evaluating Examination (MCCEE). After successfully passing the MCCEE, the applicant has to write the Medical Council of Canada Qualifying Exam (MCCQE) parts I and II (IMG Routes to Licensure in Ontario (2006). Each exam costs approximately $1,000 to write, and the residency program is largely unpaid by government support and subsidies. IMGs are able to make a request for
a residency only in the second round of matching. Generally, 96% of Canadian applicants and 70% of IMGs pass the MCCEE the first time.

In 1994, Canada established the Canadian Resident and Matching Service (CaRMS) which allowed residents to match with existing resident programs. The intake for residency spots occurs at two times a year. After these basic steps, each province has its own regulations for re-licensing. In the Eastern provinces, the physician assessment program includes multiple choice questions, short-answer case-based therapeutics exams, structured oral exams, standardized patient exams, and psychological evaluations in order to approve the applicant to be able to practice. In Ontario, the Eight-Point-Plan offers 60 new advanced-level postgraduate positions and 25 entry-level positions to IMGs through the Canadian Resident and Matching Service (CaRMS) which according Milne (2003) is a time-consuming process. The Eight-Point-Plan is intended to be a fast track model to license physicians who are practicing outside Ontario, and who are motivated to work in under-serviced areas. According to Milne,(2003) it serves to reduce the IMGs' possibilities to be considered for those underserved areas.

According to the Ontario Information Resource for International Medical Graduates there are approximately 3,000 IMGs in Ontario (AIPSO, 2004). The limited spots for their inclusion in residency programs are a critical additional barrier to licensing. Not all IMGs are registered as members of AIPSO. In 2004, Ontario offered 200 training and assessment opportunities available to IMGs a year (AIPSO, 2004). Many of them do not sustain the support, hope, study time, and finances for exam levels. Even after IMGs complete all the requirements for eligibility and licensing, many do not get residency
training positions, and therefore do not truly re-establish their medical careers (Milne, 2003).

In 2003, 12 family medicine residency spots in Ontario were unfilled after the second iteration of the CaRMS, and IMGs were deemed not eligible to apply for them (Taggart, 2003). At present, it is estimated that Ontario is short about 1,000 physicians (Calleja, 2000). This shortage occurs while potential physicians are engaged in unrelated work:

Stories of physicians' talents going to waste are poignant in a country desperate for doctors. 'We're way short of physicians, says Dr. Rod Crutcher, co-chair of the Canadian taskforce on International Medical Graduate Licensure. 'Even if we're not, there's the social justice argument that it doesn't make sense to have so many people working below their skill levels' (Milne, 2003, p.2)

According to John Connors, an international health-care consultant in Stoney Creek, Ontario when referring to FTPs: “Currently, we are wasting these untapped resources,” and “At the same time we are showing them very little respect, care and concern” (in Milne, 2003, p. 3).

Table 1. AIPSO (2002) IMG membership statistics according to years of experience as a physician

<table>
<thead>
<tr>
<th>Years of experience as a physician</th>
<th>AIPSO memberships (1067)</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>More than 15</td>
<td>156</td>
<td>18.0</td>
</tr>
<tr>
<td>11 to 15</td>
<td>162</td>
<td>18.7</td>
</tr>
<tr>
<td>6 to 10</td>
<td>218</td>
<td>25.2</td>
</tr>
<tr>
<td>1 to 5</td>
<td>329</td>
<td>38.0</td>
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<tr>
<td>Info. Not available</td>
<td>202</td>
<td></td>
</tr>
</tbody>
</table>

In December, 1999, the Association of International Physicians and Surgeons of Ontario (AIPSO) participated in the review of the Regulated Health Professions Act of Ontario in the Romanow Report. The Act of Ontario stated that the requirements for
International Medical Graduates (IMG) are the same as the College of Family Physicians of Ontario (CFPO) and the Royal College of Physicians and Surgeons of Ontario (RCPSO) except for the Medical Council of Canada Evaluating Exam (MCCEE). The AIPSO argued that the criteria that have been utilized in the evaluating professional expert process were biased. They proposed that Canadian medical graduates and international medical graduates should not essentially have to follow the same steps into the licensing process because the IMGs, not only have already previously practiced the professional period required but also some of them in fact had already experienced clinical practice more years than the required period in Canada. They suggested that those who were licensed by overseas medical schools controlled by the World Health Organization, had the previous requirements to start the licensing process in Canada.

All international physicians and surgeons should not be required to begin their integration into the health care system at the same point as new Canadian graduates. Developing methods that are comparable to the peer assessments and quality assurance programs of licensed physicians in Ontario is a more equitable approach (AIPSO, 1999, pp. 1-4).

Besides the differences in the licensing process between Canadian physicians and IMGs, Kaiser (2002) stated that successfully licensed IMGs are offered positions that are in most cases of low status and generally those rejected by most Canadian physicians. They often are required to practice initially in isolated and under-serviced areas in the Canadian North, with little available collegial mentoring and support.

Mautino (2002) reviewed the difficulties faced by foreign physicians who hope to practice patient care in the United States. They differentiated between two groups of foreign physicians: those educated in the U.S. and those educated abroad. Those who were educated overseas must also pass exams that consist of several parts, besides English proficiency. Mautino (2002) highlighted the importance of investigating fully the
immigration regulations as well as any recurrent host country changes before physicians immigrate to the U.S.

Grant (1997) examined the current reform of the Canadian health care system and analyzed the trends in the delivery of care, income, and migration of Canadian physicians over the past 25 years. Their rate of physician emigration increased over the year and immigration of foreign-trained physicians was seen as a way to attend to the needs of health care service delivery in Canada. Such a plan was seen as a way to address the reported critical shortage of physicians in Canada, and to deliver culturally sensitive care to an increasing multicultural society. Without identifying and addressing the barriers to their licensing, such a solution may never materialize and the health of this population may also deteriorate and the health system at large may be negatively impacted.

In 1994, a study conducted by Shuval (2000) documented the experiences of foreign-trained physicians entering Israel, the United States and Canada. Israel had one of the highest proportion of employed physicians in ratio to their population in the world (290/100,000), and one of the fastest processes and support systems in place to assist physicians to re-establish their professional identity in that country. The Law of Return in Israel admitted all Jewish immigrants, and it did not stipulate any other requirements for entrance and for citizenship. The Israeli government believed that open Jewish immigration is a responsible way to restore professional identity, self esteem, sense of safety and belongingness, and human capital to build positively the social environment which contributes to social capital (Shuval, 2000). That policy is configured to supply retraining and employment to newcomer trained physicians, and to re-institute them in their previous careers as soon as possible, and if is not viable, that newcomer trained
physicians are employed, provisory or definitely. In this way, the immigration process promotes the whole society through economic development, and the timely inclusion of the talents and skills of immigrants.

Immigrant physicians from the former Soviet Union who migrated to Israel were offered Hebrew language course, a two month medical vocabulary course, and a five month preparing for the licensing process at no costs. In this period of preparation, immigrant physicians were supplied with a cost-of-living income. The Russian language could be used to take the examinations. In addition, immigrant physicians with more than 14 years of clinical practicing experience were exempt from the basic licensing exams. They were allowed to work in a hospital for 6 months under the supervision of a veteran staff physician, and after this time period, and an oral exam, they were often licensed to practice medicine (Shuval, 2000).

In contrast, foreign-trained physicians take more years trying to get the medical license in Canada than in other countries and had a lower ratio (220/100,000). Shuval (2000), compared physicians from the former Soviet Union who migrated to Israel, the US, and Canada, and concluded that, after acquiring the license for general practice, newcomers physicians must follow the same path for local medical school graduates but get different support and different rates of success in each country.

The difference in the host societies' orientation to immigrant physicians is reflected in the different rates of entry into profession. After 2.5 years in Israel, approximately two-thirds of the immigrant physicians who sought licensure were working in their profession. This picture contrasts with that found in Canada and the United States, where during the same time period, very few managed to complete the licensing procedures (Shuval, 2000, p. 196).
2.3 Newcomers’ employment and labor force participation

In a study by Statistics Canada (2003), newcomers to Canada were interviewed between October 2000 and September 2001. Some of the immigrants had been engaged in the health occupations before arriving in Canada (3.5% of the men and 10% of the women respectively). However, after six months only 1.8% of the men and 4.2% of the women actually ended up with employment in health occupations (Statistics Canada, 2003). In this case, no reference was made to whether they were engaged in the same job function as before, or not. In this group of health professionals, newcomer physicians were found to be engaged in work unrelated to their skills, abilities and education in order to economically survive in Canada. Many were still engaged in the long process of attempting to reinstate themselves professionally in the new culture. The Canadian Business, Toronto, June 26, 2000 reported:

Tap any cabbie on the shoulder and you're bound to find a neurosurgeon or nuclear engineer. Even wonder why? Most...had no idea before they applied to immigrate what they would face in Canada. Some can't produce the necessary transcripts and documents required by regulatory bodies ... or the thousands of dollars for assessments, as well as national and provincial exams (Calleja, 2000, p.2).

Frennette and Morissiette (2003) examined the Canadian Census data from 1980-2000 to clarify what results would be required for recent immigrants to attain earnings similar to Canadian-born workers. The findings showed that recent immigrant cohorts had higher prior wages and this partly accounted for the sharp decline in their earnings after arriving in Canada. This study concluded that recent immigrants would have to go through a radical steepening of their comparative wage earnings in the near future in order for their earnings to be on a relative par with their Canadian-born counterparts.
According to Shuval (2000), work satisfaction, mood, self-assessed health, and self-esteem were important to newcomer trained physicians who immigrated to Israel. Their findings indicated there was a relationship between a sense of identity, the profession, and the ability to be able to work in the career and profession. The author concluded that employment in their former profession has a positive effect on self esteem and health.

The inability to work in their former profession leaves newcomer physician to experience underemployment with low pay, or unemployment and impoverishment. Gross, Schultink and Sastroamidjojo (1996), cited The World Bank, World Development Report (1990) where they defined poverty as the failure to achieve the minimum standard of living. Standard of living according to this report includes food, drinking water, housing, access to educational and health facilities, and adequate social and cultural acceptance of individuals and groups in a society.

Liu (1997), analyzed the effect of the policy regarding mainland Chinese immigration to Canada, and concluded that Canada benefited from the policy, in that it gained human capital from their contribution. Romaliu and Thurston (2003) described community involvement and its capacity to build bridges between newcomers and their new community. In Canada, training programs were established to help volunteers to involve members of the community and government agencies with this population, and thus to enable better service delivery to the refugee community.

Participation in employment for newcomers to Canada can also be influenced by prior cultural norms and gender practices regarding employment. Clark, Ramsbey and Adler (1991) analyzed the influence of culture on women's participation in the labor force. Latin American and Islamic cultures were found to exclude women from
recognized access into their paid work force. Newcomers bring with them their prior beliefs, experiences and behaviors and these can affect re-settlement and employment in the Canadian context, especially for women.

All declare that quality of life, rather than the lure of financial success, serves as their major incentive to immigrate to Canada. Moreover, the fact that they enter a society that officially proclaims its multicultural character offers them the opportunity to become Canadian but to retain their ethnicity (Marger, 2001, p. 170).

Zhang (2003) explored the earnings of immigrants from viewpoint of the accumulation of overall wealth. The author concluded that recent immigrants have lower wealth than similar Canadian-born counterparts, while immigrants who arrived in Canada before 1976 had higher wealth. Zhang also argued that immigrant families can catch up with, or surpass Canadian born families in wealth accumulation after many years of residency. This study also found that between 1986-1999 immigrant families had lower wealth than their Canadian counterparts. There is still no explanation if this was because of limited earnings, or simply an effect of not having enough residency time in Canada to accumulate wealth. At the base of wealth distribution, immigrants had lower wealth than Canadian born families. However, there was no information offered related to the age of the chief income earner, constant income characteristics, or the number of family members to explain the substantial wealth break. There is some suggestion that lower-wealth families may accumulate wealth differently than their Canadian counterparts.

2.4 Newcomers’ general health, mental health and stress

The World Health Organization has defined health as “a complete state of physical, mental, social, and emotional well being” (p. 1). This definition was expanded in The Northwest Territories (NWT) Health Status Report (2005) whereby “health is also a
resource for allowing individuals to achieve well being and contribute optimally to the life of their family, community, and society” (p. 1). O’Donnell (2001) defined optimal health as “a balance of physical, emotional, social, spiritual, and intellectual health” (p. xi).

The health status of a population is established not only by health indicators such as mortality rates, injury rates, years of life lost, and life expectancy, but also by social health determinants that include socio-economic status, employment, income, education, personal lifestyle health behaviours, and other social determinants of health. Personal health status refers to the specific state of wellbeing at a moment of time. The health status of an individual is generally estimated through subjective measures such as self-reported health, in which the individual states how he/she feels when compared to counterparts; or through objective measures such as the existence of identified disease (NWR health status report, 1999).

According to Haveman-Nies, de Groot and van Staveren (2003), health status is a broad conceptual approach that has many dimensions including emotional, physical, psychological, spiritual, and social factors. They suggest that an individual’s health status can be determined through subjective assessments of overall health status.

Stress refers to the psychological or physiologic unbalance triggered by some experience (Shah, 1998). Life events such as migration, unemployment, cultural changes, loss of professional identity and decreased self-esteem can be associated with stress, depression and anxiety which expose individuals to potential other negative health effects.
Davis (1999) and Wilton, (2003), in their studies on mental health and poverty, related that individuals who received social assistance benefits and income support, experience poverty and social exclusion. The authors pointed out that pre-immigration stress and trauma can have a direct influence in mental and physical health status immediately after arrival.

Kliwer and Jones (1998) analyzed changes in health status among several immigrant sub-groups. The authors found that higher ratings of health status were associated with: English-language fluency, being employed, using one's qualification at work, and being satisfied with job and life in Australia. According to Hyman (2001) immigrants with Humanitarian Visas had the poorest health, while those with a Business Skills or Employer Nominated Visas were found to be the healthiest. Immigrants have been found to be are from different groups such as voluntary immigrants or refugees and that they emigrate in different stages of their lives. Fowler (1998) stated that factors such as age, social isolation, language barriers, separation from family, changes in family roles and norms, lack of information about offered resources, and unemployment are of supreme significance as social determinants of health. Cross-cultural differences in information seeking patterns, communication styles, perceptions of health risks, and ideas about the prevention of disease were also found to have an impact on immigrant health (Hyman, 2001).

Skilled workers, business immigrants, and family sponsored immigrants who applied for legal immigrant status accounted for 229,091 newcomers in Canada (Citizenship and Immigration Canada, 2002). The largest immigrant and refugee populations are often geographically centered in metropolitan areas, with an estimated 74
percent located in the major cities such as Toronto, Montreal, and Vancouver (Citizenship and Immigration Canada, 2002).

Knowledge about the pre-immigration lifestyle; social and cultural backgrounds; factors that induced migration; the experience of trauma, war, violence and stress are essential to understanding the dynamic process of the newcomer's resettlement experiences and challenges. These experiences may continue to have a powerful effect on resettlement and health status.

Stress that occurs as a result of persistent experienced racism and discrimination has been found to be associated with hypertension, and cardiovascular disease (Utsey, Chae, Brown & Kelly, 2002). Chronic race-related stressors were found to be associated with negative psychological well-being, low levels of life satisfaction and low levels of self-esteem in immigrant populations.

Newcomer families facing impoverishment or living in poverty often present high levels of unemployment and overcrowding, and experience more social exclusion. For some of these families, experiences of racism, domestic violence, bullying, mental health difficulties, child abuse, alcohol and drug use, and rape are frequent. Social exclusion is often mixed with many other factors. The literature on social inclusion and exclusion that focuses on neighborhoods, often studied how factors such as housing, employment, economic development, racial integration, and community capacity can influence the life changes of families living in inhospitable environments. Educational and health care institutions can develop partnerships to coordinate services that reach out to families on the margins of society. Living in this complex new environment can allow further health
inequalities to develop. Gray (2003) highlighted the importance of developing culturally sensitive services which recognize and value diversity.

... a match of cultures between worker and service user was said to provide shared aims and goals, broke through language barriers for non-English speakers, and solidified established mutuality of feeling in so far as a shared culture of interpersonal relationships” (Gray, 2003, p. 366).

Gray (2003) stated that it was important to address the continued and inappropriate pathologizing of non-white cultures to avoid stigmatization; and to address the over-representation of ethnic minorities in health service. It was suggested that multicultural professional teams who are engaged in social change and improvement to the health care system address these issues in their activities and approaches.

Many pre-arrival conditions have been found to effect the resettlement and overall health status of newcomer refugees or immigrants to Canada (e.g. prior trauma, income, housing, employment, education, language fluency, marital status, parenting, family left behind, age, ethnic/cultural identity, sexuality, motivation to immigrate, previous health status, past illnesses and chronic conditions, drug use, religion, values hopes, beliefs, expectations and prior experiences with trauma, war, stress, violence, and rape (Barnes, 2001; Beiser & Hou, 2001; Danso, 2002; Dunn & Dyck, 2000; Goodkind & Foster-Fisherman, 2002; Kennedy; Kirmayer, 2002; Korac, 1996; Laliberte, Laplante & Piche, 2003; Mc Kelvey, R. S. & Strobel, R. (1997); Paunovic & Ost, 2002 Pedersen 2002; Romaliu & Thurston, 2003; Seymour & Hummel, 1999; Webb, J. A., Sideris, 2003; Ying, 2001.

Marger (2001) studied immigrant entrepreneurs and argued that this population only needs minimal help to be successful. Ethnic networks and family attachment generally were found to be critical factors that enabled most of business immigrants to
succeed and to operate immigrant owned businesses. Business immigrants often left successful jobs in their countries to supply their children with a more secure socio-economic environment, and focused on emigrating to countries that appeared to offer superior educational opportunities for their family. This study concluded that the basis of true social capital is not within the ethnic community alone, but comes from the broader society in general.

Many studies have been conducted related to stress, trauma, Post Traumatic Stress Disorder (PTSD), anxiety and depression in the refugee and immigrant population. Cultural differences have also been found to be related with differing stress scores. Fawzi, Pham, Lin, Nguyen, Ngo, Murphy and Molica (1997) studied Post Traumatic Stress Disorder (PTSD) and symptoms in Vietnamese refugees. This study provided evidence and support for the usefulness of the PTSD diagnosis among Vietnamese refugees. The traumatic events and trauma-related symptoms were studied using the Harvard Trauma Questionnaire. This article concluded that the PTSD stressor criterion had been found to be significant within this group of Vietnamese refugees. In conclusion, traumatic events were positively related with PTSD in this population.

Adler, (1995) analyzed the SUNDS (Sudden Unexpected Nocturnal Death Syndrome) among Hmong refugees in the US. This article gave an historical review of the displacement of Hmong people and discussed their traditional worldview, and their beliefs and practices.

Brune, Haasen, Krausz, Yagdiran, Bustos and Eisenman (2002), concluded that structured violence leads to a more severe course of PTSD. Traumatic experiences could lead individuals to deep anguish and depression, and potentially to suicidal behavior.
Ferrada-Noli, Asberg and Ormstad (1998), demonstrated that there was a positive involvement between the type of torture and the chosen suicidal plan, in individuals diagnosed with PTSD. Anger and panic attacks were found in Cambodian refugees with PTSD (Hinton, Hsia, Um, & Otto (2003). Within this group of refugees, culture-specific explanations of somatic feelings played a role in the rise of anxiety related to expecting the recurrence of the somatic symptoms of anger. Joffé, Brodaty, Luscombe, and Ehrlich (2003), explored holocaust survivors in an aging community sample, and concluded that the psychological effects of major traumatic experiences are severe and lasting. Lee, Lee, Chum, and Lee (2001), evaluated trauma experiences and levels of psychological distress among North Korean immigrants in China. High scores for PTSD, anxiety, and depression were found in this population. The authors found that all stages of the refugee's displacement had an unfavorable impact on their mental health and well being.

Hondious, Loes, Kleijn, and Ploeg (2000), analyzed the relationship between diverse types of violence, demographic and protection variables to the health complaints of Latin American and Middle Eastern refugees. Michultka, Blanckard, and Kalous (1998), studied the war experiences, demographic characteristics, and psychological performance of Central American refugees, with a focus on the diagnosis of PTSD. A high number of both war experiences and PTSD were found in this sample. This study showed that the war experiences can forecast the health prognosis of the involved population. The legalization process was found to be complicated and traumatic, and responsible for the higher severity of PTSD. Ommeren, Sharma, Sharma, Komproe, Cardena, and Jong (2002), found a strong connection between health status and PTSD, after adjusting for psychiatric co-morbidity such as anxiety and depression.
A crucial question for policy makers and others interested in the well being of refugees and asylum seekers is whether the high incidence of medical complaints among refugees is because of past experiences, or circumstances in the host country (Hondious et al, 2000, p. 631).

Palinkas (1995) suggested that the health care needs of refugees involve analyzing three features of refugee migration: where these individuals are coming from; where they are going to; and the displacement process. Effective health care initiatives and programs developed for the newcomer population can benefit from an understanding of: stress prior to migration, such as in the Nicaragua civil war; stress after migration as represented by the SUDS among Hmong refugees in the U.S.; and traumatic stress as represented by PTSD.

Hovey (1999), in his study of acculturative stress in Central American immigrants, examined the main psychosocial forecasts for this population. Detachment from the family in the country of origin, and other factors related with the new environment such as language barriers, discrimination, lack of needed social and financial resources, and feelings of not belonging in the new society were identified as acculturative stressors. Those factors play an important role in how the individual reacts to the new environment. This study examined the psychosocial predictors of social stress such as: family dysfunction, marriage, social support networks, church attendance, educational level, income, and expectations for the future.

It is important to note that each person who encounters difficulties during the acculturative process has a unique history that modulates and defines the parameters of his or her specific problem” (Hovey, 1999, p. 194).

Plante, Simicic, Andersen, and Manuel (2002), analyzed stress, coping, and health among Bosnian refugees in San Francisco Bay, and displaced Bosnian refugees in Tuzla, Bosnia. This paper verified that lower depression scores, easiness to move on in life, and
being familiar in a new environment were better forecasters of self-reported good health. Being young and single were also positively associated with overall health status. Porter and Haslam (2001), and Beiser and Hou (2001) analyzed the relationship between refugee forced displacement and their resultant mental health. They found that the environment, post flight experiences and coping stressors had an influence on the mental health of dislocated people. Kennedy, Seymour and Hummel (1999), and Goodkind and Foster-Fishman (2002) identified some barriers in the current programs for refugees, such as the difficulties with being able to participate in communities with unfamiliar cultures, languages and transportation challenges, and the lack of multi-culturally competent teams to assist them.

The newcomer groups that have been identified to be at the highest risk of developing mental disorders have been the victims of organized violence, male and female victims of rape, drug users, beaten women, unemployed and underemployed persons, seniors who do not speak English, and persons living in social and cultural isolation (Barnes, 2001). Multicultural aspects of each newcomer's group, linguistic challenges, and distrust with helping relationships often interfere with meeting the specific social needs of newcomers (Hyman, 2001). Through displacement and resettlement, newcomers are engaged in an intense life-rebuilding process, and this can have high mental health risks. Family and community support, personal strengths, and country welcome aid methods, can all assist to relieve the stressful experiences. Socio-demographic characteristics, personal and social resources, and experiences with exclusion, discrimination and racism can interfere in the health, coping and resettlement processes.
Pre-immigration stress and trauma can have a direct influence in mental and physical health status immediately after arrival. Social factors such as chronic unemployment can create anxiety, low self esteem, poverty, and depression in newcomers. Davis (1999) and Wilton, (2003), in their studies on mental health and poverty, related the experiences of poverty and social exclusion suffered by individuals who received social assistance benefits and income support. The lack of employment, housing and educational opportunities were common to those individuals. The authors concluded that people living in poverty have their personal conditions working directly against their participation in meaningful activities, and their ability to build and to sustain social relationships.

Generally, immigrants choose to relocate. Refugees are forced to migrate. Refugees may experience more stress pre-departure, during flight, and in the first country of asylum and this creates accumulated stressors which place them at special risk for social and mental health problems. In the resettlement country, refugees continue to face multiple stressors such as loss of family support, financial difficulties, and cultural and linguistic isolation.

The literature review related to physicians' health concluded that stress, depression, and anxiety rates are higher in physicians than in the general population (Burke, 1996; Mansky, 1999). Addictive disorders in physicians may be related to having increased access to drugs. Physicians were also found to search for routine medical care less often than others in the population (Mansky, 1999).

Once arriving in their new country, Hyman (2001) highlighted that the living conditions and the living environment of the newcomer often determined their health
status. Social stressors such as unemployment, underemployment, income, racism, isolation, housing, lack of health care, and the resultant experiences of poverty, marginalization, and class inequity could lead to illness.

The five year Bernstein and Shuval (1998) study of 333 immigrant physicians in Israel from the Soviet Union found that because of the income supports, education and language training put into place, most immigrant physicians were employed after 3 years of resettling in Israel, and their personal well-being was reported as improving. For others who are refused financial and educational supports or who face the permanent loss of professional status has been found to cause distress and potential suicide (Yediot Aharonot, November 29th, 1996, in Bernstein & Shuval, 1998).

Kokko and Pulkkinen (1998) related unemployment to the psychological distress caused by poor economic situations and poor self-esteem. This study defined psychological distress as psychological ill-health using The General Health Questionnaire; depressive symptoms using The General Behavior Inventory; and anxiety using The Karolinska Scales of Personality. This study related depressive symptoms to unemployment and poor self-esteem and suggested that individuals could react differently to unemployment phenomena: with distress or with depression.

2.5 Literature on research methods

A review of the literature on research methodology used in studies of newcomers and their health revealed that most of the studies used quantitative methods to gather information on the health, employment and resettlement experiences of immigrant and refugee newcomers to Canada. The National Population Health Surveys (2001; 2002) were the most common source of data. The Canadian Community Health Survey (CCHS,
2001; 2002) conducted over time has also included immigrants and newcomers in their longitudinal studies. Almost all of the studies on the immigrant population are cross-sectional, although some population health studies have had a longitudinal component. The Canadian Community Health Survey (CCHS, 2000/01) included a number of immigrants in the samples that allowed for the analysis of sub-groups. Statistics Canada has been used to study immigrant physical and mental health; health service use; and lifestyle health behaviors.

Ommeren, Sharma, Sharma, Kompoem Cardena and Jong (2002), and Joffe, Brodaty, Luscombe and Ehrlich (2003) examined Post Traumatic Stress Disorder (PTSD) and used an interview schedule with questions related to demographics; family and personal history of mental and physical health; and symptoms of anxiety and depression. This interview schedule also included a checklist of physical complaints. Hierarchical regression analyses were completed in the first study, and in 1995, SPSS software was utilized for data analysis.

Quantitative methodology has primarily been used to contribute to the investigation of general population and immigrant health behaviors. Researchers have recognized some limitations related to the use of the quantitative approach alone to understand the “immigrant health effect” whereby, immigrant health has been found to deteriorate over the first 5 years in Canada. These limitations might best be addressed by the use of qualitative methods to explore deeper experiences, perceptions and feelings related to: details, reasons, context of situations, and defining environments to help find out what variables are most relevant and play an important role in the health of newcomers throughout their settlement process.
Kopinak (1999) used the triangulation method to study refugee wellbeing, and concluded that data from qualitative and quantitative methods added together can best explore these phenomena. Data from a variety of methods were used to explain the multifaceted aspects of refugee experiences and wellbeing and included: an ethnographic interview, demographic questionnaires, health questionnaires, and observations.

Narrative research and the use of storytelling have a place in research related to refugees and immigrants. The use of the narrative is both a method of communication in qualitative interviews and a distinct research methodology and way of analysis (Casey, 1995; Connelly & Clandinin, 1990, Kvernbekk, 2003). As a method of communication, the narrative helps others to articulate their inner worlds to the outer world in order to make sense of their experience. Paley and Eva (2005) distinguished between narrative and story: “story is an interweaving of plot and character, whose organization is to elicit a certain emotional response from the reader or observer; narrative refers to the sequence of events and the (claimed) causal connections between them” (p. 83). Kirmayer, (2002) highlighted and compared the ethics of storytelling to the ethics of listening, and of witnessing and taking part in the formation of society through co-attendance with another.

Few existing research studies have used qualitative interviews with this population or sub-populations of refugees and immigrants to help explore the relationships between health, employment, self-esteem and professional identity. Fewer still, have used a mixed methodology.
The early signs of Alzheimer's disease tend to appear in the brain years before they manifest themselves.

In the early stages, memory lapses become more frequent, and people may have trouble with familiar tasks.

As the disease progresses, cognitive decline becomes more pronounced, affecting a person's ability to think, reason, and make decisions.

By the later stages, Alzheimer's can severely impact a person's ability to function independently, leading to the need for long-term care.

Early detection and intervention may help slow the progression of the disease, providing patients and families with more time to plan for the future.
CHAPTER 3.0 METHODOLOGY

3. 1. Introduction

The purpose of this study was to gain a deeper understanding of the resettlement processes and the experiences of foreign-trained physicians in Canada, particularly the loss of professional identity and how these impact on their overall sense of identity, self-esteem and health status.

A qualitative grounded theory method of inquiry was utilized to explore their experiences of resettlement, professional identity, and self-reported health status. Qualitative research was chosen as the method of inquiry because it was believed that it could provide a deeper understanding of the complexities involved in the temporary or permanent loss of professional identity by the participants including their resettlement experiences and health status. This method provided an opportunity to explore the feelings, experiences, perceptions and stories of the FTPs involved in the study. The qualitative perspective has proven to be valuable in other studies related to health and human behaviour through providing a deeper examination of the explanation of feelings, thoughts, and personal experiences (Patton, 2002). According to Kopinak (1999), this research approach documents and decodes in detail the histories of the participants through their account of their values, beliefs, feelings and meanings related to the phenomena being studied.

The key research questions of the study were:

1. What impact does having to work outside of the medical profession have on the resettlement process, sense of identity and health status of foreign-trained physicians?

2. How important is professional identity in the overall sense of identity of foreign-
trained physicians who presently cannot practice in Canada?

3. What other factors, such as prior violence and trauma, the settlement process and stress have on their sense of identity and health status?

4. What are the main barriers, facilitating factors and supports that effect re-settlement health status and the re-establishment of professional identity?

3.2 Qualitative research approach: grounded theory

Grounded theory was chosen as the research methodology. Grounded theory has often been applied in many studies related to health, as well as in traditional academic studies in the social sciences and education because of its significance in yielding information relevant to the area of inquiry and its appropriateness to generate theory (Patton, 2002). Grounded theory methodology was determined to be a relevant approach to explore the findings in this study in relation to examining the processes and experiences being investigated. It provides the capacity to utilize the new findings to create new theory or model processes, or to adapt and revise existing theories which come to light as a result of the close contacts, and relationships with the practical and real world as expressed by the participants engaged in the research (Patton, 2002). Grounded theory explores how people describe and identify their own truth, and how their convictions are linked with their performance in the real world. Reality therefore, is constructed through piecing together various meanings that are added from the specific social context and environment (Burnes & Grove, 1995).

The systematic, constant, and comparative data analysis involved in grounded theory can explain what has been observed and what has occurred, with the potential to disclose new facts. Grounded theory focuses on generating and verifying theories.
Theoretical sampling and critiquing occurs during all of the research process: collection of data, analysis, and verification. Theoretical sampling is generated on the basis of the emerging concepts.

The researcher in this study used the method chosen to look for emerging themes and categories drawn from the data collected from interviews, questionnaires, observations and researcher process notes, which helped to explain the behaviors and processes being studied. The researcher understood that people will differ in their understandings of the phenomenon under study, and consequently act and interact differently. The data collection was aimed at saturating the categories. As more data were collected, analytic memos were written down. Using grounded theory requires the researcher to move back as many times as necessary to determine and validate, and move forward between inductive and deductive thinking to analyze what has been shared (Patton, 2002). Qualitative analysis is typically inductive in the initial stage when the researcher discovers patterns, themes and categories. The final and conclusive stage of qualitative analysis is more deductive and includes the content of inductive analysis, by examining the data, and potentially generating hypotheses, processes or new theories.

Creswell (1998) stated that the results of a grounded theory study are the creation of a theory which presents the main elements of the findings: the key phenomenon, the causal circumstances, approaches, situations, environment, and results. The units of analysis and techniques of ground theory, when integrated in the research action, add rigor and reliability to the theory engendering process. Analytical deduction was one of the verifying processes used in this study (Patton, 2002).
Glaser and Strauss (1967) are credited with being the initiators of the grounded theory approach, and further adaptations to their approach have developed over time. Strauss and Corbin (1990) expanded the analytic techniques of grounded theory and provided more detailed guidelines for beginning researchers on how to conduct this method of inquiry. The goal of grounded theory is to investigate the fundamental social processes and to recognize the diversity of the interfaces that generate differences in the phenomena to be studied.

The participants were asked a series of semi-structured questions conducted in a face-to-face interview. In addition, prior to the interviews, participants were asked to fill out a survey with questions related to their demographics, health status, stress, and professional identity before emigration from their home and country, and after several stages of resettlement in Canada. The survey was used for three purposes: 1. as a tool to assist in the selection of the sample who was interviewed; 2. as a planning tool to prepare the researcher for the interview; and 3. as an additional source of data that was summarized and included in the findings.

3.3 Reflexivity in the research

The phenomena in the study were of extreme importance and sensitivity for the researcher who was also an international trained physician, living in Ontario and completing a Masters degree at Brock University. The researcher for personal reasons initially had attended meetings regarding the Canadian medical licensing process and had met with several of the newcomer physicians in Niagara. The researcher later decided to return to practice medicine in Brazil. However, the experience she brought to the research through her positional subjectivity and, having access and relationships with the subjects
were seen to be a potential strength for this research inquiry. This perspective was intended to allow the researcher to understand the sphere of this study in a more subjective manner, but it was understood that it was incumbent on the researcher to reflect on such self-knowledge and to sort out the intersections of researcher knowledge; the text of the subjects' experiences and feelings; and what could be drawn from the research (Patton, 2002).

Interviewing newcomer physicians was the method chosen to enable the researcher to engage in a rich and sequential description of facts, with an adequate use of direct quotes which allowed for the further exploration of meanings. Her subjectivity permitted and demanded self-questioning, and analytical understanding in an easier manner. The deconstruction process of critical reflective analysis used in the study has been referred to as reflexivity (Patton, 2002). “Reflexivity is a deconstructive exercise for locating the intersections of author, other, text, and world and for penetrating the representational exercise itself” (Macbeth, 2001, p. 35).

A reflexive research posture is broadly suggested for examining expert descriptions that might be relieved of the influences of gender, culture, coherence, and other convergences that the phenomenon has brought into sight. Reflexivity is one of the best methods to discover new supports for the analytic and representative exercise (Macbeth, 2001). This method allowed the author to disclose a new detailed world, where truths according to the participants had taken place for a period of time. Those disclosures have been found to allow for a continuous reflexive progress in which we learn how to verbalize, describe, interpret, and write all over again. The researcher was conscious and prepared to add her analytical and critical position to an examination of the
participants' views of their world, with watchfulness for what may be hidden, unreadable, and confidential, while being conscious of her own perspective of the world that was also understood to be socially, politically and culturally constructed. The researcher perceived, and understood the other's world as if she was seeing through the other's eyes but still with a clear and vivid image of her own world perceptions. Some of her points of view intercepted with some of the other's points of view. Some images converged, or not, depending on which prismatic angle from which she was observing the phenomenon, and which phenomenon she was observing. The researcher must be prepared to see different worlds through the experiences of the participants in the study; even if they were diametrically opposed to her own.

Reflexivity leads the analyst to take up the knots of place and biography and to deconstruct the dualities of power and anti-power, hegemony and resistance, and insider and outsider to reveal and describe how our representations of the world and those who live there are indeed positionally organized (Macbeth, 2001, p. 38).

The aim of the analytical process, through the process of using a self conscious engagement in the world, is to attend to the need for objectivity and neutral observation of the language used in various competing discourses. “Textual reflexivity leads the analyst to examine and then disrupt the very exercise of textual representation” (Macbeth, 2001, p. 35). In this way, the rigor in qualitative research is not just to attend to the technical part of the research design, but also in the analytic process of interpreting the results and the interviews.

The research process journal was used as an additional reflective and data verification source for analysis and reflexivity. Theoretical memos were written throughout the process as promoted by the grounded theory methodology. These journals
were used to shape a fundamental component of the grounded theory method, and to help examine the accompanying feelings, thoughts, doubts, and biases of the researcher. The exercise of reflexivity was accomplished and assisted by maintaining a research journal that included notes from the interview, observations during the interview, reflections on personal thoughts, feelings and experiences as a result of the interview; and notes to assist in later analysis. Beginning ideas for coding and themes emerged during the interview and data collection process.

3.4. Participant sample

Foreign-trained physicians were initially located through the Niagara AIPS0 group and other multicultural and Heritage Councils where they were meeting or engaged in English language training. Fifty-two (52) foreign-trained physicians were initially identified as registered with Niagara AIPS0 and potentially fitting the criteria of the study. Those who could be reached were invited to participate and who indicated an interest were sent the letter of consent (Appendix C) and the initial survey (Appendix D). The participant information from the surveys received was reviewed by the researcher. A maximum variation sampling approach was developed to select the interview sample, whereby the sample participants meeting the criteria and agreeing to participate in the research, would be chosen for interviews to vary in age, gender, country of origin, family/marital situations and length of time resettling in Canada.

In this study, the minimum criteria set forth for participants to be included were:

1. All participants were to be foreign-trained physicians who were not presently licensed to practice in Canada.

2. All participants were to have entered Canada in as an immigrant or as a refugee.
The text on this page is not legible.
3. All participants were to have been in Canada no more than 10 years to be considered a newcomer for this study.

4. All participants were to be engaged in the goal of acquiring their medical license to practice in Canada.

The method chosen to select the interview sample was intended to provide a richness of information, and to include as many views, experiences, and perceptions as possible in an attempt to provide a broad sample of the newcomer physician lives (Patton, 2000). It was expected that newcomer physicians who had gone through various stages of resettlement, acculturation, and engagement in the credentialing process would have accumulated new, varying and complex experiences. It was hoped that participants would also represent a good range of employment experiences since they have arrived in Canada. All participation was voluntary and participants were explained that they could discontinue involvement at any time. In the final selection of the sample, it was decided to include one female participant who had been in Canada for over 20 years, but who was actively engaged in being re-licensed at the present time for variation purposes.

The excellence of qualitative inquiry has been found to be related to the researcher’s performance and abilities in being able to listen, to observe and to analyze data (Patton, 2002). Redundancy and saturation are the primary criteria often used to end the sampling and interview process. The sampling and data collection processes are closed when no new information can be added, and a balanced treatment of the phenomena has been covered. According to Patton (2002), “The solution is judgment and negotiation. I recommend that qualitative sampling designs specify minimum sample based on expected reasonable coverage of the phenomena given the purpose of the study and stakeholder interests” (p. 247).
According to Leedy and Ormrod (2001), a qualitative interview sample size is suggested to include from 5 to 25 individuals, depending on the phenomena to be studied. It was decided to include a small group sample drawn primarily from members of the Association of International Physicians and Surgeons of Ontario (AIPS0).

3.5. Triangulation in the research

Triangulation is an approach to research analysis that supports the idea that no single method can understand or solve the problems inherent in controversial or complex inquiries and explanations. Each method used can disclose diverse realities and these are cross reviewed and cross analyzed to find meaning and to increase the validity of the results of qualitative research. Many measures can be used to ensure that the variance reflected is that of the trait being examined. Multiple methods were used in the data accumulation to supply more information to the study and to provide for further clarification and verification. Through these sources and possibilities, the researcher achieved more consistency in the study. Triangulation was used in various stages to gather, analyze and synthesize the data. In this way, it was intended that the researcher would be provided with varied ways to look at the same experience for increased credibility, and to give increased rigor to the study results (Patton, 2002). The researcher, by the triangulation process, was concerned with finding out the multiple viewpoints, rather than to search for only one reality.

A combination of interviews, process notes of observations and reflections, and survey questionnaires were used in this study. These methods, added to the previous and current close contacts that had already been made by the researcher with the FTP's through the meetings attended, positively placed the researcher in the new reality of the study and the data generated. Monthly meetings with the AIPS0 group and attendance at
weekly English classes at the Heritage Council and Multicultural Centre in Niagara allowed the researcher to be in touch with diverse ethnic groups, and to experience a variety of spoken English accents, and to become familiar with a few of the foreign-trained physician experiences.

3.6 Trustworthiness in the research

Trustworthiness is a concept that needs to be understood and addressed to strengthen qualitative research. Research studies are assessed in relation to the methods used to generate findings. Validity and reliability are proposed as having the same crucial meaning according to Graneheim and Lundman (2004). They suggest that trustworthiness can be understood as being comprised of several key elements: credibility, dependability and transferability. Each of the terms have been described by these authors and guided the research methodology in this study.

Credibility is used to insure internal validity, and refers to self-assurance in how the data and the process of analysis were conducted to get the results. Choosing a variety of participants with diverse experiences increases the possibility of reaching diverse aspects of the phenomenon to be studied and adds credibility to the research. The participant sampling technique outlined was chosen to increase the credibility of the study.

Credibility also deals with how the themes and categories absorb data and the technique used to insure that no significant data will be lost. Interviewees with a variety of ages, gender and multiple experiences enriched the variation of the phenomenon investigated, and increased the credibility of the research. The meaning units chosen were the most appropriate for the study, and it was demonstrated how they were reduced and
conceptualized. These procedures aided judgment and enforced credibility. Credibility also deals with how the comparisons are demonstrated within categories and among them. The recognition by the participants of the findings can improve the credibility and confirmability of the study and can be used as an analog to objectivity.

*Dependability* is similar to reliability and is related to how data changes over time, and how the researcher modifies his or her decisions during the analytical process to deal with any instability of the phenomenological factors. If the data collection process lasts too long, discrepancies in the data collected can take place. The data in this study was collected over a 1 month period in the same year and this minimized any discrepancies in the data and stories recounted because of time. Inquiry into the same areas for all participants increases the dependability of the results and this was attended to in this study. Data was analyzed over a year period of time.

*Transferability* (as similar to external validity) is the degree to which the findings can be transported to other situations and contexts. Comprehensible and clear reports of culture and circumstances; variety and characteristics of participants; data selections; and the analysis process used were intended to bring transferability to the highest level possible within the limits of the study. The findings followed the respective quotations and true input of those included in the study. The general and unique findings need to be reported and declared along with the limitations of the study methodology. These aspects of trustworthiness can be understood as linked and interrelated (Graneheim & Lundman, 2004).

*Patton* (2002) referred to trustworthiness is an equivalent term to “rigour”. Every attempt was made to attend to the highest level of scientific rigour possible in this study.
in the design, the methodology, sampling techniques, data collection methods, analysis of data, discussion and summary of findings. The researcher reinforced the reliability and authenticity of this study through understanding the world to be as a result of social, psychological, and political constructions, and clarified her understandings by adding new perspectives from others to her own perspective. The interview questions were piloted with the first two participants, their results included in the findings, and appropriate changes and adjustments were made to some of the questions and probes as a result of the pilot.

3.7 Research ethics

This study was reviewed and accepted by the Research Ethics Board of Brock University as REB 04-156 on January 10, 2005 (Appendix A). Participating physicians received an explanation of the nature and purpose of the study to be conducted in a general sense, and invited to voluntarily participate through an introductory recruitment letter (Appendix B). Each potential participant was sent a letter and asked if they were willing to receive a package describing the study, and an informed consent letter before proceeding with the research (Appendix C). This letter outlined the purpose of the study; who the principal investigator was; contact numbers; ways that confidentiality were protected; the voluntary nature of the participation; that the participation could be terminated at any time; and how the research findings would be communicated after the interview and findings were completed.

A designated and private office in the Nursing Department of Brock University and at two other professional community office locations were arranged to ensure the safety and confidentiality for the researcher and the participants. Any sharing of personal
history and pre and post feelings and experiences of resettlement had the potential for stressful material to be raised. It was planned that should information of a stressful or emotional nature come up in the interview, initial supportive listening and referral would be attended to by the researcher. In addition, a list of potential contact numbers was made available for follow up after the interview, if that was found to be helpful and needed.

Interviewees who participated in the study were given pseudonyms to represent them, when making references to information and in reporting the findings. The consent forms were separated from the surveys during the input of the data. The research survey participants were numbered between 1 to 17 for data input and analysis. This procedure was found to be highly beneficial in the maintenance of the anonymity of the participants in this study through the use of expressed quotes, and the reporting and summarizing of the demographic pieces of information in the final results of the research. The two first interviews were used to pilot the interview questions to ensure that the questions and probes were appropriate, that the sequence of questions was helpful, and that they yielded information relevant to the study. Any additional appropriate wording and questions that emerged were also explored in the pilot interviews. These interviews were also included in the study report.

3. 8 Data collection

This study explored the experiences and processes of migration and resettlement over time and the self-reported health status and changes in professional and personal identity for the participants. The relationship of the loss of professional employment and identity on health status was of particular interest. From those perspectives, the measures of health status were expected to be multi-faceted and the semi-structured interviews
were designed to explore experiences, thoughts and feelings related to resettlement; employment; re-licensing, personal and professional identity and health status.

Interviews were the major resource that this researcher used to develop the study and to find out from newcomer physicians things that she did not know, such as their settlement experiences, feelings, thoughts, and goals. The purpose of the interview was to go into the other person's perception, and to get information through their stories and personal narratives (Patton, 2002). The researcher made use of all efforts to obtain high quality information during the interviews.

Participant demographic information was collected before the interviews were conducted by means of a participant package that included: a Consent Letter (Appendix C); a Participant Information Survey (Appendix D); and a Self-Rating Health Survey (Appendix E). Participants were asked to fill out these surveys that included self ratings of health status; self-esteem; quality of life; and stress. They also rated their experiences with racism and discrimination; belonging and inclusion; and violence and trauma before coming to Canada, after 6 months in Canada and at the present time (Appendix E). Participants checked off their answer choices on a paper and pen survey and Likert scale choices as outlined in Section I of Appendix E. In Section II, participants were provided with a list of health conditions, diseases or problems and asked to identify if they had any of them before coming to Canada and if any of these developed since coming to Canada.

The interviewer reviewed the completed participant demographics and information survey responses before beginning the actual interviews. As a result, adjustments in the process were able to be made and appropriate probes developed for the interviews. The
responses to the surveys and the questions were summarized in chart and written form and included in the report of findings.

The qualitative interview questions and probes are in the Interview Guide in Appendix F. It is suggested that researchers usually spend 1 to 2 hours in each semi-structured interview with time for post-reflection, and two hours were set aside for this purpose. Several open-ended questions were developed for each major category of exploration (Leedy & Ormrod, 2001, p. 153). The Interview Guide (Appendix F) lists the questions and subject areas that were investigated in a systematic way. Semi-structured interview questions and several open-ended questions were developed for each category of research inquiry. Probes were developed and applied when needed to assist the interviewee to expand more fully on the area of inquiry. Probes, or follow up questions such as tell me more about and who, when, what, how, where were used to get a deeper understanding of the interviewee's experiences and life perspectives, especially those related to the areas of inquiry (Patton, 2002).

Through a guided and responsive interview style, the participants were given the chance to explain and to talk in their own words, and to express their own thoughts and ideas. The qualitative interviews sought to detail how the participants viewed their world, so that the researcher could learn further through their unique, narrative expressions and judgments (Patton, 2002). The qualitative interview questions also looked for experiences and behaviors at different times in the process: before coming to Canada, in the period of resettlement in Canada; and for the future especially in regards to: what their life is like; their profession identity and licensing; and their health and health status. Specific questions were designed to elicit responses of different nature:
• opinion and values nature questions (aspirations, beliefs);
• feeling nature questions (adjective answers such as anxious, happy, afraid, intimidated, confident)
• knowledge nature questions (rules, regulations, processes, programs);
• sensory nature questions (what is seen, touched, heard, tasted).

The questions were constructed to help participants to describe what they had seen, what they had experienced, and how they perceived to have understood the main questions (Patton, 2001). The interviews were recorded by audio-tape and transcribed with verbatim transcripts afterwards for analysis. The physicians in this sample were actively engaged in the licensing process and many were also engaged in English as a Second Language (ESL) classes. Physicians entering Canada, who intend to go through the licensing process are required to qualify with a score of 237 TOEFL on the written English test and to score 50 on the spoken English test. These groups of newcomers to Canada, even at their entrance point, are often above other newcomer refugees and immigrants in their understanding of English. Having a foundation in English helped the interview process and the participants' understanding of each question, so that interpreters were not required in the study. However, it was anticipated that foreign accents might be a challenge for transcription and understanding of the responses. The researcher prepared summary process notes after each interview that helped to check the text transcripts later. A transcriber was engaged who was a graduate in the languages program at Brock University who spoke 4 languages and was well versed with accents.

The steps outlined for the data collection process were:
1. Multiple strategies were used to recruit potential physicians to participate. There were
potentially 52 physicians in the Niagara AIPSO group to draw from.

2. The researcher attempted to contact all of the 52 FTPs on the Niagara AIPSO list by sending an e-mail, the introductory recruitment letter and they were invited to participate.

4. These strategies alone did not yield an acceptable number for the sample, the researcher made a presentation at one of the AIPSO monthly meetings, outlined the study and handed out the recruitment letter, consent form and surveys.

5. A few participants who indicated interest received an information package containing the consent letter, the participant information questionnaire, and the health survey.

6. The participants who agreed to participate, received a package, a follow up phone call or e-mail reminder to encourage their participation.

7. Once a participant was contacted for an interview and had agreed to participate, an interview date was booked.

8. The interview included a verbal re-explanation of the research and the conditions of voluntary consent.

9. A tape recorder was used to audio record each interview and the researcher made short summary notes during the interview.

10. Once the interview concluded, the researcher wrote additional points, reflections, and observations of the interview in process notes. She reviewed and organized the short notes completed during the interview.

11. The researcher notes and the audiotapes were given to the transcriber.

12. The researcher reviewed the transcriptions and clarified any misunderstood areas with the transcriber and the original interview tapes.
13. Follow up clarification contact by telephone or by a second face-to-face interview were not conducted for further clarification of the data.

The researcher was worried about keeping the questions on track, thoroughly allowing the interviewee to express their ideas, feelings and experiences while paying attention to the particular foci of the research, and the theoretical implications of what was emerging at specific given time. The researcher used the interview guide to consistently explore planned areas of inquiry and remained as open as possible to new information as it was presented. The progress of the interview was smoothed out by outlining the subjects of inquiry using the interview questions as a guide.

As the interviews proceeded and became longer, participants became more in-depth in their sharing, emotions were expressed more freely. At certain points in time the interviewer active listened, and responded to shared specific feelings of the interviewees. Those moments were characterized by similar understandings, thoughts, and feelings that emanated from a physician's life, and from the common sense of simply being human, and also being new to Canada.

Post-interview researcher notes and journals were completed with key words taken during the interview; notes written immediately after the interview; and reflections on the process and research ideas made from memory later. This added to the data, observations, analysis and research planning.

The researcher listened to the interview tapes at least three times each to add any lost pieces of information, as well as to correct some words, and add together any affective impressions and observations originating from the interviews and journal researcher notes. At the end of this listening process, the researcher was more familiar
with the specific data generated from each interviewee, and the participant's particular way of examining the world where they have lived, and their particular involvement in the society and in resettlement process. In this way, the researcher was capable of guaranteeing that the transcribed results were precise and represented a suitable expression of the interview dialogue that was created with the verbatim words and additional non-verbal expressions, or missed words that were added in parentheses to keep the intended meaning.

The excellence of qualitative inquiry is related to the researcher's performance and abilities in being able to listen, to observe, and to analyze data (Patton, 2001). This study required high level listening skills, observation skills, and interview skills to gather the data for analysis.

Redundancy and saturation were the primary criteria used to end the sampling and the interview process. In keeping with the suggestion from Patton (2001), the sampling and data collection processes were to be considered closed when no new information could be added, and a balanced treatment of the phenomena had been covered.

3. 9. Data analysis

The self-rating health surveys were analyzed to prepare descriptive statistics and frequencies by the use of SPSS, 14.0 and Microsoft Office Excel, 2003. Variations were analyzed by calculating the mean of survey responses.

Qualitative analysis is the process of making sense from an amount of data, and it depends on the analytical capacity and approach of the researcher (Patton, 2002). The analytical approach during the interview process is the beginning of the qualitative analysis, and the researcher did not develop premature conclusions. Qualitative analysis
is demanding for three main reasons: there are no standard methodical rules for breaking down and presenting the data; there are no precise and universal processes in qualitative analysis to get in the conclusions; and the lack of precise recognized processes makes the replication harder. The use of the triangulation process and having several sources of information is a very significant tool for improving the trustworthiness for the data and therefore aids in the interpretation process (Polit & Hungler, 1999).

The qualitative analytical process explored major and minor themes within the data collected. From this analysis, process models and diverse patterns of connectivity and relationships emerged and were reported in the study (Patton, 2002). Data was stored, coded, saved, contrasted, and linked using researcher triangulation and data organization methods. Leedy and Ormrod (2001) suggested handling data using the following analysis spiral, based on Creswell (1998).

Figure 2. Analysis spiral (in Leedy & Ormrod 2001).
The interviews were transcribed from the audio tapes and the verbatim transcripts were analyzed. The initial process of discovering what was important to understand and to explain the newcomer physicians' lives, was reflected in the development of the coding scheme. The data were organized into categories, themes and files, and the analysis and conclusions flowed from the data collected directly from the participants.

Essence analysis involves identifying, coding, categorizing, classifying, and labeling the primary patterns and themes that emerge in the data (Patton, 2002). The categories can be established by inductive or deductive methods, or a grouping of both methods (Strauss, 1987). Data collection is aimed at saturating categories, and moving back and forth in a central, constant and comparative method. The researcher looked for emerging themes and categories. The researcher was guided by the Leedy analysis spiral process for the data analysis phase.

Creswell (1998) illustrated a coding process for grounded theory research that was used to assist the researcher at this stage:

- **Open coding (first level):** fracturing of the data and breaking the data apart analytically. The researcher used participants' words as much as possible. At this stage, the researcher can believe, or not believe in anything. With the knowledge of the technical literature, initial categories were developed to group similar data together, and data was reduced into a small set of themes being scrutinized for commonalities (properties and relationships). The aim was to produce concepts that seem to fit the data. Small portions of data were conceptualized.

- **Axial coding (second level):** represents a synthesis of first-level codes, and it is more abstract. Categories were disassembled and reassembled in new ways to reveal central phenomenon, causal conditions, strategies, intervening conditions,
relationships, processes and consequences. Interconnections and the conditions that give rise to them, and the context in which they are embedded among categories and subcategories were identified and coded. The focus was to determine and specify more in each category. Strategies reported used by the interviewees to manage their challenges and the consequences of those strategies were analyzed in the process.

- **Third level coding:** The researcher hypothesized the relationships among earlier-level coding. The researcher wrote the story integrating the categories used in the axial coding. Categories and their interrelationships were combined to form a storyline that described what happened in the phenomenon being studied.

The grounded theory process includes a final synthesis phase where theory is again brought into the process. The researcher, based entirely on the data collected, explains how certain conditions lead to certain actions or interactions, and how those actions and interactions lead to other actions with a typical sequence of events or processes being laid out. This can result in a critique of existing theories and process models; a revised theory or process model; or the development of new theory and process model from the data analysis.

As part of the coding paradigm, some words were found to be fundamental and denoted special meanings such as conditions; (because, since, as, on account of); consequences of action (as a result, because of that, the result was, the consequence was, in consequence); and interactions (among and between actors).
The concept of data saturation or “theoretical redundancy” occurs when the categories, and theories are fully explicated and no new information about the core processes is forthcoming from ongoing data collection (Strauss & Corbin, 1998).

Core categories are important in the generation of theory. Most of the other categories and their proprieties are related to this, and it is the topic of much qualification and modification. A new generated theory often occurs around a core category which accounts for most of the variation in a pattern of behavior. The core category has different kinds of appearances under different conditions. As the relationships are discovered, the core categories become more dense and saturated. The state of much variation of behavior is explained with as few concepts as possible and this requires, maximize prudence and skill. The core category integrates the theory and exposes it.

Researcher skepticism and constant questioning of the data helped in the data analysis phase. The inductive method is generally characterized by deeply involving the researcher in the data in order to recognize the elements and features which shape significant themes and categories. The deductive method allows the researcher to apply some definite scheme recommended from a theoretical prospective, and to use instruments or particular questions to build a theory, to verify a theory or to examine processes. Some data required both inductive and deductive methods. In order to get the perceptions of the interviewees in a direct way, great confidence in the inductive method was essential to conduct this grounded theory research. Induction does not reject or exclude the use of deductive methods. Becker (1993) stressed that the researcher may come to the research with some initial hypotheses, but must proceed with sensitivity to
the environment being studied and to the interpretations of those who live in the social world being researched.

The researcher started situating the data collected in the interviews related to how the physicians' reported the experiences of their lives in three anticipated stages of their life journeys: before the resettlement, during early resettlement, and later in the resettlement. After reviewing the transcripts, the researcher realized that the foreign-trained physician experiences were primarily organized and reported in the interviews around in-depth descriptions related to 2 significant time periods: before coming to Canada and after. Resettlement originally had been conceived as including the early stages of resettlement and later resettlement.

The storytelling interview process allowed the interviewees to smoothly describe their personal and specific experiences lived in each period. The interview guide provided efficiency for the interview and helped to demonstrate a structure to gather information and added strength for this study. The appropriateness of the questions and the guide assisted the researcher to open a coding approach at the first level, taking into account the three major categories: settlement, identity, and health status. Each period of the resettlement, before and after, corresponded to distinctive lives with an evident and intense association surrounded by experiences, feelings, emotions, achievements, failures, and hopes. As distinctive lives, these resettlement periods were characterized by similar constituents of life reported for this study, such as professional identity, health status, self-esteem, barriers, facilitators, support, and future expectations, but with different feelings related to the different realities at the time.
While the interview methods and guide attempted to specify certain time periods, the researcher discovered that many in the chosen sample felt they still had not totally resettled, even though many had lived in Canada for some time. The research data from the interviews became more intricate in detail as the participants specified the tasks in the loose time boundaries between early resettlement and the ongoing process of resettlement to the present time. For many who had lived in Ontario for more than 2 years, some facts were not recalled or recounted about the early 6 month period of resettlement.

These experiences were lived and reported in the study as a whole significant journey, while they actually represented only a fraction of the whole real physician's life. Their experiences differed on change intensity, coping effects on those facing changes, and additional reports of specific events. The reported information regarding changes, adjustments, new events, and coping mechanisms allowed the researcher to identify meaningful units. The resettlement period as a quantifiable length of time became complex to estimate its boundaries since some parts of resettlement such as housing, temporary employment, and making some friends had been accomplished. The criteria to be included in this study were those who still had not recovered their professional medical identity or licensed. They were not fully included in the society or health system at the time of the interviews and had not reached the levels of employment, finances and social contacts that they had been used to and aspired to. Many expressed the possibility of emigrating again to another country even after a few years of living in Canada since they had not yet re-established themselves in their profession.

With the knowledge of the technical literature, initial categories were developed to group similar data together, and data were reduced to a small set of themes being
scrutinized for commonalities (proprieties and relationships). The transcripts were broken into "meanings units" and identified as data which were used in the constant comparative method of this study. Each "meaning unit" characterized one specific idea of the interviewees. The researcher broke the data apart analytically, and used participants' words as much as possible in the reporting of the main themes, findings, analysis and discussion.
CHAPTER 4.0  RESULTS

Initially, fifty two (52) FTPs from the Niagara Region Chapter AIPSO list were sent electronic e-mails and a letter of invitation to participate in the study. Many of the e-mails on the original contact list were found to be invalid and forty four (44) potential participants received the recruitment e-mail. This number was reflective of the actual numbers that could be reached for recruitment at the time of the study. As a second step in the planned recruitment, the researcher attended a meeting of the Niagara AIPSO. Nine IMGs attended that meeting and research study recruitment packages were made available to them. After 3 weeks, several invitations, attendance at a meeting, and follow up reminders, 4 participants from the Niagara Region were involved in the study.

Other methods of contacting IMGs in other locations in Ontario were reviewed. It was decided that the general experiences of trying to be re-licensed and re-establishing professional identity were germane to this study and not where the physician resided in Ontario. One of the IMGs who received the invitation sent the letter of invitation to AIPSO in Toronto and a representative made contact to offer assistance with recruitment for the study. Their help was accepted and the Toronto AIPSO posted a note in AIPSO Updates Feb 23, 2005, on the internet:

Survey Participants requested.
Maria Carvalho is an international Medical graduate from Brazil and currently a master student of Community Health Sciences at Brock University. She is undertaking a study titled ‘The implications of being a newcomer physician in a new society: qualitative study of foreign-trained physicians’ settlement, sense of identity and health status.’. She is seeking IMGs who would like to participate in her research process by filling out a self-rated Health Survey and interview which will last for one and half hours. Please contact her at mamadoc25@hotmail.com or call 905-688-5550 ext.5052. Your contribution would be highly appreciated.
Additional completed surveys were received both by regular mail and by electronic mail after the AIPSO recruitment announcement. Two IMG participants were interviewed in Toronto at a counseling office; 2 in London in a private office of a Community Health Centre; and 4 were interviewed in the Nursing Department at Brock University. A total of 17 completed surveys were received and input into SPSS (Statistical Program for Social Sciences) for review before the interviews and for data analysis. Eight semi-structured, and taped qualitative interviews that lasted an hour to an hour and a half were conducted throughout March, 2005. Foreign-trained physicians who migrated to Canada shared their experiences related to the loss of professional status and employment and described their prior circumstances, areas of their lives and their identities as they had been established in their prior culture before coming to Canada and after coming to Canada.

The findings and results of the study will be presented in this chapter. The descriptions and data analysis of the seventeen (17) pre-interview survey participants and the sub-sample of eight (8) participants who engaged in the interviews will be presented and discussed at the beginning of this chapter. A summary of the results of the pre-survey will be presented and discussed. The analysis, discussion and main themes that emerged from the qualitative interviews, which is the focus of this study will also be presented in this chapter. Foreign-trained physicians who migrated to Canada shared their experiences related to the loss of professional status and resettlement experiences in Canada, but they also described their prior circumstances, areas of their lives and their identities as they had been established in their prior culture before coming to Canada.
4.1 Summary of the results of the survey

4.1.1 Description of the survey sample and interview sub-sample

The pre-interview survey provided demographic data on the participants and any self-reported health problems before and after coming to Canada. In addition, participants rated their self-esteem, quality of life, health status, feelings of inclusion and belonging, experiences of racism and discrimination and experiences of stress prior to emigration and at different stages in their resettlement process in Canada. The demographic descriptions of the 17 survey participants and the sub sample of 8 participants who were involved in the interviews and drawn from the survey group will be presented here. The ratings of stress, health status and self-esteem for the interview sub sample will be further discussed along with the qualitative interviews in the respective sections focusing on those areas in the qualitative analysis. The two sources of data (the interview and the survey) were about the same phenomena and experiences. However, the focus of this study was on the qualitative interviews using grounded theory, and those parts of the results will be analyzed in more depth.

The data collected from the survey provided an opportunity for the researcher to include as much variation in the final interview sample as possible, so as to include as broad a range of experiences and perceptions as possible related to the phenomenon being studied. It also provided some helpful information to assist the researcher to prepare for the interviews. Seventeen (17) FTP participants filled out the surveys and 8 of those same FTPs were involved in the qualitative interviews.
This qualitative study included a rich variation in the interview participant sub-sample in regards to: age, gender, religion, self-reported race, visa status, marital status, children in the household, and number of extended family members living with them.

Table 2. Descriptions of the survey participants and interview participants

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Gender, age, religion, self-reported race, visa status, marital status, number of children in the household and number of extended family members in the home were described for the all survey participants and the sub-sample of interview participants in the study.

Of the survey participants (n=17), 11 were male and 6 of them were included in the interviews. Six females completed the survey and 2 of them were interviewed. The age of survey participants ranged from 26 to 56 years, with only one in the 50 to 59 age range. The age of those included in the interview sub sample ranged from 26 to 49 years of age. The largest number of interviewees was in the 20-39 years of age range.
Participants were asked their country of origin, and the 17 in the survey sample reported they were from: Afghanistan, Argentina, Armenia, Colombia, Iraq, Mexico, Pakistan, Sudan, Ukraine, and Vietnam. The largest FTP survey population was from Colombia (6), followed by Sudan (2) and Pakistan (2). The interview study sample (n=8) included a good variation: 2 from Colombia; 1 from Argentina 1 from Armenia; 1 from Afghanistan; 1 from Pakistan, 1 from Vietnam, and 1 from Sudan. Of the survey participants 12 indicated they came to Canada as landed immigrants and 2 came as refugees. Six who came as landed immigrants and 2 as refugees were included in the qualitative interviews.

Several questions were asked on the survey regarding whether the participants were married and living at present with their spouses; how many children were living with them at present; and how many extended family members were living with them in the same household. The intent of these questions was to explore settlement and re-licensing experiences with and without living with spouses, children and extended family. Family support may help in the resettlement but also presents family demands and expectations of the FTPs to work, to provide an income, to deal with family needs and at the same time for this group to be able to find time to study and be engaged in re-licensing tasks. Single FTPs may not have the additional family demands but also may not have as much family social support.

Of the survey participants, 14 reported they were married and living with their spouses and 6 of these were included in the interview sub sample. Of the survey participants, 9 had children living with them and 5 of these were interviewed. Of the survey participants 12 did not have extended family members living with them and all 8
of those interviewed did not have extended family living with them at the time. Many of the recent immigrants and refugees entering through the Niagara points of entry were reported as arriving with their spouse and with families (Settlement, 2005).

In the survey, FTPs were asked to indicate the medical specialty areas they were trained in. The largest number of those in the survey reported they were general practice physicians. Those who reported specialty areas were in Obstetrics, Anesthesiology, Sports Medicine and Plastic Surgery. Most of those interviewed (7 of the 8) had completed their general medical degree and had not developed specialty designations in their countries of origin. The interviews clarified that some FTPs confused general practice with family medicine, which is a medical specialty. In the survey sample and in the interview sub-sample all but one FTP had their medical training in the country reported as their country of origin. Only one FTP received his medical training and certification outside of his country of origin.

Survey participants were asked what type of work (paid or unpaid) they had been engaged in since arriving in Canada. Of the seventeen in the survey: 6 reported not having a job at present; 2 were taking care of their children; and 2 were involved in graduate studies; 1 in clinical trial research.; 4 were working or volunteering in allied health fields (in a diabetic program, as a Personal Support Worker, as a high risk nurse and as a volunteer observer); 2 were involved with short term work in construction, flyer delivery and greenhouses and antiques. It is important to note that even though some of the FTPs were involved in some kind of work, most of them did not have a steady job or a steady income to support themselves and their families at the time of the interview.
...
Many were either not employed or worked in jobs of short-term, sporadic or seasonal 
-opportunity only as ways to raise money to pay for the IMG exams and to survive.

Initially, the criteria of involvement in the study outlined that they had to have been in Canada up to 10 years. Seven of the interviewees met this criteria and their time in Canada ranged from 12 months to 56 months, with the average time being 4.6 years. It was decided to include one participant in the study who responded and had been in Canada over 20 years and began re-licensing to be a physician in more recent times to increase the variation of perspectives and views. The mean period of time was 72.25 months or 6 years for the entire interview sample.

In the survey sample, 16 FTPs rated it as very important to practice as a physician in Canada, and 1 considered it somewhat important. Seven of 8 interviewed rated it as very important to them to be able to practice as a physician in Canada, and one considered it somewhat important.

4.1.2 Feelings of inclusion and belonging, quality of life, self-esteem, and health status before coming to Canada; in the first 6 months; and at the present time.

The survey participants were asked to provide self ratings of their feelings of inclusion and belonging, quality of life, self-esteem, and health status during stages of their lives: before coming to Canada; in the first 6 months; and at the present time. A 5 point Likert rating scale was used. Response choices included: Excellent (5), Very good (4), Good (3), Fair (2) and Poor (1).
Before coming to Canada

In the first 6 months in Canada

At the present time

Figure 3. Rating of feelings of inclusion and belonging, quality of life, self-esteem, and health status before coming to Canada; in the first 6 months; and at present.

Survey participants (n=17) indicated a steady decrease in health status compared to their health status during their resettlement in Canada, from the first 6 months to the present time. Similarly, their quality of life decreased when first coming to Canada and it has further decreased since then.

Survey participants rated their self esteem high prior to coming to Canada and the mean rating of self esteem decreased to 2.6 after coming to Canada and has increased slightly since then, but is still below the level they experienced prior to coming to Canada. Following a similar pattern, survey participants rated their feelings of inclusion and belonging in the community high before coming to Canada and this rating went down when they came to Canada. Their rating of feelings of inclusion and belonging increased
The document contains a graph and text. The graph appears to be a bar chart, although the specific details of the graph are not legible. The text is not clearly visible due to the image quality. The context or content of the text is not discernible from the image provided.
later in resettlement to the present, but not to the levels experienced prior to emigrating to Canada.

4. 1. 3  *Survey ratings of violence and trauma; racism and discrimination and stress before coming to Canada; during the first 6 months in Canada; after coming to Canada; and at the present time.*

Participants were asked on the self-rated Health Survey to rate their level of *Violence and trauma; Racism and discrimination; and Stress* before coming to Canada; during the first 6 months in Canada; and at the present time. These items were rated on a 5 point Likert scale and coded as 1-5: Very high (5), high (4), neither high nor low (3), low (2) and very low (1).

Figure 4. Rating of violence and trauma; racism and discrimination; and stress before coming to Canada; in the first 6 months; and at present.
Survey participants rated their experience with violence and trauma as neither high nor low before they came to Canada and that it went down in the first 6 months in Canada and remains low at present.

Survey participants rated their experience of racism and discrimination as low before coming to Canada and that it went up a little after coming to Canada and has increased slightly since that time to the present. However, it still was rated as low.

Survey participants indicated in their ratings that their stress levels were similar in the first 6 months as prior to coming to Canada and that stress had increased to a high level as the resettlement time has progressed to the present time where it had reached a level higher than pre-immigration time.

While the survey results included such small sample numbers, they indicate changes in self-reported ratings in many of the areas indicated from the time before they came to Canada, in the early 6 months of the resettlement process to the present time. Their self-reported stress has increased over time. The qualitative interviews were intended to explore those areas more deeply to find out what is actually going on in those areas, why it might be happening, how it might be happening and what experiences, feelings and personal meanings are associated with those changes. The in-depth qualitative interviews were the focus of this study. The additional descriptions of feelings, opinions, experiences and insights of those interviewed were intended to shed more light on the phenomenon of being a foreign-trained physician trying to re-license in Canada and what main themes and processes were involved. The survey results helped the researcher to prepare for the interviews and to ensure inclusion of as much variation as possible in the interview sample. The survey results were used later in the triangulation
process, whereby all sources of information were found to be helpful in understanding the areas of inquiry in this study.

4.2 Qualitative interview results and findings

The findings and analysis of the eight interviews with the foreign-trained physicians and their lived experiences before coming to Canada and during resettlement will be presented. The research questions as outlined guided the interviews. The research study was constructed to understand the FTPs’ experiences and processes in several stages of their lives: in period before they emigrated to Canada and in the resettlement and reconstruction of their lives in Canada. The major themes and categories reported and the assembly of their experiences, both similar and unique will be presented. Diagrammatic figures will be used to describe and to handle the complexity of the emerging information and to show the major categories, processes and relationships along with their voices in the accompanying participant narratives and discussion. This approach was used to provide an understanding of the FTP’s struggle to survive in the new country, to resettle, to reconstruct their lives, and to restore their professional medical identity, while attempting to keep or to improve their health status.

Individuals generally advanced through the settlement process, not always following strict linear itineraries or sequential tasks, or at the same pace as their counterparts. As each of the FTP participants went through the process of creating a new life in Canada, they often shared some common experiences and feelings, but often took different paths through different phases in a diverse arrangement depending on successive interactions, opportunities, barriers, problem solving and resultant re-evaluation of their actions.
The verbatim quotes from the interviews are somewhat longer as presented in this qualitative study. It was deemed important to include longer quotes, since many of the participants had English as a second language and they wanted to fully express their thoughts, feelings and ideas. To be true to their words and meanings, and to effectively report the findings of this study, it was decided to intentionally include longer verbatim responses so as not to lose the intended meanings and to add to the credibility and trustworthiness of the findings that are particular to this study sample. These longer interview responses provided a rich and full context of meaning that was relevant to the study, to the integrity of the reported findings, and to the exploration of new theory.

The results and findings of the qualitative interviews will be organized around a description of their lives before coming to Canada and a description of their lives after coming to Canada and the main emerging themes that developed related to the study.

4. 2. 1 Physicians’ lives and identities before coming to Canada

At the beginning of the interview, the participants were asked generally what their life was like before coming to Canada. They spoke mostly about their life as a physician and what that medical identity and socialization provided. Several sub-themes emerged associated with being a physician and what that medical identity in their country gave them prior to coming to Canada.

All of the FTP participants reported that they had their social and professional medical identities established in their countries before they left to come to Canada. This identification with the profession was strong whether they had worked for a long time in clinical practice or if they just finished their residency work. They described their lives and social and professional identities with detail. Although the question was asked as a
broad question related to recounting all parts of their life before coming to Canada, much of the detail of what they shared evolved around being a physician and the work, purpose, meanings, social status, respect, income, lifestyle, self-esteem and social networks they had associated with this role.

4.2.1 Medical identity and work as a physician before coming to Canada

Hamid described that he had a well established professional life in his country prior to emigrating, and he was happy socially, and professionally. He described that his employment as a physician was related to having a good income, a good life, high self esteem and enjoyed the respect that he received. He reported his professional medical identity as being associated with having purpose and meaning, social status, a good suitable income, responsibility, a social and community network and high self esteem:

... we were doing lots of reconstructive surgery there ... I had a good job there. I was regional manager. I was doing lots of coordination jobs for these clinics that we had there. I had a very good income and good salary ... so that's basically what you want to have. Respect ... like a good life, good income for sure ... I had no problem economically. I was set up well there rather than here, cause I don't work here. Once I became doctor and then I knew it was a different life, and like having a life, and kind of enjoying having respect and ... like having a life within that community and the needs of those people ... like it was kind of a good life ... the professional life was good. So I used to like it there.

Enrique was well established in his profession in his country, which allowed him to have respect, a social status equivalent to a high middle class, an opportunity to help others and a good position. He stated:

I used to work in the emergency department there, always as a family physician ... probably for seven years... You can live well ... It is a good profession ... I would say it's like a high middle class. Everybody kind of respects you. And always the physician has the position of somebody who helps, or somebody who gives something... to people, it's a good position in the social environment.
Nanor finished his undergraduate medical degree, got his medical license and was working further on his clinical training before he came to Canada. Nanor explained:

I graduated from medical school ... I got[a] scholarship ... I did about 7, 8 months of clinical training in different types of surgery... and then I had an opportunity to come to Canada to observe.

Markus studied medicine abroad from his birth country. He was very enthusiastic about his medical career and expressed that it gave him purpose and meaning to help others. He did not refer to specifics of income or work before coming to Canada. He expressed that he would like to have the chance to go back to his own country to help his people, but the length of the civil war, which lasted for many years made him change his mind, and he came to Canada. He declared:

When you engage in the medical profession, your first part is to do something for the people. There is the material gain also, but the first thing that you have in mind is finishing your studies and come and help the world. And the world needs you, that’s for sure. So ... when I finished that was my thought ... I would go to [my country] and start working right away, helping people..

Carmen expressed excitement with her prior residency program, the excellent employment and teaching opportunities that professional medical identity gave her, and how pleased she was with her profession before coming to Canada. She declared:

And I was in my second year of residence when I graduated. But I was going to specialize more. I was working as a doctor too, and I was having other jobs. I was an assistant of surgery to orthopedic surgeons. And I was a teaching assistant in the university in my specialty ...

Minh worked for an international pharmaceutical company before emigrating to Canada. He said that he had an easy life there and related the good income and good social status to his professional medical identity: “... my life before I came to Canada was an easy life ... I lived comfortable with myself ... I worked for a pharmaceutical company. I earned good money and ... I didn’t have to work hard”.

Sophia was in an advanced stage of her [specialty] residency experience, when she interrupted her professional program because of maternity leave. After that, all her family emigrated to Canada. She shared that physicians had a high income in her country of origin and related that high self esteem and high social status was attached to her professional medical identity:

I was working in a hospital in [city], the biggest city in [my country], and I was doing [specialty] residency for three years. In [my country] the educational directive ... it's all merit based. You have to be really good to go to medical school. So people hold them in very high self esteem, and they are paid quite well too. There you would have high income ... and social status.

Juan was well employed in the academic medical field, and was practicing as a [specialty] physician before coming to Canada. He related the professional medical identity to having employment, social status and high expectations from others, but not a high income. He stated:

In my country I have a very busy life ... I work for two universities as a lecturer, as a professor and ... also I work for a [institution] as a specialist ... I have another job where I have to [do] ... evaluations for people who wanted to participate ... in some[activity]... I think the social status of being a physician is very hard ... people expect a lot of you because you are a doctor, but anyways the income that you earn is not so high.

4. 2. 1. 2 Social and community networks before coming to Canada

Most of the interviewees had a network of friends and family prior to coming to Canada with much of their friendships associated with their profession and work relationships.

Juan had a well established friendship network back in his country, and he stated:

We meet our friends every weekend generally... we share some experiences ... from time to time we have parties and often we have family meetings, celebrating birthdays... have friends and my wife also have friends and family and we visited them often.
Hamid expressed that he had a good life and friends back in his country: “I was really satisfied with my life there. I had lots ... big bunch of friends, both within the organization where I worked and at a hospital where I worked. I still have contact with them.”

Minh said he had a lot of friends and family and they spent time together:

I had a lot of friends, I spent a lot of time with my friends, my family cause my job is very easy. I just had to spend 1 or 2 hours a day and the other time I was free.

Nanor had a small, but significant friendship network before coming to Canada, and stated:

In [my country] I had maybe a couple of very good friends, and friends for me I mean ... the word friendship is very important for me. I had 2 or 3 very good friends, and then I had just the other friends who I would hang out with from the university.

Enrique had a family and reported making close physician friends at work. His wife also had another friendship group, and they spent time together. He stated:

... our families live there ... my wife’s family and my family, and aunts, uncles, grandfather, grandmother ... the group of friends where I used to work as a physician, they were [few] physicians ... we made a real attached relationship with them ... like more than work mates or co-workers. We used to be friends with each other. Also with my wife [we had] high school mates... like we have another kind of group.

Carmen reminisced about her family and her friends, and stated:

Also, I have a very close family. I need my twin sister. I need my sisters, brothers, and nephews so it’s a very part of me ... very important that I need to continue to get connected. And I have very good two friends that we left [our country] at the same time. They went to Chicago.

Many in the interview study group presented a prior picture of a strong social network of family members, friendships, colleagues at the university and colleagues in
the workplace. Those who were married also expressed how they had close relational networks with family, friends, other physicians, work colleagues and connections of their partner before emigrating to Canada.

Juan described his social networks and community participation mostly around his engagements at the university: “I was involved in education that is some kind of community participation.”

Minh felt he was not greatly involved in civic community participation outside of work but stated:

*I was ... sometimes ... [involved in] my community, have like a meeting or concerns, and I went to [city] at that time. I was some gentleman from the ... professor of [a] famous hospital in [city]*...

Interviewees referred to their participation in community matters as mostly related to their involvement in professional meetings, work meetings, or university and educational affiliations. All of these civic participations revolved around their professional social networks and medical identity. The move to Canada and losing their status as a physician, would initially remove some of those areas of familiar civic engagement, social friendships, social networking and community participation for this group.

4. 2. 1. 3 Housing before coming to Canada

All the interviewees were asked about their housing circumstances in their countries before coming to Canada. A few did not comment much on this, while most spoke freely of their prior living circumstances.

Hamid reported that he lived comfortably in housing in his prior country as physicians were used to and stated: “I had my own apartment ... furniture and belongings ... and good decorated.”
Sophia reminisced fondly of her home before coming to Canada, and affirmed:

“I still have my house back home. It’s a four bed-room house. I have a home there and it has a yard ... just like houses over here... dining room, kitchen, family room. It’s a big house.”

Enrique reported that the income was not too high as a physician in his country but that it could provide for good housing: “You can live well ... you can have access to ... in this case an apartment or like a cottage or a little apartment”.

Juan had lived with his family in an apartment in his prior country. Minh did not state anything about housing in his country. Nanor used to live with his mother when he was still medical student. Markus lived abroad from his country of origin to complete his medical degree. Before he left his country, he was living in a refugee camp. He did not comment nor describe that experience further. Carmen did not describe her prior housing situation.

Some of the participants felt that their housing circumstances were an important part of their lives and described a part of who they were prior to coming to Canada. The researcher felt for some, it was not the most important part of their description of life prior to Canada. However, for those who had been in a refugee camp or who showed emotion at missing their home, it was evident that it was painful to share this and so they did not add too much detail even when the researcher invited them to share more.

4. 2. 1. 4 Reasons to come to Canada

All of the interview participants talked about their strong and particular reasons for making the decision to come to Canada. The list of reasons given were: violence, stress,
family reasons, marriage, economic reasons, education, a perceived unfair medical system back home or unfavourable political situations in their respective countries.

All 8 participants are represented in Figure 1. All of them expressed their particular reasons to come to Canada. The main reason that many of them came had to do with their experiences of violence, war and stress in their prior countries. Two participants expressed that they did not want to come to Canada and came to follow their husbands.

![Diagram of Reasons for coming to Canada]

*Figure 5. Reasons for coming to Canada.*

Juan’s main reasons for coming to Canada were because of the violence and stress in his country and he reported:

... a very main reason was the violence that is from it’s all over [my country] ... it last at least 40 years 50 years now. And also, not just the political but the economical situation of the country ... the city is so huge that you don’t think it is violent. But you can feel it ... I didn’t see [it] but my wife and my son were very close to the bomb, and the glasses were broken ... in the apartment. It was very stressful for us ... But the violence in [my country] you have more odds to be killed anytime. And, especially because of my child... Because my country has the number
one ... the highest number in kidnapping in the world.

Enrique was already married in his country, but he was worried about being able to establish a family and to have children in his country of origin because of fear. His strong, personal experiences with violence made him change his mind about his family growing up in his country and he made plans to come to Canada. He stated:

... we had an incident in the hospital where I used to work. There was a guerilla group... [group of people] ... they had the names, phone numbers and every [bit of] data from the physicians who used to work in emergency, and they started extortion [of] us ... asking for a money ... we gave two months to them ... it's crazy. So it's an uncomfortable situation because you never know what is going to happen. So a friend of one of the physicians used to have three little kids, and the kidnapped one of them. ... I mean it's not safe to stay [there]. We got married, and we moved to Canada in [few years ago]. Once we move here we say, 'oh, maybe we could have one kid.'

Sophia and Carmen came to Canada because of family issues and to follow their husband’s career. Sophia came to Canada since her husband decided to immigrate in the business class category and she followed him. The two persons who came to Canada because of their spouses’ decisions and family issues, both expressed discontent with coming and this could be because the decision was imposed by another. The decision to come has had negative outcomes related to the loss of their own professional identity and potential to work in their profession in Canadian society. These persons not only experienced the shared disappointments that the other physicians expressed with not being able to be a doctor in Canada, but they had the additional experience of feeling like they had no control and did not make the choice themselves to be here. Gender played a role in their situation. Both indicated that in their religious and ethnic cultures (Muslim, Latin American), it is normal for women to follow the career of the man.
Sophia had witnessed bomb blasts and gun fights at home. However, she said she came to Canada to follow her husband and his work. If given the choice, she said she would not have come. She stated:

"It was my husband’s decision to come. He wanted to come because his parents were here... Pretty much most of my family is over here too... The immigration [said] ... there were no jobs for doctors. So I wasn’t happy to come here. I wasn’t happy. I saw a lot of the bomb blasts and gun fights.

The second female in the interview sample came to Canada because of her husband, but she indicated that if she had been given the choice of making her own decision, probably she would not have come. She felt she had to follow her husband. Carmen affirmed: “[I came] actually because of him [her husband]... he landed a job with a Canadian company, and that’s why I came to Canada.”

Hamid came to Canada because he married to a Canadian who had a similar country background as his own. He also reported experiences with war, violence and stress.

And the reason why I’m here, and what I’m doing here is my wife. She has been living in Canada many years... We are relatives... and [in my country there is] post-traumatic stress itself, and of course some psychological problems that exist within our community due to the war... during the war we had all this kind of violence. It was not just against women and children, but against everybody.

Minh came to Canada mainly because he married a Canadian with his country background and secondly because of what he described as the unfair and corrupt medical system back in his own country that required money to get a position. He stated:

I came here because ... first of all because of my wife [The] second reason is the unfair medical system... they don’t have a clear rule for physicians... if you have relatives [who] work in hospital before, you have money, you can get in... [it is] very difficult to get in... [you have to give] money for the person who [is] in charge of that hospital under [the] table.
Nanor came to Canada to work in an official observer position at a university hospital, and he stated: "I graduated from a medical school in 2001, and then [after 7 months] I had an opportunity to come to Canada to observe."

Before Markus went to a medical school abroad from his country, he had been living in a refugee camp. Markus did not state that the violence in his country had traumatized him, because he grew up in a war-torn country where the violence was lived as being a normal part of life, according to him. The researcher felt there was more to his story. When he finished his medical degree, he said he went to Canada because the country where he graduated sent some young physicians to Canada through a political arrangement. He was reluctant to clarify how this occurred even though he was asked about it.

4. 2. 1. 5 Knowledge of the IMG Ontario licensing process before coming to Canada

During the interviews, the participants expressed concerns related to the IMG Ontario licensing process when they recounted consistent and unanimous anxiety about their expectations of becoming a physician in Canada. Many interviewees had misunderstandings prior to coming to Canada about the actual process of licensing to practice in Canada. Some participants were not totally knowledgeable about the whole process prior to leaving and a few of them still seemed to not understand how an IMG could work through all the required process steps for licensing even now. Others had researched the process carefully, but still had some ambiguity. For that reason, the researcher explored how much they knew about the entire process, before emigrating to Canada by asking additional questions: "Were you prepared for the IMG Ontario relicensing process?" "How much did you know about the process before coming to
Canada?" The following comments on the process, prior knowledge of the process and barriers identified where given in response to the additional question posed in the interview.

Sophia did not know anything about the IMG Ontario process to become a physician before she came to Canada. What she knew was that Canada did not have jobs for IMGs at that time. She answered about her understanding of the process in relation to her friends:

People like me, or my friends, they came here with their husbands. They were not have to have a mindset about it. If you know that you have to go somewhere or that you are going to somewhere, then you start planning along those lines.

Juan stated that he did not search for any information about the Canadian medical license process, and stated: “I was not prepared. I didn’t search ... in the website about this medical license ... association.”

Carmen had only unclear information from abroad which did not specify anything about the IMGO process, and she stated:

But the interesting thing was when we went through the papers, there was a lady ... [at the Canadian consulate in the country where they were living in]. And she said to me ‘well I warn you ... that it is very difficult being a physician in Canada.’

Hamid had very little information about the medical license process in Canada before he left his country:

I knew it kind of, but I didn’t know it was that tough ... because I used to think there will be a test ... of course a medical - physical examination test ... like probably two tests, but the way it is here ... it’s kind of hard ...

Minh had no idea how hard and how long the process would take and stated: “When I was in [my country], I heard that when we come here we have to study and take some exams, but I couldn’t imagine how hard that process was at that time.”
Nanor was surprised about the Ontario licensing process and the exams and said: “Before coming to Canada I would never think I will end up doing the Canadian examinations. I didn’t know what’s [an] International Medical Graduate. I didn’t know what’s MCCEE etc ... I didn’t know anything about it.”

Enrique commented that he did not explore the medical license process while in his country, and stated: “... it was very fast between [when] we decided to go out [of the country], and choosing Canada”.

Markus knew that he had to go through some exams for licensing in Canada, but he did not realize how complicated the IMG Ontario process was going to be before coming to Canada.

4. 2. 1. 6 Summary of FTP’s lives before coming to Canada

Most of the interviewees shared that their feelings of purpose and meaning; good social status, self esteem and respect; income and employment; and social and community networks they had experienced previously were related with having a professional medical identity and being a physician in their countries prior to coming to Canada. Many described having good housing situations and friendships before coming to Canada. However, many were experiencing war and unrest in their countries.

Juan, Hamid, Minh, Nanor, Sophia, Enrique, and Carmen did not know enough about the IMG Ontario process before emigrating. Sophia and Carmen knew some of the difficulties of becoming a physician in Canada before they arrived. Carmen was told about the difficulties by the Canadian consulate in the interview, but was given no details as to why, and she felt that “once there, it is not impossible.”
Juan, Hamid, and Minh, described being engaged in some community and civic social participation in their countries before they came to Canada. Most of the participants were actively involved in their medical, educational, hospital or work communities before emigrating and this provided friendships mostly related to their professional relationships.

Juan, Hamid, Minh, Enrique, and Carmen described having a good income and social satisfaction in their countries prior to coming to Canada. The participants had an identity affiliated with being a physician in their country and employment and experiences related to this.

All participants reported having good self esteem prior to coming to Canada and that much of their self worth was associated with being a practicing physician. The respect and recognition from others was embedded in their professional position and status in their societies. They had relationships with others and a feeling of belonging to a group, the group called physicians and this belonging helped frame a big part of their overall identity and self worth. Each had important and critical reasons to leave their countries, and to come to Canada. The main reasons had to do with leaving violence, stress and war, and the second main reason was for marriage and family reasons.

The physician role that they were engaged in, for their previous society permitted them to build a particular lifestyle, social networks and to acquire a specific income related to their medical career. In addition, they reported inhabiting an established identity and a recognized and respected position in their respective societies, and that this social, medical, professional identity was accompanied with feelings of high personal self esteem and social status that they experienced in their communities. Employment,
relationships and particular accomplishments led them to live and maintain a definite social position of responsibility and purpose unequivocally related to their professional medical identity prior to coming to Canada.

![Diagram](image)

**Figure 6.** The main factors related to having a professional medical identity before coming to Canada

**4.3 FTPs lives after coming to Canada and main themes**

Resettlement is the process through which an immigrant or refugee takes up residence in a new country and establishes housing, employment, income, education, language services, health services, friendships, and support within the new community. Resettlement includes the process and tasks involved in building a new life, in a new
country, and a in a new community. However, non-licensed physicians have additional challenges related to re-establishing their medical identity, paying for and studying to take exams to get their licenses while doing all the other challenging tasks in the process of resettlement. The foreign-trained physicians in this study could not work in their profession at the time of the interviews and this led many of them to find other, what they considered to be temporary alternatives for work or for volunteer and educational experiences. Many tried to find work experiences as close to health care as they could.

The participants shared their experiences with settlement in Canada in the interviews and described some of the processes, tasks that needed to be accomplished, things they completed successfully and things still not satisfactorily completed for them. Participants talked about their goals of re-licensing as a physician in Canada; housing and living arrangements; language training and experiences; volunteer or paid employment; educational experiences; friendships and community participation; feelings of self esteem and self worth; and their health as parts of their settlement and life experiences since coming to Canada. Some described their present life as a story of its own in Canada, and others described it in contrast to the story and life they had before coming to Canada and went back and forth in describing various life experiences and timeframes. However, their discussions of employment and trying to regain their professional status were primary to their stories and overshadowed their discussions and narratives regarding all other experiences with resettling in the new society. All participants expressed that they had a strong social and medical identity established in their countries before emigrating to Canada. However, no matter what question was posed the discussion went back to the
core of their lived experiences— the desire to be a physician again and their struggle to get licensed again.

The interview participants described that they are still struggling to rebuild their lives in Canada, and that they are still trying to reach the goal of recovering their professional medical identity. The main prerequisite according to them to successfully reach this goal is to get their medical license though the established IMG Ontario process that involves: application, a series of payments, study, exams and strict and sometimes inaccessible residency clinical requirements to be re-licensed in Ontario. Only after this long and challenging process can they reclaim what they previously had - their medical identity, status as a physician and an opportunity to work once again as a physician. While engaged in this licensing process they reported being engaged in other resettlement process tasks and trying to accomplish everyday living, making an income and raising their families.

The main themes that emerged from the qualitative interviews about their lives after coming to Canada had to do with: (1) the importance of regaining the medical identity; (2) resettlement experiences and barriers; (3) the re-licensing process to become a physician as a major barrier; (4) changes to their self-esteem and changes to their health. The core theme had to do with the loss of their professional medical identity and trying to regain it, and most other experiences and themes flowed from this. The sub-themes and relationships between themes were also explored.

4. 3. 1 The importance of regaining the medical identity

All of the participants stated that becoming a physician in their prior countries was a high accomplishment and had been a difficult challenge because it was very
competitive to get into medical school. All of them had already met the barriers and challenges to become a physician the first time in their country of origin. To get into medical school, in and of itself was reported as building a strong affiliation with being a doctor, and with the institutions of medical practice in their countries. All participants expressed how important their professional identity was to their overall personhood and self identity. All of them felt they had already passed the entrance barriers, financial expectations, exams, residencies and the rigor of being accepted as a physician. The loss of this part of themselves was the main theme of the interviews. Many were discouraged to have to go through re-licensing and proving themselves all over again, even though the outcome was so very important to all of them.

Juan was very concerned about his medical career, and wanted to be licensed as a physician in Canada because he believed that his medical career was more important than anything else in his life. He stated:

... you can define identity in many ways... But I think it affects ... in some way your identity because you are defined by your job in some way, and if you choose your life to be a physician, it's something that you wanted ... that you liked to do.

Minh was apprehensive about the process and his prospects of success, and he wanted to become a doctor soon in Canada. He felt undervalued and experienced very low self esteem without it. He expressed that he felt he had lost his identity. He said:

So I assumed that now I was not a doctor anymore (laughs)... it's difficult. Sometimes I ... thought that I was not a doctor, but sometimes I feel it's very, very, very hard for me because ... I had been studying very hard to be a physician in [my prior country]... Like ... complex ... in my life, in my thoughts... About ... that between I was a doctor and now I was [am] nothing.

Hamid wanted to re-establish being a physician again as soon as possible. He stated:

Well, if I have the choice to become a physician [in Canada] ... if I could go for my residency in one of the hospitals, and probably writing the test the sooner the
possible, I would have preferred doing that... to get my license, and... start to practice as a physician.

Nanor said he was a very enthusiastic graduate student and had successfully proceeded to work and study in the medical academic field. Even though sometimes he thinks he could be a researcher, he still prefers to be a surgeon again in Canada, and perhaps to do research in his area of practice. He is conscious of the financial advantages of being a surgeon over being a researcher in Canada. His desire is to become a physician again to recover a part of himself which he felt was lost.

I see lots of things and every time I go to morning rounds at 7 am, I think, I should do [the] exam. I should get where I want. I should become one of them. I know this is a psychological thing again, but it is a method... why am I worse than them? No, it’s not that question, but I know if ... it wasn’t that difficult to become a doctor. It was like very straight forward... like one exam or two and you’re in. Um, it would have been so good if I was in the system [already].

Sophia had lived in Canada for many years. When she came to Canada, Sophia initially perceived that there were no opportunities for IMGs to get into the Canadian medical system. She has gone through the long IMG Ontario exam process, but still did not get a residency spot. She wants to become a physician in Canada “at any sacrifice.” She did not consider herself as a doctor in Canada. She lost a big part of her identity, and she said she needs to recover it at any sacrifice. She affirmed:

I would never mention that I’m a doctor here in Canada ... because I’m not working, and I don’t have a license ... Call myself a doctor over here?(Laughs). Hi my name is ... (last name), and I’ve been here in Canada for 9 years. And if somebody asks me what were you back home. Ya, then maybe I would mention that I was a doctor back home.

Enrique came to Canada a few years previous. After living one year in Canada, he particularly missed his medical profession, the hospital environment, and his patients. He expressed pride in being a physician and had high self esteem attached to this. Because he
did not get his Canadian medical license yet, he is not recognized as having this profession, and he now considered himself without a place because he feels like nothing. He lost a big part of his identity. He was concerned about getting his medical license in Canada and had just started to engage in the IMG licensing process.

... But after a year, you started missing what you are prepared to do. Like you want to be again in ... in the hospital environment, and the patients ... So it is quite hard to compare the professional life you used to have in your country and the life you have here. ... In health [care] I think you have to go down and start all the way back up. So let's say the hard part at the moment is realizing that it is so difficult to get there again ... To be a physician again. ... Here sometimes I like to say that I'm a physician, and I feel kind of good. But sometimes I prefer not to say that ... It's a very hard situation to be in the middle of everything. ... So you are kind of without a place.

Carmen has been living and working in Canada for many years. Even though she has worked in the health field, she wants to become a physician because she feels like she is dying everyday in Canada. Her professional medical identity is lost, and mostly it was not her choice, so the biggest part of her identity is gone according to her. She said:

So when I saw that we were going to stay, I said I'm going to do something about my medical career because it's my passion. It's some part of me that I cannot give up. It's like if somebody has taken a part of my life ... either recovery or I feel that I die every little of inch of [me] every day. And it's really hard to live like that.

Markus stated that being a physician is a learned profession with a strong identity. He observed that medical students generally have high self-esteem and this is developed and brought out in the medical school, where their professional medical identity is initially shaped:

And you see changes in the personality in the first year. Those studying nursing were more open, more into the parties etc ... and they were the same people ... just students in medicine are more focused, more serious, don't want to talk to anybody, they have this high self-esteem... and it was interesting to have noticed that they come in the same way but due to the profession ... they aren't the same ... it's learnable.
4.3.2 Resettlement experiences and barriers

Participants were asked about their life since coming to Canada. Most of their responses had to do with not being able to claim their physician status and identity in Canada. They described their experiences in resettling and their lives now attached to employment, income, housing and social networks. They described the barriers and facilitating factors they encountered related to resettlement and attainment of their goal to be re-licensed. Many of their comments were described in association with the core theme.

4.3.2.1 Employment experience after coming to Canada.

Figure 7 summarizes the variety of employment experiences, alternate work and limited opportunities for employment FTPs described by the study participants since coming to Canada. Many of the work experiences have been for low or no income. The lack of having a suitable income and work related closer to their professional background led many of them to feelings of isolation, loneliness and a lack of belonging. As a result, in a variety of ways, many of them expressed feeling a lower sense of self-esteem.
Figure 7. Main areas of work for FTPs after coming to Canada and their effects.

One of the criteria for participation in this research was that the participants had to be presently involved in the process to become a physician in Canada. The researcher expected that these physicians were struggling to make a living at something else in the interim and facing the other challenges that the general resettlement process presents. It was anticipated that analyzing the participants’ experiences with unemployment or employment outside of their profession during the resettlement process might be important influences on their health.

Research question number 1, "What impact does having to work outside of the medical profession has on the resettlement process, sense of identity and health status of foreign-trained physicians?" guided the interviewees to share their present employment conditions and their search for alternate careers.

Several participants enrolled in Master’s degree programs in Canada while they worked on re-licensing as a physician in order to pursue a research career, or in hopes of
finding a job in another professional activity should re-licensing take a long time or not be successful. Some FTPs searched for jobs in the health care field, while studying for the IMG licensing in Ontario. Some were working in any job available to cope with their lack of financial resources and to supply for their family and personal needs.

Juan is a specialist physician from South America. He arrived in Canada a few years prior to the research. Presently, he is finishing a Master’s degree, and his goal is to work as a researcher in the interim because he needs a job. He realizes that working as a researcher, will support his studies to go through the IMG Ontario licensing process, and to support his family. He worked as a volunteer where he gained good experience in the health care field. He stated:

*I worked as a volunteer. [I] was a coordinator of ... volunteer group that deals with a diabetic people in a Community Centre ... and in some way we were the liaison between the Latin people and the centre, I also worked as a researcher, and it was a very good experience ... and they advised us to study English.*

Hamid decided to pursue a Master’s degree, and more recently had set an interim goal to get a job as health promoter to raise his family. He said he did not know initially what he could do in life besides being a physician and he was still eager to get his medical license in Canada as soon as he could. He expressed discouragement because he was not doing what he had planned in life:

*And for me, I know it’s challenging life here. I started to go back to school. Now I’m doing my make-up for Masters at [university] which is kind of a change. But of course ... like all the physicians, they’re trying to work as a physician because this was the initial goal why we started to go to medical school If I don’t be a physician, what will I be? If I do my Masters then [I] can get a job because I won’t be economically able to stay that long and after two years, then think about preparing for the exam.*
Nanor was engaged as a Master’s student and as a paid research fellow. He explained how being in the health field and working with other colleagues made him still feel included and recognized and this elevated his self esteem. He stated:

So I was observing and then one of faculty members offered me to stay as a research fellow. I stayed for another year. Professionally I was excited. I just recently got an award ... so right now I feel the recognition by everybody, but not before. So now professionally I feel way better than when I started. And then professionally I started feeling like a part of the team doing some work equivalent. I’m a research fellow. I’m recognized ... I started [to earn] money.

Carmen in the early years of living in Canada dedicated her work to taking care of her children and taking responsibility in the home. She explained the implications of being a woman and going through the IMG Ontario process and having little time to dedicate to studying because her work to the family. She explained:

And finally I studied here, trying to take the medical American [Canadian] exams. Then finally I didn’t because I got pregnant and I had my second child. So I had to dedicate my life to the children ... so it was hard.

Sophia also reported on this re-entry to the work phase after being in Canada for a while and stated:

It is hard when you come here... The first three years of starting out ... even though you’re settled back home, but you’re starting off over here. It takes a lot of money to get settled and find jobs. And my husband had to start his money too. So I couldn’t work in something... and even when I came I had a one year old one [son] ... and it was hard for me, but I tried for the medical exams. But I didn’t have that much time for the exams.

Juan was concerned about finding a job, because he needed to support his family, and also needed time to study for the IMG Ontario licensing process. He reported that he experienced high levels of self pressure, and pressure from his family and friends to become a physician in Canada. He expressed humiliation while receiving welfare and social assistance and being limited to working in odd and low pay jobs.
If I don’t get a job here, I have to go and leave. I have to immigrate again to the States, to Australia, to Europe, Spain, Brazil... any place that can offer me a job... like researcher or physician. But I don’t like the kind of job that you can get here as a cleaner, or as a clerk. I don’t think this is good, and not for me... I think you look for something else if you are not allowed to work as a physician...

He spoke of the pressure from self and others and how his self esteem has gone down and he does not feel smart anymore himself or in the eyes of his family:

... the pressure that comes from your family... from society, from friends... but there is a very [high] self-pressure. Self-pressure about... you are not able, and you are not smart enough... you are stranded... you’re not at home, you’re thinking you don’t have the capacity to be a physician anyway... maybe you are underestimated... your capacities, because your family thinks... you don’t have the capacity to be a physician anyway... the family [members] think you are not smart.

Hamid had a new baby since coming to Canada, and he compared his previous economic status before coming to Canada, with his current status. He was discouraged, and unemployed and expressed feelings of humiliation. He borrowed money and he did not know what his financial situation would be in the future. He stated:

I had no problem economically [before]... I was set up well there [in my country] rather than being here, cause I don’t work here. I don’t have a job. I really feel I have to find a job... be any kind. As a full-time student I applied... and I did get money from OSAP as a loan.

Minh searched for jobs and found only ones with low pay. These odd jobs made him tired and made it difficult for him to attend his English classes. He identified this kind of job as a barrier to being able to study for his license. He said:

I try [tried] to find work... I got it as a cleaner... I was [am] [the] husband in family. In... my culture the husband has to work and... and the man... is the main [head] in the family... I feel [felt] very tired. Because that job I have to begin at 11 pm and finish... about 5 am, and when I got home I’m [was] very tired... and I had to sleep. I couldn’t go to English school.

Markus had been working in short term self employed contracts to supply his financial needs. He reported that according to lower paid employees he has spoken to
who make minimum wage, that physicians in Canada are perceived as belonging to a high class in the economic and social hierarchy. Being a physician and working in a low pay scale is unusual according to other Canadians he has met, and they were astonished that physicians were working at such jobs, when they find out. He really believed that the reason he was working at such jobs was because of the barriers in the licensing process for IMGs. He stated:

*I just did it for a month [worked in a construction company] to get a 1,000 dollars for the [MCCEE] exam. [At the greenhouse]... But once they knew I was a doctor, they changed their way of looking at me. And also there was ... a woman that worked with me .... She’s Canadian... But then the third day, someone told her that I was a doctor and that day when we started in the morning she was ... oh ... ‘this is how we live here the people of low income. You shouldn’t be here. You should be saving people.’ I said, ‘yes, but it’s not up to me.’ But from there on, all the conversations with her were all about me not being there.*

*Enrique* got a job at a health center after a few months of being in Canada, and he reported that many times he is too tired after work to study for the IMG Ontario licensing process. Markus also expressed being too tired to study:

*And I was doing different things ...I did a kind of position for a fulltime job at [a health centre] ... I don’t study now everyday. Some days at work it’s busy. So you get tired, and you get like you don’t want to do anymore ... But the rhythm of the study goes down because you are doing more things during the day.*

*Markus* has worked in the health field in Canada and after finishing work he felt tired and with little time to study his medical courses. Even though he was single, he stated: "I work and then [do my] medical studies. That’s very tough. Even for me it’s very tough ... because there’s no way you can cover it ... not it all."

*Carmen*, after living in Canada for few years as a homemaker and taking care of her children decided to look for a job. After looking for other available jobs in the health field and being denied, she finally found work in home care and social work, and stated:
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And I couldn’t find anything in the health field. So I noticed that in the social work field, or using your language as Spanish immigrant of course, there were some jobs... but of course, [they were] in the low rank pay. I was working as a nurse. I’m working as a community high-risk nurse... community home visiting nurse. So it’s not the same [as] a clinician or clinical nurse in the hospital, that you can inject or you can administer therapeutical [drugs]... I cannot do anything of that. What happens is I was so desperate to work for the experience that I started working in the social work field, helping immigrants in the Spanish community. I started doing... medical translations and interpretations.

Researcher’s note: Her desire to have a professional identity was so very strong that she described her work as like a nurse and as a social worker even though these are professional designations in Ontario are under the Regulated Health Professions Act (1991).

Nanor lived the first months of re-settlement facing financial problems and it made him miserable. He also felt loneliness and reported feelings of being excluded. He stated:

I was thinking I should go back and I should have some money to continue my living in [my country]. So [the] first 5 months were financially not good, and my professional life at the hospital was not as good too because I was not a part of the system. And that was kind of a pressure on me, [and] loneliness occurred. ... Separation from family. I haven’t seen my mom for three years and ... they’re more like problems ...

Sophia remembered when her family settled in Canada, and how her family had financial problems during the re-settlement period. She felt depressed and felt low self-esteem. She explained how being a woman and being unemployed and without an income has influenced her experience of the IMG Ontario process. She stated:

So I couldn’t work in something ... and even when I came I had a one year old one [son]... I was not at the point that I could go to a doctor and get a prescription. I could deal with it ... the depression ... and low self-esteem. I could deal with it. I still do. [I have some depression] sometimes, not all the time. But I had a bad time. About three years ago ... [I] just stressed out. Just not being able to do anything and... you have to try to get your license...

Carmen decided to look for a job after a few years of living in Canada when her
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children became more independent. She found some barriers in her quest for a job, and explained that her over-qualification was a barrier to find a job in Canada. She stated: "I started looking for jobs, and they would tell me 'oh... you're over-qualified. Go and practice as a doctor' Like it was so easy (laughs). So I was finding the barriers."

4. 3. 2. 2 Experience with acculturation in a new country

Many of the interviewees spoke of other experiences related to dealing with a new country and finding ways to learn about and to adopt to parts of the new culture. Juan reported his experience of living in a new country, and in a new culture as being dramatic. Not knowing the language and culture of the new country, and never have lived in an English speaking country he found it to be a very stressful experience for him, and he explained: "It was a very traumatic experience ... a very huge change when we came because we were not used to the language, and we were not used to the culture".

Manor had been learning about the Canadian culture and integrating into it and did not raise any big concerns about his acculturation. He enjoyed being in Canada and stated:

I learned things. I'm interested in this country. Historically, this country is very, very new. My country is three thousand years old, and like if there's a house ... [like] this house is 100 years old, and it's a history for Canada. But, I do appreciate Canada.

Markus experienced this new society as different from his place in the social system in his own country and as a physician before. He talked about his work here in what he felt was in a lower class. He stated:

... As a physician, and now that I should be looking because this is the way people of low [class] ... so now all the conversation is towards the social classes. And you realize that if I didn't tell I was a doctor, everything would be different. But it was interesting at the same time, to know a little bit more about the low classes ... how they feel about this model of society.
Chapter 2: Historical Context and Framework

The historical context of the current environmental and economic conditions is crucial for understanding the development of the research framework. This chapter outlines the historical background, societal influences, and technological advancements that have shaped the current landscape. It provides a comprehensive overview of the past 50 years, focusing on key events, policy changes, and technological innovations that have significantly impacted the field.

Historical Background

The industrial revolution in the late 18th century marked the beginning of a new era in human history. The invention of the steam engine, advancements in transportation, and the expansion of trade led to rapid population growth and urbanization. These changes had profound effects on the environment, leading to increased pollution, deforestation, and soil degradation.

During the 20th century, the growth of the global economy and the expansion of infrastructure further intensified these environmental challenges. The rise of consumer-driven societies and the adoption of new technologies led to increased resource consumption and waste generation. This period was characterized by the development of new industries, such as petrochemicals and electronics, which required significant amounts of energy and raw materials.

The environmental movement gained momentum in the late 20th century, with the establishment of international agreements and the creation of environmental protection agencies. This period saw the emergence of sustainable development principles and the recognition of the interdependence of human activities and the environment.

Societal Influences

The cultural and political climates of different regions have also played a significant role in shaping environmental policies and practices. The United States, for example, has a history of strong environmental advocacy, with the establishment of the Environmental Protection Agency (EPA) in 1970. In contrast, some countries have been slower to adopt environmental regulations, leading to significant disparities in environmental outcomes.

Technological Advancements

Technological innovations have played a pivotal role in both exacerbating and mitigating environmental issues. The development of renewable energy technologies, such as solar and wind power, has offered new solutions for reducing dependence on fossil fuels. However, these advancements also raise new challenges, such as the need for safe and efficient storage solutions for intermittent renewable energy sources.

The future of environmental science and technology will likely be shaped by the intersection of these historical trends and current developments. As the world faces increasingly complex environmental issues, the need for interdisciplinary approaches and innovative solutions becomes more urgent.

In conclusion, the historical context and framework provide a foundation for understanding the current state of environmental science and technology. By examining the past, we can identify patterns and trends that inform our approach to addressing future challenges.
Markus lived in a refugee camp in his country before going abroad to study medicine. From there he came to Canada. He felt the model of society here was different from the two countries where he had lived.

4. 3. 2. 3. Housing after coming to Canada

Since coming to Canada the FTs have had to find a place to live and their various housing situations were recounted in the interviews. Some described their new living conditions of living in apartments, shelters, with relatives and in low rental places or homes in contrast to what they had before. Many shared their challenges of finding a place to call home and feelings of isolation and loneliness related to where they lived.

Juan left his own apartment in his own country and came to live in a shelter when he first arrived in Canada as a refugee. He explained that it was a consequence of being unemployed and without an income. He had to live in a shelter with people from different cultural and economic backgrounds. He felt living in a shelter positioned him and his family in a lower social position than they were used to and it was humiliating to him until they could get their own apartment:

*We lived in a shelter ... a shelter is a big house where you have to share everything with people from all over the world... it was hard because I have [lived] ... for the [last] ten years with my family and it was a contrast, because we lived in our own apartment in Colombia... ...you need to cope with different cultures... we were supported by the welfare system... and they gave us just money enough to pay for an apartment in [City]...*

At first, Hamid’s family was living with his parents-in-law. He expressed dissatisfaction with his lack of privacy, and he expressed humiliation to be supported by them and having to receive donations of old furnishings. He later rented an apartment and stated;
We used to live with her parents at her parents’ house ... my in-laws, but for the first three months, but then we had to [move] ... cause they have a big family, and you know ... and we needed our own privacy and our own place, so we just moved. And now we live in an apartment.

Sophia was living with her parents-in-law when she first came to Canada and fondly and proudly reminisced about her home back in her country which made the researcher believe that her social status in Canada was not the same as she had before back in her country. She stated: “I still have my house back home. It’s a four bed-room house. I have a home there, and it has a yard ... just like houses over here. Dining room, kitchen, family room. It’s a big house.”

Enrique lived during his first year in Canada in what he referred to as a “low level” building. He did not appreciate that. After one year he got a full time job and he moved into a better house. He stated:

We used to live in an apartment ... in a building ... only [it] was a low level ... a low price. So [it] was [a] low level building. Finally, after one year we moved to a rented house in a better neighborhood. So ... I think I was lucky because I was doing a volunteer in a health centre.

In this quote, Nanor expressed dissatisfaction with his early accommodations in Canada, his low finances, limited choices of housing, and the loneliness he experienced in his housing circumstances and stated:

It was a tiny room ... even no bathroom ... no ... no washrooms in my room... lots of people. And I had very little money to live ... And that was kind of a pressure on me, be cause I didn’t like that place ... loneliness occurred.

Several expressed satisfaction with their housing situations since coming to Canada. Minh stated: “... we already have a place to live.” Markus was asked about his housing situation when he came to Canada up until now. He said that he have shared an apartment with friends but did not express satisfaction or dissatisfaction.
Carmen related that her husband is a successful executive of a Canadian company, and before they had decided that Canada was a place to live, they had lived in other places around the world. She did not refer to any housing problems, since adequate housing was offered because of her husband’s business status and stated: “But, so I really stayed ... agreeing because of his career too. He [her husband] was doing well, and I said ‘well for the kids it’s good.”

4. 3. 2. 4 Social and community networks after coming to Canada

Hamid reported that he does not have friends in Canada, and that his social life is basically around his family. He did not have friends or acquaintances here as he was used to because they did not have much in common and he felt isolated. He stated:

But coming to the friend ...the friendship, I don’t really have friends here. I don’t really have friends cause the reason is first of all, I’m in here. And the second reason is I don’t have social life. I don’t socialize... maybe we don’t have anything in common... except for the superintendent we used to say ‘hi’ and that’s the only conversation we have.

Enrique felt one of his top barriers since coming to Canada was not being able to make social connections with others. He felt that was associated with not being with other physicians and stated: “The second (barrier) will be the connection to the people. When I came I wasn’t introduced to a physician, like a GP [general practitioner].

Nanor reported that he was very socially active, since coming to Canada, unlike some of the others, and he had contacts with his own community where he lives. He reported that he has many friends, a love in his life and social connections and this did not allow him to experience much loneliness. He declared:

In the second year I had a friend who came with the same project to study here. He did that for 6 months, so I was not that lonely. And he went back. There’s a big community here, 30,000 people. I was involved. Almost everybody knows me ... almost everybody who is active in the community. I have friends... there’s a huge
difference between the first year and [second year]. I feel very happy now ... well recently I met, I think, the love of my life who is waiting for me in our house which is close to here...

Sophia’s life is dedicated to her family and community women friends who are in like circumstances. She stated: “People like me are my friends, they came here with their husbands.” Carmen also recounted that her friendship network was related to her husband’s successful career, and this affected her successful adaptation to the Canadian culture. She explained: “I wanted to tell you that because we adapted to the Canadian culture ... We made friends. My husband did well in his career. So we had company, acquaintances. We made friends”.

Markus was very enthusiastic about his work in an allied health care area since it was still close to his medical career. In addition, he reported that he is engaged in sports, participates in the community and has formed some IMG friendships. He did not talk specifically about his other personal friendships but that he was being involved in some social and recreational activities such as basketball and bicycling riding. He stated:

Most physicians ... most of them marry a girl from their country. Because also in your community you have this high standard and people are watching you, and they want you in the community so they do their best to keep you in the community.

4. 3. 2. 5 Language experiences and impacts after coming to Canada

Juan experienced some barriers like related to not knowing the English language at first, and it made him feel isolated, and he stated: “The main barrier is the language .... they won’t talk to you ... and this is something that is very important”.

Minh had some problems understanding the IMG Ontario licensing process because of the English language barrier, but he stated how he felt better as he started to study English and it elevated his self esteem and connections with others:
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I begin know a little English, and I begin to find out about the process to become a Canadian doctor. And I get more upset for because [it is] very tough. But one thing different is [that] my English is getting better. [I] communicate with Canadians better. And I feel better.

Enrique classified the language barrier as the most important barrier for him. He stated:

After four years, I'm feeling that I'm starting to understand people and a little bit better to explain [to] people.... I think the first thing you develop is written, and only after many years you can develop your speaking. And that's a real huge obstacle.

Minh reported his experience of not having language fluency and how he felt discriminated against as a result of this, and the negative impact it had on his self-esteem. He reported the subtlety of those experiences:

I have some experience now with discrimination. When I went to a [store] ... to buy something in the mall ... when I ... because my accent is very strong and people ... couldn't understand me ... and I saw some ... something in their face, and I know ... they have some talk not good about me.

Markus recognized the strong language barrier through taking the TSE exam:

And I know people who have written the TSE ten times and they speak better English than me, but I don't know what happened. If they get nervous or whatever during the exam. And they haven't passed it about 10 times... so TSE is becoming a real problem for the IMG.

Manor reported his semi-traumatic experience at the hospital because of his accent and how its affected his sense of belonging. He explained it:

My professional life at the hospital was not as good too because [of an] experience when one of the doctors asked me to read something. My English was good, but not as good as now, and I read with wrong pronunciation of words ... pharyngeal .... I was pronouncing it wrongly... just to make fun of me, but I felt really uncomfortable because my pronunciation wasn't good. And then in the first few months they were talking really fast. I wouldn't understand what they were talking sometimes. I was not a part of the system. I was observing ...I can re-call semi-traumatic...
4. 3. 2. 6 Experiences of discrimination and exclusion after coming to Canada

Several participants reported feeling some discrimination and some described it as more a subtle feeling of uncomfortableness and feeling different.

Hamid felt he had experienced some discrimination and exclusion and stated: "Well, I didn't really feel exactly, but I know like ... there is something going on for being [a] different color".

Nanor explained his feeling about his experiences of discrimination as feeling more a feeling of uncomfortableness.

But there is ... some kind of discrimination towards I think, newcomers you're kind of lost ... That's sometimes when I feel out of the conversation. It's not discrimination. Sometimes it comes to discrimination... Somebody said something that I didn't like and I though that it passed the border of uncomfortableness and discrimination.

Enrique tried to explain what he felt was discrimination against IMGs generally:

I think there is a problem when we want to generalize. Because not all the IMG are the same. So Canadians and probably Americans also, they have a prototype on the IMG. They think of the IMG as a sometimes a low level doctor who prefers to drive a taxi, or clean or something instead of pass the test ... but they don't know that the guy needs a house, needs food, needs clothes. So many of them ... Canadian physicians think about the IMGs as ... not trustful.... I think that's the unfair thing.

Carmen expressed that the IMG licensing process itself was discriminatory against the IMGs, and that this was contradictory and hard to understand because Canada was a fantastic country open to accept refugees and seen as a pioneer in many issues. She stated:

I do resent Canada ... a lot to me is a contradiction. It's such a country open to issues of space, of mediation, of understanding refugees, political issues for people in many, many ways. They are pioneers in a lot of things as a country, and as a culture. I truly resent why they are so discriminatory and racist when it comes to foreign-trained physicians. I don't understand.
Markus referred to what he knew of the discrimination experienced by the aboriginal population as an example of what he saw as similar discrimination experienced by refugees and immigrants in Canada. Markus expressed his thoughts about this general discrimination:

*Definitely that [discrimination] will always be in society, with different classes and all these philosophies that teach ... that democracy is based on. You will always find this dimension of self. You’ve stayed ... here in Canada? It’s not spoken about. People don’t show it, but it’s always there.*

Markus referred mostly to the discrimination experienced toward IMGs regarding re-licensing. Markus described what he felt was a very strict selective process that could leave room for discrimination since there was an excessive and higher number of unlicensed IMGs in Ontario all competing for positions. He raised the possibility of existing racism in the IMG Ontario process itself and recounted the story of a friend’s experience:

*I don’t care how many exams. What I care for is after I wrote ... after I write all Those exams, I should be in, because I have shown, and I have proved that I have the knowledge, and I have the skills. I know somebody who has gone through the IMG three times now. So he wrote the 3 Canadian exams, evaluating; qualifying 1; qualifying 2, wrote the American 2 exams, and have gone through the IMG 3 times; so he has 8 exams now ... and he passes. Always he goes to the OSCE (It stands for objective structured clinical examination...), but then in the OSCE they don’t admit him because ... he just can’t explain what is going on ... well actually he thinks there is some racism going on... That’s what he thinks.*

4.3.3 The licensing process to become a physician in Canada as a major barrier in resettlement

Gaining the Canadian medical license to practice in Canada is seen as the major facilitating factor in the re-settlement process according to these participants. However, in reality, these interviewees found the IMG Ontario licensing process itself to be a major resettlement barrier, since it is so long and often does not result in success for many to
actually gain their license. They see the licensing process, as it is now as a huge barrier to surpass for overall successful re-settlement for them. It is seen as the major barrier to many of the other goals: professional identity, income, self-esteem, housing and social networks.

For these FTPs, to not practice medicine ever again represented the elimination of the professional dream which they felt they had already accomplished. Through the interviews, the participants talked a lot about the re-licensing process itself that they were engaged in and their experiences and opinions of it. They identified many problems and barriers related to being able to successfully re-establish their career and to actually get their license in Canada. The barriers associated with re-licensing included: the number of exams, the cost of exams, the time involved, the lack of availability of residency spots, the protracted length of time, the institutional barriers and the obscurity of the process itself.

For many, the cost of the licensing process was identified as a problem. Juan, Nanor, Sophia, Carmen and Markus stated that the costs of taking the required exams were seen as exclusionary for those who were unemployed or employed in minimum wage positions.

Juan stated that he did the MCCEE for the first time, and passed this exam. After that he took the MCCQ1 and other exams and had to borrow money. He shared his experience:

*The qualifier one and I didn’t pass. This is a lot of money because the first one cost 1,000 dollars and the second ... 650 [dollars], and on the other hand you have to take the English exams, the TOEFL and the TSE, and [they are] 180 [dollars] each one, and you have to repeat [them] at least once or twice. The TSE that is very hard. I borrowed some money, because if you earn the salary that these people earn it’s not enough to take these exams ...*
Nanor stated that besides the high costs of the exams, the selection of those to practice by access to finances is discriminative and unreasonable since foreign-trained physicians could help the country but have little money for the licensing process.

*It will be a burden for me to pay 1,000 dollars for GP [exam]. That’s huge money ... like I don’t think there if maybe there are immigrants who are coming saving 50,000 dollars from their country... I came with almost no support.*

*It is not right to not allow people who don’t have money to become specialists and doctors. That is selection and that is discrimination. If I’m brilliant enough you should help me to become whatever want to do, because I’m going to help the country.*

Sophia explained that even after the FTPs spent a great deal of money and passed all the exams, there is no guarantee that they will get a job.

*And passing these exams does not make you ... make an assurance that you will get a job. So it was a lot of money at that time, and we didn’t have that much money. It was 1,000 dollars just for one exam and then for other exams there were different fees.*

Carmen described the high costs not only associated with the exams but also for the resources to study the courses recommended by AIPSO: “...to be certified as a doctor it’s very expensive. You need the money. They’re very expensive [the exams]. I have to pay for resources to study. I have to pay for courses.”

Marcus stated that he would like to write the next exam, but he had no money at this moment, definitely: “if I could get some more money I would be writing that written exam just to widen my possibility.”

For some, the lack of clarity of the IMG licensing process was identified as a problem. Carmen and Markus shared many thoughts about what they described as an obscure and unclear IMG Ontario licensing process. Carmen said:
[It is necessary] ... to make it more transparent. They have not been negative to me. They have been helpful and I've been treated well. I don't have any complaints regarding them [IMG]. With the government ... I don't understand sometimes their approach. Because they really need doctors, and they are putting [up] the money, but on the other hand I don't know if they... the system [will] to be able to meet the needs.

Markus claimed that it was impossible to interact directly with the examiners and decision makers, because of all the IMGs trying to get residency spots. He shared his experience with the IMG process in Ontario and having to prove his knowledge over and over and still not being certain that he would be successful:

How do you know what kind of person I am if I don't have the chance to show them who I am. So it's easy to say that... 'ok, you have very good courses, but we don't want you in because we found someone who is better than you.' But how do you know that somebody is better than me, if you haven't interacted with both? I will show them that I have the knowledge. But there is no guarantee that by showing them, I will be in.

Many of the interviewees expressed concern about the number of exams. Juan, Nanor, Sophia and Markus stated that there were too many exams. Markus agreed that having to do all those exams was difficult, but he objected mostly that even after doing all those exams, he wasn't sure he could be successful. He displayed high anxiety about, and disagreement with the IMG Ontario process and the exam process. About the number of exams, Juan stated:

I think there are many exams ... and the best way of evaluating a physician is seeing him or her in the practice. I think the practical one ... check the answers and the attitudes of ... the foreign physician and I think it's the best.

About the exams, Nanor stated: "If it wasn't that difficult to become a doctor... [If] it was like very straightforward ... like one exam or two and you're in."

Sophia explained that the system of exams in United States was different: "It's not like that over there [US]. People pass ... a lot of people pass. Some may not get a
residency spot, but they still pass. They’re still doctors. There’s just one exam for both licensing and residency”.

Sophia described how it is difficult to explain people that she is still going through the IMG licensing process:

[People] always ask me, ‘Are you still doing exams? What kind of exams is this now?’ There are different exams. People don’t understand that there are different exams. Even my husband gets confused... So they’re complicated. It’s not fair. Their own people [Canadians] don’t go through so many exams ...

Markus was not concerned about how many exams the IMG Ontario requires to succeed in getting his medical license. He did feel strongly, however that after the IMG completes all those exams successfully he or she should be able to be re-licensed and he questioned the fairness of the license process. Markus explained: “And so, are you going to tell me that with 5 or 6 exams written and passed, you don’t have the knowledge to work? There’s no way. So it’s not about knowledge, it’s about quantity [of exams].”

Many discussed the problem of having such few residency spots available for IMGs and therefore, even after completing all exam requirements many are not able to complete the last requirement of clinical practice in a residency. Juan, Hamid, Sophia, and Markus criticized the availability of such a small number of residency spots. The available numbers did not increase in proportion to the current increased number of IMGs living in Ontario. There were only 200 residency spots available to IMGs living in Ontario according to AIPSO (2004).

Juan explained: “It’s hard... it’s just a very small possibility that you have because at least there are 3,000 foreign physicians here and the positions for [residencies for] the foreign physicians are 200 [each year].” Hamid said: “And it’s very competitive because chances are very few ... it’s a long process.”
Regarding the licensing process, Sophia stated:

*IMGs? The written exam was out of 1,000 [people] ... 994, something like that their figure was ... but there were a lot of people]... There are like 550 applicants for 200 positions (laughs) They have 200 spots for IMGs ... for [beginning] level up to the practice ready level.

Regarding residency spots, Markus was concerned about the number of available positions and shared:

... it's not about knowledge, it's about quantity. So they wanted about 3 or 4 years ago ... they were accepting between 25 or 75 people only a year. But now they have raised their numbers to 200 which is...which is good, but not great yet.

Markus stated that, even though the IMGs who pass the MCCQ1 and MCCQ2, most of them will not get in the residency program because of the small number of residency spots, and if the IMG does not get in the residence program, he or she will still not get the medical license and will not be able to be called doctor.

Many expressed concern about the length of the process to be able to get their license in Canada. Hamid, Minh, Carmen, and Markus strongly disagreed with the length of time it took to go through the re-licensing process. Generally, it takes from 3 to 4 years to wait to get into a residency program even after completing all exams requirements for IMGs in Ontario (AIPSO, 2004).

Hamid strongly disagreed with the length of the licensing process because most of the IMGs at the Welland AIPSO meetings have commented that four years was the least amount of time to get into a residency program after finishing the exams, even though most never even reach this stage.

Minh related that the IMG Ontario process is very stressful, and many get depressed after a few failures. He stated:

[the IMGs] have to face a lot of stress, and [it is] easier to get ... depressed. Easier
than another group of people. I will keep on going... to reach my goal. Quickly. Anybody wants to go through that process as quick as they can ... because in fact a lot of physicians quite studying to become a physician because after a few years trying ... they give up. And it's very stressful... it's very hard for us. You just give up.

*Carmen* relates the differences between engineering field and the medical field in order to get a job in Canada. She explained as she sees the difference:

*My husband came here with a job offer as an engineer. He has worked all his life as an engineer. He has never had to take an exam and he's a professional. He's a successful executive now of a company. He never had to do anything.*

Some expressed concern over the institutional barriers they perceive to being able to get their license. *Carmen* and *Markus* believed that the power of the Canadian Medical Association (CMA) through its divergent political ideas and its institutional influence, was the central factor responsible for creating the lengthy and difficult licensing process. They identified the position of the CMA as an institutional barrier to IMG licensing and success, Markus also felt there were institutional barriers to obtaining observer positions that are fundamental to getting a Canadian acculturation medical position to gain the experience, understanding and skills to be able to work in the new societal context.

*Markus* criticized the College of Physicians and Surgeons of Ontario, which claims to want to keep the Canadian health care system as the best in the world for supporting such a difficult licensing process for FTPs. He felt they used the claim of having a good health care system to convince the Canadian population those lengthy and hard exams for IMGs, and a highly competitive process to get their medical license is required and necessary. He felt if the Canadian government wanted to improve health care to Canadians that a clearer process with residency opportunities would be more available for IMGs.
Figure 8. outlines the major barrier identified by the interviewees as the IMG Ontario licensing process and aspects of that barrier as described by the interviewees in more detail.

![Diagram showing the IMG Ontario licensing process as a major barrier and its aspects]

Figure 8. The licensing process as a major barrier and aspects of the barrier

4.3.4 Changes in FTP self-esteem and health status

This theme will discuss the findings of the study as recounted by the participants related to changes in their self-esteem and their self-related health status during their resettlement in Canada and their attempts to regain their licenses and professional identities. Participants shed light on aspects of self-esteem and health and relationships between these factors emerged from the data.

Self-esteem is the worth and regard one feels about self. Feelings of high or low self-esteem are associated with how one feels about oneself and this is known to be developed often with influences from the social context (Rosenberg, 1965). These
The text on this page appears to be a continuation of a discussion or explanation, possibly related to the diagram below it.
feelings can be influenced by life experiences, social engagements and interactions with others, and many other factors. For the interview participants, much of their self identity and self concept was attached to their role as a physician. Many of them had already experienced high self esteem by being a respected physician with a professional status in their countries prior to coming to Canada. These FTP’s who could not presently work as physicians were at various stages in resettling in Canada, and this study was interested in the impact resettlement and struggling to regain their professional identity may have had on their self-esteem and health and whether health and self-esteem were related to one another..

For those involved in the study, to be licensed again as a physician was seen as the desired route that they wanted to take to pursue their future goals and careers. The present licensing process was seen as a barrier to being able to ever practice again. They all still strongly expressed their desire to be a physician again as the most preferred way to re-establish themselves and to be happy. These IMGs were clearly directing their lives to get into the Canadian medical system.

Resettlement barriers reported by refugees and immigrants such not having their professional license, underemployment, lowered income, discrimination, exclusion, language deficiency and some social isolation often placed them in a lower socio-economic status which also contributed to lowering their overall self esteem. Their core concept of self appeared to be that of being a physician and over time not being able to operate as a physician was negatively affecting their self-concept and self esteem.

All these experiences had placed this group in a new social role in the new society as a newcomer, without a profession of their choice and without full use of their talents
and skills. They were engaged in a long route to reclaim their professional identity. This was believed to be a possible indirect and contributing factor influencing their overall health status and their self-esteem. The qualitative interviews investigated the connections between their professional medical identity and their self esteem and health during the resettlement period in Canada and found through their self-reports and words that these were connected.

4. 3. 4. 1. Self-esteem and professional identity

Juan expressed sadness when he was asked about his self esteem. He felt the pressure that came from his family and friends, and his own self pressure to become a doctor again. He clearly did not feel good about himself at the present and was even expressing doubt about how smart he is, and that something was wrong with him, since he had not successfully made his way through the exams and to be a physician again. Presently he felt under-valued, and was unable to successfully maintain a good job to support his family, while studying for the IMG Ontario license at the same time. He expressed the self pressure and pressure he feels from others to get his license and to prove himself. This pressure and stress has an impact on health.

... maybe you are ... underestimated ... your capacities because if your family thinks ... that if you are not able to work as a physician maybe...you don’t have the capacity to be a physician anyway...Ya. [wet eyes].

Even though Juan reported that he might have to pursue a different professional activity, he declared that he is under a lot of self-pressure to restore his professional medical identity because it is what he truly has always wanted to be in life. He did not like this pressure he placed on himself to be a physician again and seemed to have suffered a lot from this.
... as a human being you can be anything... anything that you wanted to be... but there is a very [lot of] self-pressure.

Juan and Hamid expressed sadness when asked about their self esteem. Juan expressed frustration, and said that the IMG should look for another career because it was so difficult to re-license. Earlier he stated that the physician's career is more important than anything else making the researcher believe that he now has mixed feelings of hope and lack of hope.

Hamid, Minh, Enrique, and Carmen reported that they prefer to not tell people here that they are physicians. They hide that they have this profession from people because they do not have their Canadian medical license. They felt they could not declare to everybody who they really were. They reported that they felt shame and embarrassment, and that their self esteem went down generally when they were not able to claim that they were a doctor in Canada anymore.

Hamid stated:

I hide it. I don't want them to know that I'm a physician. I don't tell them ... I won't tell you unless I really have to. Because it's kind of embarrassing if you ... if they know you're a physician and you don't have your license... you don't say it the way ... the self-esteem you had and the courage you have to say proudly to everyone that you are a physician. But here you can't say it with a proud [pride].

Minh stated:

... sometimes. I don't want to tell people because sometimes... I went to the place where I work [worked] ... and her customer asked her about me, and she told them that I was ... a doctor and they encouraged me a lot [and I felt] proud of myself.

In this regard, Carmen shared:

Personally myself ... I never feel good having to hide it. The only reason why I don't practice here is because they don't allow me to practice. But on the other hand, I noticed that as a country, and as a culture, I was never allowed to say I'm Dr[name]... They take that away from you. When I started working where I am, they asked me for my professional past, and they asked me what name and letters I
wanted in my professional card. And naïve of me I said ‘well, I'm M.D., and they came back to me and said we were never be able to put that for you because you're not a medical trained ... ‘I said what do you mean? I am a doctor’... but you're not certified in Canada, so you cannot carry the letters M.D. So I had to put health specialist. Or sometimes I put B.Sc. which is Bachelor [of] Science. But it's not true, because Bachelor[of] Science is half of my career.

Carmen reported feeling low self esteem, and a mixture of feelings such as embarrassment, sadness, resentment, anger, frustration, and feeling that a part of her has died since she is not able to claim her professional identity.

If you ask me, if you don’t practice medicine again, or whatever, I feel that part of me is dead.... I will feel embarrassment. I will feel anger. I will feel resentment that I have dedicated the best years of my life to a medical career, and because of destiny, I followed my husband.... Why should I have (it – being a doctor) taken from me?

Markus made references to his self esteem, and that no one (even the politicians) can take his knowledge away. However, you get the impression that he is fighting to keep his self-esteem intact: “But my self-esteem is still high because I know I have the knowledge, and that knowledge ... no one can take it. Not even the politicians.”

4. 3. 4. 2. Self esteem and its connection to health

Juan was asked if not being a physician in Canada could have an affect on his health. His answer was: “of course ...it's your job. It's our career and our career is more important than anything else.”

Enrique related that he sometimes felt depressed mainly when the tests results arrive, and he did not succeed. He almost cried, “Sometimes ... you feel sad and you feel like crying or feeling ... you don’t know if you’re doing the right thing.”

Minh, Sophia, Enrique, Carmen, and Markus all reported that their present lack of having their professional medical identity was related with their experience of low self esteem, frustration, and depression. For some, the loss of self esteem was expressed as
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linked with feelings of depression. Some felt they lost their self-esteem altogether when they lost their professional medical status. Minh stated: “[my self-esteem] goes down... on the other hand it’s depress [depressing] ... I don’t know how to describe that feeling ... a lot of time I feel very depressed ... and frustrated ... [shedding a tear.]”

Sophia stated:

I was not at the point that I could go to a doctor and get a prescription. I could deal with it ... the depression ... and low self-esteem. I could deal with it. I still do. [I have some depression] sometimes, not all the time. But I had a bad time... [I was] just stressed out. Just not being able to do anything and ... not get ... like you have ... you have to try to get your license.

Figure 9 connects the themes presented in the earlier section. The inability of this sample of FTPs to recover their professional medical identity in Canada was reported to have led to unemployment, underemployment, having to get loans, and not feeling included. All of theses outcomes were reported to have an impact on FTP’s self-esteem by their experience of feeling undervalued, humiliated, embarrassed, frustrated and angry. Many expressed the feeling of having high pressure on themselves and feeling powerless to raise their families as they wished. Participants reported that these experiences had a negative impact on their self esteem, and that this in turn impacted on their overall psychological health and many experienced feelings of depression, anxiety
and stress that resulted from their lowered self-esteem.

Figure 9. Loss of license and professional medical identity and impact on self esteem and health.

Nanor recounted in the interview that his self esteem was negatively affected during the first 6 months of living in Canada. After his achievements in the academic field, in Canada, his self esteem began to increase as indicated in his quotes. His health status elevated at the same time. Even though he considered himself lucky to be in the system as a research fellow and a Master’s student and he had a good professional network at the university hospital, he still wished he could declare the fact that he is a physician. Nanor was appreciative when his badge was visible, and people could know he was a new young physician at the hospital where he worked, although he was not licensed yet.
In this case, Nanor was allowed by the institution in which he works to exhibit his medical professional identity, so he still felt proud of being a physician. Carmen, in contrast was not allowed to claim her professional background and identity. Carmen consequently reacted with anger and resentment because she felt humiliated, and her self esteem lowered as did her health status.

In the cases of Nanor and Carmen, the researcher was led to believe that there is not a Canadian immigration standard regarding the use of a badge with the identifier as M.D. This was reinforced by Nanor’s quote, when he affirmed that his immigration card had M.D. on it, and he asked the immigration office if this was to be removed and they said “no.” This makes the researcher believe that it was a specific decision of each institution and the standards of each province as to whether they can put M.D. on their badges.

Given that the use of the written badge with the M.D. credential was not allowed for Carmen, the researcher understood that it was either an institutional decision to be clear about who is licensed to practice in Canada, or it could be a discriminatory act, because all IMGs carry an M.D. or equivalent on their medical diploma, and the researcher believes that they can state they are an M.D. but not licensed in Canada. No one can take this from them, as Markus stated when he stated his medical knowledge cannot be taken away from him. Carmen’s quote is very understandable when she recounted feeling discrimination related to the experience of not being able to say she was an M.D.

Markus realized that the IMG Ontario licensing process is the standard to meet and is a political issue, and he has decided that these will not keep him from his profession.
He stated that no one could take the medical knowledge from him, but he was afraid of losing his self esteem in the future if he was not successful in getting his license again.

As a consequence of not being able to work as physicians, these IMGs had experienced underemployment and unemployment, as well as frustration related to the unsuccessful path through the IMG Ontario licensing process. Low self esteem, anxiety and depression are associated with overall health, even though these effects may not be recognized, reported or manifested with symptoms yet. Sophia did not identify her health issues on the survey, but she referred to being stressed and depressed in the interview. Juan rated his health status as being affected mostly in the first months of being in Canada.

The pre-interview survey asked about ratings of health status, stress and quality of life before and after coming to Canada. The pre-interview survey also asked participants to identify some physical problems and diseases that were present before they came to Canada, as well problems and diseases that had developed after coming to Canada. Only 2 FTPs reported having a health disease or a health problem before resettling in Canada (asthma and thyroid problems). After coming to Canada, 3 participants reported experiencing stress, 2 reported dental problems, and 1 reported having visual problems.

4. 3. 4. 3 **Self esteem and its connection to stress and anxiety**

The qualitative interviews yielded more subjective information about their experiences with aspects of their health during their resettlement in Canada. Many expressed that their struggle to regain their professional license and identity in Canada gave them experiences of stress, anxiety and depression.
Juan, Hamid, Enrique, and Markus reported experiencing some stress before coming to Canada often related to conditions of violence in their prior circumstances. After their arrival in Canada, the stress related with previous violence in their countries lowered because their experiences with war and violence lowered after arrival in Canada.

However, Juan, Hamid, Minh, Nanor, Sophia, Carmen, and Markus actually reported that their stress levels were raised since coming to Canada which made the researcher conclude that a strong and new factor appeared to be triggering this stress. Most of the FTP sample related that the most important stressor they were dealing with was their inability to re-establish their professional identity through the IMG Ontario licensing process and all of the other areas of their life that were affected as a result (income, employment, self-worth).

In the survey, their ratings of experience with violence went down as they resettled in Canada. However, their ratings of their health status also went down. Two reported their health rating as the same after coming to Canada as before coming to Canada. Carmen’s health status was reported as lower after 6 months. One would have expected that the reduction in violence might have had a positive effect on their health status, but it would appear that resettlement, trying to re-license and not being able to practice medicine may be the paramount influencers on lowering health status.

IMGs going through Ontario licensing process require financial resources, not only to pay the fees, but also to provide support for the individual and the family and to be able to dedicate themselves entirely to study and succeed in the process. They need time and finances not only to improve their general language skills, but also to update their medical knowledge and skills and to learn about the Canadian health care context.
Hamid explained that because he could not be a physician in Canada his mental health was negatively affected, as well as his social health, and therefore, his overall health was affected as a result. Hamid relayed experiencing feelings of isolation, frustration, and discouragement: "It affects you, not just your physical health. At the same time it will affect your social health and social life, and mental health too."

Sophia rated her health status as very good during all resettlement period on the survey, but said she was stressed out and displayed a lot of discomfort with the questions about impact on her health during the interview and said:

Nothing ... just stressed out. Just not being able to do anything and ... not get ... like you have ... you have to try to get your license and at that point I was not trying. I was not even studying. I wasn't interested.

Enrique had some bad times and said: "Sometimes ... you feel sad and you feel like crying or feeling ... you don't know if you're doing the right thing."

Carmen was asked if the IMG's health could be affected during the resettlement process, and she answered:

Ya, definitely... with the stress that we went through and that they put us through to be able to practice. And you, you had it very clearly ... You displayed last Saturday at the AIPSO meeting when that Colombian doctor ... Of course. Not only that, even emotionally in his situation I assume he's a political refugee, so he couldn't go back to his country.

Carmen answered the question affirming that her health was affected and talked about her own experience of health problems such as stress, insomnia, depression, and feeling like a part of her is dead.

Markus talked about stress as being associated with the IMG Ontario exams, the process length, and perceived lack of fairness. He stated that he was under stress, and seemed very anxious when talking about this. He noted changes in lifestyle, craving poor
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foods when under stress, and being sedentary because people do not exercise or care about themselves when they are trying so hard to study and get their medical status back.

What stresses me more? Because of these exams. This process... the length of the process. It’s not the process itself but the length and the lack of fairness when I look at it. I don’t know why, but I look at it like it’s not fair. And also, there’s another point. You pass the IMG, you get in and you have to sign what they call...It’s an agreement where you have to go 5 years ... you studied medicine abroad. They didn’t have to pay for your medical status. Five years is not fair.

Stress was described as being present throughout the resettlement process, not only because of the daily challenges and barriers in resettlement that FTPs had faced, but also because of the IMG Ontario licensing process demands itself. Social support and personal coping style can positively influence the individual’s response to distressing events. This group of FTPs reported feeling stressed in the interviews and this was supported by the pre-survey information on their ratings.

Participants who talked about experiencing war, trauma and violence before coming to Canada, including Juan, Hamid, Enrique, and Markus had their level of violence lowered after arriving in Canada. However, they had their level of stress elevated during resettlement mainly because of the lost of professional identity, and the steady challenging efforts to recovering it through the existing IMG Ontario licensing process.

4. 3. 4. 4 Lifestyle changes and health impacts

Enrique, when asked if the IMG could have their health affected during the resettlement period affirmed this, but also explained some of the health risks he experienced related to this:

You change your lifestyle. Like you start having a small breakfast, probably a coffee or that’s all. A very fat lunch, like a hamburger or sandwich or something. And a big meal that you eat in the night. You start gaining weight, blood pressure, diabetes etc... But the last thing is your sport activities go to zero in winter time. Tropical countries are all the time same temperature...there is a risk for sure. High
risk. You see some of the physicians having some health problems.

The researcher asked him if he knew about other physicians [IMGs] who had some health problems, and he said that he knew some and explained:

Ya. I have some of the IMGs some of them[have] like psychiatric problems, like depress [depression] or anxiety or stress ... they don't like to talk about that. They prefer to keep from them. But some problems they cannot hide from everybody like hypertension, or gastric problems, or diabetes. What I'm sure is that the possibility of some diseases goes up.

Carmen recounted knowledge of other physicians and their health risks when she was asked the same question:

Of course we are at more at risk... high blood pressure, because I'm pretty sure that those two basic things or ... digestive psychosomatic problems. I'm sure they are much more. Definitely... ulcer, irritable colon irritable syndrome. They have higher incidence than the general population.. I'm experienced in that ... insomnia ... signs of depression, lack of sleep.

Markus was asked about the influences of resettlement on his health, and he explained changes of dietary to higher caloric food for immigrants and refugees, and that this could have possible effects on their health.

... what they realize is that people who come to Canada change their diet ... that high fiber diet they had in their countries ... to these very high caloric food ... fast food mainly ... this is the main thing you find here... I remember in Africa I have never eaten Mc Donalds, and I have some friends who came here and they would eat Mc Donalds every week...

Markus explained the changes in life style in coming to Canada and the possible effect on the health status of immigrants and refugees, because of eating high caloric foods plus having a more sedentary life that could lead them to become overweight or to develop hypertension or diabetes.

You don't exercise as much as you did in your country. So that's a contributing factor. The...but the main thing is the diet. People are changing their diet and sometimes even being a physician you don't watch what you're eating. You get all these weight problems ... mainly obesity ... all these diseases that you get as you get
obese... the sedentary lifestyle they are living in.

4. 3. 4. 5 Summary of overall factors affecting health and their impacts

The study interviewees recounted experiences in many of these areas that determine health status as Hyman (2001) had identified and suggested they could lead to illness. This study participants primarily reported experiencing stress, depression, anxiety and some lifestyle changes (dietary and exercise changes) within the interviews.

Juan, Hamid, Minh, Sophia, Carmen, and Enrique confirmed that their self esteem was negatively affected in their interviews. Hamid, Minh, Enrique, Juan and Carmen reported on the survey that they had their health status lowered since coming to Canada. Carmen expressed anger and resentment about not being able to claim her medical professional identity because she felt humiliated, and embarrassed, and her self esteem lowered, as did her health status.

Hanor had his self esteem negatively affected during the first 6 months of living in Canada. After his achievements in the academic field, his self esteem improved again as he stated on his quotes. His health status was reported to have improved at the same time.

Markus described what he identified as a political issue going on the IMG Ontario process, and that he was determined to not let this barrier keep him away from his profession. Markus stated that no one could take the medical knowledge from him, but he was afraid of losing his self esteem more in the future, and his self esteem ratings lowered after he arrived in Canada according his questionnaire answers. His health status was reported as excellent.

All participants had their self esteem lowered at one time in their resettlement period. Only one participant, Nanor had his self esteem and health status elevated after 6
months of being in Canada. However, he is also the only one who could report that although his physician status is not fully re-established he is the only one who has worked closely again in a hospital, with medical colleagues and gained some professional status and identity back. Only one participant, Markus, related the same excellent health status before and after the resettlement period, but his self esteem lowered during the resettlement period. Only one participant, Sophia, reported excellent health status, but recounted in the interviews to experience low self esteem, stress with depression. Sophia rated her health status as very good, even though in the interviews she referred to being stressed and depressed. Juan had his health status negatively affected in the first months of being in Canada.

The participants in this present study described experiences with stress, poor self esteem, depression, and poor economic conditions. They recounted experiences with unemployment and underemployment while not being a physician. They further conveyed that those experiences were primarily related to not being able to reclaim their status, identity and employment as a physician, and had negative impacts on their health and self-esteem.

The common experiences of the participants in this study, point out that this foreign physician group was passing through a long, and stressful resettlement experience, in which the most important and unfavorable barrier was their inability to get their medical license as of yet. Without the license, their medical professional identity could not be restored. Without this they experienced all the other problems of distress, poor self esteem, and poor financial situations. The regular resettlement process of being a newcomer in a new society alone was not the paramount problem for this group.
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Paramount to their self esteem, and their overall health, was to be able to be a physician again in this society.

*Figure 10.* describes the results of the overall research inquiry. It includes their stories of life and experiences prior to coming to Canada; their reasons to come to Canada; the changes and losses they experienced and the areas of life they had to rebuild and re-establish after coming to Canada. It also includes the main themes that emerged from the interviews regarding loss of medical identity; resettlement experiences and barriers; the licensing process as a major barrier; and changes to self-esteem and health.

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*Figure 10:* Summary of the qualitative interview results and main themes
CHAPTER 5.0 DISCUSSION AND CONCLUSIONS

This study investigated the experiences of foreign-trained physicians who had resettled in Ontario, Canada; who were presently not able to practice their profession; and who had a desire to be re-licensed in Canada. The loss of their professional identity, their resettlement experiences and the relationship of those experiences to any changes in self esteem and health were of particular interest in this inquiry. The results of this research added new insights into foreign-trained physicians and their resettlement in Canada. The central findings indicated there were changes in self esteem as a consequence of the loss of professional medical identity as well as the experiences of increased stress, anxiety and depression among FTPs. The findings also identified their experiences with barriers to successful resettlement; with licensing as a physician being identified as the main barrier.

The qualitative, grounded theory research methodology helped to gain a deeper understanding of the resettlement experiences of newcomer physicians, the settlement processes they go through and how various factors influence their self-esteem, health status and identity. Grounded theory is an interpretive research methodology used to help discover the main concerns of subjects and as they define their situations, common patterns of behaviours and perceptions emerge. The rich stories recounted in these qualitative interviews yielded important information related to the areas of inquiry. The pre-interview survey results indicated identified changes since coming to Canada, especially in the areas of increased stress, decreased self-esteem and their health status were occurring. The qualitative interviews yielded information about why this was happening and how it was experienced personally and subjectively. As they defined and described their lives, patterns emerged and helped the researcher to interpret the results.
5.1 Discussion of identity, self-esteem and health of FTPs

The loss of identity reported by these FTPs that occurred as a result of the loss of their medical licenses, made the regain of it, the main goal in their lives. The medical licensing process was the most relevant of the resettlement experiences were reported as negatively affecting the self-esteem and health status of these FTPs.

Figure 11. outlines some of the changes they spoke about related to some of the social determinants of health after coming to Canada. The loss of their medical license impacted on their identity, self esteem, health and many of those social determinants.
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![Diagram showing changes in social determinants of health.

**Figure 11.** Changes in the social determinants of health of FTP’s
This sample of FTPs reported losing a central ingredient in their sense of self identity when they came to Canada and were no longer able to claim their status and work as a physician. Person-based social identity, according to Brewer (2001) is built and established in the individual self concept. These concepts are specifically influenced by the individual’s attachment to a definite social group in which socialization experiences are shared. As a result of having a strong former membership in a physician group in their countries prior to coming to Canada, these FTPs longed to have this social affiliation and self concept again. This FTP sample lost a main ingredient of their social identity when they came to Canada, and in addition, lost their relational social identities and group based social identities as described by Brewer, since they were no longer formally connected to their physician role, colleagues or group institutions in the Canadian society.

Stets and Burke (2003) stated that identity theory involves having individual control over one’s behaviours in a manner that is constantly attached to their goal identity. These identity standards provide an ideal, or goal state to aspire towards. This group of FTPs had a prior strong affiliation with their medical identity, and aimed toward the ideal goal state of having a medical license and an identity as a physician in Canada.

The physician status already attained prior to coming to Canada permitted each of them to enjoy a particular lifestyle with active social and community networks, a respected and publicly recognized social standing in their society and a favourable income, no matter how long they had their medical license. The benefits of having a license to practice medicine were all found to be connected to having a personal,
professional medical identity, high self esteem and positive social status in their communities. Prior employment, relationships and particular accomplishments helped provide and maintain a way of living and a certain lifestyle related to being a physician before coming to Canada. Through having this profession, they were also able to maintain a definite level of responsibility that contributed to their own livelihood and to humanity. Many of the successes they told about were seen as connected to their strong professional medical identities that had already been established.

It had been previously indicated that the health status of the immigrant population often deteriorates over the first five years post-entry to Canada. This has been referred to as the “immigrant effect” (Hyman, 2001). This Master’s thesis exposed possible new factors and process information related to this immigrant health effect. Some of the decrease in health status after five years in Canada for this group may be based on the loss of self esteem, experiences with under employment, unemployment and the loss of professional identity associated with the changes this FTP group has experienced.

Although each of them came to Canada at different times and for different reasons, the processes and tasks of resettlement in Canada had many similarities. The tasks that they reported having to accomplish in this process included: gaining knowledge of the licensing requirements, completing the legal process of entry to Canada and eligibility to work, setting up housing, settling themselves and their family in a community, seeking employment, earning an income, acquiring language education and proficiency, building friends and social networks and participating in the community. Many steps in the process are not unlike the settlement tasks of any newcomer to Canada. Like other newcomers, if they had experienced prior trauma, violence, war, or genocide, their
resettlement and health would be even more complicated as they dealt with those internal memories, stress and potential emotional blocks.

This study showed that this particular group of newcomers had experienced resettlement and personal and professional barriers that placed demands on them in addition to the usual resettlement challenges. First, they had to deal with a significant loss that was expressed by all of them to be at the core of who they saw themselves to be; the loss of their professional, personal, social, relational and group-based identities as physicians. Second, this loss created additional tasks in the process of re-establishing self and settling that included understanding the medical licensing process, studying for a series of exams, making additional money to pay for each set of exams, finding time to study, becoming proficient in enhanced English related to medicine and competing for few potential residency spots. Participants in the study indicate that these additional tasks while trying to make a living, and relating to friends and family has had an impact on their health and self-esteem.

The participants in this study stated that a significant part of their sense of identity was comprised of being a physician, and that the loss of their professional license when they immigrated to Canada took that away. While many of them still felt like a physician inside, they could not be acknowledged as one by others or be engaged in their professional work.

After this FTP group arrived in Canada, they started to rebuild their lives and to engage in trying to get their license to re-establish their professional medical identity. This is identified as the basis of the resettlement process as stated by Bernstein (2000), and considered at the core of the settlement process and the health of these immigrant and
Research shows that the use of renewable energy sources, such as solar and wind power, can significantly reduce greenhouse gas emissions and contribute to a more sustainable future. By investing in renewable technologies, countries can not only mitigate climate change but also improve energy security and economic growth. The transition to a low-carbon economy requires a multidisciplinary approach, involving policymakers, industry leaders, and the general public. Collaboration between these stakeholders is crucial in developing effective strategies and solutions. Technological advancements and innovations play a significant role in driving this transition, with ongoing research and development aimed at improving efficiency and reducing costs. As the global community continues to work towards a more sustainable future, it is essential to foster international cooperation and share best practices among countries at different stages of development. The adoption of green energy technologies and practices can help address environmental challenges and create a more resilient and equitable world.
refugee physicians. From the results of the qualitative interviews, this would appear to be true. At the very center of each of their personal stories they stated that successful resettlement for them involved reclaiming their professional identity and employment as a physician.

The loss of professional identity led them to report stress, anxiety, and depression as the major health problems which could compromise their mental health. They also reported accompanying feelings of an empty sense of life, and a lack of hope if the recovering of the professional medical identity was prolonged over a long period of time, or not attainable.

The development and maintenance of a person’s self identity has been shown to be important and involve affiliations within a social, group and institutional context (Brewer, 2001; Brewer & Cast, 2002). The development of self worth and identity capital is seen as an investment in a present and future resource (Cote, 1966). Cote’s concept of identity capital theory suggests that individuals should be stimulated to invest in and empowered to explore their uniqueness since future additional dividends will be produced. People need to be motivated to widen their identity capital and this can aid people to surpass the stressors of their daily life. This sample of FTPs was intrinsically motivated to be re-licensed, but did not feel effectively aided by the new society in their resettlement goal to work and be recognized as a physician again. These FTPs reported facing many barriers to being able to re-establish their previous social roles and identities as physicians.

Mueck-Weymann, Petrowski, Gottschalk, and Poehlmann (2004), related that having goals are a significant factor for subjective well-being as well as for physical
health. The authors affirmed that the physical well-being depends on: feeling committed to individually important goals, the kind of goals pursued, and the degree of the progress made in being able to accomplish those goals. These participants had strong goals, but the degree of progress towards accomplishing them had many barriers in the way, and this was discouraging to them.

As Minh expressed: "[it is] complex...in my life, in my thoughts... About ... that between I was a Doctor... and now I was [am] nothing."

Carmen expressed what many of them conveyed in the interviews:

... write my story to make it known to people what I had to go through to be able to practice my profession again. And the reason why I did is... because I tell that part of me was dead.

According to Burke and Cast (2002) identity theory focuses on the degree to which individuals are able to achieve success according their pretensions. Self-esteem can have a direct effect on positive self-verification that is part of the normal process of a role-identity. The interview group of FTPs had not succeeded in going through all of the medical licensing process in Canada yet, and therefore, their positive self-verification had not been attained. They have faced not only the resettlement process stressors, but the additional stress, anxiety and depression of not meeting their own and others’ expectations to be a licensed physician again. As a result, this sample of FTPs had their self esteem decreased.

Bernstein (2000) claimed that restoring the professional status of foreign-trained physicians, as well as other professional newcomer groups after migrating to a new society, is considered at the core of the settlement process and the health of immigrants and refugees. He claimed that the re-establishment of professional identity provides
income and financial support for newcomers, and it plays a fundamental role in maintaining self-esteem and self-identity. The results of this study support those claims and relationships.

Bernstein and Shuval (2000) stated that more than for other professional newcomer groups who are new to Canada, a physician’s professional status and work function are often more prominent in their social hierarchy, and this has a potential to contribute to reinforce their positive self of identity. Not to be able to quickly reestablish a physician’s professional identity and quickly, therefore could have detrimental effects on their health, sense of identity, and self-esteem. The results of this study support his claim.

Without being able to use their skills and abilities, they felt underemployed and devalued. These experiences affected their self esteem in a negative way. They reported feeling like nothing, or sometimes feeling dead inside.

Kokko and Pulkkinen (1998) related unemployment to the psychological distress caused by poor economic situations and poor self-esteem. These FTPs expressed psychological distress in their interviews. They related much of the stress they were experiencing to the loss of professional status and work in their field, and that this was connected to poor self esteem and poor economic situations.

By being unemployed or earning mostly minimum wages, these FTPs generally could not fully re-establish their lives at the same level in this society as in their previous lives.

At the same time that the FTPs changed their economic social status and lifestyle, they reported their social life became limited to specific social groups or that they experienced isolation. They missed being included and belonging to their profession and
having colleagues in health care and medicine. Many sought work in allied health fields or health research to be close to what they had before.

Some of the FTP’s enrolled in a Master’s Program because they hoped to find a job in the future in the health field in an alternate career if licensing was not possible. The income from their reported present employment was expected to financially contribute to a family, cover housing and expenses, and to pay for the IMG licensing process in Ontario while they struggled to find time to study and to keep their self esteem at an acceptable level. In the end, the FTP’s hopes and major aspirations were to become physicians once again.

Statistics Canada (2004) indicated that social health determinants such as housing, education, relationships, employment, and income are also associated with the overall health of the individual. Kemenade (2002) stated that social cohesion is an aspect of social capital and is a health resource that allows individuals to enlarge their values, decreasing the differences in wealth and income in the same social group.

At the time of the interviews, no matter how long they had been in Canada, this FTP group felt they were still struggling to rebuild their lives in Canada, and struggling to recover their professional medical identities by trying to meet the prerequisites to getting their medical license though the IMG Ontario licensing process. Most of these FTPs reported they did not have enough information about the IMG Ontario licensing process prior to coming to Canada, or detailed information about the timeframe, costs and barriers to re-licensing.

Working outside of the medical profession, often in menial, short-term, and low paid positions generally did not allow the FTPs to restore or build the economic and
social status to which they were accustomed. Many felt like a physician inside but could not tell others that they were or to claim this in the new society. This qualitative study supported those findings and identified the relationships within and between those factors and the major barriers faced in getting their license and resettling more successfully. This information was helpful in the development of some potential models and theories using the grounded theory approach chosen for this study.

Statistics Canada (2003) reported that foreign-trained physicians have their needs frustrated when they try to restore their professional life. The International Medical Graduate (IMG) licensing process is a long, exhaustive, and expensive process which requires patience, persistence, and the dedication of a lot of time. As the process is presently established in Ontario, Canada, it may be a source of stress and act as a negative determinant of health.

Dealing with a new language, and preparing for the examinations which include practical and cultural context clinical skills, for most of the FTPs was a difficult ladder to climb. Most of the participants had to work in odd jobs to survive, to provide for themselves and their families and they had little time to dedicate to the intensive study required. Most of the newcomer physicians who cannot practice in Canada have to start from the first step of the IMG licensing process ladder, and they might never reach the top. They also often struggle to surpass the daily barriers of racism, isolation, discrimination, and depression that can be frequent experiences for immigrants and refugees. Foreign-trained physicians while trying to meet their physiological needs, such as employment and housing are challenged after passing all the examinations, to compete
for a residency program spot of the few 200 positions available to them in the Province of Ontario.

According to Milne (2003), for IMGs to be successful, they are required not only to pass all the exams in effective French or English, but also they need a solid flow of money, infinite tolerance, and determination to surpass the many barriers to re-licensing. Because of the magnitude of the barriers that IMGs face in Ontario barriers and the length of time without success, their self-esteem is negatively affected, and potentially interfered with their optimum health status. IMGs often do not get medical residencies quickly, or at all. At the same time, there is a considerable waste of time, money, human talent, and needed skills for the society when this group is under-employed, unemployed and not included as physicians. Because the findings of this study indicate that the IMG Ontario licensing process as it operates presently is a major barrier itself, it deserved a special section to be written in the findings and implications of this research study.

In the interviews, many suggested that their stress, anxiety and some depression were evident. However, all FTPs identified their greatest stressor was not being able to be a physician in Canada and was connected to their struggle to study, to make a living and to take the tests for the IMG Ontario license. This was reported by all subjects as the main stressor in their present lives. Stress was present throughout the resettlement process not only because of the usual resettlement barriers but also because of the licensing process demands and accompanying feelings of anxiety and pressure. These FTPs reported their self esteem declined not only because the loss of the personal social identities which did not allow them self-verification, but because of their experiences with other re-settlement barriers. The licensing process was the most important barrier
and provided a great deal of stress for this FTP’s group and appeared to be responsible for the major loss of self esteem. As a result, their stress, anxiety and depression were not buffered from them by a positive self concept and verification and this affected their health status (Burke & Cast, 2002).

Osborne defined self esteem as a relatively permanent positive or negative feeling about self that may become more or less positive or negative as individuals encounter and interpret their successes and failures in their daily lives (in Winstok & Enosh, 2004). Low self esteem experienced as a result of losing their professional medical identity added to their disappointments and failures through the IMG Ontario process, and supplemented by the resettlement process stress itself, could provide the multifaceted triggering factors that could lead to their reported stress, depression and anxiety.

As a consequence of not being able to work as physicians, these FTPs had experienced underemployment and unemployment, as well as frustration related to the unsuccessful path through the IMG Ontario licensing process. The fact that this group had to work outside of their medical profession was found to have a primary effect on not allowing this group the needed time, money or energy to restore their employment, their income or the social status that they had already experienced and attained before coming to Canada. Underemployment at low pay and in low status positions lowered their self esteem, and provided a barrier to licensing because they felt tired and had little time to study.

Socio-economic factors associated with chronic unemployment and underemployment can create anxiety, low self esteem, poverty, and depression in newcomers, as stated by Davis (1999) and Wilton (2003). This appears to be the case in
this study. The lack of employment compatible with their education levels also did not allow them choices in housing and educational opportunities to quickly acquire their license. These experiences were reported as common to individuals in other studies and to those interviewed in this study.

Kliwer and Jones (1998) analyzed changes in health status among immigrant groups and found that higher self-ratings of health status were associated with being employed, using one's qualification at work and being satisfied with their jobs and life. Many of those interviewed for this study did not report having these positive conditions and influencers on their health.

Hyman (2001) highlighted that newcomer living conditions and their living environment often determined their health status. Social stressors related to unemployment, underemployment, income, racism, isolation, housing, and the resultant experiences of poverty, marginalization, and class inequity were found to lead to illness.

The study interviewees recounted experiences in many of the areas that determine health status, as identified by Hyman and that could lead to illness. It also may have an impact on their experience of the immigrant health effect, whereby their health actually could deteriorate over time in Canada. This study participants reported experiencing stress, depression, anxiety and lifestyle changes (dietary and exercise changes) in their interviews.

Low self esteem, anxiety and depression could potentially have detrimental consequences to their health, even though those effects may not have been symptomised or recognized yet. As a result, this may not be fully reflected in the health status survey answers at the time. Many of the interviews showed that the FTPs went back and forth
between feelings of hope of restoring their medical identity, and feelings of hopelessness and despair. While they showed resilience in moving to Canada and making a new life, this sample did not feel they were fully settled yet without also having their physician status and to be able to work in their profession.

When newcomers come to Canada, their health challenges also include a change of diet, temperature and lifestyle to adapt to a new society. The sedentary life reported by some of the study participants while they worked and studied could also affect their health and factor into the development of other possible health problems such as hypertension and diabetes. Their reported stress, anxiety and depression are health symptoms that can work along with changes of life style, diet and sedentary life to negatively affect overall health. Stress, anxiety, and depression are factors affecting mental health, as well as potentially generating diseases well know in the medical field as having a psychosomatic source in the daily basis. Hypertension and ischemic heart diseases, diabetes, immune suppressive syndromes, dermatological diseases, sleeping disorders are some of these psychosomatic diseases.

Time and resources for leisure could also be limited, or even excluded from their daily lives, as a consequence of not being able to practice their profession in Canada. At the same time that the IMGs changed their social status and life style, their social life became limited to specific social groups, or even to social isolation in the new society that they generally were not used to.

The following definitions of health support the assertion that there is a significant relationship between health, sense of identity, and self esteem: Health is a multifaceted resource and state resulting from interrelations between the individual and the
environment (Shah, 1998). The World Health Organization (WHO, 1998) has defined health in a wider socio-ecological sense: “Health is the ability to identify and realize aspirations, to satisfy needs, and to change or cope with the environment of living. Health is therefore a resource for everyday life, not the objective of living. Health is a positive concept, emphasizing social and personal resources, as well as physical capacities” (National Forum on Health in Shah, 1998). From this wider concept of health, the measures of health must include the factors and the determinants which play a positive role in those experiences of life, and which in their absence interfere with an individual’s or group’s health status.

The results of this study yielded some helpful information about how and why health status was reported as declining for this group over time in Canada. Out of all the resettlement tasks and processes involved in coming to a new country, the resettlement goal of re-establishing their professional identity and getting their license to practice was the most important for this group. Out of all of the barriers they identified, the barriers in the re-licensing process were the predominant ones which made it difficult to get their license and reinstate their professional medical identity. Throughout the resettlement process something happens to impact negatively on their self esteem; to impact on their self-reported health status; and increase their stress, depression and anxiety. It would appear from their interviews that being without their professional identity in the new country was the major contributor.

The participants in this study described experiences with stress, poor self esteem, depression, and poor economic conditions. They recounted experiences with unemployment and underemployment while not being a physician. They further
conveyed that those experiences were primarily related to not being able to reclaim their status, identity and employment as a physician, and had negative impacts on their health and self-esteem.

*Figure 12.* outlines the barriers and the facilitating factors in the resettlement process as identified by the foreign-trained physicians interviewed in this study, and what impacts and effects it has had on these individuals.

<table>
<thead>
<tr>
<th>BARRIERS</th>
<th>Effects/Impacts</th>
<th>FACILITATING FACTORS</th>
<th>Effects/Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>No medical license</td>
<td>Isolation</td>
<td>Employment</td>
<td>More inclusion/belonging</td>
</tr>
<tr>
<td>The IMG licensing Process itself</td>
<td>Non-inclusion</td>
<td>Friendships</td>
<td>More friendships</td>
</tr>
<tr>
<td>Not knowing the language well</td>
<td>Less friendships support network</td>
<td>Community participation</td>
<td>Higher self-esteem</td>
</tr>
<tr>
<td>Unemployment/Underemployment</td>
<td>Lower self esteem</td>
<td>Income or social assistance</td>
<td>Lower stress/pressure</td>
</tr>
<tr>
<td>Over-qualification</td>
<td>Higher stress/Pressure (self/other)</td>
<td>Medical license</td>
<td>Lower depression</td>
</tr>
<tr>
<td>Low or no income</td>
<td>Higher depression</td>
<td></td>
<td>Higher income</td>
</tr>
<tr>
<td>Discrimination</td>
<td>Lower income</td>
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</table>

*Figure 12: Barriers and facilitating factors of resettlement and their impact on FTPs*

Foreign-trained physicians could be a critical positive influence on the health of Canadians if they could be licensed in a timely manner. Without identifying and addressing the barriers identified in the study, the health of these immigrants and refugees may deteriorate and the health system at large may not have the infusion of this dedicated physician group that has such a desire to work again in medicine. According to Putman
social capital recognizes the capacity that this FTPs group has to truly operate in the collective interest of the Canadian society.

5.2 New and adapted theories and models generated from this study

Grounded theory research provides an excellent opportunity to generate research-based knowledge about the behaviour patterns reported by a group. This group of FTPs shared information about the experiences and behaviours that shaped their social and professional identities and their resettlement in a new country. From the information from FTPs about what was occurring for them at this particular time in Canada, new theories and models were drawn from the results of the study. Three relevant theories and models that emerged from the interpretive analysis will be offered from this study:

- A Resettlement Process Model that outlines the tasks and steps for General Resettlement in Canada and additional tasks for Physician Re-Settlement.
- Maslow’s Theory adapted to the resettlement hierarchy of needs it relates to resettlement in general and for foreign-trained physicians.
- A suggested Physician Re-licensing Process to assist in re-licensing within 2-3 years in Canada.

5.2.1 Resettlement Process Models

This research adds new insights on the resettlement process, sense of identity, and health status of newcomer physicians in Canada. Identifying and disclosing the life experiences of these physicians during the resettlement process helped to fill a theoretical and practical gap in the literature related to foreign-trained physicians (IMGs) in Canada. There was little literature available on the resettlement processes, steps and tasks for general re-settlement of refugees and immigrants, and almost none related to the
additional processes of re-settlement and licensing reinstatement for foreign-trained physicians special circumstances. The information from the study formed the basis of the development of a General Resettlement Model that outlines the processes and tasks that all new immigrants and refugees have to accomplish and a Professional Re-Licensing Model, with the additional processes and tasks FTPs have to accomplish to be re-licensed as part of their overall re-settlement plan.

<table>
<thead>
<tr>
<th>GENERAL RESETTLEMENT MODEL:</th>
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<tr>
<td>• processes and tasks for all immigrants and refugees</td>
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<tr>
<td>✓ Knowledge of requirements before emigrating</td>
</tr>
<tr>
<td>✓ Legal process of entry to Canada</td>
</tr>
<tr>
<td>✓ Legal status to work</td>
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<tr>
<td>✓ Employment</td>
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<tr>
<td>✓ Income</td>
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<tr>
<td>✓ Housing</td>
</tr>
<tr>
<td>✓ Language education</td>
</tr>
<tr>
<td>✓ Settling self and family in a community</td>
</tr>
<tr>
<td>✓ Building friends and social networks</td>
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<tr>
<td>✓ Community participation</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PROFESSIONAL RE-LICENSING MODEL:</th>
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</thead>
<tbody>
<tr>
<td>• additional processes and tasks for FTPs</td>
</tr>
<tr>
<td>✓ Seek licensing as a physician</td>
</tr>
<tr>
<td>✓ Enhanced language education for physicians</td>
</tr>
<tr>
<td>✓ Observation and placements to learn about the culture of health care in a Canadian context</td>
</tr>
<tr>
<td>✓ Study and preparation for each exam</td>
</tr>
<tr>
<td>✓ Save additional money for the cost of each level and exam</td>
</tr>
<tr>
<td>✓ Take exams</td>
</tr>
<tr>
<td>✓ Complete additional residency requirements</td>
</tr>
<tr>
<td>✓ Build professional friendships and networks</td>
</tr>
<tr>
<td>✓ Get the license</td>
</tr>
<tr>
<td>✓ Practice as a physician</td>
</tr>
<tr>
<td>✓ Participation in the medical community</td>
</tr>
</tbody>
</table>

*Figure 13. Resettlement and professional re-licensing models: processes and tasks*
...
5. 2. 2 Maslow’s theory adapted to the resettlement hierarchy of needs of foreign-trained physicians.

Maslow’s theory was established to describe a hierarchy of needs (Maslow, 1970). According to this theoretical framework, human beings have different levels of needs which motivate them. As each level is satisfied, individuals move to higher levels of need fulfillment. It is built upon the belief that lower needs are to be completed and gratified before satisfying upper needs.

Maslow’s theory outlined five levels of needs: 1) physiological, 2) safety, 3) love and belongingness, 4) esteem needs (self esteem and recognition from others), and 5) self actualization (the desire to maximize their potential in many aspects (Maslow, 1970).

According to Maslow, and authors who further developed his work (Maslow, 1970; Heylighen, 1992; Sirgy, 1986) physiological needs refer to the needs of the body to maintain homeostasis. The second need is related to indirect threats, and it is consistent with safety and security. Love and belonging is the next level and the fundamental social, relational or membership motive which drives individuals to look for contact with others and to build pleasing relationships with them. Self esteem and esteem by others is associated with the level of happiness and belongingness. At this stage individuals will express their aspirations to succeed in life and to be recognized (Heylighen, 1992). Self-actualization is generally identified as a growth need, and is understood as the motivation to strive for improvements in the overall personality and to increase remaining potentialities, talents and competences that is never ending. According to Maslow, self-actualization relates to psychological health. The definition of self-actualization derives from Maslow’s motivation theory and was further developed by Heylighen (1992).
This study of foreign-trained physicians added further insight into the complexities of Maslow's theory. Many of these physicians had begun to fulfill some of their self-actualization needs as a physician before coming to Canada by using their potentialities and reporting experience a sense of meaning and purpose and making contributions to humanity. When they moved to another country and lost being a physician and the use of this potential and contributions. They found themselves in a new country beginning at the bottom of the needs hierarchy once again and initially they were consumed with fulfilling basic physiological needs, dealing with safety and security issues and trying to fit into and belong to the new society. Before they could once again attain the level of being a self-actualized person fully using their talents and contribute to society through their professional field of practice, this FTP group had to get their professional license.

Figure 14. recreates Maslow's hierarchy of needs in the center of the figure and expands and adapts the model that follows from the conclusions of this study. The expanded model provides further details of each of the levels as they were accomplished before coming to Canada and the challenges at each level to re-accomplish the hierarchy
Their ability to be successful in the IMG Ontario licensing process may have an impact on need fulfillment on several levels that relate to the Maslow hierarchy of needs. It would appear that to seek to be a physician again adds to the complexities of meeting and fulfilling the basic hierarchy of needs for this sample population. To meet the needs and goal fulfillments related to being re-licensed can be seen as providing for safety and security needs through having employment and income; providing for the needs of belonging and the re-establishment of friendships and a collegial network with other physicians; and re-establishing their sense of self worth and self esteem. Ultimately, to be a physician again might also provide for the need for self actualization and the sense of
purpose and meaning that they had described when they were fulfilling their role and contributing to society as a physician in previous times.

The descriptions these FTPs gave of their lives before coming to Canada appear on the left side of Figure 16 and correspond with their previous fulfillment of many of the original levels of Maslow’s Hierarchy of Needs. On the right side of Figure 16 are the levels that need to be re-accomplished after coming to Canada. They correspond to the need fulfillment levels of Maslow’s Hierarchy of Needs and expand the Model to include not only the basic need fulfillment levels, but those related to the successful re-establishment of the professional identity needs fulfillment for these foreign-trained physicians in Canada. The figure outlines a Model that describes having to start over to resettle and to become a physician again and to deal with: the basic physiological needs of housing and income; the safety and security needs by having employment and income; belonging needs by establishing friendships and a collegial network with friends, family and other physicians and health care providers; self esteem needs by reclaiming their value, identity and status as a physician; and self-actualization needs where they can develop their potentials further, contribute to humanity and realize future goals.

5. 2. 3. A suggested Process for Re-Licensing in Canada within 2-3 years.

Shuval (2003) indicated that the process of re-licensing can be supported and expedited by support for living in the first 2 years of immigration and resettlement. That study, and the lessons learned from this study indicate that several things need to be in place for quicker and successful re-licensing of this group: an income; language training; experience in the new culture and health system context; mentoring; available residency spots; and integration into the new host country. The following re-licensing process
model was developed from this study as a proposed improved process for FTPs who are motivated to be re-licensed with 2-3 years. It was developed from a review of other approaches from the literature and findings regarding the experiences and barriers identified by the interviewees in this study. This process is developed for the benefit of foreign-trained physicians and for the benefit of the Canadian health care system and is part of the grounded theory results of this study.

**A process for re-licensing within 2-3 years**

*Figure 15. Suggested process for a Canadian IMG Incentive Program*

5. 3 **Implications of the study for policy and process changes**

The results of this research study may contribute to political and policy discussions regarding improving the medical licensing process of newcomer physicians and other
professional groups in Canadian society as well as to the development of supports and services they might need to be successful. The experiences of foreign-trained physicians in Canada were found to have a negative impact on their sense of identity, self-esteem, health status and full resettlement. These findings could lead to the development of potential strategies, policy changes, and supportive initiatives that could remove barriers and facilitate licensing and health more for this group.

Although this study is not primarily about the immigration policies and processes related to newcomers and foreign-trained physicians in Canada, the findings indicate the need for further studies and changed policies related to resettlement support, and improved processes for the re-establishment of physician licensing and professional status. Addressing the barriers and increasing the facilitating factors could lead to positive outcomes for improving the use of such precious human capital and make more primary health care delivery resources available to Canadian communities. This direction could add to the overall community social capital with increased civic participation and inclusion of newcomer physicians in Canadian society.

Markus says:

So ...to certain point it's about protection somehow from those who came first or lived here all their life, to not let the foreigners take over. But the word shouldn't be 'take over' because we're not here to take over anybody's job. We just want to work. We just want to be part of the community and be part of this country ... and make it even stronger and better.

Carmen stated:

From the ministry...the representative from the ministry of health stated [March 2005 at Annual IMG meeting in Toronto] 'it very clearly that some of you will be able to get and to practice, but for some off you it won't be an option. He said it very clearly. And that's why there's a lot of IMGs now.
There appears to be a steady call for more physicians and a growing awareness of the fact that many are here and yet cannot practice. This has also impacted on changes related to the support for foreign-trained physicians and their licensing process in Canada. The process is being examined and perhaps some of the results of this study can be included in the deliberations. As Milne (2003) states:

Stories of physicians’ talents going to waste are poignant in a country desperate for doctors. ‘We’re way short of physicians,’ says Dr. Rod Crutcher, co-chair of the Canadian taskforce on International Medical Graduate Licensure. ‘Even if we’re not, there’s the social justice argument that it doesn’t make sense to have so many people working below their skill levels’ (p. 2).

Markus was conscious of the multicultural aspect of Canada, and the shortage of physicians because of aging, and retirements. He pointed out the importance of FTPs in helping to providing health care to their communities. Newcomer physicians are fundamental to renew the Canadian human resources and to provide better health care assistance where speaking others’ languages and know their behaviors, lifestyle and beliefs, is required:

Because the problem is...You say, ok, you need a medicine for the Canadian, but who are the Canadians? And those people come from those countries. So if I am from India, and there is a population of 200,000 let’s say in Toronto, here...I would be a doctor in that community. I would have lots because I know what are the needs they have...”

To not include the talents and training of this group in this new society is not only a colossal and devastating waste for the society but the fact that the years of life’s training seems to have no worth also has individual detrimental effects. The detrimental effects that the lost of self esteem can have on the individual’s health status, and the harmful influences on their social, economic, personal and family lives appear to be the personally meaningful and significant findings of the study. The development of new and
improved models of resettlement needs fulfillment and re-licensing might prevent and alleviate some of those harmful effects and they form part of the significant conclusions to this study.

5. 4  **Strengths and limitations of the research**

Studies to date have indicated that there may be an immigrant health effect and that immigrant's health deteriorates in the first 5 years of settling in Canada. This study shed some light on this phenomenon for this particular group. The participants included in the sample shared common and varied experiences on what was being investigated. The researcher had the benefit of being a foreign-trained physician herself and was able to work with the strengths and complexities of reflexivity when analyzing and understanding each of the interviews and the main emergent themes.

**Trustworthiness** of the research was addressed to strengthen the credibility, dependability and transferability of the study in a variety of ways. Trustworthiness of the research was attended to in the study in several ways. Every attempt was made to have the highest level of scientific rigour as possible in the study design, methodology, recruitment techniques, selection of the interview sample, data collection methods, reflexive analysis and summary of findings. Attempts were made to reinforce the reliability, validity and authenticity of the study through understanding the world of these foreign trained physicians that developed as a result of social, psychological and political constructions. In the research, attempts were made to clarify understanding with the participants and the new perspectives of others were added to that of the researcher.

**Credibility** (to ensure internal reliability) refers to how the data and the process of analysis are conducted to get results. Credibility was attended to in the study by including
a variety of age, gender and multiple experiences to enrich the variation of perspectives and experiences regarding the phenomenon being studied. Procedures were used to reduce and re-conceptualize several times, and these procedures aided judgment and enforced credibility. Comparisons were made within categories and among them.

Confirmability (as an analog to objectivity) is enhanced by recognition of the participants of the findings and this can improve credibility and confirmability of the study. While participants did not receive a copy of the transcribed interviews to add or confirm the data, during the interviews after the participants answered the questions they were asked frequently: “Let me see if I really understood you ….” The researcher repeated the answer as she had understood it to be and the interviewees answered “yes” or “no” or added clarifications. This approach provided a necessary step of verification. Through peer debriefing and feedback aspect of confirmability can be attended to. Weekly meetings with the thesis advisor, and presentation of the use of storytelling and narratives in research at a Storytelling and Cultural Identity Conference in Azores, Portugal, June 2005 formed part of peer debriefing, feedback and scrutiny. The research findings received a critical review by a thesis committee and an external examiner. Future presentations will be made to the research community in conferences and published articles will provide further peer review.

Dependability (for reliability) refers to dealing with data changes over time and phenomenological instability factors. To attend to this, the interviews were conducted over a one month period only, so as not to affect the data (March, 2005). Inquiry was made into the same areas for all participants using an interview guide and this increased the dependability of the data collected.
Transferability (for external validity) is the degree to which the findings can be transported to other situations and contexts. Comprehensible and clear reports of the circumstances under which the research was conducted were attended to. The procedures for the selection of participants; interviewing of participants; selection of data; and the analysis process used aided in increasing the transferability of the study.

The findings of this study describe the perceptions, experiences, feelings and opinions of a small sample of foreign-trained physicians who were still actively engaged in being re-licensed. Their experiences may not be generalizable to all FTPs, or to those who have moved on to other employment and goals. The results have uncovered helpful insights regarding other newcomer professionals in Canada who have a strongly developed sense of professional, social, group-based and institutional identity. The transferability would have to be tested to see if the perceptions, experiences and processes are similar. While there are inherent limitations to the generalizability of any qualitative results, grounded theory was used to contribute to the development of some general processes related to successful resettlement for other newcomers to Canada and for the re-licensing and re-settlement of foreign-trained physicians in particular.

Although as much variation as possible was sought in the 8 FTPs chosen for an interview ages, gender, time in Canada and other variables would have strengthened the results. A limitation in the methodology was that the participants were not given a transcription or summary of their interviews for verification and to add further insights.

5.5 Implications for future research

The results of this study indicate that some areas related to this study could be studied further using a variety of quantitative and qualitative methods:
• Additional questions could be added to this qualitative study about what would make this group stop pursuing their goal and at what point would they stop seeking to re-license.

• Pilot studies could be developed to assess the usability and effectiveness of the proposed Resettlement Process Model and Re-licensing Model.

• Qualitative interview studies could be conducted at year 1, 2, 3, 4, 5 of being in Canada and in the re-licensing process to shed even more light on what is happening in each of those first five years in Canada regarding the immigrant health effect.

• A quantitative survey could be conducted with a larger sample using a stratified random sample method so that the results could be more generalizable.

• In addition to the self-report of health status, actual health data could be collected in a longitudinal study to increase the understanding of elements of their health that were being effected over a longer period of time.

• More needs to be understood about the institutional theory of medicine, the enculturation of its members into the profession, their social identity development and why such strong bonds of personal and group identity are attached to this profession and to the status of being a doctor.

• Studies could be conducted following FTPs for longer periods of time to compare 3 groups: those who get re-licensed again; those who end up working in other allied health professions; and those who end up working outside of medicine and health care and impacts on self esteem and health.
• Studies could be conducted on a group of FTPs who work in meaningful employment close to health care while they study to re-license and those who do not and if there is any correlation to success rates at re-licensing and effects on self-esteem and health.

• Research could be conducted with other foreign-trained professional groups such as engineers or nurses to see if their professional and institutional identities operate the same as that of physicians and are central to their self-esteem and overall self-concept.

The hope that many of these FTPs will be recognized one day, and will practice as licensed physicians in the Canadian system enriching the multicultural Canadian society and the health care needs of its citizens still seem somewhat unattainable at the time of the interviews. Their limited knowledge of the Canadian health care system made some of the FTP participants believe that one day soon they would be part of the Canadian health system, but many may not, even after extended periods of resettlement time. As time has lapsed, many have looked at their hopes of being a physician in the health system and wondered if they would ever be able to reach their goal to re-establish their physician identities again. New models and processes developed from this research could improve their chances of reclaiming their professional identities to be a physician again.
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The current standard framework for model estimation assumes that
the parameters are not deterministic in nature or constant. In reality,
the parameters can be dependent on other variables or can change
over time. This limitation can be overcome by using adaptive
methods that adjust the parameters based on new data or information.

Compared to standard approaches, adaptive methods can offer
improved accuracy and efficiency. However, they also require
additional computational resources and can be more complex to
implement. Therefore, it is important to carefully consider the
trade-offs between accuracy and computational cost when selecting
an appropriate estimation method.

In summary, the standard framework for model estimation is
limited by its assumption of deterministic parameters. Adaptive
methods can overcome these limitations by adjusting the parameters
based on new data or information, but they also require additional
resources and can be more complex to implement. It is important
to carefully consider the trade-offs between accuracy and computational
cost when selecting an appropriate estimation method.
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APPENDIX A

Brock University Research Ethics Board (REB)
Application for Ethical Review of Research Involving Human Participants

Please refer to the documents “Brock University Research Ethics Guidelines” which can be found at http://www.brocku.ca/researchservices/ prior to completion and submission of this application. If you have questions about or require assistance with the completion of this form, please contact the Research Ethics Officer at (905) 688-5550 ext. 3035, or reb@brocku.ca.

Return your completed application and all accompanying material in triplicate to the Research Ethics Office in Scotiabank Hall 335. Please ensure all necessary items are attached prior to submission, otherwise your application will not be processed (see checklist below). No research with human participants shall commence prior to receiving approval from the research ethics board.

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<td>• Telephone script</td>
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<td>• Advertisements (newspapers, posters, experimetrices)</td>
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<td>• Electronic correspondence guide</td>
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<td>Letter of Approval for research from cooperating organizations, school board(s), or other institutions</td>
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<td>Any previously approved protocol to which you refer</td>
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SIGNATURES

Principal Investigator:

Please indicate that you have read and fully understand all ethics obligations by checking the box beside each statement.

[x] I have read Section III:8 of Brock University’s Faculty Handbook pertaining to Research Ethics and agree to comply with the policies and procedures outlined therein.

[x] I will report any serious adverse events (SAE) to the Research Ethics Board (REB).

[x] Any additions or changes in research procedures after approval has been granted will be submitted to the REB.

[x] I agree to request a renewal of approval for any project continuing beyond the expected date of completion or for more than one year.

[x] I will submit a final report to the Office of Research Services once the research has been completed.

[x] I take full responsibility in ensuring that all other investigators involved in this research follow the protocol as outlined in the application.

Signature __________________________________________ Date: ______________________

Co-Investigators:

Signature __________________________________________ Date: ______________________

Signature __________________________________________ Date: ______________________

Signature __________________________________________ Date: ______________________

Faculty Supervisor:

Please indicate that you have read and fully understand the obligations as faculty supervisor listed below by checking the box beside each statement.

[x] I agree to provide the proper supervision of this study to ensure that the rights and welfare of all human participants are protected.

[x] I will ensure a request for renewal of a proposal is submitted if the study continues beyond the expected date of completion or for more than one year.

[x] I will ensure that a final report is submitted to the Office of Research Services.

[x] I have read and approved the application and proposal.

Signature __________________________________________ Date: ______________________

SECTION A - GENERAL INFORMATION
1. **Title of the Research Project:** The Implications of Being a Newcomer Physician in a New Society: Qualitative Study of Foreign-Trained Physician’ Resettlement, Sense of Identity and Health Status.

2. **Investigator Information:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Rank (e.g., faculty, student, visiting professor)</th>
<th>Dept/Address</th>
<th>Phone No.</th>
<th>E-Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Principal Investigator</strong></td>
<td>María Auxiliadora Junqueira de Carvalho</td>
<td>Master Student Student number 3128303</td>
<td>Community Health Sciences</td>
<td>905 688 5550 Extension 5052</td>
</tr>
<tr>
<td><strong>Co-Investigator(s)</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Faculty Supervisor(s)</strong></td>
<td>Dr. Heather Lee Kilty</td>
<td>Assistant Professor</td>
<td>Nursing</td>
<td>905 6885550 Extension 4749</td>
</tr>
</tbody>
</table>

3. **Proposed Date (dd/mm/yyyy) (a) of commencement:** January 15, 2005  
   **(b) of completion:** June 1, 2005

4. **Indicate the location(s) where the research will be conducted:**

<table>
<thead>
<tr>
<th>Location</th>
<th>Specify</th>
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<tr>
<td>Brock University</td>
<td>[ x ]</td>
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<tr>
<td>Community Site</td>
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<tr>
<td>School Board</td>
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<tr>
<td>Hospital</td>
<td>[ ]</td>
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<tr>
<td>Other</td>
<td>[ ]</td>
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</tbody>
</table>

5. **Other Ethics Clearance/Permission:**

   (a) Is this a multi-centered study?  
   [ x ] No  
   (b) Has any other University Research Ethics Board approved this research?  
   [ ] Yes  

   If YES, there is no need to provide further details about the protocol at this time, provided that all of the following information is provided:

   - Title of the project approved elsewhere:
   - Name of the Other Institution:
   - Name of the Other Board:
   - Date of the Decision:
   - A contact name and phone number for the other Board:

   Please provide a copy of the application to the other institution together with all accompanying materials as well as a copy of the clearance certificate / approval.
If NO, will any other Research Ethics Board be asked for approval?  
[x] No

Specify University/College

(d) Has any other person(s) or institutions granted permission to conduct this research?  
[x] No

Specify (e.g., school boards, community organizations, proprietors)

6. Level of the Research:

[ ] Undergraduate  [ ] Masters Thesis/Project  [ ]

Ph.D.

[ ] Post Doctorate  [ ] Faculty Research  [ ]

Administration

[ ] Course Assignment (specify)  [ ] Other (specify)

7. Funding of the Project:

(a) Is this project currently being funded  
[ ] Yes  [x] No

(b) If No, is funding being sought  
[ ] Yes  [ ] No

If Applicable:

(c) Period of Funding (dd/mm/yyyy):  
From:  
To:

(d) Agency or Sponsor (funded or applied for)

[ ] CIHR  [ ] NSERC  [ ] SSHRC

[ ] Other (specify):

8. Conflict of Interest:

(a) Will the researcher(s), members of the research team, and/or their partners or immediate family members:

(i) receive any personal benefits related to this study - for example: a financial remuneration, patent and ownership, employment, consultancies, board membership, share ownership, stock options (Do not include conference and travel expense coverage, possible academic promotion, or other benefits which are integral to the conduct of research generally).  
[ ] Yes  [x] No

(ii) if Yes, please describe the benefits below.

(b) Describe any restrictions regarding access to or disclosure of information (during or at the end of the study) that the sponsor has placed on the investigator(s).
9. **Rationale:**

Describe the purpose and background rationale for the proposed project, as well as the hypothesis(es)/research question(s) to be examined.

The purpose of this study is to gain a deeper understanding of the resettlement experiences of foreign-trained newcomer physicians, particularly the loss of their professional identity and the impact on their sense of identity and health status.

72% of immigrants to Canada have university degrees compared to 13% of Canadians, while the unemployment rate of newcomer professionals is more than three times the provincial trend. Only 24% are employed in their profession (Calleja, 2000). The migration and acculturation process is often stressful, and accompanied by little social support, experiences of prior trauma, and unemployment.

The “immigrant effect” is defined as the trend for immigrant health status to be superior to Canadians at the time of entry and to deteriorate within the first 5 years (Hyman, 2004). Studies conducted at various points post-arrival, and with specific groups could provide helpful information about this phenomenon. The findings could also stimulate a re-examination of the resettlement and licensing processes. The research questions of the study are:

1. What impact does having to work outside of the medical profession have on the resettlement process, sense of identity and health status of foreign-trained physicians?
2. How important is professional identity in the overall sense of identity of foreign-trained physicians who presently cannot practice in Canada?
3. What other factors such as prior violence and trauma, the settlement process itself, and stress had on their sense of identity and health status?
4. What are the main barriers, facilitating factors and supports that affect resettlement, health status, and the re-establishment of professional identity?

10. **Methods:**

Are any of the following procedures or methods involved in this study? Check all that apply.

- [ ] Questionnaire (mail)
- [x] Questionnaire (email/web)
- [ ] Questionnaire (in person)
- [ ] Interview(s) (telephone)
- [x] Interview(s) (in person)
- [ ] Secondary Data
- [ ] Computer-administered tasks
- [ ] Focus Groups
- [ ] Journals
- [x] Audio/video taping
- [ ] Unobtrusive observations
- [ ] Invasive physiological measurements (e.g., ventipuncture, muscle biopsies)
- [ ] Non-invasive physical measurement (e.g., exercise, heart rate, blood pressure)
- [ ] Analysis of human tissue, body fluids, etc.
- [ ] Other: (specify)

Describe sequentially, and in detail, all procedures in which the research participants will be involved (e.g., paper and pencil tasks, interviews, questionnaires, physical assessments, ...
This study will utilize **qualitative research methodology** to gain a deeper understanding of the resettlement experiences and the loss of professional identity of newcomer foreign-trained physicians and those factors that impact on their health status and identity. A **grounded theory qualitative approach** will be used to focus the areas of inquiry and to aid the analytical process of generating or verifying theories. Grounded theory transfers the research into the actual world, potentially explaining the internal essence of human understanding and disclosing possible new meanings (Patton, 2001). The systematic, constant, and comparative data analysis of grounded theory can help explain what has been observed, what has occurred, and potentially disclose new facts. The goal of grounded theory is to investigate the fundamental social processes and to recognize the diversity of the interfaces that generate differences in the phenomenon to be studied.

This phenomenon is multifaceted and complex, and **qualitative interviews** will be the main method of data collection (Interview Guide; questions and probes in Appendix G).

**Research Sequence:**

- All 52 of the foreign-trained physicians who are registered with the Association of International Physicians and Surgeons of Ontario (AIPSO) in Niagara will be contacted from their e-mail list and invited to participate (Introductory Recruitment Letter in Appendix B). The AIPSO e-mail list is not publicly available. The principal investigator is an AIPSO member. She has met other IMG through monthly meetings. For those meetings the researcher has received invitations monthly in which all registered IMGs of Niagara Chapter have had their email addresses disclosed. The researcher has personally requested emails for further contact. The criteria to be included are: they must be foreign-trained physicians who are not presently licensed to practice in Canada; they entered Canada with immigrant or refugee status; they have been in Canada up to 10 years; and they must be engaged in the goal of acquiring their medical license to practice in Canada.

- If they indicate an interest in participating, they will receive a package including the Consent Letter (Appendix C), the Participant Information Survey (Appendix D), and the Self-Rated Health Survey (Appendix E) and asked to mail them back.

- These surveys (Appendix D and E) will also be used by the researcher prior to the interview to assist with planning the interview and with selecting a sample to participate in the 10 interviews to insure a variation in those participating (gender, country of origin, family situation, and length of time in Canada ...). The results of the surveys will also be summarized in the report findings.

- Should almost all agree to participate, the final 10 will be chosen randomly from the variables outlined to ensure variability, reliability, and credibility in the study (gender, country of origin, family construct, length of time in Canada). A multivariate sampling approach will be used if only a few more than 10 agree to participate. If not enough agree to participate, a reminder e-mail contact will be made and a presentation made at the monthly Niagara AIPSO meeting.
Multicultural Centres and Heritage Councils in Niagara will also be contacted if needed.

- Participants agreeing to participate in the interview and chosen for the sample, will be contacted for re-consent to be interviewed and an interview will be booked and conducted in a private office in the Nursing Department at Brock University.
- The first 2 interviews will serve as pilots of the questions and summaries will be included in the findings.
- Interviews will be audiotaped, transcribed, (third Party confidentiality letter in Appendix H) and analyzed.
- Process notes will be made by the researcher during and after the interview and added to the data for analysis.
- Followup clarification of data may be conducted by telephone, e-mail or a face-to-face interview.
- Data will be summarized, analyzed, and reported in a Master Thesis

11. **Professional Expertise/Qualifications:**

Does this procedure require professional expertise/recognized qualifications?  [ ] Yes [x] No

If YES, specify:

Do you, your supervisor, or any members off your research team have the professional expertise/recognized qualifications required?  

[ ] Yes [x] No

12. **Participants:**

Describe the number of participants and any required demographics characteristics (e.g., age, gender).

This study intends to include a sample of approximately 10 foreign-trained newcomer physicians who are not presently licensed to practice in Canada. It will include a sample drawn from the 52 members of the Association of International Physicians and Surgeons of Ontario (AIPS0) who are from the Niagara Region and who are attached to the Heritage Councils and multicultural centers in the region.

In this study, the minimum criteria set forth for participants will be:

- All participants must be foreign-trained physicians who are not presently licensed to practice in Canada.
- All participants must have entered Canada with immigrant or refugee status.
- All participants must have been in Canada from up to 10 years to be considered a newcomer for this study.
- All participants must be presently engaged in the goal of acquiring their medical license to practice in Canada.

The interview participants will be chosen from the numbers of the 52 contacted who consent to participate in the study and from their participant information to vary in
gender, country of origin, family/marital status construct, and length of time of resettlement in Canada to provide a richness of information. An attempt will be made to include as many views, experiences and perceptions as possible in an attempt to be a good sample of the newcomer physician lives (Patton, 2001, p.234). It is expected that newcomer physicians who have gone through various stages of the resettlement, acculturation, and engagement in the credentialing process have accumulated new and complex experiences of life. It is hoped that participants will also represent a good range of employment experiences since they have arrived in Canada. All participation is voluntary and can be discontinued at any time.

The excellence of qualitative inquiry is related to the researcher’s performance and abilities in being able to listen, to observe and to analyze data (Patton, 2001) Redundancy and saturation are the primary criteria to end the sampling and interview process. The sampling is closed when no new information can be added, and a balanced treatment of the phenomena has been covered (Patton, 2001). According Patton (2002) “The solution is judgment and negotiation. I recommend that qualitative sampling designs specify minimum sample based on expected reasonable coverage of the phenomena given the purpose of the study and stakeholder interests” (p.247). A usual practical sample size is suggested to be from 5 to 25 individuals depending on the phenomena to be studied (Leedy, 2001).

13. Recruitment:

Describe how and from what sources the participants will be recruited, including any relationship between the investigator(s), sponsor(s) and participant(s) (e.g., family member, instructor-student; manager-employee).

*Attach a copy of any poster(s), advertisement(s) or letter(s) to be used for recruitment.*

All 52 foreign-trained physicians who are registered with AIPSO in Niagara will be contacted and given a recruitment letter signed by the researcher/Masters degree candidate explaining the study and encouraging their participation (Appendix B). They will all be sent an e-mail letter and some will be handed out to the physicians who meet monthly at the Heritage Council in Welland to study for their licensing exams. The letter explains that they are to contact the researcher to indicate interest by telephone or e-mail. Once they indicate interest, a package will be sent to them with further information and a consent form for signature along with the self-administered surveys to be mailed back to the researcher. Those selected for the interview sample will be re-contacted for consent and to arrange an interview time.

*Should the letter not recruit enough physicians; the researcher will make a presentation at the AIPSO meeting and make contact with the multicultural centres who have indicated that they will help recruit participants should the letter not be sufficient as a recruitment strategy.*

14. Compensation:  

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(a) Will participants receive compensation for participation? [X]

(b) If yes, please provide details.
SECTION C – DESCRIPTION OF THE RISKS AND BENEFITS OF THE PROPOSED RESEARCH

15. Possible Risks:

1. Indicate if the participants might experience any of the following risks:

a) Physical risks (including any bodily contact, physical stress, or administration of any substance)? [ ] Yes [x] No

b) Psychological risks (including feeling demeaned, embarrassed worried or upset, emotional stress)? [x] Yes [ ] No

c) Social risks (including possible loss of status, privacy, and/or reputation)? [ ] Yes [x] No

d) Are any possible risks to participants greater than those that the participants might encounter in their everyday life? [ ] Yes [x] No

e) Is there any deception involved? [ ] Yes [x] No

f) Is there potential for participants to feel coerced into contributing to this research (e.g., because of regular contact between them and the researcher)? [ ] Yes [x] No

2. If you answered Yes to any of 1a – 1f above, please explain the risk.

Participants may disclose information of an intimate; stressful; or otherwise sensitive nature.

3. Describe how the risks will be managed (include the availability of appropriate medical or clinical expertise, qualified persons). Give an explanation as to why less risky alternative approaches could not be used.

The researcher conducting the interview is a trained foreign-physician from Brazil who has had some psychiatric specialty training. Should information of a stressful nature come up in the interview, initial supportive listening counseling can be given. In addition, a list of potential contact numbers for counseling will be made available for follow up after the interview if needed.

16. Possible Benefits:

Discuss any potential direct benefits to the participants from their involvement in the project. Comment on the (potential) benefits to the scientific community/society that would justify involvement of participants in this study.

Participants will benefit from involvement in this study by having an opportunity to tell their individual story. In addition, the findings may lead to discussions regarding changes in policies and settlement, employment or supportive...
services that could make licensing and professional re-establishment more feasible, more supportive, and perhaps even faster.

- An understanding of the foreign-trained physician’s experiences and processes of settlement and re-establishment of professional identity the impact on their health may help to develop future strategies to positively impact on the health of this population who bring rich new contributions in Canada. Knowing the present and past self-reported health status of foreign-trained physicians who relocate in Canada, and understanding the effect of resettlement, stress, unemployment, trauma, and support are essential for this study. This could increase our understanding of the immigrant health effect to prevent future newcomer physicians and others from having their health status negatively affected through the resettlement and the social and professional identity development process.
- A re-examination of the policies and process for resettlement and re-licensing of physicians may lead to some improvements in the process.
- This study could make further contributions to research by: paving the way for future research; or generating new theories.
- In a wider societal sense, it may lead to improvements in the use of such rich human capital and perhaps an increase in the number of experienced and culturally diverse physicians to deal with the Canadian shortage. Including these professions more in participation in society could make an increase in the overall social capital available in Canadian society.

SECTION D – THE INFORMED CONSENT PROCESS

17. The Consent Process:

Describe the process that the investigator(s) will be using to obtain informed consent. Include a description of who will be obtaining the informed consent. If there will be no written consent form, explain why not.

For information about the required elements in the letter of invitation and the consent form, as well as samples, please refer to:

If applicable, attach a copy of the Letter of Invitation, the Consent Form, the content of any telephone script and any other material that will be utilized in the informed consent process.

The consent process is comprised of a set of explanations which are clearly written in the consent letter. Any doubt that could arise from these explanations will be promptly clarified personally, by the email addresses, and by phone numbers specified in the Participant Informed Consent Form.

The Participant Informed Consent Letter focus on the main topics:

1. The participant has been given and has read the Letter of recruitment and Introduction provided to him/her by the interviewer conducting the research study.
2. The participant understand that this study in which him/her consent to participate will involve the completion of a participant survey and a self-rated health survey.
3. The participant understand that he/she can be chosen to participate in a interview. In order to be interviewed the participant will receive a Participant Informed Consent Form Interview.
4. The purpose of this study which is understand the experiences of being a foreign-trained physician settling in Canada, is clearly written down in the consent letter.
5. The participant understand that his/her participation can bring every day psychological risk
which can be explained as a minimal risk or harm. Those minimal risk was explained to the participant.

6. The participant understand that his/her participation in this study is voluntary and that he/her can withdraw from the study anytime without penalty.

7. The participant understand that if he/she was invited for an interview, and for any reason the interview is interrupted, a new appointment will be scheduled to complete the interview.

8. The participant understand that the interview will be audio taped.

9. The participant understand that his/her privacy is being invaded, if he/she feel offended, or that a question is inappropriate, the interviewee has no obligation to answer.

10. The participant is allowed to ask questions anytime during the interview.

11. The participant understand that his/her participation is free.

12. The participant understand that all personal information will not be disclosed and that all information will be coded so that his/her name will not be linked with his/her answer.

13. The participant understand that the researcher can be asked to be re-contacted to clarify some points in the further.

14. The participant understand that the principal investigator, the faculty advisor, and the transcript will have access to the data and that they are also bound by confidentiality.

15. The participant understand that the results of this research will be used as a part of the thesis project. Information may also be used during presentations or written projects produced from this, but name will not be divulged.

16. The participant understand that his/her signature below the consent form validates his/her free willed participation.

18. **Consent by an authorized party:**

If the participants are minors or for other reasons are not competent to consent, describe the proposed alternative source of consent, including any permission form to be provided to the person(s) providing the alternative consent.

19. **Alternatives to prior individual consent:**

If obtaining individual participant consent prior to commencement of the research project is not appropriate for this research, please explain and provide details for a proposed alternative consent process.

20. **Feedback to Participants:**

Explain what feedback/information will be provided to the participants after participation in the project. Include, for example, a more complete description of the purpose of the research, and access to the results of the research. Also, describe the method and timing for delivering the feedback.

The participant in this research will be thanked for his/her help, and appreciation will be expressed for being involved. These questionnaires and interviews are part of the
research project studying the implications of being a foreign-trained physician who has resettled in Canada, and the experiences and challenges that many of physicians face in relocating to a new country. We are aware that immigration is a multifaceted process in which many factors play a significant role affecting individual lives. Newcomers to Canada who are trained doctors, more than most other skilled workers, have a challenging process to restore their professional life, and to find meaningful employment. It requires resources, support and commitment. Many will be successful in re-establishing their credentials, and others will make new plans.

Their opinions, stories, insights, and feelings are of particular and important experiences, which will allow Maria A. J. de Carvalho to better understand and to clarify the phenomenon of newcomer trained physician resettlement, and the search to re-establish professional identity.

The results and summaries of all of the interviews will be included her Masters Thesis Report. An executive summary will be provided to them upon request. They are pleased to use the following contact information to request a summary report. If the participants would like us to send a report to them, they will be asked to provide an address, e-mail or a means by which the principal investigator and the faculty advisor can send this to them after 5 months. If they have any concerns or they need any further clarification about this study, they are free to contact Maria de Carvalho 905-688-5550 Ext. 5052 or e-mail mamadoc25@hotmail.com. They may also contact Maria’s advisor, Dr. Heather Lee Kilty at 905-688-5550, extension 4749 or e-mail at heather.kilty@brocku.ca, or the Office of Research at Brock University at 905-688-5550, extension 3035.

While we know that you have some access to support that they may need, if any topic or issue has distressed you during this interview, we offer you these contact if needed:
Niagara Distress Centre 905- 849-4541
The Multicultural Centre of Fort Erie 905-
Barbara Dewar, Psychotherapist 905-988-0088

21. Participant withdrawal:

a) Describe how the participants will be informed of their right to withdraw from the project.
Outline the procedures that will be followed to allow the participants to exercise this right.

- The participants will be informed before they sign the Participant Informed Consent Survey Form and the Participant Informed Consent Interview Form that their participation in this study is voluntary and that they can withdraw from the study anytime without penalty. All their paper records will be shred, and audio tapes will be erased immediately.

b) Indicate what will be done with the participant’s data and any consequences that withdrawal might have on the participant, including any effect that withdrawal may have on participant compensation.

- All their paper records will be shred, and audio tapes will be erased. Their
withdrawal has no effect on the participant and no compensation is involved.

SECTION E – CONFIDENTIALITY & ANONYMITY

Confidentiality: information revealed by participants that holds the expectation of privacy (this means that all data collected will not be shared with anyone except the researchers listed on this application).

Anonymity: information revealed by participants will not have any distinctive character or recognition factor, such that information can be matched to individual participants (any information collected using audio-taping, video recording, or interview cannot be considered anonymous).

22. Given the definitions above,

a) Will the data be treated as confidential?  [x] Yes [ ] No
b) Are the data anonymous?  [ ] Yes [x ] No
c) State who will have access to the data:

The principal investigator, the faculty supervisor, and the transcriber

(d) Describe the procedures to be used to ensure anonymity of participants and/or confidentiality of data both during the conduct of the research and in the release of its findings.

Participant interviews will be audio taped and a number, but not a name will be given at the beginning of the tape. No names will be required to be included on the survey/questionnaire. All data will be kept at a secure university office to ensure confidentiality. During the interviews, a private office will be provided with the door closed. The office is in the Nursing Department where many students come and go and provides safety and confidentiality. A list of names and numbers will be known only to the principal investigator and the transcriber.

The findings will contain no identifying names and pseudonyms only will be used in the narrative reports. In addition, some of the findings will be in summary form of the major themes and individual quotes will be carefully screened to ensure that no information of a personal and private nature is attributed to an individual or can be identifiable. Transcribers and third party research assistants will be required to sign a statement of confidentiality.

e) If participant anonymity and/or confidentiality is not appropriate to this research project, explain, providing details, how all participants will be advised that data will not be anonymous or confidential.
null
f) Explain how written records, video/audio tapes, and questionnaires will be secured, and provide
details of their final disposal or storage (including for how long they will be secured and the
disposal method to be used).

All data will be kept at a secure university office to ensure confidentiality. During
the interviews, a private office will be provided with the door closed. The office is in the
Nursing Department and provides safety and confidentiality.

SECTION F – SECONDARY USE OF DATA

23. a) Is it your intention to reanalyze the data for purposes other than described in this application? [ ] Yes [x] No

b) Is it your intention to allow the study and data to be reanalyzed by colleagues, students, or
other researchers outside of the original research purposes? If this is the case, explain how
you will allow your participants the opportunity to choose to participate in a study where their
data would be distributed to others (state how you will contact participants to obtain their re-
consent)

c) If there are no plans to reanalyze the data for secondary purposes and yet, you wish to keep the
data indefinitely, please explain why.

SECTION G – MONITORING ONGOING RESEARCH

24. Annual Review and Serious Adverse Events (SAE):

a) Minimum review requires the completion of a “Renewal/Project Completed” form at least
annually. Indicate whether any additional monitoring or review would be appropriate for this
project.

It is the investigator's responsibility to notify the REB using the “Renewal/Project
Completed” form, when the project is completed, or if it is cancelled.
http://www.brocku.ca/researchservices/Forms/Forms.html

*Serious adverse events (unanticipated negative consequences or results affecting
participants) must be reported to the Research Ethics Officer and the REB Chair, as soon
as possible and in any event,
no more than 3 days subsequent to their occurrence.

25. COMMENTS

If you experience any problems or have any questions about the Ethics Review Process at
Brock University, please feel free to contact the Research Ethics Office at (905) 688-5550
ext 3035, or reb@brocku.ca
I invite you to participate in a research study titled “The implications of being a newcomer physician in a new society: Qualitative study of foreign-trained physicians’ resettlement, sense of identity and health status.” Foreign-trained physicians have faced many experiences in their resettlement process, including exploring getting licensed to practice medicine in Canada or to find other meaningful employment. I am from Brazil where I am a pediatrician and a Public Health physician. Currently I am a graduate student in the Faculty of Applied Health Sciences at Brock University, Department of Community Health Sciences, and I have been working under the supervision of Dr. Heather Lee Kilty in the Nursing Department.

Your participation and input are essential and important in this study. You will be asked to complete a consent form and to answer a short Participant Information Survey, and a Self-Rated Health Survey. After this, you may be asked to participate in an interview which will last approximately one and a half hours. This interview will ask you questions about the changes of your life since you came to Canada (e.g. how was your life before coming to Canada?), your experiences with finding employment and trying to restore your professional life (e.g. What is like for you not being able to practice medicine in Canada?), as well as questions about health and future hopes and expectations. All of your ideas, thoughts and feelings are very important to my research. This study could make important contributions such as: the development of future studies, the development of new theory; potential policy changes (resettlement support/improvements in the process of International Medical Graduate (IMG) licensing and reestablishment of professional status); improvement in the use of human capital; more physicians to deal with Canadian shortage; and increase social capital in Canadian society

The interviews will be conducted at a time of your convenience at the Nursing Department at Brock University. Please contact me at 905-735-6884 or 905-688-5550 Ext. 5052 or by e-mail at mamadoc25@hotmail.com to let me know if you are interested in participating in this study and a Consent Letter and Survey package will be sent to you.

This study has been reviewed by, and received ethics clearance through the Brock University Ethics Board File #____________________

I invite you to participate in this study and hope you will be involved.

Sincerely,

Maria A. Junqueira de Carvalho
MA Candidate
Department of Community Health Sciences
Appendix C
Participant Informed Consent Form
Brock University, Faculty of Applied Health Sciences

Title of Study: The Implications of Being a Newcomer Physician in a New Society: Qualitative Study of Foreign-Trained Physicinan's Resettlement, Sense of Identity and Health Status.

Principal Investigator: Maria A. J. de Carvalho, M.A. Candidate, Faculty of Applied Health Sciences, Brock University

Faculty Supervisor: Dr. Heather Lee Kilty, Department of Nursing, Brock University

Name of participant: (please print)

- I have been given and have read the Letter of Recruitment and Introduction provided to me by the interviewer conducting the research study.
- I understand that this study in which I consent to participate will involve the completion of a participant survey and a self-rated health survey and may also involve an interview which will last approximately one hour and a half to two hours in length. The purpose of this study is to understand the experiences of being a foreign-trained physician settling in Canada.
- I understand that my participation will bring little or no risk or harm to me. These minimal risks have been explained to me.
- I understand that my participation in this study is voluntary and that I can withdraw from the study anytime without penalty.
- I understand that I may participate in filling out the surveys only, or that I may also be contacted for an interview.
- I understand that if for any reason the interview is interrupted, a new appointment will be scheduled to complete the interview.
- If I feel my privacy is being invaded, if I feel offended, or that a question is inappropriate, I have no obligation to answer.
- I understand that I may ask questions at anytime during the interview.
- I understand that my participation is free.
- I understand that all personal information will not be disclosed and that all information will be coded so that my name will not be linked with my answers.
- I understand that I can be asked to be re-contacted to clarify some points further.
- I understand that only the principal investigator, the faculty advisor, and the transcriber will have access to the data and that they are also bound by confidentiality.
- I understand that the results of this research will be used as a part of the thesis project. Information may also be used during presentations or written projects produced from this, but my name will not be divulged.
- I understand that my signature below validates my free willed participation, as

Participant’s signature: ______________________ Date ________________

Additional notes and mailing address on the next page ...
ADDITIONAL INFORMATION

This study has been reviewed and approved by the Brock Research Ethics Board

(File#__________)

If you have any questions or concerns about your participation in this study, you may contact Maria A. J. de Carvalho at 905-735 6884 or 905-688-5550 Ext. 5052 or by e-mail at mamadoc25@hotmail.com or Dr. Heather Lee Kilty: 905-688-5550 extension 4749, e-mail heather.kilty@brocku.ca.

Concerns about your involvement in the study may also be directed to Research Ethics Office in the Office of Research Services at 905-688-5550, extension 3035.

Feedback about the use of the data collected will be available in July, 2005 from Maria A. J. de Carvalho in the Nursing Department of the Faculty of Applied Health Sciences at Brock University. An executive summary will be available to you at that time. Please provide a suitable method to make the executive summary available to you at the completion of the interview.

Thank you for your help. Please make one copy of this consent form for further reference.

PLEASE send a copy of your consent letter and the completed surveys back to:

Maria de Carvalho
c/o The Nursing Department,
500 Glenridge Avenue,
St. Catharines, Ontario.
L2S 3A1

I have fully explained the procedures of this study to the persons named above in the letter form.

Researcher’s Signature _______________________ date ____________
APPENDIX D

PARTICIPANT INFORMATION SURVEY

For office only/ Date: ___________ Participant code #: _______ Pseudonym: ____________________

1. What is your gender? Male____ Female____

2. What is your age? ______

3. When did you arrive in Canada? Month?_____ Year?______

4. Where are you from (country)? ______________________________________________________

5. Would you consider yourself to be (check which one)
   Married/Common-law____ Separated___ Divorced___ Widowed____ Single____

6. Describe the family you live with presently (eg. Husband with 2 children aged 6 and 10; grandmother and grandfather)
   ________________________________________________________________________________

7. What religion would you consider yourself to be? ______________________________________

8. What race would you consider yourself to be? _________________________________________

9. Did you enter Canada as (check one)
   an immigrant____ as a refugee____ other (specify), ________________________________

10. What is your profession and area of specialty? _________________________________________

11. What country did you get your medical training/certification from? _____________________

12. Are you presently working on getting your medical license in Canada? Yes____ No____

13. How important is it for you to practice as a physician again? (check one)
    Very important____ somewhat important____ not too important____

14. What work have you been doing since you came to Canada? ____________________________

Thank you for completing this form ...
Please go to the next page to complete the self-rated surveys ...
APPENDIX E

SECTION I: SELF-RATING HEALTH SURVEY (health, self-esteem, stress ...)

1. Generally, how would you rate your health status before coming to Canada?
   Excellent ___ very good ___ good ___ fair ___ poor ___

2. Generally, how would you rate your health status in the first 6 months in Canada?
   Excellent ___ very good ___ good ___ fair ___ poor ___

3. Generally, how would you rate your present health status?
   Excellent ___ very good ___ good ___ fair ___ poor ___

4. Generally, how would you rate your quality of life before coming to Canada?
   Excellent ___ very good ___ good ___ fair ___ poor ___

5. Generally, how would you rate your quality of life in the first 6 months in Canada?
   Excellent ___ very good ___ good ___ fair ___ poor ___

6. Generally, how would you rate your present quality of life?
   Excellent ___ very good ___ good ___ fair ___ poor ___

7. Generally, how would you rate your self esteem before coming to Canada?
   Excellent ___ very good ___ good ___ fair ___ poor ___

8. Generally, how would you rate your self esteem in the first 6 months in Canada?
   Excellent ___ very good ___ good ___ fair ___ poor ___

9. Generally, how would you rate your present self esteem?
   Excellent ___ very good ___ good ___ fair ___ poor ___

10. Generally, how would you rate your feelings of inclusion and belonging in the community before you came to Canada?
    Excellent ___ very good ___ good ___ fair ___ poor ___

11. Generally, how would you rate your feelings of inclusion and belonging in the community in the first 6 months in Canada?
    Excellent ___ very good ___ good ___ fair ___ poor ___

12. Generally, how would you rate your present feelings of inclusion and belonging in the community in the first 6 months in Canada?
    Excellent ___ very good ___ good ___ fair ___ poor ___

13. Generally, how would you rate your stress level before coming to Canada?
    Very high ___ high ___ neither high nor low ___ low ___ very low ___

14. Generally, how would you rate your stress level in the first 6 months in Canada?
    Very high ___ high ___ neither high nor low ___ low ___ very low ___

15. Generally, how would you rate your present stress level?
    Very high ___ high ___ neither high nor low ___ low ___ very low ___

16. How would you rate your experiences of violence and trauma before coming to Canada?
    Very high ___ high ___ neither high nor low ___ low ___ very low ___

17. How would you rate your experiences of violence and trauma in the first 6 months in Canada?
    Very high ___ high ___ neither high nor low ___ low ___ very low ___

18. How would you rate your present experiences of violence and trauma?
    Very high ___ high ___ neither high nor low ___ low ___ very low ___
19. How would you rate your experience of racism and discrimination before coming to Canada?
   Very high high neither high nor low low very low

20. How would you rate your experience of racism and discrimination the first 6 months in Canada?
   Very high high neither high nor low low very low

21. How would you rate your present experience of racism and discrimination in Canada?
   Very high high neither high nor low low very low

16. Overall, how would you rate Canada as a place to live?
   Excellent very good good fair poor

17. Overall how would you rate the city/town that you live in as a place to live
   Excellent very good good fair poor

For office only/ Date: _______________ Participant code #: ______ Pseudonym: _______________________

NOTE:
Health status questions 1,2,3; quality of life questions 4,5,6; self-esteem questions 7,8,9; inclusion and belonging questions 10,11,12; stress questions 13,14,15; trauma/violence questions 16,17,18; racism and violence questions 19,20,21; rating of community questions 19,20
APPENDIX \( \text{IE} \) cont.

SECTION II: HEALTH CONDITIONS/DISEASES/PROBLEMS

1. Of the following list of conditions/diseases, please check which ones you had before coming to Canada?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Check</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Heart disease</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Multiple sclerosis</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
</tr>
<tr>
<td>Emphyzema</td>
<td></td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td></td>
</tr>
<tr>
<td>Chronic back pain</td>
<td></td>
</tr>
<tr>
<td>Osteoporosis</td>
<td></td>
</tr>
<tr>
<td>Chronic fatigue syndrome</td>
<td></td>
</tr>
<tr>
<td>Arthritis/Rheumatism/bursitis</td>
<td></td>
</tr>
<tr>
<td>Fibromyalgia</td>
<td></td>
</tr>
<tr>
<td>Other (Specify)</td>
<td></td>
</tr>
</tbody>
</table>

2. Of the following list of conditions/diseases, please check which ones you were dealing with before coming to Canada?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Check</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Heart disease</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Multiple sclerosis</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
</tr>
<tr>
<td>Emphyzema</td>
<td></td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td></td>
</tr>
<tr>
<td>Chronic back pain</td>
<td></td>
</tr>
<tr>
<td>Osteoporosis</td>
<td></td>
</tr>
<tr>
<td>Chronic fatigue syndrome</td>
<td></td>
</tr>
<tr>
<td>Arthritis/Rheumatism/bursitis</td>
<td></td>
</tr>
<tr>
<td>Fibromyalgia</td>
<td></td>
</tr>
<tr>
<td>Other (Specify)</td>
<td></td>
</tr>
</tbody>
</table>

3. Of the following list of other health problems, please check which ones you were dealing with before coming to Canada?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Check</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision problems</td>
<td></td>
</tr>
<tr>
<td>Dental problems</td>
<td></td>
</tr>
<tr>
<td>Emotional problems</td>
<td></td>
</tr>
<tr>
<td>Speech problems</td>
<td></td>
</tr>
<tr>
<td>Mental health problems</td>
<td></td>
</tr>
<tr>
<td>Chronic pain problems</td>
<td></td>
</tr>
<tr>
<td>Hearing problems</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>Stress problems</td>
<td></td>
</tr>
<tr>
<td>Drug problems</td>
<td></td>
</tr>
<tr>
<td>Gambling problems</td>
<td></td>
</tr>
<tr>
<td>Alcohol problems</td>
<td></td>
</tr>
<tr>
<td>Sleep problems</td>
<td></td>
</tr>
<tr>
<td>Social interaction problems</td>
<td></td>
</tr>
<tr>
<td>Behaviour problems</td>
<td></td>
</tr>
<tr>
<td>Menopause</td>
<td></td>
</tr>
<tr>
<td>Other (Specify)</td>
<td></td>
</tr>
</tbody>
</table>

4. Of the following list of other health problems, please check which ones you developed since coming to Canada?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Check</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision problems</td>
<td></td>
</tr>
<tr>
<td>Dental problems</td>
<td></td>
</tr>
<tr>
<td>Emotional problems</td>
<td></td>
</tr>
<tr>
<td>Speech problems</td>
<td></td>
</tr>
<tr>
<td>Mental health problems</td>
<td></td>
</tr>
<tr>
<td>Chronic pain problems</td>
<td></td>
</tr>
<tr>
<td>Hearing problems</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>Stress problems</td>
<td></td>
</tr>
<tr>
<td>Drug problems</td>
<td></td>
</tr>
<tr>
<td>Gambling problems</td>
<td></td>
</tr>
<tr>
<td>Alcohol problems</td>
<td></td>
</tr>
<tr>
<td>Sleep problems</td>
<td></td>
</tr>
<tr>
<td>Social interaction problems</td>
<td></td>
</tr>
<tr>
<td>Behaviour problems</td>
<td></td>
</tr>
<tr>
<td>Menopause</td>
<td></td>
</tr>
<tr>
<td>Other (Specify)</td>
<td></td>
</tr>
</tbody>
</table>

SECTION III: RATING OF ACCESS TO SERVICES/RESOURCES

Overall, how would you rate your access to the following services/resources since being in Canada? If you have not needed/used the specific service, please circle 0 for NA (Not Applicable)

<table>
<thead>
<tr>
<th>Service</th>
<th>NA</th>
<th>Excellent</th>
<th>Very Good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Access to a physician</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Access to child care</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Access to English language</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Access to transportation</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Access to employment</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Access to employment in health care</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Access to education for you</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Access to employment help</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Access to housing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. Access to counseling services</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. Access to support to get re-licensed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Thank you for your participation. Your input is appreciated.
Appendix F

Letter of appreciation after filling out the surveys

March, 2005

Dear participant

Thank you for participating by filling out the participant information survey and the health status survey. Your participation has been very helpful, and I would like to express my appreciation to you for being involved. This surveys and interviews are part of a research project studying the implications of being a foreign-trained physician who has resettled in Canada, and the experiences and challenges that many of you face in relocating to a new country. We are aware that immigration is a multifaceted process in which many factors play a significant role affecting individual lives. Newcomers to Canada who are trained doctors, more than most of skilled workers, have a challenging process to restore their professional life, and to find meaningful employment. It requires resources, support and commitment. Many will be successful in re-establishing their credentials, and others will make new plans.

Your opinions, stories, insights, and feelings are particular and important experiences, which will allow Maria A. J. de Carvalho to better understand and to clarify the phenomenon of newcomer trained physician resettlement, and the search to re-establish professional identity.

The results and summaries of the research will be included in my Masters Thesis Report. An executive summary will be provided to you upon request. Please use the following contact information to request a summary report. If you would like us to send a report to you, please provide an address, e-mail or a means by which we can send this to you. If you have any concerns or the need for further clarification about this study, contact Maria Carvalho: 905-735-6884, 905-688-5550 Ex. 5052 or e-mail mamadoc25@hotmail.com. You may also contact Maria Carvalho’s advisor, Dr. Heather Lee Kilty at 905-688-5550, extension 4749 or e-mail heather.kilty@brocku.ca, or contact the office of Research at Brock University at While we know that you have some access to support that you may need, if any topic or issue has distressed you during this interview, we offer you these contact for follow up if needed:
Niagara Distress Centre 905-
The Multicultural Centre of Fort Erie 905-
Barbara Dewar, Psychotherapist 905-988-0088

Thank you for your sharing and participation.

Sincerely,
Maria A. J. de Carvalho
Appendix G

For office only/ Date: ___________________Participant code #: __________ Pseudonym: ________________________

INTERVIEW GUIDE: QUESTIONS/ AREAS OF INQUIRY AND PROBES

1. Describe your life before you came to Canada ... (research questions 2, 3)

Probes: What was your (work, profession, health, housing, family, income, friendships, social life, support, community participation, experience of trauma, health care) before you came to Canada...

2. Why did you make the decision to come to Canada? ... (research questions 3, 4))

Probes: Were they (economic reasons, fear, war, need for change, opportunity, family) reasons for coming to Canada? How prepared were you before coming to Canada for the steps it would take to get your medical license?

3. Describe your entry into Canada and life for you in the first year after arriving in Canada ...(research questions 1, 3, 4)

Probes: Describe your experiences with (finding work, legalities, finding a place to live, meeting new people, dealing with health, food, language) in the first year.

4. Describe your life in Canada throughout the resettlement process and at the present time ... (research questions 1, 3, 4)

Probes: Describe your experiences with (finding work, finding a place to live, meeting new people, dealing with health, food, language) throughout the resettlement process and at the present time. Describe what obstacles/barriers you have faced in resettling in Canada? Describe what help and support you have received to settle in Canada?

5. What impact has not being able to practice medicine had on your sense of identity, resettlement process, and health since coming to Canada(questions 1, 2, 4)

Probes: What impact has it had on your self-esteem, family, income, friendships, community participation, use of talents? What makes up your sense of who you are mostly? Is being a physician an important part of who you are? How are you studying and preparing to be licensed in Canada? Describe the obstacles/barriers you have faced in trying to get your medical license in Canada? Describe the help and support you have received in trying to get your medical license in Canada?

6. Describe your future hopes and aspirations ...
LETTER OF CONFIDENTIALITY FOR THIRD PARTIES: Research Assistants and transcribers involved in the research project.

Study: The Implications of Being a Newcomer Physician in a New Society: Qualitative Study of Foreign-Trained Physicians’ Resettlement, Sense of Identity and Health Status.

I _________________________________ (name) agree to keep all information confidential related to the transcriptions of interviews and my research work on the above project entitled. I will take every precaution to handle the data in a confidential manner to ensure the privacy of the participants and their individual information interviews.

DATE: ____________________________ SIGNATURE: ________________________________

DATE: ____________________________ WITNESS: ________________________________
Appendix I

Letter of Appreciation and feedback after the interview
[to appear on Brock University letterhead]

October, 2004

Dear Participant

Your participation in this interview has been very helpful, and I would like to express my appreciation to you for being involved. This interview is part of research project studying the implications of being a foreign-trained physician who has resettled in Canada, and the experiences and challenges that many of you face in relocating to a new country. We are aware that immigration is a multifaceted process in which many factors play a significant role affecting individual lives. Newcomers to Canada who are trained doctors, more than most other skilled workers, have a challenging process to restore their professional life, and to find meaningful employment. It requires resources, support and commitment. Many will be successful in re-establishing their credentials, and others will make new plans.

Your opinions, stories, insights, and feelings are particular and important experiences, which will allow Maria A. J. de Carvalho to better understand and to clarify the phenomenon of newcomer trained physician resettlement, and the search to re-establish professional identity.

The results and summaries of all of the interviews will be included in my Masters Thesis Report. An executive summary will be provided to you upon request. Please use the following contact information to request a summary report. If you would like us to send a report to you, please provide an address, e-mail or a means by which we can send this to you. If you have any concerns or the need for further clarification about this study, contact Maria tel: 905-735-6884 or 905-688-5550 Ex. 5052 e-mail mamadoc25@hotmail.com. You may also contact Maria's advisor, Dr. Heather Lee. Kilty at 905-688-5550, extension 4749 or e-mail at heather.kilty@brocku.ca, or the Office of Research at Brock University at 905-688-5550, extension 3035.

While we know that you have some access to support that you may need, if any topic or issue has distressed you during this interview, we offer you these contact if needed: Niagara Distress Centre 905-
The Multicultural Centre of Fort Erie 905-
Barbara Dewar, Psychotherapist 905-988-0088

Thank you for your sharing and participation.
Sincerely,
Maria A. J. de Carvalho  M.A Candidate
I am not sure if I can read this text naturally. It looks like it is a page from a document, but the content is not clear. Could you please provide more details or context?