

The Anglo–Celtic construction of national identity in Australia and the acculturation of the ‘other’ doctors

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ABSTRACT

International Medical Graduates (IMG) remain integral to the Australian health workforce, particularly in rural areas. Stakeholders who recruit, support and acts as educators assist IMGs in their transition into and through the Australian health care setting. A study was conducted to examine IMGs and their acculturation in rural Tasmania. Twenty-three IMG stakeholders were interviewed regarding the challenges facing IMGs who live and work in rural Tasmania. Critical Discourse Analysis was used to determine if social power, dominance, and inequality are enacted and reproduced through the text and talk of stakeholders. The results indicate dominant views and practices were both intentionally and unintentionally produced within the Tasmanian health care setting. These issues were reported to be contributing to the marginalisation of IMGs in Tasmania, thus impacting on their retention. However, the participants were positive and respectful in their vocalisation of IMGs and their contribution to the Tasmanian health system and community

Keywords: International Medical Graduates; rural; hegemony; critical discourse analysis; national identity

BACKGROUND

International Medical Graduates (IMGs) are an integral part of the Australian health workforce. It is conservatively reported that IMGs represent 24% of all medical practitioners in Australia (Australian Institute of Health and Welfare, 2011), whereas the Department of Health and Ageing (DoHA) state this number is as high as 39% across Australia and 52% in a number of rural and remote areas (House of Representatives Standing Committee on Health and Ageing, 2012). Under current Australian policy, an IMGs first ‘placement’ or location within Australia is in a rural and remote area, particularly ‘areas of need’ where identified gaps or shortages in the local medical workforce exist (House of Representatives Standing Committee on Health and Ageing, 2012).

Nationally, many concerns regarding immigration procedures, appropriate support and ongoing professional examination processes have been expressed by IMGs, most of whom arrive as temporary residents and are sponsored by an employer to work in Australia on limited registration (Department of Immigration and Citizenship, 2012; House of Representatives Standing Committee on Health and Ageing,

2012). Previous IMG research in rural Australia has focused primarily on employment integration, satisfaction and practice support as a measure of acculturation and retention (Alexander & Fraser, 2007; Carlier, Carlier, & Bisset, 2005; Durey, 2005; Hawthorne, Birrell, & Young, 2003; Terry, Lê, Woodroffe, & Ogden, 2011). However, very little research is given to the integration and acculturation of IMGs, specifically within a Tasmanian context.

Tasmania is a small island state off the south east coast of mainland Australia with a population of just over 500,000. Tasmania has three area health services in the South, North East and North West of the state, which each contain a major public hospital (Australian Bureau of Statistics, 2012; Department of Health and Ageing, 2011; Health Recruitment Plus Tasmania, 2011). IMGs constitute a significant proportion of the state's medical workforce, accounting for approximately 30% (n=350) of all registered medical practitioners in Tasmania (Department of Health and Human services, 2011; General Practice Tasmania Limited, 2011).

This paper reports on one stage of a larger study which investigates and examines the lived experiences of IMGs who live and work in Tasmania. This study included interviewing and surveying both Tasmanian IMGs as well as stakeholders. 'Stakeholders' are defined in this paper as key individuals working for organisations who recruit, support and act as educators and advisors to IMGs in the Tasmanian public and private health workforce (Hawthorne, et al., 2007). These stakeholder participants included medical educators, directors of clinical training and recruitment staff. They were selected to participate in the study due to their expertise and knowledge working with Tasmanian IMGs, particularly the key issues and challenges faced by IMGs who enter, work and live in the Tasmanian rural context.

An element of this study was to use the qualitative data generated from the stakeholder interviews to critically analyse the presence and social order of power and inequality in language among participants using critical discourse analysis (Blommaert & Bulcaen, 2000; Van Dijk, 2001). Critical Discourse Analysis (CDA) "primarily studies the way social power abuse, dominance, and inequality are enacted, reproduced, and resisted by text and talk in the social and political context" (Van Dijk, 2001, p. 352). CDA was used within this paper to observe and determine the areas where social power, dominance, and inequality were enacted, reproduced, and resisted through the text and talk of and between Tasmanian IMG stakeholders. This type of critical analysis focuses on moving beyond describing discursive practices, and is principally concerned with illustrating how discourse is fashioned and wrought by its relationship with power and ideologies (Billig, 2003; Blommaert & Bulcaen, 2000). It therefore inherently incorporates viewpoints such as ideology, hegemony and discourse to explore language and power relationships within societies (Dunmire, 2011; Van Dijk, 2001; Wodak, 2002; Wodak & Meyer, 2009).

The CDA paradigm was first clearly defined in the early 1990s by a number of scholars, namely Fairclough, van Dijk, Kress, van Leeuwen and Wodak. The initial formation of CDA has developed further since these initial discussions and consensus regarding approaches and methodologies (Billig, 2003; Blommaert & Bulcaen, 2000; Wodak, 2002; Wodak & Meyer, 2009). Wodak & Meyer (2009, p. 3) highlight CDA as an established academic discipline and state it uses problem-oriented approaches and "is characterised by the common interests in de-mystifying ideologies and power through the systematic and retroductable investigation of semiotic data (written, spoken or visual)".

Critical Discourse Analysis considers language as social practice where a relationship exists between an event and the situation in which it occurs (Wodak, 2002; Wodak & Meyer, 2009). As such, a critical analysis of discourse within a society or group is used as discourse is "socially constitutive as well as socially conditioned [it] is an opaque power object in modern societies" (Blommaert & Bulcaen, 2000, p. 448). CDA thus aims to bring this power out of obscurity and make it more discernible, as Blommaert

and Bulcaen (2000, p. 449) state CDA “should have effects in society: empowering the powerless, giving voices to the voiceless, exposing power abuse, and mobilizing people to remedy social wrongs”.

It is also not defined by one specific theory or methodology, it is informed by a wide range of approaches, which draws on linguistics, psychology and sociology (Wodak, 2002; Wodak & Meyer, 2009). CDA can be theoretically and analytically diverse and may be quite different when analysing different texts, for example personal conversation, political discourse or even media discourse (Van Dijk, 2001). CDA is a heterogeneous paradigm allowing for innovation, flexibility and improvement, when compared to other theories, if requiring changes to aims and goal of a study (Blommaert & Bulcaen, 2000; Wodak, 2002; Wodak & Meyer, 2009).

With respect to analysis, CDA occurs typically at three levels, the micro, meso and the macro. At the micro level discourse needs to be systematically analysed with the view of ‘discourse-as-text’. This means analysing discourse in terms of the linguistic patterns used and the organisation of the text, including vocabulary, grammar and how the text is structured (Blommaert & Bulcaen, 2000; Fairclough, 1992). At the meso level, ‘discourse-as-discursive-practice’, discourse is analysed as being text which has been produced, circulated, distributed, consumed with in a community or society. The analysis focuses on speech acts, coherence and intertextuality, which all link text to its context (Blommaert & Bulcaen, 2000; Fairclough, 1992). Finally, discourse at the macro level, ‘discourse-as-social-practice’ is where CDA is concerned with hegemony and changing hegemony (Blommaert & Bulcaen, 2000; Fairclough, 1992). This level of exploration analyses “the way in which discourse is being represented, re-spoken, or rewritten. [It] sheds light on the emergence of new orders of discourse, struggles over normativity, attempts at control, and resistance against regimes of power” (Blommaert & Bulcaen, 2000, p. 449).

Nevertheless, Blommaert & Bulcaen (2000), highlight the debate regarding those who used CDA have a preponderance to analyse discourse with a view which is biased by their own political views and prejudices of the discourse (Blommaert & Bulcaen, 2000; Schegloff, 1997). However, Van Dijk (2001) argues those researchers who engage in critical discourse analysts must assume an unambiguous position as their aim is to “understand, expose, and ultimately resist social inequality” (Van Dijk, 2001, p. 352).

METHODS

The study used qualitative research to investigate important social and political and professional insights into the acculturation and professional experiences of IMGs. This was achieved by interviewing medical educators, directors of clinical training and recruitment staff, who work with IMGs and understand the main issues faced by IMGs (Bernard, 2000; Broom & Willis, 2007; Calnan, 2007; Davis & Scott, 2007). Gathering data by interviewing IMG stakeholders was important due to their wealth of knowledge regarding IMGs, their specific challenges and needs within the Tasmanian context (Hawthorne, Hawthorne, & Crotty, 2007). Phenomenology was employed as the conceptual framework to analyse and interpret the data and guide the study. Phenomenology’s primary focus is the everyday subjective experiences of the lived world from the perspective of the person who is having the experience which generates rich information, compatible with other qualitative approaches (Bowling, 2005; Greenhalgh, 2007; Liamputtong & Ezzy, 2005).

Data were collected through semi-structured interviews with twenty-three (n=23) IMG stakeholders in Tasmania, which generated concepts, ideas and discussion (Liamputtong & Ezzy, 2005). This sample represents 59% of known IMG stakeholders in the state. A purposive snowball sampling method was used to recruit stakeholders. This included initially recruiting from third party organisations that assist

IMGs in either the acute care sector or general practice sectors of Tasmania. Participants included those who were in clinical and non-clinical backgrounds who worked full or part time in various capacities such as medical educators, directors of clinical training, program officers, organisational heads and recruitment management and staff.

Participants were interviewed once in English by one researcher. The interviews were between 20 and 75 minutes (average 34 minutes) in duration and were conducted between September and December 2011. The interviews consisted of questions relating to demographic background, the participant's role and experiences working with IMGs, including questions relating to the stakeholder's own observations regarding the professional and social transition challenges typically faced by IMGs. Other questions related to what services are available to IMGs and what could be done to assist IMGs settle into rural communities and improve IMGs health and wellbeing in Tasmania. At the conclusion of each interview a reflexive journal entry was made by the interviewer. The use of reflexive diaries is an increasing practice of qualitative researchers in both the interpretive process and in achieving research 'rigour' (Koch & Harrington, 1998, p. 884). The diary allowed the researcher (who is neither an IMG nor stakeholder) to write the views, feelings and impression gained from the participants during and after the interview process and which may have been forgotten during the transcription and analysis stage. This reflexive process also allowed the researcher to highlight and review their own role and any biases which may have arisen throughout the research.

Ethical approval for the research was obtained from the Social Sciences Human Research Ethics (Tasmania) Network. The interviews were voice recorded, transcribed, coded and analysed by one researcher using QRS-NVivo v10.0 software (QRS International, 2012).

Thematic analysis was used to identify recurring themes, patterns of living, behaviour and experience which then became a description of the lived experiences of IMG and their integration in rural Tasmania (Aronson, 1994; Braun & Clarke, 2006; Fereday & Muir-Cochrane, 2008). While the findings of the thematic analysis are not reported here; this process was a vital step in the critical discourse analysis of the participant interview data. The initial thematic analysis allowed an uncritical review of the text by "submit[ing] to the power of the text... thereby accepting the reading and offering unquestioning support of the status quo" (McGregor, 2003, p. 4). The text was then reviewed for "a second time with a critical eye... [by] revisiting the text at different levels, raising questions about it, imagining how it could have been constructed differently" (McGregor, 2003, p. 4). Thus, a critical analysis of the text aimed to identify underlying power, dominance, bias and inequality which were used implicitly and explicitly within the language of IMG stakeholders when talking about and discussing IMGs (Dellinger, 1995; McGregor, 2003). This was achieved through the widely used features such as connotations, metaphors and stereotypes, while still analysing the text as a whole (McGregor, 2003).

Critically analysing the participant's interview discourse highlighted a number of unique insights into the underlying ideology and hegemony of the power relationship between stakeholders, IMGs, the institutions in which they work and associated professional bodies in Tasmania. Much of the discourse was centred on the workplace and the relationship which exist within the various institutions. The focus of CDA within this study was concerning the social domains of racism, ethnocentrism, and immigration with regard to power and dominance of specific social groups through institutional, professional, community or group discourse (Van Dijk, 2001).

In addition, other domains such as political and media discourse which also contribute to ethnocentrism and immigration discourse were also included as a backdrop to the analysis (Van Dijk, 2001). It should be noted, the relationship which occurs concerning contemporary media discourse and its significant power and ideologies between IMGs and the views of the wider community is an area which requires

further research. Historically the media has played a significant role (Black, 2011; Harvey & Faunce, 2005; Kunz, 1975), however the current role the media play in terms of the community acceptance of IMGs, after the conviction of Dr. Jayant Patel, is relatively unknown, yet has been reported to have kindled public debate and concern (Dunbar, Reddy, & May, 2011; Elkin, Spittal, & Suddert, 2012; Wijesinha, 2005). Dr. Jayant Patel is an IMG, implicated with 87 deaths occurring at the Bundaberg Base Hospital in Queensland, Australia between 2003 and 2005 (Birrell & Schwartz, 2006, 2007; Harvey & Faunce, 2005; Moynihan, 2010). Patel was found guilty, in 2010, of criminal negligence resulting in 3 deaths and one case of grievous bodily harm, and sentenced to seven years in jail (Flatley, 2010). Subsequently, Dr. Patel appealed his conviction which was upheld in the Australian High Court on August 24, 2012, but is facing a retrial in November 2012 (Cirrus Media, 2012; Remeikis, 2012).

The systematic analysis of the stakeholder interviews reported in this paper occurred at the micro, meso and macro levels. The analysis initially examined the stakeholder discourse in terms of its use and the linguistic patterns of the interviews. This included the use of vocabulary, grammar and how and interview structure (Blommaert & Bulcaen, 2000; Fairclough, 1992). The discourse was also analysed in terms of how it was produced within the context of the views of migrants and different cultures in Australia (Blommaert & Bulcaen, 2000; Fairclough, 1992). In addition, how the current discourse demonstrates social hegemony within the workplace is also be highlighted and outline in detail below.

RESULTS

Micro level – stakeholder discourse as text

The stakeholder discourse was diverse and wide-ranging, with much of the discourse being positive in the delivery and expression. However, the analysis also revealed within certain texts, colloquialism and turns of phrase were used which were less positive. This demonstrated an underlying, yet palpable chiasm between the views some participants held, and the work they were doing with IMGs. It must be noted, similar colloquialism and less positive phrases were also used by the two participants, when they use the term ‘old codgers’ when speaking about the elderly. Similarly, terms such as ‘un-educated’ were used when speaking about individuals from a lower socioeconomic background. Participants reported such discourse was also used by a number of patients and other healthcare staff when speaking of, to and about IMGs.

The text which were used in some instances when referring to and speaking about IMGs included ‘Muslim doctors’, ‘boat person’, ‘these particular people’, ‘an international’, ‘some of them we have had’ and ‘for them, it is...’. This highlights the separation and distinction between the binary of ‘us’ and ‘them’ or ‘whiteness’ and ‘otherness’ which fundamentally is being vocalised when speaking of IMGs, or those who are less ‘us’ (Caldas-Coulthard, 2003; McLeod & Yates, 2003). Nevertheless, when speaking about colleagues or other professionals within the hospital context, texts such as ‘the hospital is becoming more accepting of the Muslim faith’ were used within the discourse. While participants were often speaking ‘positively’ of changes to tolerance or workplace practices there were some participants who were simultaneously and unintentionally using words or expressions which showed a lack of respect and the dehumanisation of individuals. Dehumanisation is an expression of personally mediated racism. Where personally mediated racism is defined as:

Prejudice and discrimination, where prejudice means differential assumptions about the abilities, motives, and intentions of others according to their race... [which] can be intentional as well as unintentional, and it includes acts of commission as well as acts of omission. It manifests

as lack of respect, suspicion, devaluation, scapegoating and dehumanization. (Jones, 2000, pp. 121-1213)

Also within the text, subtleties of discourse were structured in such a way that it demonstrated a lack of awareness of others individual culture and the 'Australianess' of the views of both participants and other healthcare professionals. Individuals were denoted by skin colour, rather than their specific cultural group and skin colour was used to indicate if an individual was an Australian citizen or not. For example, when speaking of the perceived increase of migrants in Tasmania, one participant stated "ten years ago you wouldn't see someone who didn't look 'Anglo' ... [but] you go to Melbourne and Sydney and you go 'spot the Aussie'" (Stakeholder 2). Nevertheless, it must be noted that migration from Europe to Australia and Tasmania increased after the Second World War (Terry, Lê, & Hoang, 2012) and continues today with 19,636 (48.8%) of people living in Tasmania having migrated from European countries (Australian Bureau of Statistics, 2011). However, these migrants of European descent have been argued to be the 'less visible' migrants (Colic-Peisker, 2009).

In addition, IMGs were categorised and denoted as 'refugees' on at least two occasions within the text. Once this was said by a participant themselves, and second when another participant relayed how a colleague had spoken in this way about an IMG. Although IMGs were discussed as a heterogeneous group, on many occasions speech was used by participants, which denoted IMGs homogeneity. In one example, a participant actually self-corrected themselves when speaking about IMGs as they by stating "I am saying they, generalising again" (Stakeholder 5). Also when speaking of IMGs, participants often discussed differences and challenges among those of different CALD backgrounds. However, simultaneously omitting, not commenting on or were unaware of the challenges, faced by IMGs from the England, New Zealand, US and South Africa. This discourse was particularly evident when one participant stated:

[A Caucasian doctor from a different country] told me this year that he felt so lonely and isolated and felt as if nobody cared. When he came here and went to the temporary housing he said he felt like he was an alien... This doctor had post-traumatic stress disorder from how upset and fearful and anxious he felt when he first came here. It was a real eye opener to talk to him 18 months down the trek and find out he was an absolute wreck... I thought why was this allowed to happen? (Participant 4)

In addition, another stakeholder was surprised to find the great challenges faced by IMGs, from non-CALD backgrounds, to fit into Australia. This participant stated "British doctors come across and you think it would be an easy transition, but it is not always" (Participant 3).

In addition to these assumptions made within the wording of the text, many other subliminal texts were used to describe IMGs when discussing the practise of and a number of social issues. This was provided not only by the participants but also to participants through other colleagues. Text which was used to describe IMGs were 'they are almost useless to us', 'a dangerous group', 'poor clinical knowledge', 'they tend to milk the system' and 'there is always a family crisis'. The language used by the participants and views expressed by colleagues was in contrast to the Australian Medical Council's processes and objectives to verify an IMGs credentials and ensure they are safe to practice in Australia. The process varies depending upon the skill and experienced of an IMG, however in most cases this is achieved through the administration of a multiple choice question (MCQ) exam. Once this the MCQ and provisional medical registration occurs, either a clinical interview, workplace based assessment or a clinical examination is conducted (Australian Medical Council, 2009b, 2012). This process allows an IMG to apply for full registration once competency has been demonstrated and established (Australian Medical Council, 2009a, 2012; Medical Board of Australia, 2010).

Although, one may argue the comments and views expressed are not blatantly racist, under the notion of *new racism* or *cultural racism* (Forrest & Dunn, 2011), subtle racist language is “now manifests in more muted or veiled terms, in contrast to the old fashioned, blatant or red-necked forms which were shaped in constructs of hierarchy and claims of superiority” (Foster, 1999, p. 323).

While Quayle & Sonn (2009) have stated the concept of new racism, as a discursive practice is:

constantly being reconstructed, and renegotiated through text and talk [and] the people who practice this new racism believe in and uphold the basic values of democratic egalitarianism and would thus emphatically deny that they are ‘racist’, while articulating views that are exclusionary and oppressive in their effects. (Quayle & Sonn, 2009, pp. 9-10)

Regardless of these instances, it must be noted that the majority of stakeholders were extremely positive and respectful in their vocalisation of IMGs and the contribution which they make to the Tasmanian health system and community. However, there were a small number (n=6) of individuals, who through their discourse and subtlety of language were inconsistent with the message they provided and manner in which the information was disclosed. These subtleties may, not be the individual racist views of the stakeholders themselves. It more precisely they reflect the everyday commonplace prejudice within Australia (Dunn, 2005; Dunn, Klocker, & Salabay, 2007; Jones, 2000) which is continually “constructed discursively through the social practices and processes of everyday life” (Quayle & Sonn, 2009, p. 8). Nevertheless these on-going cross-cultural interactions among the various cultures within the health settings “can inspire positive attitudes and perceptions under certain conditions: where the groups have equal status, common goals, intergroup cooperation and where there is official support [and] opportunities to become friends” (Forrest & Dunn, 2011, p. 438).

Meso level – stakeholder discourse as discursive practice

In addition to discourse as text, discourse was also analysed in terms of how it has been developed and produced within the context of Australia’s mainstream views regarding migrants and different cultures. Since the abolition of the *Immigration Restriction Act 1901* also known as the “White Australia Policy” in 1974, it has been reiterated that Australia is a multicultural nation (Dunn, 2005; Dunn et al., 2007; Forrest & Dunn, 2011; Louis, Duck, Terry, & Lalonde, 2010; McLeod & Yates, 2003). However, the view of national identity remains limited where ‘white’ Australians are argued to be still awarded:

A special and privileged position to Anglo-Celtic heritage [and] has been reinforced in the official reassessments of multiculturalism... There is a reiterative citation of Anglo-Celtic Australians as the confident hosts, or what have been called ‘spatial managers’, whereas migrants or ethnics are repetitively constructed as guests or worse still as parasites, contagions, or diseases. (Dunn, 2005, pp. 43-44)

It is this historical and dominant Anglo-Celtic construction of national identity and citizenship, which informs and gives credence to the discursive practices of power, dominance and exploitation (Forrest & Dunn, 2011; Quayle & Sonn, 2009). Particularly today where some commentators argue that white Australian fears the ‘other’ and wants to keep them out (Every & Augoustinos, 2008). This is clearly highlighted in the 1990s by “the new social conservative movement [which is] critical of Australia’s policy of multiculturalism and warn[s] of the danger of Australia being swamped by foreigners” (Louis et al., 2010, p. 653). Today this is an issue which continues to divide Australians as many passionately challenge the new social conservative movement, while other Australians continue to embrace its philosophy (Louis et al., 2010).

As such, it is through both the informal and formal use of language which individuals, society, media and governments use who continue to reproduce and authenticate dominant discourses or power and exploitation (Forrest & Dunn, 2011; Louis et al., 2010; Quayle & Sonn, 2009). It is therefore within the context of the Anglo-Celtic construction and maintenance of national identity, which the stakeholder discourse is analysed as being a text which has been produced, circulated, distributed and consumed within the community or society (Blommaert & Bulcaen, 2000; Fairclough, 1992).

This has been clearly delineated through what both a number of participants have said and what other health professionals have previously discussed with participants. For example, one participant relayed their experience of when they first started working in their current role with IMGs when they said

When I first came here... somebody very wise, a senior consultant, said... this is Australia and we have people from everywhere here, we can't fit in with all that, they have to learn to fit in with us, they can keep their cultural beliefs and behaviour at home and everything else, but there are certain things because of safety, infection control, that we have to insist on. (Participant 4)

As demonstrated in the quote above, for some participants working in Tasmania, IMGs as a collective group were perceived to be 'here' (in Tasmania) and this view of 'fitting in' both at home, within the workplace and wider Tasmania was a strongly held view regardless of the origin or cultural diversity of IMGs. In addition, there was a lot of assumption around exactly what fitting in meant and how it could be achieved. Another stakeholder felt IMGs eating similar foods to Australian doctors in the workplace would bring about greater connection with the medical community. As such it was stated "instead of them bringing their own food they can partake of what is here and feel more a part of the doctor community" (Participant 5). There was a lack of cultural or religious understanding within the text and talk regarding the consumption of the same foods as the local doctors. In addition, there was an assumption the local (dominant) food would in some way would bring about a greater connection with or make IMGs feel any more a part of the medical community. Yet, it was not discussed how this would be achieved.

In addition, there were other instances where stakeholders felt a number of the challenges IMGs were facing were unrelated to cultural differences. The discourse used at times was dismissive of cultural background, stating the challenges faced by IMGs and Australian doctors were not different and that there are factors outside of the IMG population that causes high turnover. For example, two participants stated living rural areas was difficult for IMGs, but "most Australian doctors don't last long in these communities either" (Stakeholder 20). This may be of course true, however it was felt, by five participants, cultural background was almost irrelevant when discussing issues of retention, high turnover and fitting into a community. This is highlighted by one stakeholder who stated:

Getting suitable housing is difficult to start with. That is probably the same for most people and schooling for kids, but I am not sure if it is any more difficult for any other new people who come or whether it is because it is an international, the effect of the foreigner and whether that is why they find it difficult to get accommodation or schooling or whether it is the fact that it is difficult for everyone. (Participant 10)

In addition to this discourse, there were also comments made about the financial challenges faced by IMGs as they migrate to Australia. Ten participants stated IMGs had to meet great financial costs as they moved to Australia. This included the financial challenges of educating children, health care cost, meeting training requirements and remittance being sent home, to support relatives. One stakeholder even broke the costing down to demonstrate the great burden it was for each IMG and their family. However, there were general assumptions made with elements of resentment voiced, where it was

viewed many IMGs did not face any financial challenges as they were observed to return home annually, have children in well paid schools, were from wealthy backgrounds and were being well paid in Australia. This was most evident when one participant was asked if they were aware of any IMGs who had experienced financial challenges, in reply they stated:

I don't think so because they do go back home, once a year for long periods of time, they seem to be able to afford child care and good schools. I don't know, but coming from a higher socioeconomic background from where they come from, so they may be wealthy to start with, but they get paid well here too, so I haven't heard of any financial problems (Participant 5)

This example was one of the main stereotypes being used within the text and are “often the result of a lack of knowledge about immigrants” (De Fina, 2003, p. 3).

Nevertheless, there was a larger amount of discourse which viewed IMGs as ‘poor doctors’, which in turn perpetuated a discourse of ‘deserved pity’. This at times was the motivation for stakeholders providing assistance outside their normal work activities, which was often regarding meeting social needs when IMGs first arrived, which service was lacking or absent. For example, a stakeholder stated “I mean, I did that off my own back because I thought ‘oh poor thing’ coming to a whole new country with family and children” (Participant 6). These types of sympathetic rather than empathetic discourses reflect the national identity notion, earlier highlighted, that “Anglo-Celtic Australians as the confident hosts... whereas migrants... are repetitively constructed as guests” (Dunn, 2005, p. 44).

Macro level – discourse as social practice

In addition to the Anglo-Celtic construction of national identity, and elements of personally mediated racism, the discourse also highlighted issues regarding some aspects of prejudice and discrimination within Tasmanian institutions (Jones, 2000). This was clearly demonstrated when a stakeholder stated:

Whether there is, I won't say discrimination, but a preferential process whereby there is automatic decision to employ local doctors and again there are certain regular reasons for that in terms of employing Australian citizen and permanent residents versus employing temporary residents... [also] having a contraction of the registered medical officer workforce... means that you tend to keep the current profile that you have rather than perhaps diversifying with incoming doctors. (Participant 13)

The same participant also went on to add the following comment:

There are individuals within the Tasmanian system as there are in any system who make it hard for IMGs they make it hard, and it is not just a matter of not recognising the particular cultural, linguistic, social isolation issues, it is actually a matter of making it particularly hard on them because they don't like them. I think it would be silly for me to suggest that that doesn't happen... While I don't think there is a culture of bullying or cultural of racism, a culture of discrimination in Tasmania's hospitals I think that sometimes there is a culture of tolerating it. (Participant 13)

Within this discursive text, five concerns regarding institutional prejudice were identified. There is an underlying preferential process of employing local doctors, which is now facilitated or at least mediated by the current financial climate (Giddings, 2011). Also evident, prejudice and discrimination from colleagues is reported to occur in mainland hospitals. This too also occurs in Tasmania, however there is less capacity to move within the state from discrimination, therefore to move away from it means leaving the state. Finally, there is an underlying acceptance or tolerance of prejudice and discrimination,

which is occurring on both the mainland and within Tasmania. Lastly, the view that IMGs themselves have to move from prejudice and discrimination, rather than its practice being controlled or stopped, is observed as the best alternative.

In addition, there was discourse provided by participants, regarding the power regulatory bodies had, such as the state medical council, where it was felt certain individuals within regulatory bodies had a sense of hegemony over IMGs. For example, it was relayed by one participant that IMGs had encountered problems with some individuals from the Medical Council. The participant stated

[There were some individuals] representing the Medical Council... [who would] just treat these doctors as objects and not like people. I mean there is obviously some people who don't do that but there is some people in position of great power that I find them so unprofessional the way they deal with some of the IMGs... I have had doctors burst into tears saying have I done something wrong, the officious, rudeness is unbelievable. (Participant 4)

Furthermore, this participant stated, prior to highlighting this issue, that there may be repercussions for discussing such matters. For example, they stated that "some people will shoot me down in flames" for highlighting the concerns regarding the Medical Council (Participant 4). Such comments further demonstrate the hegemony extended beyond the IMGs but also toward those who questioned or spoke against those in power.

Also within the text, there was discourse regarding the hegemony which government bodies had over the regulatory bodies. The example of the Patel case was provided by a stakeholder, to demonstrate Government hegemony over regulatory bodies. It was presented as blame toward government, with the emotive discourse removing all responsibility from regulatory bodies involved. However, this was demonstrated to not to be the case by Black (2011), but was an oversight of both government and regulatory bodies. This was demonstrated when a participant highlighted the struggles of power and hegemony which occurs not only between jurisdictions and IMGs, but also between jurisdictions, such as the Australian Medical Association and State and Federal governments. The participant stated

The profession is infinitely more mindful of regulation and professional behaviours than jurisdiction are, so jurisdictions will rape and pillage and suit their own ends without any cognizant of the quality. History tells you if you look at the Queensland experience that is what happened there. The Patel issue was a jurisdiction issues, it wasn't a collegiate or a professional issue... So whilst the profession and the regulatory authorities might try and make all the due process tight for the best benefits for patient and doctors, jurisdictions can sometimes ride rough shot over the lot and blow it out of the water. (Participant 16)

CONCLUSION

This paper reports on twenty-three interviews with stakeholders who support, educate and place IMGs in Tasmania. The interview data was analysed using CDA and highlighted a number of unique insights into the underlying ideology and hegemony of the power relationship between stakeholders, IMGs, the institutions in which they work and associated professional bodies. By examining vocabulary, grammar and for linguistic patterns used including how the discourse was organised by stakeholders in the interview it was concluded most stakeholders were positive about IMGs and their contributions to Tasmania's health system. However it was also noted there were elements of personally mediated racism within the text. This was evident as unintentional in most stakeholders and at times was about making assumptions, lack of respect or the devaluation of IMGs.

There were also discursive practices, which was commensurate with the dominant Anglo-Celtic construction of national identity. It is this dominant view of national identity which was present within much of the discursive practices amongst stakeholders and their reports of colleagues. These practices are woven into the fabric and context of contemporary society, media and government debates, where the new social conservative movement regarding the views migrants and asylum seekers remains a raw issue. In addition, aspects of prejudice and discrimination were highlighted to occur in Tasmanian institutions.

It is these discourses of national identity, which legitimise and maintain social norms, which have been exposed and occur within the workplace. These dominant views and practices which intentionally or unintentionally continue to marginalise, discriminate and impact on IMGs which contributes negatively to the long term retention of International Medical Graduates. Nevertheless, the majority of participants were extremely optimistic about the changes which they had observed within health care system to accommodate, assist and respect IMGs. Furthermore, participants were also positive when discussing the valuable contribution which IMG make to the Tasmanian health system and community.

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