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# Professional integration as a process of professional resocialization: Internationally educated health professionals in Canada

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ABSTRACT

This paper examines the process of professional resocialization among internationally educated health care professionals (IEHPs) in Canada. Analyzing data from qualitative interviews with 179 internationally educated physicians, nurses, and midwives and 70 federal, provincial and regional stakeholders involved in integration of IEHPs, we examine (1) which aspects of professional work are modified in transition to a new health care system; (2) which aspects of professional practice are learned by IEHPs in the new health environment, and (3) how IEHPs maintain their professional identity in transition to a new health care system. In doing so, we compare the accounts of IEHPs with the policy stakeholders' positions and analyze the similarities and the differences across three health care professions (medicine, nursing, and midwifery). This enables us to explore the issue of professional resocialization from the analytical intersection of gender, professional dominance, and institutional/organizational lenses.

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## 1. Introduction

The global movement of internationally educated health care providers (IEHPs) has become one of the central topics for health researchers and social scientists alike particularly in the last decades (Joudrey and Robson, 2010). This literature seems to be nearly singularly focused on the individualistic "push" and "pull" factors that drive health professionals to emigrate and to choose a particular destination country (Buchan and Sochalski, 2004). The ethical issues related to recruitment of health care workers from the global south to the global west are also prominent (Buchan, 2006; Labonté et al., 2006), but the actual process of integration into the health care system in the host country has received scant attention. When the integration process is under investigation, it tends to focus on the barriers and facilitators to licensure neglecting to look beyond the attainment of a license to practice as the key indicator of integration.

In this paper we focus on the integration *process*. The transferability of one's clinical skills is implied in the mobility of health professionals, but the cultural specificity of these skills can often be a barrier to successful professional integration. This has begun to be documented in the cases of immigrant nurses and physicians adjusting to the working environment in the U.K. (Cowan and Norman, 2006), Canada (Baumann et al., 2006; Bourgeault and Neiterman, 2013) and elsewhere (Bernstein and Shuval, 1998; Harris, 2011).

We situate this examination in the context of the sociological literature on professional socialization. This literature provides useful insights into the process of learning a professional culture but it has almost exclusively focused on the process of socialization among neophytes to the profession (Becker et al., 1961; Haas and Shaffir, 1987; Olesen, 1968). Expanding the concepts of professional socialization to the case of the professional integration of IEHPs provides the opportunity to examine it as a form of professional *resocialization*. We describe this as the modifications made to the approach to professional work and professional identity in the process of professional integration, which includes both the universal and the culturally-specific aspects of being a professional,

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and the intersection of the professional identity with wider cultural norms and ideologies.

## 2. Professional (re)socialization

Through the process of professional socialization, individuals – typically students newly enrolled in professional schools – learn not only to acquire the knowledge and skills necessary to the profession, but also to master the acquisition of a professional culture and the creation of their identity as professionals (Becker et al., 1961; Fox, 2000; Howkins and Ewens, 1999; Mackintosh, 2006). Classic ethnographies on medical socialization demonstrate how students internalize the norms of medical culture (Becker et al., 1961), learn to deal with medical uncertainty (Fox, 2000) and to present themselves as physicians through a cloak of competence (Haas and Shaffir, 1987). Similarly, studies of nursing socialization emphasize how nursing ideology and the ethos of care can be lost during the socialization process as neophytes transition from perceiving nursing as *caring* to nursing as *competence* (Mackintosh, 2006; Price, 2009). Accounts of professional socialization among midwifery students explore the role of informal sharing and personal communication in enculturation to midwifery (Ulrich, 2004).

The vast majority of this literature focuses on the standpoint and experiences of students new to the profession, describing the process of identity formation and adaptation to professional practice. Cross-cultural, inter- or intra-professional transition – or *resocialization* – has been analyzed by researchers to a considerably lesser extent (but see Baj, 1997; Farnell and Dawson, 2006). In each case, there is not only new learning but also an unlearning to be accomplished, albeit to varying degrees. Any change in workplace setting, even from one medical ward to another, can require adaptation (Farnell and Dawson, 2006). There may also be resocialization needed to reflect changes in practice models within a profession, such as what Nimmo and Holland (1999) described of the pharmacy profession with the transition from more technical to more interpersonal models of pharmaceutical care.

Even more profound can be the transition from one profession to another because each has its unique culture which is acquired during the process of socialization and clinical training (Hall, 2005). There are also vast differences among the cultural models of professional practice, since local culture, ideology, and health care organization shape the cultural capital that is acquired during professional training (Kingma, 2006; Khokher et al., 2009). Analyzing the transition of pharmacists into physicians, Austin et al. (2007), for example, described a similar "culture shock" akin to geographically moving from a middle power (e.g., Canada) to super power (e.g., the US).

Transitioning to a sometimes entirely new health care culture, IEHPs can experience cultural shock requiring the learning of the local aspects of practice, including dynamic hierarchies of authority in the workplace, protocols of care, and the management of treatment (Baj, 1997; Harris, 2011). Although IEHPs may have several years of professional experience prior to immigration, there may be significant differences in the models and culture of professional practice in the host and home country. Baj (1997) points out that nurses trained in the former Soviet Union faced unique challenges in integrating themselves professionally in the United States, challenges which stemmed partially from their lack of familiarity with the local health care system and different cultural expectations connected to the nursing role. Adjusting to the local culture of practice, IEHPs have to learn the new professional landscape simultaneously with learning the cultural norms of the host country (Erel, 2010; Elias and Lerner, 2012; Bourgeault and Neiterman, 2013). This process is compounded by the salience of the professional identity among immigrants who see their occupational status as core to their sense of self (Bernstein and Shuval, 1998).

The literature on resocialization more broadly can also be instructive. Traditionally focused on the impact of total institutions in "fixing" the deviant social roles and behaviors of criminal offenders or individuals suffering from mental health problems (Bereswill, 2004; De Hert et al., 1997), the process of resocialization was perceived as completely erasing the previously held identity, substituting it with the one crafted by social institutions which take on a role of socializing agents (Thornton, 1984). Some studies, however, challenge this assumption highlighting the contingency between the old identity and the one acquired during the process of resocialization (Daly, 1992; Freyberg and Ponarin, 1993; Golden, 2002; Thornton, 1984). Focusing on resocialization of Russian immigrants in Israel, Golden (2002) shows that the adoption of new identity – that of an Israeli citizen – does not erase migrants' previous identity completely, but rather modifies and adjusts it to fit the expectations of belonging to Israeli nation. In short, resocialization necessitates learning and unlearning of certain aspects of identity, but some elements persist.

## 3. Immigration and integration of IEHPS in Canada

The context of the immigration and integration of IEHPs in Canada is bifurcated. On the one hand Canadian immigration policies encourage highly skilled migration, including of IEHPs (Kapur and McHale, 2005). This has created a large pool of immigrant health professionals seeking professional integration in Canada but one which has not kept pace with the provincial regulatory infrastructure to integrate them into professional practice (Bourgeault et al., 2010). On the other hand, Canada, like many other western countries, has a long history of reliance on IEHPs (Bourgeault, 2008). In the past decades, close to 25% of Canadian physicians (approximately 17,600) were born and trained internationally (CIHI, 2012a). Between 2007 and 2011 about 7% of Canadian 360,000 nursing workforce had been trained abroad (CIHI, 2012b). Since formal midwifery education was not established in Canada until the 1990s, it is not surprising that the internationally trained midwives have dominated the Canadian midwifery workforce.

Although IEHPs have always played a vital role in the Canadian health care system, the recruitment and integration of IEHPs has become a more controversial policy issue (Bourgeault, 2013). Canadian health workforce policy is focusing more on self-sufficiency and domestic production of health professionals, in part due to growing concerns with the ethics of South to North migration of health workers. The increase in domestic production has still left significant distribution issues with rural and remote areas remaining medically underserved and some provinces and health regions recruiting from abroad (Bourgeault, 2008). This creates one path of entry into the Canadian workforce, i.e., those who are recruited directly are eligible to work largely immediately under a provisional license agreement. This path is restricted to those IEHPs who are deemed "practice ready" in Canada based on their education and skills, such as those trained in the U.S., for select nurses from the Philippines and (until most recently) doctors from South Africa (Grant, 2006; Joudrey and Robson, 2010). The second path taken by IEHPs who are not recruited (i.e., those who come to Canada through its selective immigration process) can take considerably longer to enter practice. Many IEHPs are perplexed by the paradox of gaining points for immigration application for their credentials and what they regard as a cumbersome and complicated process of obtaining licensure (Bourgeault et al., 2010).

Although there are some differences between provinces in the licensure process of physicians, nurses, and midwives, generally, all

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