Overseas doctors in Australian hospitals:
An ethnographic study of how degrees of difference
are negotiated in medical practice

Submitted in total fulfilment of the requirements of the degree of Doctor of Philosophy

October, Two Thousand and Nine

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Thesis Abstract

In this thesis I ethnographically examine overseas doctors' negotiations of hospital settings that are similar, yet simultaneously unfamiliar, to those they have previously known. The study foregrounds the social labour involved in moving medical practices from one clinical context to another, a process too often hidden from view in the myth of medical universalism.

The stories take place in hospitals on the metropolitan fringes of a large city in Australia. The research assumes that doctors with overseas (i.e. non-Australian/New Zealand) medical qualifications have developed a different set of practices to 'locals' because they have received their education and training in medical places 'elsewhere'. In the thesis, I argue that overseas doctors negotiate these various differences with modes of adjustment. I examine adjustment as an embodied, sensory and situated process that entails constant threading between the overseas doctors' past and the environment they find themselves part of, revealing something of both along the way. The overseas doctors' new environment is one that includes an evolving arrangement of people and paperwork, registration and assessment procedures, and buildings and tools. Whilst adjustment to these human and non-human aspects of a doctor's ecological terrain is an everyday event in medicine, I suggest that it is made more obvious by international migration, by practitioners who do not take their new environments for granted.

For overseas doctors, subtle variation can mean an exciting, yet more often unsettling world of difference. This research highlights the contextual nature of medical practice, exploring its embeddedness within a multifarious environment. At the same time, the thesis departs from the majority of literature on overseas doctors, and skilled migrants more generally, that regards their skills as too context specific, thus requiring their integration into a nationally distinct system through the acquisition of nationally distinct practices. With this thesis I contribute an empirically and theoretically rich analysis that
provides a more nuanced perspective of this political issue in Australia (and other 'receiving countries'). It is a thesis that will be of interest to migration and organisational researchers, medical educationalists, sociologists and anthropologists of science and medicine, individuals and organisations concerned with the steadily growing number of overseas doctors working in hospitals around the world, and last, but not least, overseas doctors themselves.
Declaration

This is to certify that:

(i) the thesis comprises only my original work towards the PhD

(ii) due acknowledgement has been made in the text to all other material used

(iii) the thesis is less than 100,000 words in length, exclusive of tables, maps, the list of references and appendices

Anna Harris

23rd October 2009
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Without the contributions of so many over the years, this thesis (and I) would have fallen apart at the seams. In particular I am indebted to: the participants and staff at the fieldsite hospitals who accommodated me with an overwhelming sense of generosity; Johannes, who made the project happen and constantly cheered me along; Marilys, much more than ‘project organiser’, who was inspiring; Hans, for his never-ending encouragement and Sue for the pearls of wisdom; my ‘unofficial’ supervisors, Eleanor, Robyn and Martha; Alan, a passionate mentor; Annemarie Mol for an incredible conversation/polder walk; the students and staff at the Amsterdam School for Social Science Research, who were so welcoming during my stay there; and the Faculty of Medicine, School of Population Health and School of Graduate Studies at the University of Melbourne for financially supporting this research.

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Style Notes

Terminology

The term ‘overseas doctor’ is used in this thesis to refer to a doctor who has received their primary medical qualifications outside of Australia or New Zealand (NZ). It was a term often used by participants and one I considered more appropriate than other alternatives common in the literature such as overseas trained doctor (OTD), international medical graduate (IMG), foreign medical graduate (FMG) or migrant doctor.

Whatever you name it, it is, always will be, because we can’t escape this terminology, we can’t not name something, so there will be always the reference to the foreigners.
(Dr Nikolai Nagorsky)

Overseas is a word that I am using in a very non-literal way to refer to somewhere ‘elsewhere’. Therefore I am not including NZ graduates as overseas, despite them being educated across the Tasman Sea. Conversely, I once heard a Syrian doctor refer to his ‘overseas’ training in Romania. The term ‘overseas’ helps to capture a sense of a different context of previous practice.

Pseudonyms

All of the research participants have been given pseudonyms to help protect their anonymity. These pseudonyms appear throughout the thesis in full (e.g. Dr Nikolai Nagorsky), except in the fieldnotes. I have done this to simultaneously represent both ways that overseas doctors were referred to: commonly by their ‘first name’, or an anglicised version of, in Australia; as well as the majority of participants’ preference for
the doctor title followed by their surname, as they were accustomed to in their previous workplaces.

... not calling the doctor by surname what we used to do, just calling the doctor with the first name and that was sort of the difference, if you are talking to me about what is the difference in the medical field.

(Dr Mladen Mück)

The hospitals were this fieldwork took place have been given the pseudonyms of Hospital X, Y and Z. These three hospitals were in the same healthcare network in Victoria and are described in more detail in Chapter Two and Chapter Six.

**Quotations**

Quotations from participants and sections of fieldnotes are italicised and justified to the outer margins of the document. Lengthy quotations (longer than three lines) from the literature are indented. According to Australian convention, quotations are framed by single quotations marks and quotations within quotations or fieldnotes are framed by double quotation marks. Square brackets indicate either paraphrasing or other necessary details that did not arise from direct speech. Data editing is indicated by the use of ellipses; otherwise participants' quotations remain largely unchanged.
**Acronyms**

*The biggest difficulty was when my colleagues used abbreviations!*

(Woodward-Kron et al. 2009)

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AMA</td>
<td>Australian Medical Association</td>
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<tr>
<td>AMC</td>
<td>Australian Medical Council</td>
</tr>
<tr>
<td>ANT</td>
<td>Actor network theory</td>
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<tr>
<td>AON</td>
<td>Area of Need</td>
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<tr>
<td>CanMEDs</td>
<td>Canadian Medical Education Directions for Specialists</td>
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<tr>
<td>CCTV</td>
<td>Closed-circuit television</td>
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<tr>
<td>CE</td>
<td>Clinical examination</td>
</tr>
<tr>
<td>CT</td>
<td>Computed tomography</td>
</tr>
<tr>
<td>DHS</td>
<td>Department of Human Services</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency department</td>
</tr>
<tr>
<td>EEA</td>
<td>European Economic Area</td>
</tr>
<tr>
<td>EEG</td>
<td>Electroencephalogram</td>
</tr>
<tr>
<td>GP</td>
<td>General practice/General practitioner</td>
</tr>
<tr>
<td>HMO</td>
<td>House medical officer (similar to intern)</td>
</tr>
<tr>
<td>HMO2</td>
<td>Senior house medical officer</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive care unit</td>
</tr>
<tr>
<td>IMG</td>
<td>International medical graduate</td>
</tr>
<tr>
<td>IQ</td>
<td>Intelligent quotient</td>
</tr>
<tr>
<td>IT</td>
<td>Information technology</td>
</tr>
<tr>
<td>IV</td>
<td>Intravenous</td>
</tr>
<tr>
<td>LIF</td>
<td>Left iliac fossa</td>
</tr>
<tr>
<td>MIT</td>
<td>Massachusetts Institute of Technology</td>
</tr>
<tr>
<td>MJA</td>
<td>Medical Journal of Australia</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>NUM</td>
<td>Nurse unit manager</td>
</tr>
<tr>
<td>NZ</td>
<td>New Zealand</td>
</tr>
<tr>
<td>O&amp;G</td>
<td>Obstetrics and gynaecology</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
</tr>
<tr>
<td>OET</td>
<td>Occupational English Test</td>
</tr>
<tr>
<td>OSCE</td>
<td>Objective structured clinical examination</td>
</tr>
<tr>
<td>OT</td>
<td>Operating theatre</td>
</tr>
<tr>
<td>OTD</td>
<td>Overseas trained doctor</td>
</tr>
<tr>
<td>PA</td>
<td>Public address</td>
</tr>
<tr>
<td>PC</td>
<td>Personal computer</td>
</tr>
<tr>
<td>PID</td>
<td>Pelvic inflammatory disease</td>
</tr>
<tr>
<td>PMCV</td>
<td>The Postgraduate Medical Council of Victoria</td>
</tr>
<tr>
<td>PNG</td>
<td>Papua New Guinea</td>
</tr>
<tr>
<td>P.R.N.</td>
<td>Pro re nata (as needed)</td>
</tr>
<tr>
<td>PSA</td>
<td>Personal service attendants</td>
</tr>
<tr>
<td>PV</td>
<td>Pervaginal</td>
</tr>
<tr>
<td>RCPSC</td>
<td>Royal College of Physicians and Surgeons of Canada</td>
</tr>
<tr>
<td>RCT</td>
<td>Randomised controlled trial</td>
</tr>
<tr>
<td>STS</td>
<td>Science and technology studies</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>US</td>
<td>United States of America</td>
</tr>
<tr>
<td>USSR</td>
<td>Union of Soviet Socialists Republics</td>
</tr>
<tr>
<td>VCE</td>
<td>Victorian Certificate of Education</td>
</tr>
<tr>
<td>VMPF</td>
<td>Victorian Medical Postgraduate Foundation</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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Chapter One: Introduction

A reverberating: ding, ding, ding; the woman’s voice on the PA repeating ‘Code Blue’. A medical emergency on the wards! It was Dr Zhou Jiaying’s first day of working as a doctor in Australia. She said she heard the call when she was with her registrar...

...who came from Sri Lanka – that’s worse! We did not know which direction to go. Usually the hospital has a good team – but we are both new. We did not know the drugs to use – I was not familiar with the drugs. The consultant arrived and said “where the hell did you get these people from?” a comment aimed at me and the registrar. I thought, humpf, a bit offensive. That is a print on my brain. I felt, humpf, I’m usually very confident; I like to be on top. But in the emergency situation you forget to mention what you are doing and you just do it ... [this caused some trouble with the nursing staff] so to the nurse, I said, “is the patient alright? Yes? Well then why are people still talking about this? Because both of us are overseas or because something wrong happened?”

(Dr Zhou Jiaying)

As a discipline, medicine has expanded by moving its practitioners, with their skills and knowledge, from one part of the world to another. Amidst this expansion there has been considerable effort put into creating a sense of uniformity about biomedical practice, at both global and national levels. With medical schools blossoming around the world, health professionals migrating in increasingly large numbers and technologies proliferating everyday, more energy is being channelled into this drive for cohesion of medical practices. The appeal for uniformity can be found in protocols, core physician competencies appearing in medical school curricula and in the push for universal standards and randomised controlled trialled evidence-based practice. To help create this sense of universalism, medicine has suppressed, or hidden from view, the social labour involved in moving practices between contexts (Berg 1997b, p169; Bowker and
Chapter One

Star 1999, p292; Ingold 2000, p229). With this thesis I contribute towards an unveiling of this social labour, with an ethnographic study of overseas doctors in Australian hospitals. The thesis explores what happens when a doctor finds themselves in a hospital where the building layouts are strange, the drug names unknown or their relations with nurses different.

Much empirical work in the social sciences now suggests that medicine happens in local worlds, lying in tension with scientific universalism (DelVecchio Good 1995a, p199). For some time, anthropologists, sociologists and philosophers have been undertaking studies in healthcare settings, revealing that rather than being a unified medical world, there are divergent cultural practices (Maretzki 1989; Good and DelVecchio Good 1993; Berg and Mol 1998; Bowker and Star 1999; McKinlay et al. 2006). Researchers have argued for studying the complexities of the locatedness of medicine (Berg 1997b, p170). Difference, heterogeneity and multiplicity are now increasingly common words in the vocabulary of the social study of medical practice, particularly in the field of science and technology studies (STS).

Until now, there has been little research concerning overseas doctors that has engaged with these critical perspectives. Those who have studied the nature of medical migration in Australia have largely been involved in large scale scoping projects or demographic research which analyse the needs of overseas doctors and consider methods to improve retention, safe practice and the acquisition of new skills (e.g. Postgraduate Medical Council of Victoria 2002; Confederation of Postgraduate Medical Education Councils 2003; Hawthorne et al. 2003; McGrath 2004). These scoping projects raise many important issues and document the changing nature of this situation in Australia; the quantitative material juxtaposing with the qualitative focus of this thesis (something explored further in Chapter Five). Whilst overall these studies aim to improve the situation for overseas doctors, too often I believe that the overseas doctors' difference is regarded, however subtly, in a negative way. Their difference is seen as
being something which *impedes* their ability to practice competently in Australia (Hawthorne et al. 2003, p10). For example, overseas doctors' practice is often considered 'too context specific'. As sociologist Bob Birrell and demographer Lesleyanne Hawthorne write:

Persons graduating from the diverse medical schools of Asia, the Middle East and Eastern Europe bring a variety of skills, knowledge and experience with them. There is, however, no guarantee that their training is relevant to the Australian setting.

(Birrell and Hawthorne 2004, p97)

These beliefs are embedded in many research questions, such as those shaping the interview questions posed by American researcher Joann Porter and colleagues (2008, p38) to local medical faculty members, who were asked to identify skills and competencies that international medical graduates were considered to be lacking compared to local graduates.

In much of the existing research on this topic in Australia, overseas doctors are perceived as needing to *assimilate* into their new workplaces by *acquiring* 'Australian' ways of doing things. Their own skills are viewed as being lost with their change of job because of context specificity (Australia’s Bureau of Labour Market Research cited in Hawthorne et al. 2003, p11). This section of an interview with one hospital's House Medical Officer (HMO) Manager is indicative of these commonly held beliefs:

And it’s rare that you will get a unit head ringing up about an Australian trained doctor and say “I’m struggling with this doctor, can you swap them?” But it’s not so rare for them to ring up about an IMG and say that. And I think it’s partly due to their skills, that their skills aren’t to the same standards as an Australian trained doctor and we know that ... here we have a view that we will build upon their skills and improve them.
The HMO Manager emphasises the dominant view of ‘IMGs’ in Australia; that they are not up to local standards and so need to acquire better skills to assimilate into the Australian system. Whilst very occasionally this view is made explicit, more often it remains hidden; in the way that funding for supervision and orientation is issued; the way that orientation programs and assessments are designed; the way that jobs are allocated; and in the way that researchers pose questions to stakeholders and the overseas doctors they interview or survey. There is an implicit assumption in many of these discourses and practices that whilst the overseas doctors’ own skills are not applicable in local hospitals, they are able to re-appropriate what is fundamentally a universal medical practice into the Australian setting.

In this thesis I take a different approach. It is an approach that still recognises that the skills of the overseas doctors are ‘contextual’, having been developed in local settings of practice, in which, as practitioners, they were engaged with the medical world they inhabited (Ingold 2000, p216). However, I do not consider the overseas doctors as ‘losing skills’ nor as re-appropriating any medical universalisms. Rather, I consider overseas doctors as travelling from one local context to another. Using a critical perspective which highlights the ecological complexities of locatedness, my approach considers the overseas doctors as adjusting their embodied practice from situation to situation, context to context. It is these adjustments that I believe are the work, the social labour required, to go from one setting of medical practice to another. It is these adjustments which help to reiterate how medical practice is woven into the environmental context in which it is situated. It is also these adjustments, occurring in hospitals everywhere, everyday, which make biomedicine such a powerful, adaptable, rich and tenacious discipline (Mol 2002, p115).

In this thesis I examine the work that the research participants did to move from their
previous settings of practice to their new hospital environments by analysing a series of ethnographic stories. Through these stories I discuss what I consider are modes of adjustment. The term ‘modes of adjustment’ responds to the degrees of difference within the group of overseas doctors and hence the multiplicities of their engagement. The term also captures the variable nature of the environment they found themselves in; a multifarious setting made up of any number and form of people and things.

I propose that the overseas doctors’ modes of adjustment entailed a constant threading between their past and their present. Whilst this may be an everyday experience for all doctors, I argue that the process is made more obvious by migration because of the overseas doctors’ experiences in hospitals ‘elsewhere’. The new hospitals the overseas doctors found themselves in were different to those they were previously used to, sometimes ever slightly, with unfamiliar and unexpected materialities, atmospheres and social mores. These were aspects of the environment taken for granted by the locals who wore it like a well fitting white coat. It is through the overseas doctors’ negotiation of their new workplaces that we thus learn about these hidden aspects of local hospital life.

This chapter serves as an introduction to the thesis. So far I have presented the thesis argument and a few characters in the story. The following section helps to set up the project further and points to gaps in our current understandings of the topic. The remains of the chapter are then divided into three major sections outlining the assumptions upon which the thesis argument is built. The first section establishes why overseas doctors are different from the locals, drawing upon the overseas doctors' classifications of difference which provide further complexity. The second section explores the overseas doctors' new clinical environment, which was identified by both participants and organisations concerned with their employment as 'the system'. The final section then discusses in more detail how overseas doctors negotiated this system, through modes of adjustment.
Chapter One

Filling gaps

Doctors who have received their medical qualifications overseas make up a substantial and growing proportion of the healthcare workforce in resource rich countries such as Australia (25%), Canada (22.3%), the United Kingdom (UK) (33.1%), the United States of America (USA) (25%) and New Zealand (35.6%) (2005 figures cited in Organisation for Economic Co-Operation and Development 2007). Australia is one of the largest economies in the world to be growing through the expanding immigration of medical and other skilled workers (OECD 2006; Syed 2008, p30) and one of the few 'receiving' OECD (Organisation for Economic Co-operation and Development) (2007, p191) countries to have specific targeted migration policies for doctors; yet Australia's relationship with internationally trained doctors has been one of extraordinary ambivalence. For over a century, any doctor who has been trained outside of the Commonwealth has faced a number of hurdles in getting recognition, their employment often dependent on gaps created by poor workforce planning. Whilst their employment is officially encouraged under Australia's skilled migration programs, there is the parallel and seemingly paradoxical discourse that assumes that overseas doctors lack skills necessary for good medical practice. Infamous malpractice cases have also helped to tarnish overseas doctors with a brush of incompetence in Australia, and family connections have led to suspicions of terrorism (Wijesinha 2005; Crawford and Hudson 2007; Parnell and Hart 2007).

There is thus widespread political interest in ensuring that overseas doctors, whilst filling gaps in the workforce, integrate smoothly into the Australian healthcare system and deliver, without mishap, the medical services that are so needed. Resources are provided so that the foreign doctors can acquire the skills they are presumed to be missing for the Australian context, with much funding currently being channelled into orientation, supervision and assessment. It seems that the more often overseas doctors appear in the media, the more attention and money is given to their integration.
Introduction

As previously mentioned, until now, scholarly research of this situation has tended to lie within the domain of demographers rather than the realm of social scientists. Recently, the OECD (2007, p25) recognised that international mobility raised serious questions about the transferability of foreign skills in receiving country labour markets. Social research into the nature of ‘skills translation’ amongst overseas doctors has been minimal, with several exceptions. I briefly discuss two of these studies, to highlight the similarities and differences with my research.

Human geographers Allan Williams and Vladimir Baláž (2006; 2007; 2008b) are interested in the role of international migration on learning and knowledge translation in the workplace, using nurses and doctors migrating within Europe as case studies. Their focus is upon tacit knowledge translation, which they argue is currently under-realised amongst most migrants (Williams 2007, p30). Their analysis segments knowledge transfer into the typological components of embodied knowledge, embrained knowledge, embedded knowledge and encoded knowledge. Williams and Baláž (2008a, pp40 - 41) define embrained knowledge as conceptual skills and cognitive abilities, embodied knowledge as practical thinking rooted in specific contexts, encultured knowledge as shared meanings arising from socialisation, embedded knowledge as organisational understandings and encoded knowledge as that embedded in signs and symbols. Williams’ (2008, personal communication) typology acknowledges that these components are enmeshed together ‘in the real world’ that they are rather ‘aspects’ of knowledge that are part of a whole. Nonetheless, there is a risk that their typology reiterates a Cartesian dualism that splits cognitive and embodied learning, and separates the individual from their context. In this research I argue that skilled migrants cannot be extricated from their workplace settings, and that medical practice is woven into its environmental constituents. Whilst Williams and Baláž have opened up a theoretically rich way of thinking about migration in the workplace, their work leaves room for much more detailed and empirically based studies of the situated nature of workplace learning. Williams (2007) recognises the limitations of their work and the
Chapter One

need for more ethnographic research in this area.

The second study I want to briefly cover is Judith Shuval and Judith Bernstein’s (1997b) edited book *The Immigrant Physicians: Former Soviet Union Doctors in Israel, Canada, and the United States*. This is probably the most extensive social study of overseas doctors to date. It is a piece of comparative sociological research based upon in-depth interviews with physicians who migrated to Israel, Canada and the USA from the former Soviet Union. In this collaborative project, overseas doctors were understood to be transporting their set of traditions, conditioned by training and experience in the Soviet Union, into different contexts of medical practice with an established medical culture (Shuval 1997, p10). Shuval and Bernstein (1997a, p156) suggest that ‘it is probably more fruitful to consider the nature of medicine in terms of a universalistic culture overlaid with particularistic qualities that are rooted in local cultures’. The process of adaptation found amongst the participating doctors was defined by a need to maximise the universal elements of their professional identity and reduce the particularistic components to which they were socialised (Shuval and Bernstein 1997a, p156).

Shuval and Bernstein’s collaborative study raises important considerations such as the precarious nature of the professional identities of overseas doctors. However, as previously argued, rather than considering medicine as a global-universal that is adapted into a local context, in this thesis I regard adjustment in medicine as something that happens as a practitioner moves from context to context. I consider the process as a constant dialogue between the overseas doctors’ habitual practice, ingrained in one setting, to the new situation they find themselves in. Thus, this research diverges theoretically from Shuval and Bernstein’s study whilst drawing inspiration from many aspects of their work.

My research also differs methodologically from the two studies detailed in this section because of its *embeddedness* in the everyday lives of the overseas doctors in hospital
settings. In the many (and growing) needs-based analyses and other demographic studies on overseas doctors in Australia that I have already alluded to, few of these researchers have also spent significant time with overseas doctors in hospitals. Most often the opinions of key stakeholders are prioritised, as an attempt to address the issues and problems perceived to be inherent in overseas doctors' practice (PMCV; Hawthorne et al. 2003; McGrath 2004). In contrast, with this study I contribute research based on observation, conversation and interviews with overseas doctors, when I was able to listen to what the overseas doctors said and pay attention to what they did in hospitals. Unlike the reports on the needs of overseas doctors, or the statistics of their examination failure rates, this research focuses on the overseas doctors' practices in the hospital. It puts the people back in the picture, and by doing so, highlights just what is at stake for these medical practitioners in moving from one context to another.

This thesis therefore fills a number of gaps in our understanding of the ways in which a growing number of overseas doctors adjust in their new workplaces. It contributes towards addressing unresolved issues not only of skilled migration but also of situated learning in hospitals, a process little discussed outside of the educational setting. It is a thesis that should be of interest to those in the academy undertaking migration and organisational research, and researchers from medical education and STS. It should also be of interest to migration and organisational researchers, medical educationalists, sociologists and anthropologists of science and medicine, individuals and organisations concerned with the steadily growing number of overseas doctors working in hospitals around the world, and last, but not least, overseas doctors themselves.

The overseas doctors: differences within differences

This thesis is built on the assumption that overseas doctors have developed a different set of practices from their local counterparts who have been educated and trained in local hospitals. These different practices, developed in contexts elsewhere, are what the
overseas doctors are adjusting. This section examines in more detail how this difference is often constructed as problematic by governments, medical organisations, researchers and associations concerned with the integration of overseas doctors. It is when we start to listen to how overseas doctors classify each other that differences, and differences within differences, emerge. In the final part of this section I build upon these concepts to introduce further multiplicities.

Categorisation of overseas doctors

When I worked as a medical intern in an Australian hospital, overseas doctors were known as ‘OTDs’ which stood for overseas trained doctors. Occasionally derogatory, more often than not, this term was a way of referring to one of the many doctors trained overseas in the hospital in an offhand, generalising way. In much of the existing literature about overseas doctors in Australia, they are similarly generalised into a group, as a category of doctors who are problematic, their difference often viewed as inadequacy and their unfamiliarity with the system as incompetence. Here is a quote from an article about a pre-employment program for ‘OTDs’ in Australia in which these assumptions are implicitly embedded:

By definition, OTDs have been educated, trained and have usually practised in cultural settings where disease patterns, levels of technology, treatment options, forms of health care delivery, workplace hierarchies and etiquette may differ. Thus OTDs, when compared to local graduates at entry to the Australian medical workforce, are potentially disadvantaged.

(Sullivan et al. 2002, p618)

Here difference is viewed as a disadvantage. Overseas doctors’ difference is also considered a deficit with an emphasis on what they are lacking to work in Australia. In such discourses, the difference of the overseas doctors is clumped together, and they
are ‘othered’.

Many researchers however recognise that overseas doctors are not a homogenous group, but rather have differences within. Some categorise the doctors into groups such as those from ‘mainly English speaking backgrounds’ and those from ‘other countries’ (Hawthorne et al. 2007, p7). Those from English speaking backgrounds are considered to be more ‘similar’ to the locals. As the Australian government struggles to fill workforce gaps, these similar doctors are advantaged and have special consideration in their applications, a topic which I explore further in Chapter Three. A similar dualistic categorisation occurred on the wards. One locally trained emergency department (ED) registrar told me:

*There are two distinct groups of IMGs – those that come from Canadian, American, UK, South Africa, who do exceedingly well, and those from other countries, who have different philosophies and standards, actually I don’t know about standards but different philosophies.*

(Name unknown)

Many researchers and hospital staff however find further national diversity within these two categories. Researchers delineate doctors by their country of origin or country of training. Back to the wards, local staff also made national generalisations about the foreigners, best captured in this section of my fieldnotes:

*I got into a conversation today with a nurse and told her the topic of my research. She says that she has observed many of the overseas trained nurses, and found that “the Chinese nurses are very good with the paperwork [she makes the motion of chop, chop, straight down the line], but aren’t as good with their hands – not as touchy feeling, you know [spreading out her hands to me]. Oh, don’t get me wrong, they’re great – and the Sri Lankan and Indian nurses, they’re very calm, but they cut corners [in a slightly lower*
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voice — pointing over the nurse unit manager (NUM) who was a male Sri Lankan doctor. Then, leaning forward, she touches me on the arm]. I'm not saying anything against them — but you know they’re from a third world country and it’s probably why — and the Vietnamese, they’re a little messy — the kitchen is always left in a mess — but I've been to Vietnam and I know that that is what it’s like there ...”

(Fieldnotes)

The racist connotations of this nurse’s quote are hard to ignore and worth addressing here, as I spend little time throughout the rest of the thesis explicitly dealing with issues of racism or discrimination. The reason that I have not focused on these issues is not because racist practices were not evident during fieldwork but rather that I have prioritised other aspects of the overseas doctors’ adjustments in this analysis. Certainly I heard stories of interpersonal racism. Occasionally doctors perceived comments towards them as being racist when I had not considered this and vice versa. The fact that I did not witness any direct interpersonal discrimination does not mean that it did not happen, and is very likely to be an artifact of the research method whereby I am very present as researcher. Interestingly, it was when I was with an Australian-born, overseas trained doctor that I heard the most racist comments from local staff. On another level, institutional racism is arguably infused throughout the way that overseas doctors are marginalised in Australia (examined in Chapter Three), and in the way that their overseas qualifications and skills are discounted relative to locally trained employees (Esses et al. 2006, p114; Williams 2007, p37). For, as psychologists Victoria Esses and her colleagues (2006, p118) argue, it is discriminatory attitudes that may be underlying the generic and seemingly legitimate concern about migrants’ lack of fit with their new local work environments.

All of these issues of racism and discrimination would need a lot of unraveling to do justice to them and is too broad a topic for the scope of this thesis (see Racism in Medicine: An Agenda For Change (Coker 2001) for a more detailed study in this area).
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There is a risk that by focusing on practice I am losing sight of these broader identity politics enmeshed in the lives of the overseas doctors. However, what I have wanted to highlight in this section, by presenting the nurse’s statements, is that in the hospital, there are numerous ways in which the overseas doctors are categorised in fairly generalising ways, that hide differences and multiplicity.

Categorisation has been a staple of biomedical practice for centuries, evident for example in the biological orderings aesthetically materialised in classical museums (Strathern 2002, p14) and nosographical delineations of disease (Foucault [1963] 2003). The classificatory principles used by governments, researchers and hospital staff to refer to overseas doctors, whether as a general group, in two distinct categories or by nationality, reflect this dominant discourse of biomedicine. Such classification works to support a social order which is arguably infused with what some would regard as racist politics. Further complexities arise however when listening to how overseas doctors classify each other. The next section explores emic perspectives of difference that problematise the neat categorisations previously examined and introduces multiplicities that do not dissolve difference but rather make it less linear.

Overseas doctors' classifications of difference

As sociologist and anthropologist Pierre Bourdieu (1989, p19) has written, nothing classifies someone more than the way they classify. In conversation with Dr Mladen Mück, a charismatic doctor who had trained in Bosnia and London and was staff specialist of an obstetrics department, said:

*After many years of working – every doctor who has trained overseas in an accredited university – well you can’t compare with learning traditional medicine in China and you can’t compare with some in Russia, well besides the ones in Kiev, Moscow – but the subjects are the same all over the world – and anyone can translate this into the system*
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— it is easier for those who studied in English, in Pakistan, India, it is easier — but in subspecialties ... Eastern European doctors — they have a reasonably good attitude — they are trained to respect. I find Indian doctors, they read British text books, but despite this the hospitals are not well equipped and because of this they have a different attitude ... You will see that if you employ Muslim doctors, you will see problems — African Muslim, Middle Eastern — they feel that there is something against them — they make overseas doctors feel [not right].

(Dr Mladen Mück)

Dr Mladen Mück distinguishes Chinese doctors with traditional medicine degrees from Russian doctors (rural vs major city trained), Indian doctors from Muslim doctors (African and Middle Eastern). Dr Elena Radulescu, who was at medical school during the 1989 uprising in Romania and was working as a resident on the rehabilitation ward when I met her, adds:

I can see the reason why they test us. I think that this is more necessary for some doctors than others — for example, I had no idea that in Egypt they had two types of medical courses — a full course and a half-course and that some doctors working here have done the half course. There are two different systems.

(Dr Elena Radulescu)

Full Egyptian doctors and half Egyptian doctors ...

Neelan, one of Mladen's residents in obstetrics, from a small town outside Colombo with “rural imaginings”, told me today that only the top percentage got into medical school “back home” in Sri Lanka. He said the medical education system was not privatised and totally government controlled. When I asked him what he thought about it being like this he said that this was a good thing because it meant that they “take the cream”. He said it was not like the former USSR where they have a lot of private medical schools — he
said that even people from his own country go to some of these medical schools but that “when they come back they are at the bottom of the list”.

(Fieldnotes)

Public schooled Sri Lankan doctors and private schooled Sri Lankan doctors, public schooled Russian doctors and private schooled Russian doctors (+/- major cities) ...

Surekha [a quiet but feisty doctor with a fondness for Indian-Chinese food, working as a rehabilitation ward resident] said that there were two sorts of medical schools in India, public and private. She said the private curriculum was the same as the public colleges but the examination is not so strict and if you paid enough money you could pass the exams. The public courses on the other hand she said were very cheap but very hard to get into. To go to these colleges you had to have very high marks. She herself went to a “premier medical college“ and she blushed when I said that she must have done very well in the exams. A third option she said was for students who could not afford to go to a private college and who didn’t get into a public college and that was to go elsewhere for medical school. These doctors may be from a small town and often went to countries such those in the former USSR. She says that for them it was really different. She believed that these doctors had a bigger adjustment to make when they then migrated elsewhere.

(Fieldnotes)

Private Indian doctors, public Indian doctors and those who went to the former USSR to Russia (public and private, +/- major cities). One last comment from Dr Surekha Sadafule:

We went on to talk about the private schools and she said that “some of them were more highly regarded and some students from these schools were very good”. However she also thought that it was possible to tell that many had paid their way through
medical school. Then she refused to generalise by reiterating that some students from the private colleges were very good and some students from the public colleges were not so good.

(Fieldnotes)

Medical education is just one example, an obvious example, of how the overseas doctors classified each other in increasingly complex and overlapping ways. They used other ‘markers of difference’ as well. For Dr Wassan Khalid Al-Ameed, a petite doctor educated in Iraq who moved liked the dancer she was after-hours, these were spread out along a spectrum of overseasness, with entailed degrees of different mixtures of familiarity and foreignness to the system. She told me this after we had left a conversation with Dr Rani Kale, another petite (and extraordinarily fiery) young doctor trained in the UK, who had been complaining about the injustices of her roster. Dr Wassan Khalid Al-Ameed and I had left to go and get a bite to eat from the cafeteria. On the way down the stairs she told me that the roster was one of the problems of overseas trained doctors but the problem was mainly to do with Dr Rani Kale being a British doctor, which was different from the problems of other overseas trained doctors. She said that:

They are overseas doctors, but they are not as overseas as us. They know the local system; it’s similar to their own. They have different problems.

(Dr Wassan Khalid Al-Ameed)

Dr Rani Kale did not regard herself as an 'IMG' either. She commented in regards to the difficulties that she was having with the Administration department:

Why do your own local graduates put up with it? I think that it is because they don’t get it as bad as the overseas doctors and I know technically I am probably not an overseas doctor, but still, I know that if it came to the crunch – when it comes to advanced
training — we could get through the exam, but the Aussie docs are going to get priority.

(Dr Rani Kale)

I met other overseas doctors who were 'not really' overseas doctors. When I spent time with Dr Sheng Qi, an Australian born, Irish trained doctor and acupuncturist, in a busy ED, one of his consultants said to me, upon hearing my project subject, 'oh, we don't really think of Dr Sheng Qi as an IMG'. In the intensive care unit (ICU), several consultants from Scotland and the UK seemed surprised that I was interested in their stories for my project. The Scottish doctor told me that it was different if you came from some strange place, like Iraq (pointing to Dr Wassan Khalid Al-Ameed who was on the other side of the ward).

The subtleties of the distinction between who was an overseas doctor and who was not, the gradations of overseasness, were of course very slight. Nonetheless, for now, I maintain that there was a difference between overseas doctors and locals, and that this was because overseas doctors were trained elsewhere; they developed their medical practices in other contexts. It was those on the fringes who delineated this most clearly. For example, Dr Wassan Khalid Al-Ameed had a sister who started medical school in Australia. The difference between the two sisters highlights the distinction between local and elsewhere, whilst emphasising the subtleties of this distinction.

My sister, she joined the medical school, because she came in younger — it is a different situation — part of my family is in the system — and half of my family out of the system — me. I am the overseas and my sister is the local graduate, like a lot of the doctors knew that she was a local graduate — her colleagues, they knew her — but the nurses, when she talk with them because they hear that she has an accent they start to judge her and treat her differently, and she was so angry and said she is not overseas, and apparently there was a different way of treatment. She said that they think that I am an overseas because of my accent. They treat her like she doesn't know because nurses they do not know —
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they just judge you from the accent. But her colleagues know her - but is kind of a funny thing. I laughed. The local graduates do not see this situation – my sister does. It is different, very different.

(Dr Wassan Khalid Al-Ameed)

Dr Wassan Khalid Al-Ameed raises some of the more subtle markers of difference that I discuss in the next section. Her story and her sister's story, like the others in this section, have added complexity to easy categorisations of difference amongst the overseas doctors, revealing differences within differences and grades of overseasness. I analyse difference in more detail next by building upon the overseas doctors' stories and emphasising further multiplicities and subtleties, so as to reformulate dominant categorisations and classifications of the overseas doctors' difference.

Degrees of differences

There is difference within any group of local doctors just as there is difference amongst overseas doctors. Hospitals are filled with differences, the overseas doctors are just some among many. So what makes overseas doctors' practices so interesting? As I have already written, overseas doctors are interesting because of their mobility as skilled migrants. They have been trained in contexts elsewhere and have thus developed different sets of practices than the locals. Their differences stem from a diverse series of local developmental contexts (Ingold 2000, p187).

It is not just internationals that got their judgement, but we have an extra judgement for background, might be my gender sometimes, yeah a lot of things ...

(Dr Wassan Khalid Al-Ameed)

These traces of difference - 'lots of things' - I believe are not so easily categorised by country of origin or training. Overseas doctors, like all skilled migrants - like all migrants,
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like anyone - rarely have ‘one point’ of origin. Many of the participants in this research had a colourful patchwork of past work and educational experiences in diverse medical contexts. In their demographic research Lesleyanne Hawthorne, Graeme Hawthorne and Brendan Crotty (2007, pp7 - 8) found that 66% of overseas doctors in Australia had reported five major geographic moves prior to their current position, with a substantial number working in a second country for two to seven years prior to migration. What Hawthorne, Hawthorne and Crotty (2007, p7) refer to as ‘hyper-mobility’ problematises the very notion of a nationally defined medical trainee.

Instead of being easily categorised by country of training or origin, I believe that the overseas doctors’ difference was entangled and overlapping, in complex ways. It was in the practices they had developed in a series of countries with communist regimes, in towns where there was an increased expectation to provide pharmaceuticals, in hospitals where the ratio of administration to practical work was lower than in Australia, where the degree of patient autonomy, organisational frameworks, teamwork relations, financial arrangements for radiology services, demographics of patients, normative blood pressure readings, medical textbooks, layouts of operating theatres and patient’s expressions of pain, all differed from Australia. Differences were embodied in the overseas doctors’ practices, in their ways of doing things. Dr Wassan Khalid Al-Ameed told me:

*Sometimes international graduates, they have different expressions, they have different way of body language, and their reaction to something might be slow. I don’t mean something like emergency but something like when you speak to them - or a joke or something – yeah you might find it the same or you might laugh differently - you just feel the sense of the stranger, you feel, a sense of you are different.*

(Dr Wassan Khalid Al-Ameed)

And Dr Nikolai Nagorsky, working in rehabilitation medicine (see Interlude Seven for
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more of his story), reiterated:

Everyone has different mindsets – like Australian doctors have similar mindsets – and this is not just from medical school but also primary school and high school – it is not just a medical issue it is a social issue too ... its simple things like you have to smile all the time and if someone smiles at you, you have to smile back ...

(Dr Nikolai Nagorsky)

These are the registers of difference that political theorist William Connolly (cited in Thrift 2004a, p71) describes as ‘surpluses, traces, noises ... stutters, gestures, looks, accents, exclamations, gurgles, bursts of laughter, gestures and rhythmic or irrhythmic movements’ that inhabit us and are intensive enough to make a difference to the selective ways in which judgements are formed. These more subtle differences are only possible as lists of examples, rather than being able to be represented in a classificatory system (Mol and Law 2002, p14). They appear throughout the thesis in the ethnographic stories. I am aware that such markers of difference can be used to categorise migrant workers as inferior and ‘other’ (McDowell 2008, p499). Rather than regarding these differences as problematic, I am interested in the various ways that the overseas doctors adjusted them in hospitals. For there were as many ways of adjusting difference, as many differences, as there were participants to spend time with, wards, events and aspects of the hospital environment to observe.

When using the term ‘overseas doctor’ I am thus aware that this risks a sense of singularity (Law 1999, p11), glossing over differences that are not easily reduced to essential categories such as gender, class, nationality, religion, age and so on (Rapport 2003, p16); categories that are essentially fluid, multiple and interconnected (Kondo 1990). Nonetheless, ‘overseas doctor’ was a term commonly used by the participants, and one which I have begun to unpack in this section. In the following section I analyse another term the overseas doctors commonly used: ‘the system’.
The system: a multifarious environment

Every participant in this project was concerned with 'the system' in one way or another. This section begins by analysing the system from the viewpoint of social scientists researching in hospitals, who construct the system as contained or national, as well as governments, medical organisations and educational institutions who also conceptualise it as something nationally distinct and learnable outside of practice. This section then explores the viewpoints of overseas doctors who struggle to maintain the system within their grasp as a 'target object' (Star 1999, p381), yet who are continually confronted by evolution and multiplicities. Finally, I build from the stories of overseas doctors, to further develop the system empirically and theoretically as a multifarious, constantly changing environment that was learnt in the midst of situated practical engagement.

A 'national' system

For many years, social scientists have constructed the hospital as a contained and well-ordered system. Sociologist Irving Goffman ([1961] 2007) depicts the hospital as an asylum or total institution and in what is one of the most comprehensive accounts of the hospital to date, sociologist Renée Fox (1989, p160) describes the hospital as a total institution-like enclave, an encompassing social system, interlaced with many smaller social systems. This is a system that has rational organisation, systematic division of labour, high degree of specialisation and authority, with statuses, roles and offices structured according to hierarchy, and governed by rules and norms (Fox 1989, p145). This version of the hospital system, which sociologist Rose Coser (1962, p3) describes as a ship or fortress, is a world unto itself, where life is bound within the hospital walls. These classic constructions of the hospital system represent it as a 'well-oiled' machine that shapes and orders all those who enter it.
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More recently anthropological hospital ethnographers have moved away from what they have argued is a microcosmic way of considering hospital culture to a view that incorporates an understanding of the permeability between the institution and surrounding society (Quirk et al. 2006). For example Sjaak van der Geest and Kaja Finkler (2004, p1995) write that the hospital is a place that both reinforces and reflects dominant social and cultural processes of their societies. Authors in their edited special edition of Social Science and Medicine of ethnographies in Ghanaian (Andersen 2004), Bangladeshi (Zaman 2004), South African (Gibson 2004), Dutch (Vermeulen 2004) and Mexican (Finkler 2004) hospitals, propose that despite globalisation, the hospitals within which biomedicine is practised are nationally specific.

As I have previously alluded to, this essentialised nationalistic view of hospital systems in fact seems to differ very little from the universalistic perspective of biomedical practice. There is once again an assumption that national practices are an interpretation of something more global. For example in Finkler’s (2004) study of a Mexican hospital, she argues that a globalised biomedicine is reinterpreted in the Mexican context. In her consideration of reinterpretation, she implies a core quality of medicine, a universalism that is merely adapted to a local context.

There are certainly national features of the healthcare system in Australia, shaped by critical historical episodes and particular conjunctures of events (Kirkpatrick et al. 2009, p651), by political parties, policies, immigration laws and the degree of involvement of the state and medical organisations (Akrich and Pasveer 2000; Williams and Baláž 2008a, p116). Yet it is precisely these historical and political factors which falsely construct skills as being country-specific (Williams 2007, p35) and medical practice as being ‘nationally distinct’. Whilst medicine may be politically shaped along national lines, I believe that rather than a grand body of knowledge there are everyday practices enacted individually by practitioners in local rather than national contexts (Akrich and Pasveer 2000). The overseas doctors are set up as having to re-learn a distinctly
Australian system that is another version of universal medicine. What I argue that they did instead, was to adjust what they knew within each local context of practice.

In Australia, nothing better captures the strong belief in a national system than orientation programs. These programs are now mandatory for overseas doctors to complete within three months of employment, and are considered essential to their ability to work successfully in the Australian healthcare environment (see Appendix for Australian Medical Council (AMC) (2007) orientation guidelines). Orientation encapsulates all that is considered distinct about ‘the Australian system’, and about what is considered different about the overseas doctors.

Orientation can take the form of tutorials, lectures, paper resources, web-based programs, computer laboratories, training manuals, videos, mp3 files (virtual orientation programs on IPods) and simulation centre sessions (Majumdar et al. 1999, p180; Hawken 2005, p4; Australian Medical Council 2007, p2; Curran et al. 2008; Porter et al. 2008, p39; Wright 2009). Recently there has been a move to condense orientation into a one or two day programs, taught to overseas doctors who have attained a position within the Victorian healthcare workforce before commencing employment. Aspects of the Australian system considered by those proposing, designing and evaluating these programs as the most unfamiliar to overseas doctors include: the patient-physician relationship, in particular patient-centeredness; multidisciplinary teamwork; confidentiality; documentation and legal issues; and the demands of medical technology and medical ethics (Confederation of Postgraduate Medical Education Councils 2003, p48; Gastel 2006; Hallock and Aschenbrener 2006, p55). Overseas doctors are viewed as needing to learn ‘Australian English’, ‘Australian body language’, the ‘doctor-patient relationship in Australia’ and more broadly, ‘Australian patients’ and “‘typical” Australian culture’ (Australian Government 2007). The DoctorConnect website (Australian Government 2007), considered by many authorities as the reference point for international medical graduates, (yet mentioned and used by none of the participants in
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This study offers an orientation for overseas doctors online that is a 'brief introduction to the language, culture and society of Australia ... a starting point for the knowledge, skills and attitudes necessary for safe medical practice in Australia'.

Orientation programs are claimed to 'improve the standard of practice of OTDs entering the ... hospital system' (Sullivan et al. 2002, p620). They are declared to ensure the public's continued confidence in standards of medical care (Australian Medical Association 2004). The AMC (2007) states that the aim of orientation is to 'enhance the IMGs' understanding of the Australian healthcare system', 'to enhance the IMGs' understanding of relevant communication and cultural issues' and 'to assist the IMGs' transition to clinical practice via the provision of information about the local jurisdiction, health services and facilities, and the legislative and professional practice environment'. The Australian Medical Association (AMA) (2004) states that 'the mode of delivery will need to be flexible. The program will need to be modular, based around nationally developed guidelines and be tailored to the applicant’s skills and background'. Whilst the AMC and the AMA claim that the structured (yet flexible!) programs aim to enhance the overseas doctors' existing knowledge, they are fundamentally about teaching the foreign medical professionals about Australian ways of doing things, so that they can acquire these different practices. As the AMA (2004) has stated, the long term aim of their 'pro-active approach' is to 'ensure that OTDs are able to adapt to the Australian health system and enter the community as seamlessly as possible and that their skills are developed over time'.

Often in these orientation programs, the system is described as the organisation and funding of healthcare (Australian Government 2007). For example, in the Postgraduate Medical Council of Victoria's (PMCV) (2009) orientation manual, the health care system is stated to be a complex mixture of public and private services involving three tiers of government, including the government agency Medicare and one of its programs, the Pharmaceutical Benefits Scheme. Whilst I have no problems with the system being
described as nationally distinct in this way, for as I have outlined, historical and political
process and events shape the system nationally, I disagree with the way that Australian
medicine is conflated to encompass a nationally distinct set of practices.

Similarly, I do not believe that orientation can be completed outside the setting of
practice. Recently, the PMCV mapped the current provision of orientation according to
the AMC orientation guidelines in Victoria. They found that orientation to the Australian
healthcare system, communication and cultural safety, and legislation and professional
practice, were all covered in some shape through manuals, one-day orientation sessions
provided through medical boards and Medicare, or through online units. The only
aspects of orientation considered covered within hospitals, either through handbooks or
initial orientation sessions, concerned IT systems, safe medication practice, infection
control and occupational health and safety (PMCV 2009).

Orientation is thus largely considered to be a process of formal instruction. However I
believe that pre-employment orientation programs, especially those conducted in very
short periods of time, suppress or hide from view, the social labour involved in adjusting
to new workplaces. They neglect the learning that happens in practice. Learning about
a national system through orientation emphasises acquisition (of new skills, knowledge,
values, behaviours etc) and assumes that learning is something that happens only before
entering the new work environment. As this thesis unfolds, I argue otherwise, exploring
the implications of this further in Chapter Nine when considering how we can design
better orientation programs, sensitive to the ongoing nature of workplace transition and
situated learning.

Orientation to the system is a useful concept for medical and governmental
organisations and employers because it can be 'ticked off' for the overseas doctors, as
signs that they are competent. At the same time the overseas doctors are not
confronted with something 'too complex', but rather something 'learnable'. The
overseas doctors also set up the system in this way, as a target object within their grasp. They did so for a number of reasons, which I explore in the next section. Yet in their negotiations they revealed something more complex, oscillating between a desired singularity and the multiplicities they found in practice.

The system as a target object

Almost every overseas doctor in the study had an opinion on ‘the system’.

*Well, yes, but you know, medicine is all the same, it is just the system which is different.*

(Dr Ashin Kuthala)

*Because sometimes you don’t know the system – nothing to do with your medical knowledge.*

(Dr Mara Radovanovic)

Not knowing the system was something which the overseas doctors could use to explain many of the difficulties they had upon starting work in Australian hospitals. It was something they could externalise. The system became an overarching way of describing all the differences they found. The overseas doctors constructed the system as something that must be learnt, many giving a time frame of when it could be learnt by. Two participants describe this:

*To be frank, when I first came here I hated the system ... it took some time to learn and adapt to it. But you have to adapt. You can’t apply the system from back home here. Medical culture is one culture with different systems.*

(Dr Neelan Tiruchelvam)

Dr Nikolai Nagorsky: *This system is, let’s call it established ...*
Anna: What does the word system mean to you?

Dr Nikolai Nagorsky: The established system of medical care. Which is different from where I have come from. Everywhere looks the same – the anatomy and the physiology are the same – but the system is different.

In these quotations the participants reiterate the commonly held view in biomedicine, regarding the monolithic and universal nature of the discipline. The overseas doctors also echo what they had been taught about the distinctly Australian nature of the system they had to learn, that they just needed to get a handle on.

Generally in our countries we follow the doctors centre style – over here it is the patient centered style – as long as we are following the patient centered style we will not have difficult in our management.

(Dr Ashin Kuthala)

So far the quoted overseas doctors have tended to push ‘the party line’. It is only when they started to describe the system in more detail that it took more shape and became more complex. Every doctor had a different version. This is Dr Surekha Sadafule’s definition of the system:

Medical system? Medical system – like in India it is just the clinical stuff, like you are the doctor, you write the medication and send the patient home or refer to whatever specialties you think – ask the patients to make their own appointments. But here it is all interlinked. If the patient enters the medical system – like if you see him and think he needs an ophthalmologist appointment, then it is your duty to organise that and speak to the ophthalmologist and speak to the secretary and make sure the patient gets the appointment from that and follow it up whenever ... you see the patient again and make sure it happened, whereas in India, you just stay in your own particular field and that’s it.
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You really don't follow-up on other things. Here, all that administrative stuff, like organising appointments and allied services and social work - this was all really new to me, the whole medical system again, here as I call it. And the way colleges work and the training program and how do you get a job - that was again something really different ... there is the hospital system here, like the administrator, and the nurse in charge and then social work and allied work - all that stuff - organising appointments, speaking to the GP, and taking the collaborative history from the wife who is in Perth, or ex-wife ... now after nearly two years I am really comfortable with most things. You can send me to any department - I would not know surgical stuff but I think I could manage - because now I know the system ...

(Dr Surekha Sadafule)

This is a much more complex system than those we encountered previously. Dr Surekha Sadafule describes an interlinked system filled with relations to people and things: ophthalmology consultants and secretaries and patients, appointments and referrals, accreditation processes and training programs and job interviews. There turned out to be as many aspects of the system as there were doctors to talk to, each overseas doctor emphasising something similar, or different, much overlapping. The system that the overseas doctors described emerged, often in unexpected ways, as they spent time in the hospital, rather than being something that was previously dictated to them. The specificities of the hospital were not 'Australian' but rather those they found before them, in their local settings of practice.

I believe that the overseas doctors were constantly oscillating between a version of the system as singular (i.e. obtainable) and the multiplicities that they encountered in practice. Everyday, overseas doctors would find further aspects of their new environment which were unexpected. Some caught their attention more than others. It is some of these multifarious aspects of the system that I have built the chapters around; what I have grouped together and considered as the content of their
adjustment. These are aspects of the system that appeared prominently in the overseas doctors' stories, all interlinked, constituting the new, richly textured, environment they found themselves in.

**A patchwork theoretical approach to the system**

It is when everyday medical practices are looked at closely that medicine becomes less monolithic, less national, and appears as a coordination of a long series of social relations (Akrich and Pasveer 2000, p75). As was revealed by Dr Surekha Sadafule, these social relations are *materially heterogeneous* (Law 1994, p2). They are connections between the overseas doctors with both human and non-human aspects of their environment. This concept is foreign not only to those designing orientation guidelines but also to many social scientists who view medicine as a cultural system made up solely of 'patterns of interpersonal interactions' (Sargent and Johnson 1996, p301). In hospitals, many sociologists have previously focused mainly upon professional relations or doctor-patient interactions (e.g. Fox 1989, p161; Cassell 1991, 1998; Bosk 2003; Cassell 2005), and tended not to incorporate material aspects of doctors' work.

Unlike many of these studies, my research does not privilege the doctor-doctor or doctor-patient interaction. In fact, because of the nature of the overseas doctors' work, patients appear very rarely in the stories. Whilst central to the purpose of the participants’ work, the overseas doctors personally engaged with patients only occasionally during the working day. Work more often entailed navigating the hospital, filling in forms and talking to colleagues. Because the research followed the overseas doctors, and let the nature of enquiry unfold in this way, I have ended up not looking closely at the patient. There are many other studies which focus on this more comprehensively.

I am thus more aligned with the sociologists of science and medicine who are interested
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in the *details* of medical work (Casper and Berg 1995, p396) who argue that medicine is a jumble of different practices incorporating human and non-human dimensions (e.g. Mol and Law 1994; Timmermans 1997; Casper 1998; Akrich and Pasveer 2000; Berg 2000; Dugdale 2000; Pope et al. 2003; Moreira 2004; Goodwin et al. 2005; Thompson 2005; Winance 2006; Moser 2008). Following the overseas doctors around the hospital and listening to their stories revealed a system that was made up of an interrelation of paperwork, buildings, registration procedures, people, tools and assessments, amongst others. Researchers in STS have also highlighted, through a series of ethnographic studies, that medical work is constructed through such heterogeneous social relations.

Whilst aligning myself with these STS researchers, I have drawn upon a diverse array of other theoretical approaches to help elucidate various aspects of the research material. Each theoretical approach illuminates discussion of a fragment of the environment that the overseas doctors were adjusting to. For example, the chapter on registration processes, Chapter Three, draws from work on multiculturalism, the political economy of healthcare worker migration and skilled migration policy. This allows an understanding of the social organisation that governs the local registration process alongside the overseas doctors’ everyday experiences (Quinlan 2009, p628). In the chapter on buildings, Chapter Six, theoretical work from architecture, STS and geography pulls in different and similar directions (Gorawara-Bhat 2000, p17; Yaneva and Guy 2008), creating deeper understanding about the interrelations of people and place. In the chapter about tools and instrumental practice, Chapter Seven, sociologist of science Madeleine Akrich’s (1992) work on the script of objects both parallels and challenges Bourdieu’s work on the habitus of bodies, both theorists being situated alongside studies of musical practice to help tease out the improvising nature of adjustment. Tying this patchwork of theories together is the work of philosopher Maurice Merleau-Ponty ([1945] 2008) and anthropologist Tim Ingold (2000). Their work brings to the study a phenomenological and ecological frame. It is Merleau-Ponty and Ingold’s theoretical work that I outline in most detail below, whilst the work of other theorists
are stitched into the remaining chapters.

In drawing upon the work of Merleau-Ponty ([1945] 2008, p66), I am examining a layer of living experience which he describes as a system of 'self-others-things', emerging as one comes into being, that the overseas doctors are part of in their new hospitals in Australia. Merleau-Ponty ([1945] 2008, p520) places the practitioner firmly within their environment - 'I am situated in a social environment' - and is attuned to heterogeneous relations, the subjective and objective, what he regards as the human and non-human world (Merleau-Ponty [1945] 2008, p469). He writes, 'I perceive everything that is part of my environment, and my environment includes everything of which the existence or non-existence, the nature or modification counts in practice for me, the storm which has not yet broken' (Merleau-Ponty [1945] 2008, p374). Merleau-Ponty revels in the incomplete, in the continually formed, and in the ambiguous. Crucially, he places the body centrally, arguing that the body carries with it intentional threads to its surroundings and in doing so, reveals the perceived world (Merleau-Ponty [1945] 2008, p83). I expand upon these concepts of embodiment in the next section of this chapter.

Drawing from Merleau-Ponty, Ingold is also interested in environmentally situated and perceptually engaged practice, whereby the agent is in its environment rather than confronting a world 'out there'. Like Merleau-Ponty, Ingold views the relations between humans as merely a sub-set of ecological relations. Whilst Merleau-Ponty focuses on perception, Ingold builds upon this to write more explicitly about learning in practice. He argues that we learn in a richly structured environment through sensory adjustment in the midst of practical engagement. For Ingold (2000, p196) it is through repeated practical trials and observations that the practitioner gradually gets a feel for things, thus being able to fine-tune their own performance through 'sensory corrections' to 'ongoing perceptual monitoring'.
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This perspective on learning through practical engagement differs from that presented early in this section in the form of orientation. Ingold (2000, p353) suggests that we need to move beyond a model of social learning that separates the transmission of information specifying particular techniques from the application of this information in practice. This ecological approach differs from what Ingold (2000, p19) terms 'conventional ecology' whereby the organism is external to and thus encounters their environment, an environment that is set up as a specified set of physical constraints. Ingold argues that the conventional ecological approach sets up the organism and environment as mutually exclusive. His own ecological project takes as a point of departure the whole-organism-in-its-environment (Ingold 2000, p19). This is an indivisible totality. The practitioner is located within an active perceptual engagement with their surroundings rather than just being an observing, copying subject. Ingold uses anthropologist Gregory Bateson's image of the skilled woodsman, notching the trunk of the tree he is felling with an axe, to underscore his ecological approach. Ingold claims that to understand this action we must understand the man-axe-tree system, not the individual body but rather a total system of relations, a richly structured environment. This environment, he emphasises, is never complete, nor is the organism (Ingold 2000, p20). This is an environment that the overseas doctors are part of. They are, as Merleau-Ponty ([1945] 2008, p255) writes, in the world, wrapped up in it.

Overseas doctors talked to me about having to know the system, the Australian system, a system neatly contained and defined. They distinguished it as an entity external to them, something they were outside of. Yet I listened to how they described the system and watched how they negotiated it, through their relations with humans and non-human elements. It was the arrangement of these things that was the system, and the overseas doctors' interrelations through adjustments made up part of the ecological terrain. I paid attention to how participants moved within their new environments, and the longer I spent with participants, the more difficult it was for me to delineate the overseas doctors from a neatly defined and separate system. The system was not
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anything to look at, to grasp, but rather a process that they were part of (Ingold 2000, p201).

The overseas doctors were part of the system just as much as anyone and anything else in the hospitals. As I followed the overseas doctors’ paper trails and ward rounds, I gradually found the overseas doctors inscribed into the system, not external to it, but within it, part of it, wrapped up in it.

Just initially, you make a good bonding with the overseas doctors, just initially you know, once you realise the certain or similar type of problem or adjustment, but later I could not feel the difference… initially we felt we are still searching what is going on. I felt easier, to be a part, if I can tell, of overseas graduate doctors, but ahh, later I couldn’t see the difference. Once you’ve worked together, when you have spent six months in one environment… we got to know each other, we got used to our qualities, you have lots of opportunities to present yourself, your sort of skills. You just feel that you are part of the network – initially it was like overseas doctors and ahh, ahh, Australian graduates and things, but later it was really about experience, experienced doctor, inexperienced doctor. I cannot see that there is that way we classify each other – overseas or Australian or something like that – or it is so, you cannot find an Australian doctor [laugh] – have a look at our environment!

(Dr Mladen Mück)

The environment that Dr Mladen Mück highlighted is one of ongoing change, continually being formed and incomplete. I have used Ingold and Merleau-Ponty to frame a theoretical understanding of the system as one in perpetual motion, change which the overseas doctors were part of, a system they interacted with, in all its multifariousness, in embodied and sensory ways.
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Adjustment: from the past to the unfolding present

In the first section of this chapter I argued that overseas doctors have different practices from local practitioners but that there was a non-categorical array of differences both amongst overseas doctors, as well as amongst the local staff. In the second section I then discussed the system and argued that rather than being a distinctly national one, as often presented, the system was not learnable beforehand but rather emerged as the environment the overseas doctors were part of, through situated practice. In this section I build upon these two foundational points to examine how overseas doctors, with all of their difference, adjusted to the system they found themselves in.

Adjusting

\text{adjust, v. 1. a. To arrange, compose, settle, harmonise (things that are or may be contradictory, differences, discrepancies, accounts). 2. a. ellipt. intr. To adjust (sc. differences, or oneself): To come to terms, or to an understanding; to arrange. Obs. b. To adapt oneself to; to get used to. Also absol. 3. a. To arrange or dispose (a thing) suitably in relation to something else, or to a standard or purpose. Const. to, rarely by, with.} \text{(Oxford English Dictionary [1933] 1973)}

The word 'adjust' is based on the premise that things are contradictory, discrepant and different. In the previous sections I established that the overseas doctors were different from the locals, and that the overseas doctors found differences in their new environment. As will be discussed in more detail soon, adjustments for difference were everyday happenings in the hospitals.

\text{If you are at Hospital X, one set of rules, at Hospital Y, another. It doesn’t matter if you}
are overseas or not. It just matters how fast you become part of the team – you have to change, to modify.

(Dr Mladen Mück)

Because of their practices developed in a number of distant medical places, however, the adjustments of overseas doctors were more obvious. They did not take things for granted like the locals did. Adjustment is also a good word to describe the experiences of the overseas doctors because it attributes some degree of agency (adjust oneself (Oxford English Dictionary [1933] 1973), whilst at the same time recognising structural constraints, as adjustment is to something, rather than with it (const. to, rarely by, with) (Oxford English Dictionary [1933] 1973). As will become evident throughout the thesis, the overseas doctors often encountered limitations upon their practice.

In the context of this research, I propose that adjustment had six main characteristics. First, adjustment was required by many different overseas doctors to various aspects of the environment, continually over time, and therefore entailed modes of adjustment. I have used the term ‘modes of adjustment’ in this thesis because it better captures the different types of adjustment that happened when overseas doctors entered, became part of, their new multifarious environments. The term implies and highlights multiplicities (Law 1994, p31). ‘Modes of adjustment’ is a term which concerns adjustments of practices as diverse as tactile manipulations of instruments to methods of studying for exams. The term also appreciates that because of their non-categorical differences, overseas doctors each had their own, individually unique, modes of adjustment to each aspect of the environment. As the overseas doctors became further ingrained in the system, the types of adjustments they were making also changed.

This leads to the second point, which is that adjustment was required on an ongoing basis because the system was continually changing. Rather than a stable set of features, overseas doctors were constantly adjusting to a system which was a process made up of
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an interrelated set of social connections that were continually evolving in incomplete ways. The overseas doctors were responding to an environment, an ecological terrain that was in a state of perpetual emergence. We see this become particularly evident in Chapter Three, as the overseas doctors negotiate registration procedures.

Third, adjustment happened as an embodied process. As Merleau-Ponty has highlighted, the world is experienced through our bodies, a world that we are wrapped up in. Fourth, and this is where I more fully expand upon the theoretical work presented in this chapter so far, adjustment implies moving from the past to the unfolding present; from the overseas doctors’ previous environmentally situated practices, to their new contexts. Adjustment implies constant threading back and forth. Fifth, the mechanisms of adjustment mean that glimpses are attained of both of the overseas doctors’ pasts and the system they were becoming part of. Finally, this adjustment took a significant amount of emotional work, for the overseas doctors, professionally, had much at stake. Each of these characteristics of adjustment are foregrounded in various ways throughout the thesis chapters. I explore some of them in more detail in the remaining parts of this section.

Embodied adjustments

On the train, Abdul asked me if I was interested in body movements and body language because he thought that this was very important and very hard to forget.

(Fieldnotes)

In the previous section I argued that orientation courses often presume that the system can be learnt outside the setting of practice. These learning models assume a cognitive approach whereby the body is regarded as passive, as an inert thing which responds to cognitive consciousness or stimuli from the external environment (Seamon 1980, p155). The theoretical perspectives that I outlined in the previous section depart from cognitive
theories of learning that separate the context from learning itself. I regard the environment not as the background, but as part of learning. Rather than learning being something that takes place as a form of acquisition (Hodkinson et al. 2007, p416), situated learning (Billett 2002, p460) recognises the relational and embodied nature of learning, the knowing that happens in practice.

In *Phenomenology of Perception*, Merleau-Ponty ([1945] 2008, p14) advocates for the need to understand knowing as something which happens through our bodies. His phenomenological approach draws from psychology, and then extends it. He is interested in the pre-objective realm (Merleau-Ponty [1945] 2008, p14), the phenomenal body that he calls 'being-in-the-world' (Merleau-Ponty [1945] 2008, p92). He suggests that the body opens one out upon the world and places one in a situation there (Merleau-Ponty [1945] 2008, p191). Merleau-Ponty ([1945] 2008, p273) writes that 'my body is the fabric into which all objects are woven, and it is, at least in relation to the perceived world, the general instrument of my "comprehension"'. The philosopher believes that the relation between things always has the body as vehicle (Merleau-Ponty [1945] 2008, p373), and that ‘the problem is to understand these strange relationships which are woven between the parts of the landscape, or between it and me as incarnate subject’ (Merleau-Ponty [1945] 2008, p61). For example, the following section of fieldnotes highlights the embodied nature of the overseas doctors' adjustments:

_Hossein [mathematician, researcher and young doctor from Iran] wants to sound more like a natural speaker — he says that he watches local doctors use different words, different gestures “and I try and catch them, but I can’t”. He tries to copy the accent. He said that his interactions in Australia are completely different — such as presenting a patient to a consultant, or speaking to the patient. He wondered how I would be able to research this. He says that he works so hard that he doesn’t have time to eat his lunch, that it is exhausting and dehydrating. He doesn’t get time to drink water — his whole_
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body feels different. “I just don’t have any energy”, he sighs.
(Fieldnotes)

This thesis concerns adjusting through the body, through bodily practices. It details the ways that overseas doctors engaged in embodied adjustments to the environment they found themselves in. Ingold writes that such a process:

Of almost continual improvisation is forced by the exact configuration of forces that presents itself to actors at any point in time which in turn requires a more or less skilled response to the arrangement of things ... [which] requires all manner of spatial operations linking contrast, separation, combination, tension, movement, alternation, oscillation worked out in a series of different registers: bodily movement as exemplified by gesture, the different combinations of sound, touch, vision and smell that typify a situation, the lie of the land which pushes back on the body in all kinds of ways, for example through balance, through the tools that are to hand, and so on.

(Tim Ingold cited in Entrikin 2001, p144)

The overseas doctors’ adjustments were a constant response to the arrangement of things in their new environments, both the human and non-human. The overseas doctors engaged in an oscillation that, as Ingold suggests, was worked out in a series of bodily registers. The ways they moved through spaces, picked up instruments, smiled and wrote on forms were all performed through the body. All bodily adjustments were sensory, involving sounds, smells, images, touch and kinesthetic movement. These sensory details are infused throughout the chapters, appearing with the scent of old dusty journals, the screech of someone taping boxes, the rhythm of machines, the smell of antiseptic, the taste of coffee and walnuts, the hum of a generator and the feel of the growing contours of an unborn child. They are the sensory details of the overseas
doctors’ practices and of the research method, for, as sociologist John Law (1994, p31) writes, ‘this, it seems to me, is what ethnography – and I think, any form of learning – is about. It is about seeing, hearing, noticing, sensing, smelling, and then raking over what has been noticed, and trying to make some sense out of it’.

**Adjustments everywhere**

As suggested, overseas doctors were not the only practitioners in the hospital undergoing these situated, embodied, sensory adjustments. This was, in fact, part of the everyday life of hospitals. Hospitals were filled with practitioners constantly adapting their ways of doing things to their environmental conditions. Adjustments that Bourdieu (2000, p138) regards as necessities of ‘the field’, what he describes as one’s social world. Everyone working in the hospitals was undergoing a process of continual rearrangement to changes in developed protocols, to new consultants, technologies, architectural design and new patients.

Those shaped by the field they act within tend to adjust themselves spontaneously without intention or calculation (Bourdieu 2000, p138). For local doctors, change in practice was accepted, part of a gradual growth. There was a certain taken-for-grantedness of their positions and of their ways of learning. Bourdieu talks of these insiders as having:

> A practical operation of quasi-bodily anticipation of the immanent tendencies of the field and of the behaviours engendered by all isomorphic habitus, with which, as in a well-trained team or an orchestra, they are in immediate communication because they are spontaneously attuned to them. (Bourdieu 2000, p139)

This adjustment which is ‘neither thought nor willed’ (Bourdieu 2000, p143), lies ‘not in
bodily movements themselves, but in the responsiveness of these movements to surrounding conditions that are never the same from one moment to the next’ (Ingold 2000, p353). This is a process that happens almost tacitly in familiar contexts, in moments of minute improvisations when we often become unconscious of the actions and processes by which we achieve results (Polanyi 1958, p62). Doctor and sociologist of science Michael Polanyi (1958, p62) describes this as feeling our way to success without knowing how we do it.

Overseas doctors also took their adjustment for granted in their previous contexts. One Chinese doctor commented that she found the Australian interns more relaxed but when she was an intern in her home country, it was ‘our country, our hospital, our patients’ and that she was relaxed too. Dr Wassan Khalid Al-Ameed told me:

_I found the students from first year, they know that, they know the culture, they are used to this hospital whilst we are used to different hospitals. So I asked these questions and sometimes other staff, might be some of the staff they mix before with the overseas doctors, they know what difficulties we face, but some of them they don’t have an idea or they don’t mix with the ahh, they don’t have an experience with international doctors so they, they just find it very strange and they just start to like start to undermine them or they think that they do not know or they are stupid or they do not know what they are doing but in fact they just overwhelmed by the reality, they have the knowledge they have everything but they don’t have the system adaptation._

(Dr Wassan Khalid Al-Ameed)

Dr Wassan Khalid Al-Ameed highlights how there was often less room allowed for overseas doctors' adjustments than those of the local staff; they had less of a grace-period for learning, or their period of harmonisation with the new workplace was not sanctioned. Whilst adjustments were happening everywhere, overseas doctors’ negotiations were not only more obvious but also less tolerated.
Allan Williams (2006) argues that whilst all newcomers to organisations face barriers to learning, migrants face particular hurdles to learning in work environments because they lack shared norms and face stereotypes and intercultural communication barriers. Overseas doctors had to put a lot of work into moving from the past to their new environment. As foreigners, they arrived and were 'out of place' in the ecological environment they found themselves in. Adjustment for them was not a luxury but a necessity, if they wanted to practice medicine. The work that this entailed was bodily, sensory and also emotional. It was exhausting and often demoralising. The overseas doctors needed to be persistent and resilient, creative and improvising. This work, so different from that required of the local doctors, was needed because their past lives were textured with medical work histories in contexts different from the hospitals in Australia.

**Historical and emotional density**

The doctors come with luggage – there is the system – and they are the newcomers.

(Dr Nikolai Nagorsky)

In his imagination every migrant worker is in transit. He remembers the past: he anticipates the future: his aims and his recollections make his thoughts a train between the two.

(Berger 1975, p64)

Adjustment is a threading movement between the past and the present. This can be thought of in terms of the two layers of the body Merleau-Ponty ([1945] 2008) writes about in *Phenomenology of Perception*. One layer is that of the habit-body, developed from past experiences, that is neither cognitive nor reflexive but rather bodily, as Merleau-Ponty ([1945] 2008, p166) puts it 'knowledge in the hands'. The habit-body is developed in the environment that a doctor grows up and into, shaped by an
intermingling and inseparable mix of skills labs (see Medical Glossary), medical schools, teachers, hospitals, the political economy of the country, disciplines studied and patients encountered. This body is developed in this rich environment of practice that becomes the familiar (Bourdieu 2000, p147), as Merleau-Ponty ([1945] 2008, p96) has put it, that 'humdrum setting which is mine'.

Merleau-Ponty's notion of the habit body became central to Bourdieu's concept of the habitus. By the habitus, Bourdieu (2000, p135) suggests that through sensory comprehension, the body is impressed and modified by the world around it, and thus acquires a system of dispositions attuned to the surrounding regularities. Bourdieu (2000, p138) writes that the body becomes inscribed by past experiences predisposed to react to recognised stimuli, during which the body has immediately adjusted without realising it. It is a world, Bourdieu (2000, p143) believes, that the practitioner takes for granted, because they are 'caught up in it, bound up with it; he inhabits it like a garment (un habit) or a familiar habitat. He feels at home in the world because the world is also in him, in the form of habitus'. The habit-body and Bourdieu's extension of this, the habitus, helps us to understand how medical practice becomes ingrained and learnt in familiar contexts.

Merleau-Ponty's ([1945] 2008, p95) second layer is that of the body-in-the-moment. The body-in-the-moment is similarly a practical engagement with the surrounding environment, the environment that one finds themselves in at any one time. In familiar environments, the habit-body and the body-in-the-moment are often closely aligned, leading to tacitly enacted practices. In the unfamiliar environment, the body-in-the-moment is situated within the unexpected and one finds oneself somewhere, however slightly, 'strange'.

Adjustment, I believe, is the movement between the habit-body/habitus and the body-in-the-moment. The two were often seen more obviously to be separate with overseas
doctors because of past practices developed in environments elsewhere. Thus adjustment involved not only the present but also the past; it was historically dense. Merleau-Ponty ([1945] 2008, p162) regards perception as consisting of drawing together a succession of previous perceptions which envelop each other into the body. His ideas about how the past is enfolded into the present help us to understand how doctors adjust their bodywork, forever present in the form of the habit-body, or habitus.

Adjustment is a threading back and forth that has been described by others as ‘tuning’ (Ingold 2000, p356), ‘honing’ (Sennett 2008, p50), ‘tinkering’ (Knorr-Cetina 1992), ‘repair-work’ (Berg 1996, p514), ‘accommodation’ (Pickering 1993, p580) or ‘artful juggling, gestalt switching, and on the spot translating’ (Bowker and Star 1999, p292). These are all words and terms for describing moving between the implicit and explicit, the process of making-do, patching things together, constantly engaging in something that meets the purposes temporarily set out upon (Clarke and Fujimura 1992, p11), in a moment to moment historical engagement with the environment. It is a threading between local settings of practice and those elsewhere, between hospital buildings, assessment formats and ways of using tools. It is a movement from context to context rather than a re-learning of nationally distinct ways of doing things.

There is often an implication that immigrants cast off the baggage from their previous lives in an attempt to make a new one (Kelly and Lusis 2006, p832). However adjustment was not a process of assimilation or integration. Rather, the term appreciates that doctors came to Australia with their own practices. Thinking about adjustment as a movement between the habit-body and the body-in-the-moment accepts that doctors came to their new workplaces with their own pasts, their own macro-institutional histories, their own mixing trails (Akrich and Pasveer 2000, p79), their own melodic lines of development (Grosz 2008, p43). There was a mess of lines behind them, a constellation of stories connecting the subject to a whole world of instances (Soja 1989, p23), components of what is a highly complex geography
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(Permezel and Duffy 2007, p360).

It means that the hospital is what geographer Ash Amin (2002, p979) calls a ‘space of travelling cultures and peoples with varying geographies of attachment’. I have argued that the overseas doctors' histories were more complex than categorisations of ‘other’ or national generalisations. These doctors were ‘travellers’ with varying and layered histories of practice. Dr Nikolai Nagorsky emphasises how these histories were built upon in Australia, but not without effort:

*The certain features a doctor holds are to be loyal, honest, passionate, empathetic – all of these together is the package. When we are going through all of the trials – you can fall apart all of these features – for us to go through this filter – it is not to stop us but to refine us – but this refining process [is hard]. Our ego identifies us with this package and this affects the confidence when the refining process denies us our own uniqueness. I’m thinking about our transformation here on an emotional level – how the body responds.*

(Dr Nikolai Nagorsky)

Adjustments are material, embodied and emotional (Winance 2006). I asked what Dr Nikolai Nagorsky meant by uniqueness and he replied that:

_Everyman is an island. We have the boundaries, certain preferences, our past which dictates how we perform here as an individual – an island floating towards land – and when we merge we feel like we will lose but in actual fact we gain. Because it is growth ... This comfort zone that we created – we need to move from this but it is painful._

(Dr Nikolai Nagorsky)

As they adjusted their practice, the doctors needed to adjust their sense of professional identity. Sometimes this was a perceived need to adjust in response to perceptions of inadequacy or incompetence, issues which I have touched upon briefly when previously
discussing racism in the hospitals. Conversely, the overseas doctors could feel as if they were adjusting 'down', to a system that was not as efficient or sophisticated as those they had previously come from. Either way required rearrangements of the notions of a professional self. Sociologist Paula Feder-Bubis (1997, p73), who took part in Shuval and Bernstein's (1997b) collaborative study, suggests that overseas doctors' professional identity will only ever be partially restored upon migration. Many of her participants described this professional compromise as a price they would pay to integrate professionally and personally (Feder-Bubis 1997, p73).

Overseas doctors often had prestigious pasts, and adjustment required a change in status both within the hospital and the community (explored further in Chapter Seven). This was often painful for them, as Dr Nikolai Nagorsky points out, and destabilised the core idea of what it meant for them to be a doctor. This disruption reveals that what it means to be a doctor is an environmentally situated concern, that practice is ecological, tied into all of the human and non-human relations in a medical workplace.

Adjusting from the past did not mean disregarding all that had gone before however.

_The point is that, for us coming into this country, coming with all of our beliefs and luggage, is for us to somehow, unload that luggage, have a look at what we have got there, and what is necessary throw it away and what is missing there, put there just to add some things ..._

(Dr Nikolai Nagorsky)

Dr Nikolai Nagorsky describes arrangement, composition, attempted harmonisation of practices to the local system. This is a drawing together of a succession of previous perceptions which envelop each other (Merleau-Ponty [1945] 2008, p162). The longer an overseas doctor works in Australia, the more the 'past' becomes not only medical places elsewhere but also the practices developed in Australian hospitals. Merleau-
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Ponty ([1945] 2008, p162) writes that ‘at each successive instant of movement, the preceding instant is not lost sight of. It is, as it were, dove-tailed into the present’.

Changing along the way

For the local doctors, their previous practice had been in the same, familiar, humdrum environment. For the overseas doctors, they had experiences in different environments as well as accumulating experience in the now local environment, the two becoming increasingly intertwined. Therefore, along the way, the overseas doctors’ practices changed. Dr Yang Fuquan who had worked for six years as an ophthalmologist in China and travelled to Australia 20 years ago to improve his English told me:

*In the new environment doctors change. It is like ourselves are a mix of our past and now not just the same as the past. It is a mix of the past and the new.*

(Dr Yang Fuquan)

Dr Yang Fuquan talked about how he noticed when he was doing something from the past and he criticised himself for doing it; he said that it was a ‘past mark’. He remarked:

*I won’t be the same as the doctor trained here but at the same time I am not like a doctor who only worked in China – when I go back [to China] I really notice the difference.*

(Dr Yang Fuquan)

In new hospital environments overseas doctors adjusted their past practices, which were ‘taken apart, and then put back together with a new inflection, an unexpected accent, a further twist in the tale’ (Chambers 1994, p23). The past was not forgotten, but new experiences were accumulated. People’s knowledge of their environment changes as they move about it in (Ingold 2000, p230), and their modes of adjustment
alter over time. Dr Nikolai Nagorsky described this as a tuning into the environment, of adjusting your instrument and changing along the way:

*IMGs are like musicians – using the same instruments – to play a different song ...* [the] *musical instruments are the same but you can get different music from them - like an organised melody. In a team it is going to be quite beautiful music; it depends on how they are played and under what conductor ... You have your own instrument and you are trying to adjust your instrument to those around you. That’s the system – trying to adjust, trying to watch the conductor. You can play different tunes with the same instrument. I’ve changed a lot – my character, my attitude, my medical practice ...*

(Dr Nikolai Nagorsky)

When did the overseas doctors stop adjusting and when did they become fully-fledged members of the hospital orchestra? When did an overseas doctor stop being an overseas doctor? When they were part of the team, Dr Mladen Mück suggested. When they had learnt the system Dr Surekha Sadafule said. Dr Zhou Jiaying’s registrar suggested that once you were on a specialist program it stopped mattering whether you were overseas. Many felt that you could never stop being an overseas doctor; once an IMG, always an IMG.

Dr Marian Munteanu: *It was 95% what I expected to find – the [pre-employment] IMG program, meaning that I was familiar with things and that I was not diving into an unknown sea. I can swim almost with closed eyes now.*

Anna: *And the other 5%?*

Dr Marian Munteanu: *Oh you are never 100% - you are still learning – I won’t be 100%.*

Certainly there were constraints on the overseas doctors’ practices in Australia which meant that many overseas doctors felt limited in their ability to fully develop their medical careers. These limitations on career choices have been discussed by other
researchers in more detail (Decker 2001, p41; Raghuram and Kofman 2002, p2079; Syed 2008, p35). In Australia, being a skilled migrant means a good probability of finding employment, but lower chances of obtaining a desired job (Syed 2008, p35). There are documented differences in the career structures between locally and overseas qualified doctors in the UK, with overseas doctors working longer hours, having less autonomy and lower morale, and being disadvantaged structurally in their careers (Healy and Oikelome 2007). This was the glass ceiling that many overseas doctors mentioned, which appeared for those who had not graduated from a local university.

_Ahh, I can't tell that it is possible to assimilate fully — at all. That is just the fact that we need to accept. Maybe ten years is minimal time to be sort of, not fully assimilated [laughs] but at least to feel like that, but to be part of the team. But ahh to be realistic and pragmatic, to be fully assimilated, I don't think so that is possible without finishing the university here._

(Dr Mladen Mück)

Dr Mladen Mück suggests that to be fully integrated, to no longer be ‘overseas’, overseas doctors had to go through local training.

_It means you will be faster assimilated after finishing five or six years after the training, despite of being clinically so advanced — and then what does this mean to be in the training program for six years? You will be really trained according to local habits — I cannot tell properly trained — of course it is properly trained for this environment._

(Dr Mladen Mück)

But as the overseas doctors worked in their environment they did become part of it ... It is what many of the doctors hoped for, such as Dr Rudrangshu Mukherjee, a well-respected, self-proclaimed “cosmopolitan” who played Tabla in Indian, Pakistani and Bangladeshi bands.
And everyone will be working in the hospital as a doctor for example, you have to wear the coat of a doctor, you don’t have to wear the coat of an overseas doctor – being overseas is secondary, primary is that you are a doctor. And I think that that should be the take home message for all overseas doctors: do not feel that you will not be accepted into the system. Eventually you will be accepted into the system and be able to work as a doctor. I think we also have to get rid of the stigma of being overseas actually. I think that it will probably never go away ...

(Dr Rudrangshu Mukherjee)

And as they became part of the environment they became part of its change. Workers alter the social ecology of work (Gorawara-Bhat 2000, pxiv), for at an ecological level, change is not just individual but systemic (McLaren and Hawe 2005, p7). The dynamicism of the system became a form of co-evolution as the doctors changed and the system changed simultaneously, both being incorporated into each other. As Ingold (2000, p168) puts it, ‘the coming-into-being of the person is part and parcel of the process of coming-into-being of the world’. In her analytical framework for a cultural study of biomedicine, anthropologist Mary-Jo DelVecchio Good (1995b) focuses primarily on biotechnologies and research as major sources of transformation in biomedical institutions. The expanding migration of doctors and other healthcare workers is another, under-realised, aspect of this change.

Revealing the overseas doctors’ pasts

In the process of their adjustment, in the midst of this change, glimpses are obtained of what is being altered and something is learnt about the overseas doctors’ pasts. Geographer Meric Gertler (2003, p94) writes that it is often not until we cross borders that our mindsets and settled habits are made aware to us. Dr Yang Fuquan noticed the difference when he went back to China or when he did something from the past. A ‘past mark’ was a previous habit, developed through years of practice as an ophthalmologist
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in China. Adjustment revealed aspects of the overseas doctors' pasts but what is revealed is not always clear; there may only be glimpses (Interlude Two).

In this thesis there are very few details about the participants' backgrounds with a focus on the markers of difference that arose in situations: accents, gestures and subtle ways of doing things. It was almost impossible to draw out all of the components of the overseas doctors' histories (Bourdieu 2000, p155), impossible to determine what the specific influences were for each practice that helped shape each of their social relations, just as it was difficult to categorise or classify each overseas doctor. Elements of the overseas doctors' histories appear in their stories, particularly in interviews when recollections are made and comparisons to the past made explicit. It may be a comparison between operating theatres [OTs] or waiting rooms that reveals underlying political and economic differences in contexts. More often it was something difficult to describe, perhaps an atmosphere or a subtlety which delineated a practice as different. Anthropologist Nigel Rapport writes that:

> For a world of travelers, of labour migrants, exiles and commuters, home comes to be found far more usually in a routine set of practices, in a repetition of habitual interactions, in a regularly used personal name, in a story carried around in one's head, in 'words, jokes, opinions, gestures, actions, even the way one wears a hat'.
> (Rapport 1995, p268)

These are the subtleties that I have tried to pay attention to, what I mean by bodily practices. I have used theorists such as Merleau-Ponty and Tim Ingold to illuminate this analysis because their approach is more open to such affective registers. These affective dimensions give an environment an atmosphere and give a practice style, and although often neglected, are important to consider in any study of adjustment and the learning process.
Revealing the system

The stranger, remarks the sociologist Georg Simmel, learns the art of adaptation more searchingly, if more painfully, than people who feel entitled to belong, at peace with their surroundings. In Simmel’s view, the foreigner also holds up a mirror to the society into which he or she enters, since the foreigner cannot take for granted ways of life that seem to natives just natural.
(Sennett 2008, p13)

As much as the subtleties of the overseas doctors’ pasts were revealed in adjustment, so too were elements of the system that locals took for granted. For the local doctors the system remained invisible. Overseas doctors began to reveal elements of the system because they did not take it for granted.

*When our decisions are overturned by colleagues – what you would do back home would be absolutely perfect there but here it is overturned – you start to question the system. Because you know that it works quite well – you begin to question the system.*
(Dr Nikolai Nagorsky)

Following the participants revealed paradoxes of registration procedures, the social norms inscribed in paperwork, the standards embedded in assessments and the local rules of interaction. In this way, doctors emerge as ‘key agent[s] of enlightened values’ jolting the taken-for-granted world (Ley 2004, 159). Many have commented upon this in relation to migrants. Human geographers have noted the potential for overseas doctors to reflect and compare systems, and their capacity to challenge organisational norms and the legitimacy of practices within organisations that this implies (Williams and Baláž 2008b, p1925). Mobility between organisations and crossing contextually different divides are viewed as making more visible the processes of social production (Ledema et
al. 2005, p330) and revealing institutional forces (Gertler 2003, p94). Periods of transition are considered especially fruitful times to study processes of professionalisation (Shuval 1997, p10). The stranger or newcomer is a source of learning (Lave and Wenger 1994, p122; Bowker and Star 1999, p295). They hold the mirror. Bourdieu (2000, p163) suggests that those who occupy such awkward positions are ‘more likely to bring to consciousness that which for others, is taken for granted, because they are forced to keep watch on themselves’.

Paying attention to the overseas doctors’ processes of adjustment is thus something of an opening. It is a way of learning about the differences and commonalities between systems, about the colour of local hospitals. Overseas doctors made everyday and mundane things more obvious, as they travelled between contexts. The chapters of this thesis thus often explore aspects of medical work that locals may have found uninteresting or dull. It pays attention to simple procedures such as inserting a cannula, taking blood pressure and catherisation, to the way a doctor fills in a form, throws a coffee cup in the bin, walks down a corridor or studies in the library.

Overseas doctors, as newcomers, were more alert, more attentive to these dimensions of their medical work because they had to be. Architectural theorist David Seamon writes that locals, or those familiar with their environment:

> Can manage routine demands automatically and so gain freedom from their everyday spaces and environments. In this way, they rise above such mundane events as getting places, finding things, performing basic gestures, and direct their creative attention to wider, more significant life-dimensions. (Seamon 1980, p157)

On the contrary, overseas doctors’ practice was wrapped up in much of the mundanity of medical work. For them it was the subtle difference which counted in practice.
Summary

I started this project because I was interested in the struggles of overseas doctors whom I had met in Australian hospitals. They were often working in junior positions, as I was. We were all learning the ropes. The adjustments that they were making however seemed very different from mine. There seemed to be a lot more at stake for them; they seemed silently passionate about the professional careers they were carrying forward, whilst my recently graduated cohort stumbled nonchalantly along. Overseas doctors became a group that was considered different. Whilst acknowledging that the overseas doctors were needed, there was some ambivalence about where they belonged. This research is inspired by the overseas doctors I worked with when I was a junior doctor and is hopefully, however partially, testament to their resilience. It began as a study of their working lives and has emerged as a study of how overseas doctors negotiate difference through their practices of adjustment.

With this thesis I contribute original, empirically and theoretically informed research on ways of adjusting for difference, on some of the overseas doctors' 'countless ways of making do' (de Certeau 1984, p29). In doing so, I depart from the literature that regards overseas doctors as a homogeneous and problematic group who require integration into a nationally distinct system and the acquisition of new, 'Australian' ways of doing things, outside the settings of practice. Neither overseas doctors nor the system appear in this thesis as contained categories. This research opens up our thinking about both overseas doctors and the system, by moving away from presumptions of homogeneity, totality or uniformity.

In this chapter I have given some broad theoretical frame to the chapters that follow. There are further theoretical insights introduced throughout the thesis, in response to the events discussed. In this chapter I have also established some of the assumptions that this thesis is based upon; namely that overseas doctors were a diverse group, and
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that their difference was non-categorical. However the overseas doctors were different from local practitioners because the overseas doctors had developed practices in local contexts elsewhere. In this chapter I have also established the assumption made in this thesis that the system the overseas doctors were becoming part of was an evolving, multifarious environment, and that they were part of its change. I have outlined the main argument of this thesis: that the overseas doctors negotiated difference in their new environment through modes of adjustment. This term acknowledges that overseas doctors arrived in Australia with past geographies. Rather than acquiring or transferring knowledge, they adjusted practices in embodied, sensory, situated ways.

This threading back and forth was rhythmic (Ingold 2000, p197). There was a constant sense of history being entwined with the present. Whilst adjustment was something that both overseas doctors and local doctors engaged in (the overseas doctors merely highlighting what happened everywhere), the overseas doctors not only made more obvious these adjustments but also had more at stake in this engagement. For the overseas doctors, adjustment was more painful, undergone more searchingly. This is important. For the overseas doctors, adjustment took effort. They had to engage in multiple efforts because of their differences in the new environment of practice. There was often a lot riding on this.

When you start something in a country it is really difficult to get back to Iran again. Because I have to gain, being involved in exams over there, you know, it's really difficult, so I have to choose just one way. So it is really scary when you are choosing just one way for your life. And people who have been born and raised in Australia, they don't have these sort of difficulties. They can choose ahh, their life anytime they want, they never feel old, or something. But, for us it is really difficult. You cannot go in the wrong way because there is no other way, no reform. You cannot correct ourselves to be in the right way again.

(Dr Farokh Mostofi)
Many overseas doctors expected to find medicine the same everywhere. The new environment was instead filled with differences which their past practice did not exactly match. My empirical task was to try and find difference in practice, differences that arose during investigation (Strathern 2002, p15). I have ended up with several aspects of the overseas doctors' new environment that have been sectioned out into chapters: registration (Chapter Three); paperwork (Chapter Four); assessment (Chapter Five); buildings (Chapter Six); tools (Chapter Seven); and people (Chapter Eight). These are components of a sensual environment, perceived through touch, hearing, sight, smell and taste. Each doctor who appears in this thesis had different ways of dealing with the Administration department, different ways of negotiating the hospital layout, different ways of studying for the exams and of dealing with equipment; all modes of adjustment with varying shades of difference. The overseas doctors were not a homogeneous group adjusting in one type of way. What are presented here are just some of the relations in the field. There were others, more than one and less than many (Mol 2002, p82). The next section gives a summary of how the thesis unfolds.

Outline of chapters

Following from this chapter, Chapter Two sets the scene of these stories and details the methods used in the research. The chapter describes the hospitals where fieldwork took place. It discusses how I took much about this setting for granted, only realising this by observing and listening to what the overseas doctors did not take for granted. As someone who had practised medicine, undertaking ethnographic research entailed a process of situated, reflexive adjustment; the very process that I argue is central to the experience of the overseas doctors. I describe my methods as a continual tacking back and forth, between old theories and observations, conversations and readings. In this chapter I provide an outline of those who participated in the research, I provide details on the methods of recruitment and describe how I spent time with the doctors, as well as discuss the analytic approach and my role as researcher in the hospital.
Chapter Three focuses on the complex and dynamic registration process that the overseas doctors negotiated to work in Australia. It looks at the past, present and future of an ever-changing process quilted together by an interconnected group of actors including the government, medical professional bodies, employers, policies and other documents. In this chapter, I analyse the attempted 'management' of the employment of overseas doctors in Australia, arguing that despite constraints, overseas doctors adjusted with varying degrees of flexibility. Often the price to bear for this however was precarious periods of uncertainty. This chapter foregrounds the social labour involved in obtaining employment and negotiating a rhetoric of standardisation, in practice.

Chapter Four follows paper trails, paying attention to documents which were inscribed with the institutional norms of the system, the papers which overseas doctors negotiated as they learnt this system. Once again the overseas doctors' past is held in greater relief, whilst we learn more about the social norms built into the ways in which the paperwork trail is designed to run smoothly and seamlessly. It is another perspective in this study of adjustment, one which highlights a mundane aspect of adjustment and the everyday, embodied ways that all practitioners negotiate between the formal and informal in their daily hospital work.

Chapter Five takes a detailed look at the assessment process. In this chapter I explore how overseas doctors adjusted to the slippery standards imbued in assessments by examining their study practices. I look closely at how overseas doctors studied in hospital libraries, cafeterias and tutorial rooms, at how they memorised past questions and learnt the techniques of the exams. Chapter Five focuses on what the overseas doctors' adjustments reveal about the standards embedded in Australian assessments. It provides a critical analysis of these assessments, of the role of standards in contemporary medicine and of the ways in which medicine tries to cover up the work and effort involved in travelling between settings of practice.
Introduction

The overseas doctors' adjustment to the hospital building is examined in Chapter Six, in which I argue that the materialities of place not only provided arrangements for the overseas doctors' practices of adjustment but were also something adjusted to as well. By focusing on the ways in which overseas doctors negotiated the materialities of the hospital, the ways in which other hospital inhabitants adjusted everyday to the building is also highlighted, revealing more creative practices of adjustment than are often documented to be taking place in hospitals. The chapter tells us more about how the overseas doctors negotiated pathways to belonging to their new clinical environments.

Chapter Seven looks at ways in which overseas doctors adjusted their procedural skill. It examines adjustment in moments of mismatch through a series of ethnographic stories including one of my own clinical stories. In this chapter I explore the technical and instrumental environment of overseas doctors' practice and argue that it is during 'mismatches' that more is learnt about the everyday nature of adjustment in hospitals. The tactile nature of practice is foregrounded in this chapter, as are the ways in which the status and roles of doctors are embedded in their heterogeneous work settings.

In Chapter Eight, the nature of adjustment through interpersonal interaction is examined. I critique the ways in which the social relations of overseas doctors are generally assumed to be problematic and thus requiring monitoring and retraining. In contrast, by empirically studying the fine grain of overseas doctors' interactions in the hospital, as they happened, the chapter contributes an understanding of the overseas doctors' social engagement not as something problematic or needing to be managed but as something negotiated, day-to-day, in the midst of practical engagement with their environment. The chapter foregrounds the nuances and subtleties of interactions and adjustment, once again examining how, as newcomers to the system, the overseas doctors reveal both social norms and prosaic forms of communication that locals took for granted.
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Chapter Nine summarises the argument of the thesis and the content of the chapters. It considers the contributions of the thesis theoretically, methodologically and practically, as well as the implications of this research upon how we consider the social labour involved in moving between different medical contexts.

A final word

The thesis is an accumulation of ethnographic stories: a study of patches. Quilted together, each story makes up a larger story that is far from complete, for the anthropologist can do no more than catch a fleeting moment in a never-ending process (Ingold 2008, p74). Each moment however is a compression of the past that brought it about and contains the tension of future possibilities (Ingold 2008, p74). Each moment is historically dense. The moments add up and eventually the stories have an accumulative effect that gradually builds the argument of the thesis.

The chapters, stories, characters are not contained, generalising nor representative. On the contrary, they are intended to highlight multiplicities of differences, differences within differences. Each chapter foregrounds particular aspects of adjustment and particular social relations, artificially separating them out but recognising that all are part of the environment simultaneously. Elements that are foregrounded in one chapter are in the background of another, but all are always present in some way. The chapters could have been arranged differently, with different contrasts and similarities highlighted. Interludes inserted between the chapters create some connections and leave more gaps. They are intended to stitch the chapters together, relating in some way to what has occurred previously and what is to come, whilst stepping outside of the chapter formats momentarily...
Interlude One: The Yo-Yo Quilt

Whilst crafting this research I was making a patchwork quilt. It was a yo-yo quilt; a very simple hand-sewn quilt made from circles of cloth of different colours, patterns and textures that I had collected during a year of overseas travel. To make patches for a yo-yo quilt you sew stitches around the edge of a circle of cloth and then pull them in tight so that the edges are puckered like a wheel. When ironed flat, the patch looks like a cross-sectioned yo-yo. These are then sewn to each other 'at a teeny place where the circles touch' leaving 'lacy holes where they (don’t) touch' (Morales 1994, p939). Such stitching continues to the quilter’s discretion, the style of the quilt meaning that there is no specified end point, the circles meandering in many possible directions. Like weaving a basket, sewing a quilt comes into being through gradual unfolding, through the sensuous engagement of the practitioner and material, so that the form of the quilt emerges (Ingold 2000, p342).

In many ways sewing the quilt was analogous to the process of adjustment that overseas doctors underwent in the hospitals, through practical engagement in their environment. Their past and their present were linked through stitches, adjustment a threading between the two creating links between habitual practice and the moments they found themselves in. The yo-yo quilt is also a metaphor for the research process, which is discussed in more detail in Chapter Two. The research began in a way similar to collecting materials in fabric shops and department stores, material collected over time. The quilt is a metaphor for the process of conducting ethnographic research including all the practices of fieldwork and writing, of forever collecting patches of material to use to make a story. The thesis is the material version of these ethnographic practices, made of paper and ink, that in its format is intended to look somewhat ‘quilt-like’, with the chapters stitched together with interludes.

Yo-yo quilts are messy and potentially never finished. There are many gaps between
Interlude One

Figure 1: A portion of my yo-yo quilt

each fragile connection of fabric which help to tell the story. These could be, as Law (2002, p94) writes, viewed as the absences that define the presences both of our research method and of our research subjects. As the research unfolds, extending out in many directions, there are ‘more and more gaps’ (Strathern 1991, p119). In The Body Multiple, philosopher Annemarie Mol (2002, p82) describes the hospital as an organism that has gaps and tensions inside it, that hangs together, but not quite as a whole. The quilt is like this, its inherent fragmentation and never-ending nature symbolic of the incompleteness inherent in the postmodern analytic approach adopted in this thesis (Geertz 1973, p29).

The yo-yo quilt I made is a particularly apt metaphor for this ethnography because there are so many patches from different countries. Like the overseas doctors with whom I spent time, these pieces of fabric do not have singular forms but multiplicities, revealed
through connections with others. These connections are not just defined by where the material was made. Some of the patches are connected by colours, others by texture, some by their silkiness or coarseness. Other patches are connected by how they were made, where I bought them, how the cloth was measured out. These are the ingrained practices hidden in the material of every patch.

In each of the chapters there are stories which are connected at points, and theories which help to illuminate these stories. These theoretical approaches are often quite diverse, even within a chapter. They meet at some points but differ quite substantially at others. Connections are not always harmonious; patches come apart at times and have to be sewed back together. Yo-yo patches pull a bit at the seams, friction or tensions leading them to unravel. Tension does not just occur between different types of textiles, but also within the same grouping of patches. Patches also come apart within themselves, and open up spectacularly, this having nothing to do with other patches; their own form of undoing.

At the meeting points, differences are also highlighted. As the overseas doctors negotiated their new environments, it was often at points of contact and presumed similarity, that differences were most obvious. The quilt is a metaphor, for what de Certeau writes is a:

System of spaces [that] result from the operation of distinctions resulting from encounters ... [where] bodies can be distinguished only where the "contacts" ("touches") of amorous or hostile struggles are inscribed on them. This is a paradox of the frontier: created by contacts, the points of differentiation between two bodies are also their common points. Conjunction and disjunction are inseparable in them ... the frontier functions as a third element. It is an "in-between" — a "space between".

(de Certeau 1984, p126)
Interlude One

Differences only arise in points of contact, in the overseas doctors’ adjustments to the new environment. They are found in stories that tell of these conjunctions and disjunctions. Thus the thesis is shaped out of ‘fragments of trajectories and alterations of spaces’ (de Certeau 1984, p93). Gaps are found in the awkward silences between colleagues, in sections left blank on forms, in the empty spaces in the hospitals and in the thesis interludes. The interludes between the chapters also serve to embroider each section together.

... within a musical note a “micromelody” can be picked out and the interval heard is merely the final patterning of a certain tension felt throughout the body ...

(Merleau-Ponty [1945] 2008, p245)

Figure 2: Gaps and connections
I listened to the sounds of foreign cities and towns as I cut out the patches for my quilt. When I sewed them together I played back these aural memories in the same way I listened to moments of captured soundscape on digitally recorded interviews and in the same way I looked at a photo montage of empty ethnographic sites (see Interlude Six). Anthropologist Kirsten Hastrup writes that fieldwork experience is memory before it becomes text (Strathern 1991, p48). Sewing the yo-yo quilt I also had embodied memories of past places and experiences and sensations. My hands used a surgical knot learnt in medical school to tie off the cotton threads and stitches learnt from my mother. With knots and ties the quilter sews the quilt together, interweaving what they find that comes to hand, the quilt evolving out of the past. These embodied memories, both of the overseas doctors and my own, constitute an ongoing perceptual engagement in the field, of situated adjustment.

The quilt, and quilting, is a form of ‘material thinking’ (Carter 2004), metaphorical for both the structure of the thesis, the nature of the research process and the stories of the overseas doctors. The quilt as metaphor allows us to ask questions in new and interesting ways, questions about the ecological nature of adjustment that may be visualised in thread-like (Bowker and Star 1999, p316) or quilt-like terms, such as: what ties are there to this person? Are the threads between past and present knotty or smooth? Where do the tensions lie? Do patches complement or contradict? What are their points of contact and difference? What is the texture, the colour of the doctors’ practice? How do the overseas doctors become wrapped up in their new environment? Can we understand this process as incomplete and never-ending? How can we better design programs for overseas doctors that allow for this incompleteness, that use materials that come to hand? These questions are quilted into the remaining chapters, some tied off, others remaining open.
Chapter Two: Research Methods

Doing ethnography is about patching together found objects, little observations and scraps of half-heard conversations (Strathern 1991, p10) to make a story. You have to be on your toes, taking it all in, ready for anything. This chapter is about the crafting of the research story that has materialised into this thesis. It is the chapter where I am most prominent as researcher, though I am never too far away from any of the stories in the rest of the thesis; I do not make myself invisible. I am part of the context in which the stories are framed, for there is an interaction between what I observed and myself as observer (Law 1994, p4). This chapter ‘sets the scene’ in terms of the research methodology. It also sets the scene for the empirical and theoretical study of adjustment, for undertaking ethnographic research was an ongoing process of embodied, situated learning with participants, another mode of adjustment. The chapter first outlines the physical setting of the research, and then proceeds to a more detailed discussion of fieldwork methodologies.

The setting: the hospitals

The hospitals where I spent one year doing ethnographic fieldwork, Hospitals X, Y and Z, can be found on the edges of the grey stain that represents Melbourne on a Google satellite map. These are not peripheral city slums of the kind that urban theorist Mike Davis (2006) details in larger megalopolises such as Lagos and Manila, but rather the rim of a sprawling suburbia inhabited by young homeowners, retirees, recent and long-term migrants and refugees. Within this fast growing outer-metropolitan assemblage are towns with vegetable markets, halal butchers, newsagencies selling Indian newspapers, two-dollar stores, and Sudanese restaurants where inner-city dwellers might venture after reading a review in the local newspaper The Age.

I was deposited in this suburban periphery, like many of the overseas doctors I spent
time with during that year, by half-read-newspaper-littered trains, which had wheezed by inner city streets lined with cafés, then rows of small flats with small backyards, then factories with broken windows and large empty car parks. Depending on the fieldwork location I then either walked to the hospital or caught a bus. One town had a courtesy bus that went from the train station to the hospital, stopping at the local fruit and vegetable market on the way. Dr Surekha Sadafule told me that the rumbling vehicle with its peeling plastic seats made her feel homesick for India. On the bus you knew when you were starting to near the hospital, as radiology and pathology services appeared nestled amongst residential buildings. Then the doctors' private rooms, with their waiting areas plastered with framed certificates from universities, colleges and laparoscopic courses, started to come into view and you were getting even closer.

Each of the hospital buildings (it could have been any of the three where I did fieldwork) lay in the middle of all of these private rooms, markets, radiology suites, bitumen schoolyards and takeaway food stores. Stepping inside the sliding glass doors of the main entrance, the stale-clean smell of the hospital hit you immediately. There was a foyer, a reception desk, waiting chairs and a public telephone. A large sign listed wards and departments, a detailed floor plan positioned below. An overhead announcement might have crackled with news that grand rounds were about to start in the main lecture theatre. Cappuccino odours wafted from the new café, slightly disguising that more pervasive smell that understandably disturbs many visitors and becomes part of the daily oxygen of the doctors, nurses, cleaners and theatre technicians that inhabit hospitals.

It was a setting that for many overseas doctors was simultaneously familiar and strange; what I call, following from cultural geographer Nigel Thrift (2004b, p585), the ‘unknown familiar’ or ‘familiar unknown’. The overseas doctors had spent years in hospitals; they were places where they felt ‘at home’. The new hospital settings were also unsettling, however, because although they looked very similar to those they had studied and
worked in before, there were local peculiarities, slightly different ways of doing things.

When I first started fieldwork in February 2007 I remember being struck by the air-freshened-slightly-sickly smell of the hospitals, this smell which I had been unaware of when I was a medical student or intern. Like the overseas doctors, I had a certain degree of familiarity with hospitals before I started the research. I knew how to scrub and stand in theatres, how to walk through doors during ward rounds (consultant always first), the names of the diseases and treatments and tests routinely ordered. However it had been some years since I had done clinical work and I was not entering the hospital as a doctor but as a graduate student ethnographer, a novice anthropologist. Thus, like the overseas doctors, for me the setting was one of partial familiarity and simultaneous newness.

Ethnographers conventionally narrate the setting of their fieldwork to help locate the author and the reader in a world that was initially strange, allowing the author to then render it comprehensible to the reader as it became familiar to them in the process of doing research (Kondo 1990, p7). However, as outlined, in this case the setting was not completely unfamiliar and there was a lot about the research setting that I found myself taking for granted. There were little practices that I was not aware that I knew until I spent time with the overseas doctors. For example, in some early fieldnotes from my time with Dr Pham Ba Hung, a middle-aged doctor from rural Vietnam who had spent his first years in Australia working in plastics factors (with the scars to show for it), I wrote:

*I'm standing with Pham in the operating theatre corridor. A man and woman in scrubs appear, wheeling a humidicrib [see Medical Glossary] with newborn baby. Presuming one is the midwife and the other the father, I instinctively said congratulations to the father. Pham was surprised and asked me how I knew that it was the father. He had only recently learnt that fathers could go into the operating theatres during caesarian sections.*
Chapter Two

(Fieldnotes)

Put simply by STS scholars Geoffrey Bowker and Susan Leigh Star (1999, p291), ‘people often cannot see what they take for granted until they encounter someone who does not take it for granted’. This incident in the operating theatre corridor was a kind of epiphany (Kondo 1990), one of those experiences that ruptures routines and provokes redefinitions of the self (Denzin 1992, p26). It was a moment that enabled rich insights into the research. The challenge, I realised, would be to take apart my tacit knowledge, that which had become so self-evident and habitual, it seemed natural (Sennett 2008, p183). It dawned on me that as I was trying to heighten my anthropological imagination, stopping taking things for granted and attempting to see them ‘afresh’ in a slightly familiar setting, the participants in the study were trying to lose their sense of anthropological strangeness (Bowker and Star 1999, p299) of a place which they also found slightly familiar.

A brief introduction to methods

Undertaking ethnographic research is a remarkably similar process of situated adjustment that I have argued is central to the story of the overseas doctors. Ethnography arises from ongoing learning in the environment from participants. Fieldwork involves a continual threading from past ideas, experiences and arguments, to newfound encounters and suppositions, and back again. Anthropologist Marilyn Strathern (1991, p54) writes that ‘people are always expanding and contracting ideas that they already hold – substituting old for the new’. Ethnography has similarly been described by another anthropologist Liisa Malkii, in her methodological study of an email correspondence between supervisor and student, as:

A continual ‘tacking back and forth’ between the familiar and unfamiliar, the plan and its execution, theoretical insights and surprising empirical
discoveries ... with false starts, adjustments of research questions, mistakes, and surprises along the way ... it is processual.
(Malkki 2007, pp183 - 185)

The research question for this project was continually adjusted, this readjustment ‘on the fly’ being characteristic of qualitative research methodologies such as ethnography, which is open to realisation in the field. Theories are developed through the participants’ practices, which direct the focus of the research. In this chapter I provide detail of how I undertook such ethnographic research in the hospitals and continually analysed the results, at the same time enabling a better understanding of adjustment that enriches the overall thesis argument from a reflexive, methodological perspective.

In the following sections I outline the participants in the research and stages of recruitment, then describe how I spent my time with these doctors. Methods of observation, participation, recording fieldnotes, interviewing and taking photographs are then discussed. Finally the analytical approach taken is detailed with further reflections upon my role in the hospital as researcher.

Participants

As mentioned, this research took place in hospitals in Melbourne’s peripheral suburban fringe. This is the location where a large majority of doctors with overseas qualifications were, reportedly, working in hospitals in the state of Victoria, Victoria being one of the three most popular migration destinations for doctors in Australia (Hawthorne et al. 2007, p22). Fieldwork was arranged after a few false starts, upon being introduced to an overseas doctor in a Melbourne hospital network who was excited about the research. As the Director of Clinical Training of International Medical Graduates in the network, he was able to sponsor the research. Consequently ethics clearance was obtained through the hospital ethics committee (for participant information and consent forms see
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Appendix).

The first stage of recruitment involved the Director of Clinical Training identifying all overseas doctors working in the hospitals in the network covered by ethics clearance. Overseas doctors were defined as doctors who had obtained their medical qualifications outside Australia or New Zealand. I initially approached all potential participants by email, following an introduction from my sponsor. I introduced myself, the project and asked them to contact me if they were interested in taking part in the research or wanted to discuss matters further. I then met individually with approximately ten interested doctors, talked about the project with each of them, especially in relation to what involvement could possibly entail. Participants took a consent form (which they signed and returned the next time we met) and we arranged a convenient time to spend together according to their rosters and my fieldwork schedule.

During fieldwork I continued to page overseas doctors and loiter in cafeterias and common rooms, where I was open to possible opportunistic conversations that might lead to further interactions with overseas doctors. I also deployed a snowball recruitment technique where, as the fieldwork progressed, participants would introduce me to other potential participants. An emergency department registrar introduced me to most of her colleagues ‘on the floor’ as possible recruits. In an operating theatre I began a conversation with one of the technicians who then introduced me to a technician in the neighbouring operating theatre who had worked as a general practitioner in Burma. Over time I also randomly met more overseas doctors working in the hospital, who were visiting patients, studying in the library or meeting socially in the cafeterias.

Recruitment was essentially an open process with little targeting in the initial stages. However, as the fieldwork progressed, and themes started to arise, I approached some overseas doctors directly for participation, with the premise that their stories could
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enrich emerging ideas. The best example would be that as the focus of the project swung towards the nature of adjustment, I realised that I needed to talk to overseas doctors who had been in the system for 'some time', who were at later stages of adjusting. So I sought out overseas doctors nearing retirement, in the private rooms scattered around the hospitals. Similarly I needed to talk to overseas doctors who were at the very initial stages of being involved in hospital work, which meant that I searched for doctors participating in orientation programs in the hospitals. These were recruitments based on the doctors’ practices and stages of adjustment rather than demographic details such as age, gender or nationality, so were, in essence, a form of theoretical sampling (Charmaz 2006, p96).

The descriptive details of participants collected throughout fieldwork were recorded progressively in an Excel spreadsheet (see Appendix). To summarise, of the 34 overseas doctors I spent a significant amount of time with, 24 were male and 10 were female, reflecting (without aiming to represent) the gender distribution of overseas doctors in Australia of 2:1, male: female (Hawthorne et al. 2007, p83). The range of nationalities of the doctors was: Indian (6), Sri Lankan (5), Iranian (4), Romanian (3), Bosnian (2), Burmese (2), Iraqi (2), Chinese (2), Russian (2), British (2), Malaysian (1) Australian (1), South African (1) and Vietnamese (1). Once again, these reflected, without intention of representation, the array of countries of origin which have been recorded amongst large numbers of overseas doctors (where the top ten of the 139 source countries of AMC medical candidates in Australia at the time of the study were India (13.5%), Sri Lanka (7.9%), Egypt (6.6%), Bangladesh (5.2%), China (5.1%), the UK (5.0%), Iraq (4.3%), South Africa (4.3%), the Philippines (3.8%) and Pakistan (3.2%) (Hawthorne et al. 2007, p113)).

All doctors who participated in this research had received their primary medical qualifications in their 'country of birth', with the exception of a Sri Lankan doctor who had gone to medical school in the Czech Republic and the Australian doctor who had been educated in Ireland. Over two thirds of the doctors had worked in one country
before arriving in Australia (not necessarily their country of training), seven had worked in two other countries, and three had worked in three other countries before Australia, echoing the hypermobility which Hawthorne, Hawthorne and Crotty (Hawthorne et al. 2007, p7) have documented. The amount of clinical experience the doctors had prior to arrival ranged substantially from doctors who had had no prior experience to those who had worked for 30 years in a specialty. Prior specialties included paediatrics, obstetrics, general practice (GP) and ophthalmology. Declared religious affiliations included Islam, Christianity, Judaism, Baha’i, Hinduism and Buddhism. In the hospital, doctors were mostly employed at a HMO level (12), a liminal position between HMO and registrar (3), a registrar level (7), another liminality between registrar and fellow (3), or as a consultant (2). One participant worked as a venepuncturist and another as a researcher, the remaining participants not being employed. The length of employment for doctors working in the hospital ranged from three weeks to 40 years.

When I started to review this completed Excel spreadsheet, the categorical complexity of the doctors I had spent time with appeared overwhelming. Traditional sociological/anthropological categories, markers of identity, such as nationality, language, gender, age and religion were densely interwoven; and these were just the categories I had recorded. Specialties expanded into length of experience in that specialty which expanded in geographical directions. It was in recording these differences in categorical ways that I had to start dismantling them as descriptions of difference.

This led me to consider the overseas doctors’ difference in the non-categorical ways I described in Chapter One. For some time now, there has been a move in the social sciences away from categorising research participants in a reductive manner. The singularity, separateness and wholeness of a range of social categories have been questioned (McDowell 2008, p501). Feminist researchers are at the forefront of dealing with the limitations of single analytical categories. Many have embraced
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'intersectionality', the awareness of relations along multiple dimensions, modalities and subject formations (McCall 2005, p1771). There are various ways of approaching intersectionality methodologically, such as through poststructural ante-categorisation or through an approach that addresses inter-categorical, or intra-categorical complexity (McCall 2005). Overall there is awareness in most literature on intersectionality, and related topics, that contemporary subjects have multiple identities that are fluid, fragmented and malleable. In this thesis I focus upon how differences and multiplicities are enacted in practices, as observed during fieldwork and spoken about in conversations.

Fieldwork

How did I spend my time with these overseas doctors? In classic anthropological style I would essentially ‘hang around’ with them most days of the week, for a year. Equipped with a small bag stuffed with notebook, pen, consent forms, coins for coffee, digital recorder and short articles to read, I would pace with them on ward rounds, sit next to them during administrative tasks, follow them into meetings and seminars and grab lunch and coffees together. I hurried around with participants on surgical, medical, rehabilitation, neurosurgical and paediatric wards, in and between corridors, emergency departments, outpatients’ clinics, chemotherapy day units, staff rooms, outdoor eating areas, resident lounges, cafeterias, operating theatres, radiology departments, cafes and tutorial rooms. I watched what the overseas doctors did and listened carefully to what they said to me, and to others. Sometimes I was present, with or without an audio recorder and other times I overheard conversations as I watched their shadows on the walls.

The length of time I spent with each participant in the hospital varied according to what they and I considered appropriate. I spent at least five working days with most participants and less with others. I also spent time with groups of overseas doctors in
the hospital libraries and cafeterias. On the wards I tried to give participants space when I felt that they needed it, but kept close to them throughout most of their working day. I watched. I listened. I made notes. Sometimes I could sink easily and comfortably into the observer's role. At other times I was brought out of reflective reveries by observant consultants in ward rounds or in a tutorial when the tutor joked that I would be the next role-player (when I felt the rush of adrenalin and blood to my cheeks). I negotiated each situation separately, deciding when it was appropriate to make notes or record conversations, and when it was not.

Periods of fieldwork with the participants were never discrete. The overseas doctors' lives criss-crossed within the hospitals. On a speedy ward round with Dr Hossein Youssefian, the mathematician who realised he wanted to stay in clinical medicine after volunteering at the earthquake in Bam, I went to the ED where I saw overseas doctors from an evening tutorial completing patients' notes. I had lunch with Dr Pham Ba Hung in the residents' lounge where I ended up in conversation, unknowingly, with Dr Surekha Sadafule's husband. Dr Elena Radulescu read the notes that Dr Hossein Youssefian wrote one evening about a patient with epilepsy, when he was a neurosurgical resident. Instruments and forms exchanged hands. Spaces within the hospital were crossed by different participants, hours, weeks, months apart, highlighting the co-existence of multiple worlds in the hospitals. Following the overseas doctors in the study closely revealed how the hospital was socially connected, how the relations were loosely intertwined, how multiple pathways collided and intersected.

There were never clear boundaries between the observer and the observed (Clifford and Marcus 1986; Tyler 1986, p126). I watched doctors. Doctors watched me. Doctors watched each other. Roles switched constantly. Others watched the doctors and watched me; we were all being watched by CCTV! One day I went into the operating theatre and a technician asked if I was lost previously that day because they had seen me cross the car park from the glass windows of the operating room on the third floor.
Before an evening tutorial, doctors new to the assessment process would go into the library to observe how other overseas doctors studied. In the tutorial itself, doctors were appointed as observers, to critique each other’s performances (which I also observed). In many ways the overseas doctors were ethnographers of the system that they entered, a critical point that I raise again in Chapter Nine in relation to the potential outcomes of this research.

Although principally an observer, I also participated in ward life. I helped doctors by opening packets when a stitch was needed for a drain, for an arterial line (see Medical Glossary) insertion in the ICU or ED. I brought up blood results on the computer, put stickers on X-Ray forms, took a photo of a newborn baby in the obstetrics OT, helped with log rolls and held a wound closed whilst a doctor put glue on a child’s forehead (panicking when my fingers started to get stuck to the infant’s flesh). I tried to establish important things, like finding out which nurse owned which mug before making myself a cup of tea. I worked out how to use the free coffee machine, which became integral to my escapes from the wards. I got written into the scripts of the hospital, becoming a ‘member of the team’ in some units, written literally into medical notes in another. Before ward rounds a consultant might ask who I was, sometimes with the raise of an eyebrow, nod and then move on with the business at hand. There were places where I did not blend in so easily, such as the Administrative offices or in the small consulting rooms when we ran out of chairs and I needed to stand up near the bed, hovering conspicuously over the consultation. Once again, I negotiated my role in the hospital from moment to moment, deciding what was appropriate ethically and practically at any one time.

I recorded my observations and notes from conversations in a notebook, chosen with much consideration after consulting with other students in my department doing hospital ethnographies. I did not always feel comfortable taking the notebook out and sometimes never did, other times waiting ten minutes or so before asking if it was OK.
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tried to record my notes on the wards quickly, ducking into toilets when necessary. Sometimes I would retreat from the chaos of ward life to the relative quiet of the cafeteria to write notes whilst drinking a free coffee. When I got home at night I expanded on these brief notes and sketches and made longer entries on a laptop. When making notes I literally followed the action of the doctors and paid attention to the practicalities of their work including the places in which they dwelled, moods or atmospheres, the objects they used and the people they interacted with.

As a result, the fieldwork site was not easily delineated. The setting of this research - the environment, the system, the ethnographic field - started with three hospitals, and soon spread out to private doctors' rooms, libraries around the city, concert halls, trams, trains and train stations. Like the system, the research context was far from being a contained, restricted, bounded site. Branching out and following the action reflected, reinforced and created this openness (Law 2004). This is the 'reiterating' nature of doing qualitative research, where categories, fieldsites and context are constructed both by the researcher and the researched (Goodwin et al. 2003, p576), each observation reiterating the next as the researcher becomes sensitised to developing themes (Crang 2003; Law 2004).

So far I have outlined how fieldwork revolved around overseas doctors, which was my intention in the field. In spending time with participants I was following their social relations. I also spent time with their colleagues and the patients they saw during their working day. I encountered and interacted with other overseas doctors, ward clerks, locally trained doctors, personal service attendants (PSAs), medical students, interpreters, nurses, security guards, pharmacists, physiotherapists, cleaners, theatre technicians, HMO managers and the pastoral care team. They were all part of the overseas doctors' social relations revealed during fieldwork. Also intertwined in their work were texts such as information sheets handed out during tutorials, referral forms, CT scans, discharge scripts, posters on the walls, photocopies of past exam papers,
textbooks, PowerPoint presentations, emails, Internet sites and picture books from Iran. In amongst all of this were also Styrofoam cups, mobile phones, cannulas (see Medical Glossary), doctors’ bags and wheeled suitcases, free lunches sponsored by drug companies with pens and tissue boxes, palm pilots, pagers (see Medical Glossary), computers, catheters (see Medical Glossary), mocha coffees, microwaves, chairs, photocopiers, curries and family photo albums. These were part of the overseas doctors' new environments and rather than being the background for activity, they were all elements of interaction, all of theoretical and empirical interest.

This list of relations includes both the human and non-human, in fitting with the ecological perspective that frames this thesis. Inspired predominantly by actor-network theoretical (ANT) approaches, my method was to take each relation that I encountered in the field as it presented itself, rather than pre-assuming what might have been important, or what people/things/places might represent. ANT recognises that objects, technological and otherwise, are also woven into the sociomaterial fabric (Conradson 2003, p1982), that social relations are heterogeneous. ANT is post-structural and semiotic, telling stories that have to do with processes that erode the micro and macro distinction (Law 1994, p18). This is seen to be ‘a more open, heuristic approach to analysis that allows “things”, as and when they arise, to offer theoretical possibilities’ (Henare et al. 2007, p2). ANT asks, what are the conditions or circumstances of practice (Clarke and Fujimura 1992, p17)? When talking about why it is important not to define in advance what sort of social aggregates are studied, sociologist of science Bruno Latour (2005, p32) argues that this is the very constant task of the actors themselves: ‘actors do the sociology for the sociologists and sociologists learn from the actors what makes up their set of associations’.

These approaches consider humans and non-humans in symmetrical relations, where neither is privileged and everything can be analysed in the same terms (Law 1994, p12). However in this thesis I privilege the human actors and they take stage as the central
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actors. I follow from some scholars in STS who recognise that agency is distributed differently at times, and that the accountable human actor can challenge symmetrical accounts (Mort et al. 2005, p2036). In this thesis I am most interested in the ways in which the overseas doctors adjust, in the ways in which they negotiate their environment as human subjects. Thus this thesis is centrally about people with stories, people struggling with all sorts of differences in the hospital. Actor network theory remains important in illuminating many aspects of this adjustment, with other theories in the chapters used at points of contact, leaving gaps as well.

In following the action I tried to pay attention to the sensory dimensions of practice, of the environment not only visual and verbal but also the tactile, acoustic, olfactory and kinaesthetic. How something feels, looks or sounds are the important textural subtleties one needs to be attuned to when learning (Ingold 2000, p416). Paying attention to these sensory modalities often revealed aspects of the environment I had previously taken for granted. The smell of the hospital is one example. Another is a momentary auditory tuning into a ward which revealed intravenous [IV] drip machines beeping in the room behind me, indicating some tubing was blocked, with several patients’ buzzers sounding in tandem. I noticed these sounds, but at the same time realised that as fieldwork was progressing I was becoming more immune to these hospital noises.

Interviews

During the course of the fieldwork I conducted interviews. In many instances these were more like coffee room or corridor conversations (Long et al. 2006), captured during an available moment in the day. On other occasions the interviews were more traditionally ‘sociological’, pre-arranged with a digital tape-recorder and question guides. The reason for conducting these more focused, lengthier interviews, was to tease out, in a relatively unstructured way, aspects of the overseas doctors’ practices which had been highlighted during fieldwork or comments they had made about their
work. All of these interviews and conversations took place in English, and as English was the second or third language for many of the doctors, they were translations in many senses of the term.

There is a mixed acceptance of the place of interviews in ethnographic research. Some researchers find them inadequate (Becker et al. 1961, p29), and others view its methodological weakness tied in with the interviewees’ possible need to provide an official account (Hoffman 2007, p33). Interviews are also argued to decontextualise topics of discussion around the research event rather than focus upon everyday practices (Nespor 2000, p562). Mindful of this, in using interviews as part of a research project concerned with practice, I have mainly paid attention to participants’ stories of what they did. Mol (2002) refers to this as treating participants as their own ethnographers.

I conducted 13 digitally recorded, semi-structured interviews with doctors who had become key participants, either through the amount of time I spent with them or through a certain level of insight they had into their practice. Several of the interviews took place relatively early in the research, though the majority of recorded interviews occurred towards the end of the fieldwork. These interviews were based on interview questions derived from an analysis conducted from the first six months of fieldwork data. Interview questions were adjusted between and during each interview, taking into account the participant and the setting. One overseas doctor asked for the question guide ahead of time and spoke from a page of scribbled prepared notes. I tried to pay attention to the participants’ and my own subtle shifts in emotion and tone during the interview (Hoffman 2007, p339). I noted the settings, the offices decorated with framed certificates, the shopping mall on the first day of spring, the soft carpet in the Administration building. I wrote fieldnotes after each interview and for those that were digitally recorded I transcribed a written text for analysis. As I transcribed the conversational material I also listened to other soundscapes captured on the digital file.
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These were sounds of the hospital: the Code Blue warning bleeps, nurses asking for drug chart rewrites, cafeteria chairs scraping on the easy-to-clean and often polished linoleum floor, and coffee machines in the newly installed cafes. The sounds, rather than being distracting noise, helped me to analyse interviews taking place, evoking the fieldsite for me once I was home or in my university office space.

Photography and other data

After a couple of months of negotiation with the hospital public relations department, I returned to the hospital with a photographer who took photographs of places in the hospital inhabited by overseas doctors. We decided that nighttime would be the best time in the hospital considering the relative sparseness of staff and visitors (for we had not wanted to include any people in the photographs for confidentiality reasons). This seems quite fitting in reflection, considering that overseas doctors work more after-hours shifts than their local counterparts (OECD 2007, p199) and maintain a peripheral location on the margins of the local medical profession (as discussed in Chapter Three). An interest in photographing empty spaces in the hospital previously inhabited by the overseas doctors had also arisen from an awareness of how the overseas doctors, particularly those not employed by the hospital, used fringe places in creative and adaptive ways (explored in Chapter Six). The absence of people and the late-night ambience made many of the places that were photographed appear even more evocatively peripheral.

These photos were initially taken as a way to evoke the fieldsite in aesthetic ways for research presentation and to help aid analysis after leaving the field. However their function evolved during the project. Alongside other material collected during fieldwork, such as notes and diagrams scribbled on the backs of envelopes by doctors or pamphlets and brochures, the photos became another text that added layered meaning to the research story. The photographs revealed minutiae of the fieldsite, seen through
the photographer's eyes, that I had missed during fieldwork. It was another of the multiple ways of reading the site.

Through their absence from the photographs, the overseas doctors' presence also seemed to be more evocatively portrayed than through the fieldnotes. There was simultaneously a decentering from the humans and a focus instead on the non-human aspects of the overseas doctors' practices, such as their study tools, the places they worked and the paperwork that made up their environment. The photographs allowed an oscillation between subjectivity and objectivity that added depth of understanding to the adjustments that the overseas doctors were making in the hospital. These photographs appear in Interlude Six as a photographic essay of meeting places, places of pragmatic usefulness, of memory and belonging; places imbued with affective layers that were hard to capture in words.

As well as the photographs taken specifically at the fieldsites, there are other visual materials which are quilted throughout the thesis. Photographs from a National Geographic Magazine and the World Health Organization appear in Chapter Four and Chapter Six. Architectural sketches highlight the open, fluid nature of buildings (Chapter Six) and sketches of instrumental procedures point towards the limitations of learning practice from diagrams and written material (Chapter Seven). As well as visual material, the thesis is littered with quotations from fiction, often capturing, like the photographs of the hospital, affective, emotional, sensory dimensions of adjustment that social scientists have difficulty describing.

**Analysis**

The undertaking of analysis was a multi-staged, evolutionary, process. In the beginning, during the first year of research, I made incredibly neat diagrams and flow charts of organisational structures, migration patterns and assessment processes. As an example,
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I had drawn a world map from my research on the international migration of doctors, that charted the results of numerous quantitative studies on ‘mobile medics’ (Jinks et al. 2000), doctors becoming arrows making their way across an abstract, flattened cartographic landscape. This ‘view from nowhere’, made up of moving traces in the forms of arrows (Law 2002, p24) looked so neat. The numbers did not match, a lack of ‘comparative’ data and ‘reliable’ statistics often noted to be lacking in this area (Organisation for Economic Co-Operation and Development 2007, p162), but the map seemed to plot a mesh of global trajectories within which I felt the participants I was about to meet would be situated.

![Figure 3: Mapping the research](image)

I began fieldwork with an analytical focus on professional or occupational identity. I was initially interested in how the overseas doctors negotiated their roles within the medical establishment and how they coped with their new circumstances. I based my pre-fieldwork writing on the assumption that migration would prove to be a significant point
of interruption or reassessment of identity in a doctor’s career. I was concerned with both an individual sense of medical identity, and a collective identity that I assumed would be fostered by social interactions between overseas doctors in the hospital. Similarly I was interested in how the overseas doctors’ identities would be shaped through interactions with their colleagues and patients.

Once in the field however, it soon became evident that the overseas doctors’ identities as medical professionals were tied up with their practices, and that their negotiations of hospital life were largely pragmatic, involving a vast array of social relations. The ways in which participants negotiated their new surrounds were inherently practical. I began to focus more on what participants did and less upon a psychological sense of self. I focused on how participants’ medical work was ‘enacted’, what their medical work was ‘made up of’, rather than on what they thought about their medical work.

Subsequently, I was very quickly ‘dazzled’ (Law 2004, p107) by the many practices and social relations I encountered, that were not so easily mapped two dimensionally. The field seemed filled with what appeared to be ‘limitless possible realities’ (Law 2004, p110). At the early stages of analysis in the field I was swimming in the joy of these complexities and thrill of being amongst the action, a little like Blue, the protagonist in one of novelist Paul Auster’s postmodern detective stories:

Blue keeps looking for some pattern to emerge, for some clue to drop in his path that will lead him to Black’s secret. But Blue is too honest a man to delude himself, and he knows that no rhyme or reason can be read into anything that’s happened so far. For once, he is not discouraged by this. In fact, as he probes more deeply into himself, he realizes that on the whole he feels rather invigorated by it. There is something nice about being in the dark, he discovers, something thrilling about not knowing what is going to happen next. It keeps you alert, he thinks, and there’s no harm in that, is
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there? Wide awake and on your toes, taking it all in, ready for anything.

(Auster 1999, p229)

Of course I was not completely ‘in the dark’ for I had a range of theoretical frameworks which were guiding my collection of data. Ethnographic research is theoretical from the start, with continual questioning about the categories of enquiry. Fieldwork is a continual threading between observation and accumulated evidence to theoretical moulding and back to collecting data again (Bronislaw Malinowski cited in Cerwonka and Malkki 2007, p172). It is a continual process of adjustment. The researcher moves constantly back and forth between newfound understandings and older theoretical insights and questions, new methodological ideas and older ones, rhythmically threading back and forth as the overseas doctors did, between the past and the present.

As the analytical process progressed, I took various breaks from fieldwork to more thoroughly analyse collected data and to make further reconsiderations of the direction of the research. After six months I engaged in more detailed analysis, handwriting notes along the pages of fieldnotes and tabulating these thematically. I returned to the field to elaborate on these themes, with concepts also forming the basis of my interview questions. The direction of analysis had expanded from where it began, but was also becoming somewhat refined. I began to read more theoretical work underpinning emerging concepts, oscillating between academic texts and the data as ideas emerged. It was a process that continued throughout the writing of this text. The data and theory started to resonate and amplify each other to produce more patterns (Law 2004, p111). Sideways bubbles formed from which I wrote articles or conference presentations. Sometimes these helped develop my ideas, other times ‘forcing’ an analysis too early, the idea falling flat. At one stage I presented to some of the participating overseas doctors in a feedback session, during which we discussed emerging ideas and they gave me further suggestions, which helped to strengthen the argument presented here.
One body of literature I kept returning to was the ethnographic study of medical practice in science and technology studies. Practice has been a consistent and growing focus of study in this field. In STS, descriptions of medical practice routinely revolve around clinical work. Practices such as surgical procedures, administration processes, pathology specimens or microbiological instruments are examined. In my analysis however, after extending my initial limited assumptions regarding the nature of the overseas doctors’ social relations, I found that I was encountering a field of medical practice much broader than that usually used in STS to define medical work. Ethnographically following the overseas doctors’ practices revealed aspects of their medical work that were non-clinical in that they bore no relation to patient care. These practices may have revolved around negotiating registration requirements or studying for examinations, concerning doctors who were not employed in the hospital yet inhabited its peripheral spaces. They were practices unrelated to a patient, yet fundamental to overseas doctors’ identities as medical professionals and to their processes of adjustment within the Australian system.

What emerged through analysis therefore were aspects of a broadly defined ‘system’ that overseas doctors both described as being important to their adjustment, through descriptions of their practices, and aspects of medical work which I observed as being important to their adjustment. This list could have been longer, including ethical frameworks, gender relations or computers for example, but these themes did not appear so prominently in the field. Aspects of the system focused upon in this thesis were part of a system that locals took for granted, yet which were made more obvious in the doctors’ stories and negotiations as newcomers. Each part of this patchwork system forms a chapter that connects to other surrounding chapters, never completely separate. The chapters have also been chosen because they worked well to explore the different ways that each overseas doctor had of negotiating their new environment, enabling a more detailed exploration of modes of adjustment. They were aspects of the system remarkably neglected in the participants’ formal training and orientation. Thus,
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through a number of evolving analytical choices, I moved from my initial research focus on identity to examine the practices involved with registration, paperwork, assessment, buildings, tools and people.

Incorporating this diverse array of social relations meant that I utilised a ‘situational analysis’ methodology incorporating both the human and non-human aspects of a situation, as well as my own experiences as a researcher as one among many of multiple worlds (Clarke 2005, p13). Diversity can also be found in the range of materials analysed, as I have incorporated ethnographic fieldwork and interview data, as well as photographs and tables, maps, illustrations and architectural sketches. In Chapter Five I insert several quantitative boxes which contain a quantitative story that is sometimes the same, sometimes different, always similar to what is written in the body of the text. These are little moments of interference and juxtaposition, that hopefully opened up further questions (Law 2002).

Often in sociological and anthropological writing, when seemingly ‘different data’ such as qualitative and quantitative material is put together, it is often used as a form of triangulation, as a way of making singularity from various data sources (e.g. Hoffman 2007, p330). For example, ethnographer Vered Amit (2000, p12) argues that, as a methodological approach, participant observation is characterised by many absences that can be acquired through interviews, archival documents, artifacts and media materials. However, I agree with Law (2004, p9) who argues that this wrongly implies a ‘set of discoverable processes out there’, and that rather, these different texts highlight the multiplicities of the object of study.

Insights from both human and non-human centred approaches can spark new insights in their connection as suggested in Chapter One and Interlude One. However, as geographer Hayden Lorimer (2005, p88) warns, care must be taken in this approach that the diverse assemblages of objects, technologies and practices are not given a flattened
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smear of equivalence. In this thesis I recognise that there are irreducible differences between approaches required in the analysis of observations of relations with people and with instruments (Mol and Mesman 1996, p437). Rather than a weakness of analysis however, I regard these differences as a strength of the research, as a way of emphasising the multifariousness of a system to which the overseas doctors are adjusting, as well as the many modes of adjustment. During analysis I tried to be mindful of how different social relations and different approaches could add richness to the argument. For, as Law (2002, p191) argues, I believe that by putting different social relations and data sources together and oscillating between them, moving from one narrative to another, there is more of an imperative to look for gaps and ambiguities that contribute to a way of knowing about things. This highlights the prospect that there are different and valid knowledges that may not be centered or necessarily coherent (Law 2002, p197).

A few notes on reflexivity

To speculate, from the Latin speculatus, meaning to spy out, to observe, and linked to the word speculum, meaning mirror or looking glass. For in spying out at Black across the street, it is as though Blue were looking into a mirror, and instead of merely watching another, he finds that he is also watching himself.

(Auster 1999, p216)

Ethnography is a long, meandering, social and temporally situated activity in which the researcher is inextricably embedded in participants’ lives (Cerwonka and Malkki 2007, p177). Identity boundaries blur, just as the fieldsite borders do. Whilst many participants saw me as a researcher and some called me a friend, others identified me as a member of the local system.
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I think because you are also from this system and you start as a medical student here quite young, and so you think that everyone would think that they are superior, but if you come from a different area then you know what actual hierarchy is and then you would know that it is nothing here.

(Dr Surekha Sadafule)

As Dr Surekha Sadafule highlights, many overseas doctors saw me as someone who knew the local ways. Whether this was as a previously trained local doctor or as a locally situated person was not clear. A lot of doctors responded specifically to me as a researcher, having done research themselves (see Interlude Eight), respecting the process. Participants often introduced me to others in the hospital as a ‘doctor doing a PhD’. Regardless of how they identified me, I have no doubt that my local-ness in the system, my past as a doctor, were some of the reasons that many overseas doctors allowed me to spend time with them. For, as anthropologist Michael Herzfeld (2009, p137) points out, there are obvious and subtle ways of connecting to participants in this way, of ‘signaling that one is a virtual insider in the midst of a public space ... (a) most effective way of achieving the necessary rapport’. I am also sure that these are some of the reasons that several doctors did not want to spend time with me.

My position as a researcher within the hospital was constantly adjusted, simple things such as my identification badge being pragmatic compromises. On my first day in the hospital, I went to security to get my prerequisite badge assembled. In the cramped room filled with television screens, the security guards played on the computer with my image and then went to find a label. They asked, if I was a medical student? No. A doctor? No. I asked if they had a label of researcher, and they could only find research assistant. So I settled on student. An ethical decision about how I would identify myself which I had laboured over prior to fieldwork was resolved within a couple of mouse clicks in that cramped room.
In these initial phases of fieldwork I found it difficult to identify with any position clearly. I felt lost. Here is an excerpt from my fieldwork diary:

*It is so different being “in the field” rather than sitting at your desk where you can easily identify as an anthropology student. In the field you are constantly questioned about your reasons for being there and particularly in medicine, about your methodology... (Fieldwork diary)*

I read many methodology chapters of hospital ethnographies at that stage, going back and forth to what those had done before me, so much of which was similar to my experience. The fieldsite I encountered was also different in many ways; it was a new territory to negotiate. I learnt from those who had gone before me and added new ways of doing things. I was adjusting to the environment as a researcher. In another diary entry I wrote:

*I have an old teacher from medical school asking me about keeping up my medical registration. I checked and there is no set limited time on when you have to reapply for it – you just need a letter of good standing from your previous employer. This makes it very easy for me to re-register again compared to the participants who find it so hard. During my week in O&G [obstetrics and gynaecology] I was jokingly asked by Mladen if I was registered and if I could scrub in an operation. When he found out I wasn’t registered he was surprised. It is very difficult being in the hospital - I feel useless and helpless. I am not doing what I have been trained to do here. When the ICU nurse told me that I was a “great little door opener” today I was furious!* (Fieldwork diary)

In adjusting from being a doctor in the hospital to being a researcher, I started to realise what I could be taking for granted.
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I have a problem with asking open-ended questions in the field. Often I will know what the doctors are talking about in terms of medicine or the medical structure and that leads me to close off the questions and to not delve as deeply as I would if I was completely naïve. I need to become more naïve...

(Fieldwork diary)

It was difficult to 'become' more naïve. Rather I had to be more reflective of what I was taking for granted that the overseas doctors were not. As I spent longer in the hospital I became involved in the participants' lives and this had its own set of challenges.

I become uncomfortable when the doctors start developing some rapport with me or confiding in me because I feel like this goes into a more personal relationship that is taken advantage of by me being the researcher. Whilst they might find these conversations part of us getting to know each other, for me they are data. And it is a strange relationship that is really one-sided, where I am hiding or not divulging many aspects of my story to let their story come through.

(Fieldwork diary)

These are some of the many everyday ethical moments of fieldwork that do not appear explicitly on application forms for the hospital ethics committees.

It is hard sometimes doing things the participant's way when I would do otherwise myself. For example not being introduced to the patients by the doctor [ethically however I had to introduce myself to them, even though the participant had said that it was not necessary] and hanging out a lot in the tearoom between cases in theatre when I knew that there was other work to be done – I do not want to appear lazy or inconsiderate!

(Fieldwork diary)
These are all negotiations of adjustment. In reflecting upon the research process and my own negotiations as researcher I learnt more about the overseas doctors’ modes of adjustment and vice versa.

*I realised today that the participants could teach me as much about the research process as they do about their own lives...*(Fieldwork diary)

Ingold (2008, p82) emphasises that anthropologists work with people, and that they learn from participants in a way that educates their own perception of the world. To do anthropology, he writes, is to open up the world, a flip between ways of being (Ingold 2008, p84). Observation and engagement are ongoing outside the boundaries of fieldwork; they happen in continuous encounters with participants, colleagues, in meetings and when teaching. Doing ethnographic fieldwork is hard work. It requires constant multisensory attentiveness and extensive personal compromise to fit in. It is personal and challenging, and imbued with feelings of awkwardness, discomfort, self-doubt, confusion and anxiety. It is these challenges however that make fieldwork rewarding and productive (Hume and Mulcock 2004, pxxiv), and it is often the awkward moments that turn out to be the richest sources of insight and revelation (Hume and Mulcock 2004, pxxv).

**Summary**

The methodological practices outlined in this chapter have justified and brought this research into being. Applying analytical insights from STS to the social sciences, Law (2004) argues that there is not a reality out there which is discovered through a set of methodological procedures but rather that our methodological practices enact those realities. During the course of the PhD I met various other researchers working on topics concerning overseas doctors. They brought different stories into being, some of which I
have drawn upon in the following chapters. For example, I met a post-doctoral fellow from Canberra using innovative on-line focus group methodologies to instigate discussion between overseas trained GP registrars in rural Australia. Unfortunately, launching her focus group so soon after a controversial media case concerning an overseas doctor, meant that doctors were hesitant to voice their opinions online, political events leading to a research story of absence. I met with a marketing research team who had been commissioned by the state government’s Department of Human Services (DHS) to conduct a ‘quick and dirty’ study of the key stakeholders concerned with the IMGs. Their needs-based focus unsurprisingly echoed the research story of numerous other needs-based scoping projects completed in the last ten years. I also met with researchers undertaking psychological testing and conversational analysis. I met with several overseas doctors in the hospitals undertaking small research projects whilst working nights and weekends and with a documentary filmmaker looking for an exciting angle on the foreign medics. I learnt from these researchers, collaborated, shared information and followed their work. Each project not only revealed a diversity of approaches to one topic, but also the way that their theoretical frameworks and research questions shaped their research. They forced me to reflect on my own methods and the story emerging from my research practices.

In this chapter I ‘set the scene’ of the research and gave an account of the methods used. In giving a classic ethnographic description of the location of the research, I discussed its simultaneous sense of familiarity and strangeness for both the overseas doctors and myself. Whilst I was engaged in a process of trying to see this setting afresh, the overseas doctors were trying to lose any sense of strangeness, both activities entailing modes of adjustment. The next chapter now treads much more empirically into the field and begins to look closely at overseas doctors’ adjustment to the registration process. Tying this chapter and the next is a painterly interlude.
Van Gogh’s paintings have their place in me for all time, a step is taken from which I cannot retreat, and, even though I retain no clear recollection of the pictures which I have seen, my whole subsequent aesthetic experience will be that of someone who has become acquainted with the painting of Van Gogh.

(Merleau-Ponty [1945] 2008, p457)
Interlude Two

[Bleep*] [Bleep*] [Bleep*] As I type this interlude I can hear the photocopier jam across the corridor. The season-less air in my office is very still. I have paper all around me in this little room without windows that I share with three other students. A cup lies in the periphery of my vision, at the bottom of which is a rim of dried coffee. I type these words without looking at the keys, my fingers having learnt the QWERTY set on electronic typewriters during my high school education.

I am a historically dense person working in a multifarious environment in sensory ways. Everyday I am making different types of adjustments: as I switch from my Apple laptop to the office PC; in my posture on the chair; in my interactions with whoever is sharing the room with me that day. Each adjustment is a stitching between the past and the present moment. The past often lies on the fringe of experience, as an atmosphere (Merleau-Ponty [1945] 2008, p25), not always able to be made explicit. I bring this past with me wherever I go, and as I learn I am always engaging with it. I am learning as I write this thesis, adjusting through my body, within the environment I inhabit. Each overseas doctor carries with them their past travels, their past hospitals, their past patients. Not always explicit, they lie on the fringes of their experience ...
Chapter Three: Registration

During fieldwork, the histories of the overseas doctors were slowly revealed in glimpses. I learnt about their internships, about patients they had treated and their colleagues at medical school. I learnt about their families and their reasons for migrating. The participants had an enormous range of reasons for coming to Australia; there were as many reasons as there were doctors, and more. Dr Nikolai Nagorsky left the Ukraine for political and religious reasons. Dr Mladen Mück wanted to offer his children a different way of thinking. Dr Pham Ba Hung yearned to earn enough money in Australia to open a clinic in Vietnam for the poor. Dr Surekha Sadafule had a longing to experience something new, an alternative medical system to the Indian one in which her work was limited by structural deterioration. She convinced her husband to accompany her. Dr Hossein Youssefian was chatting online one night with a friend working in Australia and decided he should travel there too and escape the constraints of the Iranian government.

Whatever their reasons, the overseas doctors were mostly confident that they would find work quickly. Many were therefore surprised and frustrated by the registration process they found themselves entangled in, in Australia. This process involved, amongst other bureaucratic procedures, the application for visas, written and clinical examinations and finding a job. There were numerous national policies driving these procedures. Many individuals, organisations and much paperwork were involved in implementing, shaping and managing the rules and regulations, all striving towards the quest for equivalence and standardisation. Rumour and word of mouth circulated amongst the overseas doctors concerning what was needed to get through the process quickly and to get a job. However everything always seemed to be changing. And there were so many different pathways to employment. Just when the overseas doctors seemed to have a handle on one aspect of the registration process, something new would appear.
Chapter Three

This chapter focuses on this complex and dynamic process of registration that the overseas doctors negotiated, in varying ways, to work in Australia. Registration is a word which encompasses accreditation of past degrees and experience, as well as employment. Many participants referred to registration processes as ‘the system’ in its entirety. This chapter is the first empirical patch in the patchwork system the overseas doctors found themselves in, one aspect of their new workplace ecology. It is placed early in the thesis so as to also provide detail on the structural aspects of their work in hospitals. In this chapter I draw upon discourses in public health, political economy and those concerning multiculturalism, to analyse the actors interconnected in what often appeared to participants to be the faceless, structural constraints on their work in Australia.

What emerges in this chapter revolves around what overseas doctors were required to do, to enable their prior qualifications to be recognised in Australia. It has rather a large cast of characters including the state, medical professional bodies, hospital managers who employed the doctors and changing policies. To give this dynamic process temporal detail, the chapter refers to historical events in Australia and projects into the future. I argue that the registration process imposed a certain level of constraint on the overseas doctors’ practices in Australian hospitals because of a devaluing of their past experience and an attempted management of their employment opportunities. Rather than being passive recipients in this process however, I argue that the overseas doctors negotiated the rules and regulations with varying degrees of adjustment. These adjustments were ongoing, happening ‘on the hop’, as the system was continually changing. By following the overseas doctors through this evolving registration process, something is learnt not only about the Australian system, but also about the precariousness of adjusting to new environments and the uncertainties inherently embedded in this.

The chapter is arranged so that the first half outlines the structural details of registration and the second half concentrates on the overseas doctors’ modes of adjustment
(although there is clearly some overlap). I begin geographically and historically, by sketching the international ‘flows’ of doctors and the history of medical migration in Australia. This section begins to examine the complex interplay of actors involved in these processes. I then follow the more recent history of policy change, as a reaction to broader political economic events, examining the impact this has had on the employment of overseas doctors. The second half of the chapter then attends to the ways that overseas doctors have adjusted to these constant changes and the effort that this has entailed.

**International flows of doctors: the medical carousel**

If it was possible do a time-lapse cartographic illustration of the movement of doctors around the world, a dynamic version of the map I presented in Chapter Two, there would be significant changes in the flows of travelling doctors over time. This would be predominantly shaped by various economic, political and historical factors. The factors of change which are of most concern to me here, are related to the changes in migration policies and registration requirements internationally that have affected the movement of doctors.

In many of what have been classified as ‘receiving countries’ of migration, ongoing changes in policies and employment requirements have been constantly directing the flow of doctors. The European Union is currently one of the most striking and well-documented examples of this process, as doctors’ movements often reflect the opening of reciprocal agreements between various countries. For example, there has been a flow of doctors from Slovakia to fill gaps created by Czech doctors migrating to Germany (Mareckova 2004). Another example is the recent change in immigration rules in the UK which has restricted the employment of non-UK or European Economic Area (EEA) nationals (British Medical Association) and stemmed the previously steady migration of doctors from Commonwealth countries such as Australia. Regional flows have also been
affected by agreements such as the Trans-Tasman agreement between New Zealand and Australia and the North American Free Trade Agreement (Bach 2003, p5). The temporary policy-supported migration of doctors from Cuba (Alkire and Chen 2004, p2; World Health Organization 2006, p102) and the specific training of doctors for migration in countries such as the Philippines, India, China, Indonesia and Vietnam (Astor et al. 2005; Mullan 2006; Ray et al. 2006; WHO 2006, p102) further shape these migration flows. Mode 4 of the General Agreement on Trade in Services under the World Trade Organization marks another step towards labour market liberalisation which could potentially lead to drastic changes of the terms under which highly skilled workers such as doctors move to work temporarily (Khoo et al. 2007, p482; Iredale 2009).

From the international public health perspective, migrating doctors are viewed as one of the factors exacerbating crumbling healthcare systems in many resource-poor regions of the world. The World Health Organization (WHO) (2006) declared in their 2006 World Health Report that healthcare worker migration was one of the most significant health issues of contemporary times. This is an important aspect of my research which is not discussed in detail, and which would need a thesis or more of its own. However this issue does raise questions about how overseas doctors adjust to these inequalities and reveals aspects of the sociopolitical structures they are leaving and joining (Gish 1979, p1).

Research on why doctors have left their country of training highlights factors such as low wages, poor or unsafe working conditions, heavy workload, lack of career advancement, limited resources, deteriorating healthcare systems, fragile political situations, inadequate living conditions and rising crime rates (Alkire and Chen 2004, p9; Astor et al. 2005; Grant 2006; Oberoi and Lin 2006, p25; Ray et al. 2006, p184; WHO 2006, p99). There are glimpses of these economic discrepancies in this thesis, more often subtly in a section of conversation or in an overseas doctors’ observation. My focus in this section
Figure 5: Local regional flows
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however has been on how overseas doctors move internationally according to changes in registration requirements reflecting political economic events. Similarly, in the next section, a historical study of the registration process in Australia reveals a dynamic series of policies and programs corresponding to political economic changes in the country and more globally. It also outlines how the overseas doctors' employment has been managed based on rigid and devaluing categorical notions of difference.

Doctors at Sea

From the arrival of the first non-indigenous health practitioners by boat during colonisation (studied in-depth in historian Robin Haines' (2005) book *Doctors at Sea: Emigrant Voyages to Colonial Australia*), there was a regular flow of doctors from the UK into Australia. Numbers began to increase more dramatically in the mid-nineteenth century, with British doctors escaping increasingly competitive conditions and stringent accreditation requirements created in Britain from oversupply. In the early 1860s it was estimated that 94% of physicians working in Australia had qualified in the UK and Ireland (Willis 1983 pp39, 41). Around this time, the Melbourne Medical School opened and started to produce the bulk of new medical graduates. The local medical workforce, which until then was almost entirely British or Irish educated, began to change form (Willis 1983, p39). Whilst specialist training in British universities was still highly valued, Australian graduates perceived their five year long undergraduate course to be superior to the British course of three or four years. Sociologist Evan Willis (1983, p55) argues that this resulted in segmentation within the medical workforce between Australian and British educated graduates, with Australian medical graduates steadily forming into a dominant unified group.

With the outbreak of war in Europe in the 1930s, and the escape of refugees to Australia, larger numbers of doctors arrived from outside the Commonwealth, particularly from central and eastern European countries such as Hungary, Lithuania,
Poland, former Czechoslovakia, Bulgaria, Latvia and Estonia (Kunz 1975, p23). The rift between British and Australian graduates then became less of a concern and Commonwealth doctors turned their attention to the differences they found in their European colleagues. The non-Commonwealth doctors became the ‘foreigners’. Notions of who was an overseas doctor – then termed New Australian Doctor, alien medical practitioner or displaced doctor – began to shift, reflecting new classifications of difference.

Historical demographer Egon Kunz (1975), who has extensively documented this period of migration in his book The Intruders, argues that it was not long before stringent barriers were erected to bar the medical employment of refugee physicians in Australia. The UK was now seen as a ‘reference point’ for skills accreditation, and those not from English-speaking countries were regarded as ‘unskilled’ (Groutsis 2003, p70). A bifurcated accreditation system developed. Doctors with qualifications from British, Irish and New Zealand universities, or Commonwealth universities in Africa, Asia or America, were accepted into Australian employment without question. Those doctors educated outside the Commonwealth had to fully re-qualify at an Australian medical school (reportedly this included a displaced doctor who had to correct a quotation in his Australian exam from a textbook that he had written himself fifteen years previously (Kunz 1975, p52)).

Some of the doctors arriving at this time did find medical employment in ‘fringe areas’ such as in rural settings, in Papua New Guinea (PNG), or on ships bound for Antarctica. Many doctors understood that after several years of this fringe work that they would be free to practice medicine anywhere in Australia. It seems however that there were no such official arrangements at the time. Other refugee doctors found non-medical work in Australian hospitals as orderlies, medical attendants, hospital cleaners or junior nurses (Kunz 1975, pp9, 100). Allocation of overseas doctors to non-professional areas in hospitals was seen as a compromise between the Department of Labour and National
Service who wanted the doctors in employment related to their training and the medical boards who arguably wanted to exclude the overseas doctors from professional practice (Kunz 1975, p93).

The closest that many refugee doctors are recorded to have come to practising medicine in metropolitan or outer metropolitan areas during this time was in covert capacity in their own migrant communities or in migrant centres as employed orderlies, where they were occasionally given the unofficial responsibility of performing medical duties (Kunz 1975, p122). An attempt at containment continued even in these posts and whilst the work of migrant doctors was apparently unofficially recognised, officially, upon hearing that refugees were being addressed as doctor, authorities ordered: 'It has come to my notice that orderlies attached to your hospital are still being addressed as ‘Doctor’. This is to be discontinued FORTHWITH. Disciplinary action will be taken against offenders' (cited in Kunz 1975, p95). Unfortunately there are few other details in the historical literature of how overseas doctors handled their managed positions, either in medical or non-medical work during this time.

From under foreign rule

A letter from a group of overseas doctors in South Australia to the Medical Journal of Australia (MJA) pointed out the problems with these ambiguous inclusionary/exclusionary practices and the hypocrisies of European-Australian relations in medicine. The letter declared ‘it seems paradoxical enough that while Australian doctors are eager to go to European Universities to brighten their medical knowledge and experience, the graduates of these Universities are not allowed to work as doctors in Australia’ ("A national conference on medical registration" 1953, p609). As an illustration of this paradox, an editorial in the same journal was published around a similar time, in which the editor called simultaneously for more stringent registration requirements for foreigners coming to Australia and the easing of registration requirements for Australian
doctors wishing to work in the UK ("A national conference on medical registration" 1953). Flow was encouraged in one direction but not the other.

Reasons for this disparity were (and still are) often couched in terms of inferior standards and ethics of medical practice. Kunz (1975, p40) argues that during this period of time there were 'repeated but always vague charges that European doctors had 'different medical ethics' that would cause a 'lowering of existing Australian medical standards'. Kunz (1975, p27) claims that many new arrivals were told that their qualifications had no standing in Australia because they could have been bought on the European black market. The perceived unscrupulousness of the overseas doctors is reflected in a letter to the editor published in the MJA, on December 16, 1939:

Firstly, Sir, are these refugees trained to our standards in general medical work? Also, will they stay in these unattractive locations? I am sure not ...

The present agitation will again raise its head to grant further licence, or else the newcomers themselves will deliberately circumvent the restrictions in some other way. Indeed, I would ask, how many cases have already arisen in which these aliens have flouted the law by surreptitious practice? ...

Impudence implies dishonesty. These men come from Vienna mostly, and, I presume, with passports. Can their identity be definitely established, and if so, the authenticity of their diplomas also? I am sure not, especially as their country of origin is under foreign rule ... I believe I know the technique of these alien people. One will be introduced by a friend "on a friendly visit", and will forthwith insinuate himself into a home and a family's confidence. Is this playing the game? Decidedly not - at least in the light of British standards. Why, then, this urge to introduce alien practitioners who every knowledgeable person knows full well are possessed of what may be termed eastern European standards of ethics? Our profession will not benefit, nor the public. All will suffer. I hope the profession will take cognizance of this
matter. Laymen are so likely to be cozened and misled, their intellectual standard notwithstanding, where medical matters are concerned.

(Maxwell 1939, p919)

This letter highlights not only how issues of regulation were couched in terms of differing standards, but also how the local medical profession can be seen to have taken it upon themselves to vet the foreigners for the sake of the naïve public. The local medical profession not only defined who and what the alien doctors were, but also wanted to manage their employment. There is a sense of uneasiness about the unpredictability of this foreign group of medical professionals, a potential unruliness of migrants that anthropologist Ghassan Hage (1998) argues strikes fear into the heart of many of what he has termed ‘white racists’ and ‘white multiculturalists’. Labour studies scholar Dimitria Groutsis (2003, p75) writes that ‘the “flooding” of the medical market with overseas-trained professionals has, and continues to be, considered a great threat to local practicing doctors’.

Already a number of actors have appeared in this chapter who are involved in the attempted management of overseas doctors: the local medical profession, government departments, medical boards, authorities in migrant centres, universities, letters to the editor and memos. In his scathing account of Australian medical history, Kunz argues that one of the strongest forces behind the barriers created for refugee doctors was the local medical professional organisation, the Australian Medical Association. At the time the AMA had members in government, state health departments, state medical boards and on university senates (Max Kamien cited in Iredale 2009, p14). Kunz (1975) believes the powerful group was threatened by the competition and specialised workforce from Europe. He cites statements from the AMA justifying their stringent accreditation requirements, including claims that the standard of overseas qualifications was low; that the ethics of refugee doctors were ‘doubtful’ and ‘not proper’ and that the country’s absorptive capacity was stretched (cited in Kunz 1975, p60). Kunz argues that behind
the concern for uniform ethics and professional standards was essentially a need for local self-preservation and a regard for economic self interests (Kunz 1975).

In 1950, the AMA somewhat prophetically declared that 'whatever is done in relation to the foreign doctors already in Australia will provide a pattern for the future' (Kunz 1975, p72). Indeed, from the 1950s onwards, the Australian medical professional bodies have continued to attempt to control, to certain degrees, the employment of overseas doctors. Whilst specific details of the registration process have changed constantly, as outlined in the following section, there seems to be little change in regards to the ambiguous, often contradictory, nature of attempted limitation based on classifications of difference couched in discourses of inadequacy. The experiences of overseas doctors in my research closely resembled those who Kunz studied, for whom:

> It was not only that language was a barrier to those who did not speak it initially nor that distance inhibited communication for those placed far from the centers of affairs, though both of these factors undoubtedly did create difficulties during the first year for doctors in search of advice on their professional opportunities. As much as anything it was the maze of the federal system, to which they were newcomers, and the wide scope this provided for "passing the buck" which confused them. (Kunz 1975, p28)

Unlike Kunz however, I do not regard this 'maze of confusion' as solely due to the action of medical organisations such as the AMA. Rather, I have suggested that there was a complex interconnected set of actors, including various organisations, governments and employers, policies and other paperwork which constituted the process of registration that the overseas doctors adjusted to. I believe that because of the number of actors involved, there was no one person, policy or piece of paper to account for the regulations, devaluation of skills or limitations on overseas doctors' practice. At the
same time, the closely aligned work of actors helped to reiterate dominant management positions, and this work was embedded implicitly in the registration process. It is this dense, ever-changing, somewhat overwhelming system that overseas doctors adjusted to in various ways.

The next section outlines the recent history of employment conditions for overseas doctors in Australia. They were the conditions that had a direct impact on the participants in this study. I argue that the official recognition of overseas medical qualifications has been predominantly a reactionary approach to short-term perceived shortages or surpluses in the workforce. Furthermore, I suggest that the attempted management of the employment of overseas doctors continues to be couched in terms of different standards of practice.

**Overseas doctors p.r.n.**

The recent history of migration into Australia has principally been one of labour migration (Hage 1998). Although this was initially into unskilled positions, from the 1960s, migrants with qualifications from non-English speaking countries began to be encouraged to move into more specialised workforces in Australia (Groutsis 2003, p70). Since the 1970s, statistics show an increase in migration from non-European regions, particularly Asia and the Middle East (OECD 2001, p292). Unfortunately, the histories and stories of an expanding number of overseas doctors arriving in Australia during this time has been poorly documented. Researchers resumed their interest in overseas doctors from the early 1980s, during a time when it was very difficult for doctors of most nationalities outside mainly English-speaking countries to find work in Australia (e.g. Kidd and Braun 1992).

The restricted entry of overseas doctors at this time was based on the premise that future doctor-to-population ratios were going to be too high (Birrell 2004). Overseas
doctors in the system were seen to exacerbate this labour market overcrowding (Groutsis 2006, p60). A restriction was therefore placed on overseas doctors entering Australia, on the number of overseas doctors passing the AMC exam and thus entering the workforce, and on their Medicare billing privileges (Groutsis 2006, p60). Doctors wanting to enter general practice were restricted to a maximum of ten per cent of the number of Australian graduates entering general practice (Groutsis 2003, p78). Priority was given to overseas doctors with temporary visas, who were restricted to two years work and no private practice (Groutsis 2006, p61). This was to ensure that temporary doctors did not crowd the local market, or overbalance the desired proportion of foreigners in the workforce.

Hage (1998, p126), whose work I have drawn upon earlier in this chapter, argues that such worrying about the existence of ‘too many’ foreigners, or the total concentration of foreigners, is a privilege of the dominant. In their restrictions of the overseas doctors’ employment in the 1980s and in maintaining their ratios and concentration, the AMC are what Hage would term ‘managers’. Hage (1998, p90) writes that migrants’ ‘belonging to the national environment in which they come to exist is always a precarious one, for they never exist, they are allowed to exist. That is, the tolerated are never just present, they are positioned’. Hage (1998, pp135 - 136) argues that this leads to a complex dialectic of inclusion and exclusion whereby labour is positioned ‘in liminal space’; in an in-between space that is neither inclusion nor exclusion.

Hage’s work helps to illuminate analysis of the overseas doctors’ situation in Australia, of a registration process which has been historically infused with tactics of simultaneous inclusion and exclusion. It is a process that has been continually reproduced to this day, as overseas doctors’ employment in Australian remains precariously balanced. More is heard about this in the second half of the chapter through the overseas doctors’ stories. Negotiating the registration process is one of the first stages of adjustment for overseas doctors. Hage’s work has highlighted the role of the managers in shaping this process.
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He also remains cynical about the move in Australian politics, as elsewhere, towards multiculturalism, which once again he suggests is shrouded in conditions of containment and a perpetuating attempt at management.

Recognising diversity

In 1989, the National Agenda for Multicultural Australia program was officially launched by the government, part of whose mission was to highlight the ‘need to maintain, develop and utilize effectively the skills and talents of all Australians, where these skills and abilities are employed without barriers of discrimination or prejudice’ (Groutsis 2003, p71). It was an approach deemed central to the ‘managing and valuing’ diversity agenda of multiculturalism in Australia at the time. Employment of foreign-trained professionals was viewed in the context of the economic usefulness of their skills (Groutsis 2003, p71), an emphasis in migration that in Australia has continued to this day. Unlike those who thought the country’s absorptive capacity was stretched in the 1950s, or those in the early 1980s who considered there to be too many overseas doctors, the skills of the overseas workforce appeared now to be valued. Groutsis (2003, p73) echoes Hage’s sentiments when she writes that these multiculturalism policies did ‘little to scrutinise the institutions within which power differentials are borne and where the dominant culture was, and continues to be validated’. This diversity rhetoric is explored further in Chapter Eight.

When the AMC was forced to lift the quota of those sitting the AMC exam after a landmark case, Dr Siddiqui vs the AMC and the Commonwealth Department of Human Services and Health (Groutsis 2006, p62), many started to worry about the positioning and numbering of the multicultural medical workforce again. Birrell quickly produced figures that showed that overseas doctors were over-represented in the medical workforce in proportion to the general proportions of migrants to non-migrants in the country (Zinn 1995, p772). Once again the ‘issue at stake’ was the ‘maintenance of a
Registration

high quality medical workforce, trained according to the needs of Australian patients’, as well as fair access to medical careers for local graduates (Zinn 1995, p772). As the government announced cuts in medical school places, a move opposed by the AMA, Birrell declared that:

The competition for places in medical schools which [locals] face is about to intensify, partly because of the government’s difficulties in controlling the inflow of overseas trained doctors. The simplest solution would see the government refuse to register any permanent resident for medical practice who had not been trained in Australia as a local student.
(cited in Zinn 1995, 772)

These measures were not taken. However in 1996 the Australian government did prevent doctors from taking part in the skilled migration program through the imposition of a 25-point negative weighting. Doctors continued to arrive in Australia during this time however, mostly on family migration or refugee visas (Hawthorne et al. 2007, p10). Hawthorne, Hawthorne and Crotty (2007, p10) refer to these doctors who were not ‘screened in advance’ as contributing to a ‘backlog of medical migrants’, adding to the ‘pool of OTD arrivals’.

It was not long before the Australian government needed to do the exact opposite of what Birrell had recommended. With the population expanding, the restrictions on medical employment placed on local graduates and overseas doctors in the 1990s become evident in falling doctor-to-patient ratios. An ageing population, decreased working hours and a local graduate preference for inner city hospitals exacerbated the severe workforce shortages in healthcare around the country, in rural and outer metropolitan areas, as it also did in many other parts of the world. The Australian government and medical bodies were forced into a two-streamed approach to increase the number of doctors in the Australian workforce: increase the number of domestic
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trained doctors and fill the current gaps with overseas trained staff.

By March 2006, six new medical schools opened in Australia, set to increase the number of domestic medical graduates from 1600 per year nationally to 2500 per year in the following five years (Hawthorne et al. 2007, p99). Also in 2006, Victoria received 220 additionally funded places in undergraduate medical schools and in 2007, the number of full fee paying students allowed to enroll was increased. These changes were predicted to increase the number of domestic graduates from 348 in 2008 to 690 in 2012 (Department of Human Services 2008). The nature of these appointments in the short and long-term future however remains uncertain, with much speculation about the upcoming shape of the Australian medical workforce. Some current medical students fear a ‘medical tsunami’ of local graduates entering the workforce in 2012. There was certainly much rumor amongst the overseas doctors in this study, of more competitive conditions on the horizon.

The second response by government to the medical workforce shortages in Australia has been an increased reliance on overseas doctors to fill gaps in general practice and in outer-metropolitan public hospitals (Hawthorne et al. 2003). In 2003 an incentive package was announced which contributed funding towards the recruitment of doctors from overseas (Birrell and Hawthorne 2004). In May 2004 medical practitioners were included on the Skilled Occupations List (AMC 2006) under the Australian government’s General Skilled Migration Program, which meant that doctors no longer needed a sponsor to migrate to Australia, with the 25-point penalty being removed (Hawthorne et al. 2007, p5).

And so the reactionary approach continued, where governments, organisations and medical professionals remained in control of the employment of overseas doctors, shifting policies according to perceived needs, in many ways attempting to manage the overseas doctors. However, as has previously been argued, overseas doctors have not
been passive. There have already been hints of how overseas doctors have adjusted to the changing registration process. For example, many refugee doctors found ways of practising medicine in 1950s Australia, either in covert capacities in the migrant camps or in their fringe allocations. Doctors worked within the constraints. The following sections in this chapter provides empirical detail of how overseas doctors adjusted to the registration process in contemporary Australia, after first outlining their conditions of employment.

A policy of patches

As noted, Australia is currently one of the few OECD countries with specific migration policies for health professionals (OECD 2007, p191). At the time I undertook fieldwork, overseas doctors could be employed as both temporary resident doctors practising in Australia on temporary visas, and permanent resident overseas trained doctors living in Australia on permanent resident visas or as citizens. Temporary resident doctors were generally only eligible to work in 'Districts of Workforce Shortage'. These districts were categorised as those communities where there was less access to medical professional services than experienced by the population in general, either because the community was remote or because of lack of supply of services or a combination of the two. Temporary doctors could also work in an 'Area of Need' (AON), which was different from a district of workforce shortage as they were determined by a state or territory health department rather than by the federal government. An AON was a position or location where there was a lack of medical practitioners, or the medical position remained unfilled for some time (Australian Government 2007). Temporary resident doctors did not have to sit the AMC exams or an English test and could proceed directly into medical practice (Hawthorne et al. 2003, p7). There was a fast-track pathway for the processing of specialists wanting to work in an AON. Doctors could also work on an occupational trainee visa, intended to allow doctors to develop skills in Australia (Hawthorne et al. 2003, p7). On this specialised temporary visa category, doctors were
appointed as junior doctors and as trainee specialists in hospitals with an approved training program. Mainly training in surgery, these doctors were increasingly being employed in general junior hospital positions (Birrell and Hawthorne 2004; Birrell 2004). Finally, because state medical boards were responsible for the registration of doctors, specific conditions of employment differed from state to state.

The previous paragraph contains the details necessary to help understand the structural conditions of employment of the overseas doctors in this study. Yet the information is somewhat depersonalised. Because there are more details of this complicated process to follow, I want to now include some images from an Australian graphic novel The Arrival (Tan 2006), which illustrates, with more humanist detail, what is in fact a process concerning individuals, who are bundles of fear, anxiety, hope and uncertainty.
To practice unconditionally in general (non-specialist) medicine in Australia, all permanent resident overseas doctors were also required to pass the AMC examinations (written and clinical) and satisfactorily complete a year of supervised training in an accredited hospital post (AMC 2006). At the time of the research there had been a recent trend in many states, including Victoria, to allow permanent residents to be registered conditionally by state medical boards before fully completing the AMC exam.

Overseas trained specialists could practice after undergoing a specialist assessment procedure (separate from the AMC exam) and assessment of their training and experience by the relevant specialist medical college (AMC 2006). Overseas doctors were often initially assessed by the relevant specialist college and then given restricted registration for up to two years to complete supervised specialist practice. If the college then deemed that they required further training, doctors needed to go through the AMC examination pathway (AMC 2006). Each specialist college set their own requirements.
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Thus, whilst overseas specialists wishing to continue working in dermatology were required to go through the full local examination process, psychiatrists wishing to practice in their field only had to pass an oral examination. Thus, a pattern emerged, in which specialties experiencing workforce shortages often had less assessment requirements. In general practice, doctors could proceed directly to clinical practice and in emergency medicine and rehabilitation, doctors only had to sit parts of the exam. Highly competitive specialties such as ophthalmology required doctors to start the assessment process from the beginning (AMC 2006).

The registration process appears once again to be one of differences and discrepancies, depending on the state or specialty. Whilst the Australian government recognises that it is a ‘particularly complex’ system (Douglas 2008, p29), commentators such as Groutis and Canadian doctor Susan Douglas (2008, p29) further that it is more fragmented and irregular than is often proclaimed. Dr Dumitru Bara, a slightly jaded obstetrics registrar from Transylvania, who had migrated for adventure via France and the USA, expressed a similar frustration:

*Medicine here is now five years — no longer six. It keeps changing — very weird. They don’t know ... I know migration laws around the world very well — in Australia until recently they didn’t want doctors, there were too many here, there was underground migration – not illegal – many trying to get into the system. Now we open gates. Should we put a cap, a quota? Who knows how many they need? No one knows the demographics... Australia had this policy of No, no no, yes, yes yes – don’t let them in, oops, some need AMC, no AMC. There’s a lot of crap going around – it’s not a present that they give and then take – it’s not something that I’ve begged for. For me it was not easy to go back [to study for the AMC] – but I realised this will give me the qualifications. If you will do psychiatry they will grab you with two hands ... the system got itself into a crisis – they had a policy of patches. I don’t know, seems a weird place ...*

(Dr Dumitru Bara)
Since finishing fieldwork in the hospitals and writing these words, there have been continual changes in the registration process. Just when most of the overseas doctors seemed to have some resemblance of an understanding on what they needed to become registered or to work in Australia, another change would be announced. There has been a push for an improved national process for IMG assessment, entailing nationally consistent standards, as it was deemed important for the public to know that the doctors were competent, for the public to be confident in their medical care.

In 2007, a very significant change was announced. Four new pathways to employment were introduced by the AMC, which were implemented in 2008. They included new assessment and registration pathways: the competent authority pathway; the standard pathway with AMC examination; the standard pathway with workplace assessment; and the specialist assessment pathway for those working in specialist positions or AON (AMC 2006). The competent authority pathway was the most striking of the new changes. This pathway was intended for overseas doctors applying for non-specialist positions who had completed training and assessment through ‘approved overseas competent authorities’. Doctors who were able to take this pathway to registration did not have to sit the AMC written or clinical exam (AMC 2006). The bodies currently listed on the AMC website as competent authorities are in the UK, Canada, the USA, New Zealand and Ireland.

After a late night tutorial I received a lift to the train station from a group of overseas doctors. It was not long after the new pathways had been announced. On the ride to the station they started talking about how it was discriminatory to have two separate pathways for UK doctors and others. They felt that if you had graduated from a WHO approved university that you deserved to be treated equally. It got very heated in the car that night. The doctors were worried about what the changes in the exam might mean, because you studied for the exam in one way and then the format changes to another. One doctor thought that this would only affect those doctors the following
year but another said that this was when he was going to sit the exam. The doctor sitting next to me then turned to ask if I could remember what my own final year exam was like – and whether I thought the format was similar to the one here. I could not really remember ... This doctor had trained in Afghanistan and had been in Australia for five years. He was thinking about doing his exams next year but was concerned about the term used for the UK doctor pathway being proposed – ‘competent authority’ – he was worried that it implied that other doctors were ‘incompetent’. We continue driving. There was some silence and then the driver sighed and said, ‘I just can’t wait until this is all over’.

They seemed utterly exhausted by it all.

The overseas doctors became part of a system that was ever-changing and filled with discrepancies. It was tiring keeping up with the changes. Many overseas doctors, like Dr Dumitru Bara, acknowledged the managing principles behind the registration process, and that they were primarily employed to fill workforce gaps, or as the local media has reported, to ‘plug holes in our health system’ (McArthur 2007). These workforce gaps are the Districts of Workforce Shortage and the AON positions outlined in this section. They may be in rural and outer metropolitan areas, in junior hospital positions as occupational trainees, in conditional appointments whilst undergoing the AMC pathway, or in junior positions whilst completing the year of supervised practice. In the hospital networks in Australia, these positions were in the peripheral margins of Australian medicine, in terms of geographic locality, disciplines and the social order within these. Some have even called this the ‘peripheralisation’ of overseas doctors (Healy and Oikelome 2007, p1928). The next section explores this further.

Off ROAD: working the suburban rim

Technically, with Melbourne’s suburban sprawl, the hospitals where I did fieldwork were
on the edges of some of the fastest growing neighbourhoods in the country and so were losing their peripheral status. In the eyes of city trained local graduates however, they were still marginal hospitals, and less desirable locations than the inner-city establishments where there was more supervision, teaching and technology, as well as proximity to the swirling centres of their social lives. Waiting for a hospital courtesy bus one day I spoke to a local medical student who said that she would apply for internships on the basis of lifestyle, location and whether or not you got paid for overtime. These prized locations were spread by word of mouth amongst the local medical students, as were the best hospitals and disciplines to work in. One Australian educated doctor, locuming as Dr Elena Radulescu’s resident, told me of a saying that “we” like to keep quiet’. I had asked him about his desired specialty and he replied that the advice was to ‘stick to the ROAD: radiology, ophthalmology, anaesthetics and dermatology’, these being the most privileged specialties in terms of financial remuneration and lifestyle. These are the specialties with difficult or long pathways of assessment, which many overseas doctors regarded as ‘closed shops’. Trained in the UK and escaping restructuring of the National Health Service (NHS), Dr Rani Kale told me she had come to Australia to pursue physician training, and was ‘scared that [she would] be shoved into a specialty based on what other people don’t want’. Dr Dumitru Bara felt that this was already beginning to happen for him.

Dr Dumitru Bara: It is a difficult situation – and you cannot win on all sides – I feel that the system wants us to be GPs.

Anna: Is this made explicit?

Dr Dumitru Bara: No. In Hospital Y – they knew I had done O&G – but in the ED I see lots of patients per shift and am on top. I didn’t care about taking breaks. I was good in the ED to the patient. Then they just rotate me in ED! To the point where they had a stamp made up with my name on it! They knew I wanted to do O&G – and then they only offer me a post in ED.
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Overseas doctors are often also marginalised when it comes to rostering, and in Europe, have been shown to work more night shifts than their local counterparts (OECD 2007, p199). A story was related to me by one participant about ‘an Australian patient’ who said to his nurse that he wanted an Australian doctor. The doctor who came to him (an overseas doctor) said that unfortunately he was on the migrant shift that lasted from Friday to Monday and included public holidays; if he wanted an Australian doctor he would just have to come back outside these times!

Migrants are often found in the margins of the labour market (Kelly and Lusis 2006, p836) and overseas doctors are not really an exception (Shuval 1997, p16). In the USA, overseas doctors are employed in teaching hospitals in large urban areas that have ‘traditionally served large numbers of minorities, uninsured, and low-income patients’ (Howard et al. 2006, p2156). Here they are reported to work longer hours than local doctors (Pincock 2007). This marginalisation is shaped by employment practices and the needs of the local medical workforce who leave the gaps. It often limited the overseas doctors’ abilities to work in their chosen specialties or geographic area, or preferred time of the day. This situation promises to become exacerbated as local doctors become more streamlined in their professions and fastidious about where they want to work. Marginalisation means that overseas doctors have a precarious existence, where, as Hage (1998) writes, they are ‘allowed to exist’.

When I was leaving a HMO manager’s office after an interview one day, another manager asked how my project was going and I said how interested the doctors were in participating. She replied, ‘oh yes that group are. The IMGs – you ring them up to fill in any shift and they always agree’. Many overseas doctors told me that they felt that they could not refuse these shifts because of the precariousness of their positions. They recognised also the futility of these shifts in terms of their career advancement. Dr Mladen Mück told me that:
You are working more and more – you are earning lots of money [in overtime] but even though you may ask for things you are not part of the training program.

(Dr Mladen Mück)

The role of Managers in shaping the employment prospects of overseas doctors is explored further in the next section.

The Managers

Administrators and Managers were often viewed by the overseas doctors to control access to training programs. Managers were recruiters in the hospitals and thus helped to shape its local workforce. They were actors in the registration process, who directly and literally managed the overseas doctors. I spoke to some of the hospital managerial staff who acknowledged the realities of the limitations on overseas doctors’ work in Australia. Here is a section from one interview with an administrator that took place on a busy morning, between constant interruptions on her mobile phone, assistants coming in with coffee, and overseas doctors ‘cold calling’ (see Medical Glossary) for jobs.

Umm, getting into specialty training programs is already difficult for them. I don’t know whether that is going to improve – sorry that’s a reminder, I keep having to press snooze – I don’t know if that is going to improve in the future either, because, I don’t have a feel for there being great plans to increase, to largely increase the number of specialty training positions. I think there will be an increase – but it might be more than soaked up by all the new medical students coming out, and so 2012 is extra interns, but then 2013, 2014, are HMO positions, and then they’ll be looking at getting into, you know advanced training of some description, within those sort of four years of so and hmm, and I think that that is going to mean that a lot of the IMGs who are coming through will either, go into GP training or emergency training. Which is an area of significant workload
shortage at the moment. And psychiatry. Which is happening now, but it may even be that it narrows even more ... I mean I have had, I know IMGs that have got into anaesthetics, have got into O & G, have got into paediatrics, have got into paediatrics, have got into medical jobs, advanced training. Some have got into surgical training, but I am noticing that it is getting harder – it is getting more competitive. I had someone in here yesterday who wants to do paediatric training, and she is lovely but I just don’t think she is going to get in because it is just so competitive and they’ve got their pick of graduates, and she just cannot compare to other Australian graduates that I know. Her interview wouldn’t be as good. She has no back-up plan, and how do you say to someone, “have a back-up plan”, without kind of implying that she might not make it. But look, maybe she might, maybe she might be lucky next year and no one wants to do paeds. I don’t know, but it’s very hard talking to these people because you just don’t know how much to encourage them and how much you are setting them up for a fall by encouraging them, you know.

(HMO Manager)

The HMO Manager displayed sympathy and wanted to be helpful to the overseas doctors. She acknowledged their limited career choices. During the same interview she also acknowledged her role in perpetuating their marginality.

HMO Manager: it’s all stupid, you know. There’s all these rules you have to follow in terms of recruitment and selection and I’m happy to follow them and document and all that, but at the end of the day you can’t take it away from the fact that it’s highly discriminatory, because you are picking one person over another on some basis and sometimes it can’t even be determined on what basis you pick someone. Because it might be all things are equal, but you think this person might fit more into the culture of the organisation better than that person. Well that’s discriminatory isn’t it? Because that’s an assessment you make in an interview of 45 minutes, or whatever.

Anna: Because they are from the culture that you come from?
HMO Manager: Yeah, that's right, and, how much of that is influenced by your own attitudes? Pretty much most! [laugh] Not that I think that I am particularly discriminatory - I talk to a lot of doctors trained, a lot of people trained overseas and they come from all different walks of life and I don't think that I am inherently, you know discriminatory, but umm, I like to think that I talk to people in the same way wherever you have come from – but ahh, yeah at the end of the day if I have to choose between an Australian trained doctor and an international medical graduate – which one am I going to go for? Frankly.

Anna: That's very honest.

HMO Manager: Because my recruitment at the end of the day, that's my responsibility, to make sure I recruit good people.

The HMO Manager articulates what I have argued is underlying many of the marginalising limitations on the overseas doctors' employment: classifications of difference which imply inferiority, leading to the devaluation of skills because they are 'foreign'. There is a recognised profound disjunction between the cultural diversity rhetoric and labour market reality as perceived by employers (Syed 2008, p36). The viewpoint that skilled migrants lack 'country-specific' skills leads to perceptions that they are less productive than local counterparts (Syed 2008, p32). Local graduates are usually employers' first choice (Birrell 1997, p53; Syed 2008, p32). However, perceptions of physician competence vary enormously across contexts, created through historical, economic and political circumstances (DelVecchio Good 1995a). I have argued, and will continue to argue, in this thesis that whilst medical practice is contextual, it is not 'country-specific'. What is national are constructions of competence.

Hospital managers and administrators have the power to both encourage (value and tolerate) (Hage 1998) and place limitations on overseas doctors' practice according to their own constructions of competence. These managers operate within the soft-carpeted world of hospital Administration, dealing directly with hundreds of cold calling
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overseas doctors and those emailing curricula vitae in the search for jobs, every day. Managers make do with what they have time for. At the same time their practices of recruitment constrain, manage and funnel the overseas doctors’ employment. However overseas doctors do find ways to adjust to this process, as starts to become more empirically evident in the next section.

Shifting goals

In the following excerpt Dr Mladen Mück talks about how he remained in obstetric practice by working within the system:

_In terms of assessment with the college [O & G] I was assessed close to ahh Australian consultant and I needed to achieve the fellowship, of full recognition - the condition was to pass my membership exam and spend two years of advanced training and unfortunately I continued to work full time and I was good in that field but I could not ahh manage to ahh, achieve that goal you know, to pass the exam in that period of time required and that’s the reason why five years after working as a senior registrar at the Royal Women’s I needed to change the hospital and come, actually I came to Hospital X and ahh to work in what we called, a hospital in ahh an Area of Need, and that’s the reason I continue here. It’s my fourth year in Hospital X._

(Dr Mladen Mück)

Because Dr Mladen Mück did not pass the specialist exam in the time required, he was not able to practice freely in his field. There was another way of practising in obstetrics however, and that was to work in an AON on temporary registration. This was a way of circumventing the restrictions placed on his practice and adjusting so that he could remain in obstetrics. However, as a consequence, Dr Mladen Mück lacked a great deal of job security and suffered from the ambiguities of his position. He felt anxious about studying for the exams again and the possibilities of only being accredited to be a GP if
he passed. He had two teenage children to support, who were attending private high schools in an expensive suburb of Melbourne. He remained in his temporary position, without promotion or possibility of private practice, supervising registrars that would go on to become locally qualified consultants; in his words, accepting the ‘crap’ of other doctors and of the hospital in general.

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

(Dr Mladen Mück)

Dr Mladen Mück’s story highlights the precariousness of adjusting. His statement ‘you are OK to work as an obstetrician here but not here’ reiterates the incongruencies and patchiness of the registration process, which is simultaneously inclusionary and exclusionary.

Groutsis (2003; 2006) has been the most astute at analysing how labour market spaces available to overseas doctors in Australia are defined. In particular she argues that geography shapes the credentialist requirements of overseas doctors, which in turn affects their entry into the Australian medical labour market. She looks at differences in doctors with temporary and permanent visas and the spatial demands of the medical
labour market. Focusing on a period of time from the mid-1990s to the mid-2000s, Groutsis (2006, p60) challenges the medical fraternity’s justification of their accreditation approach as a need to uphold standards of medical practice. She claims that the historically enforced exclusionary tactics are a response to spatial demands underscored by migration policies. Groutsis (2003, p75) argues that the accreditation process has, and continues to be, used as a tool for controlling supply rather than simply assessing the quality and standards of the qualifications. She sees the accreditation process as a way of regulating available stocks of labour, the inconsistencies inherent within this system discriminating particularly against permanent resident doctors, favouring short term labour. She believes that instead, rules determining entry into the labour markets should be applied equitably to overseas doctors regardless of migration statuses and spatial demands.

Groustis’ work raises critical insights on the issue of overseas doctors’ employment. She highlights the differences within the system and the structural complexities of the registration process, something which has emerged in this chapter, as actors have become increasingly intertwined. Others have attempted to tease out these relationships in more detailed ways. For example, the relationship between European policy and organisational viewpoints has been explored in a paper examining the movement of doctors from the EEA into the UK (Jinks et al. 2000). Health policy scholars Clare Jinks and her colleagues (2000) argue that the perception of EEA doctors is mismatched to policies encouraging their employment; doctors themselves feeling they were judged to be different. The authors believed that this demonstrated the paradoxical tension between formal and ‘real-life’ recognition of medical qualifications. Geographers Parvati Raghuram and Eleonore Kofman (2002) also studied the complex interplay between immigration and registration regulations affecting the entry and stay of migrant doctors in the UK. They found the state to be a key player, closely linked to recognised professional bodies (Raghuram and Kofman 2002, pp2074 – 2075).
Groutsis (2003, p74) has argued in Australia, that the medical labour market has been principally controlled by the medical fraternity, who have drawn on state support to restrict overseas doctors from entering the labour market. She writes that essentially the Commonwealth, state and territory governments in Australia have placed the responsibility of overseas doctors’ accreditation with professional licensing bodies. Although the governments have become increasingly involved, there has been little change in the bases of power institutionalised in professional body structures. She argues that there has been sparse dialogue between the many players involved in these processes, hampering resolution of conditions experienced by the doctors in the labour market (Groutsis 2003, p81). Groutsis echoes Kunz’s previously outlined position on the AMA. Kunz (1975, p101) was careful to separate the treatment of refugee doctors by individuals from that of the medical boards, often detailing stories of local doctors who helped their colleagues to professional recognition. Similarly here, the registration process that was described to me by the overseas doctors was often a faceless one of regulations and requirements, a system that seemed to many participants as devoid of individuals.

As I have previously indicated, what is missing from both Groutsis’ and Kunz’s erudite accounts are how overseas doctors negotiated this process. Their studies are missing details of overseas doctors’ adjustments, something which I focus on in this research. The overseas doctors in this study maneuvered around and within structural constraints and were constantly working out their options. We have already heard Dr Mladen Mück’s story. Another example concerns a doctor on an occupational visa from a large cardiac hospital in Malaysia, completing a rotation as a registrar in cardiothoracic surgery. Dr Saimon Ambi very quickly worked out his chances of being employed on a long-term basis in Australia. He told me that he found the local surgeons very protective of their group and ‘didn’t want to share a piece of the cake’, adding that:

_I did entertain the thought [to stay] but I thought it would be very difficult – for surgery it_
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would be difficult. If I got a post as a consultant the pay would be a lot better but if I got a post as a registrar it would not be. I doubt that they would give me a post unless I got married to an Australian. In Adelaide for example there are only three cardiothoracic surgeons and only four posts for registrars. I've found out what's going on – I've been discussing it with so many people. I have a good post back home – to migrate here; it's too uncertain.

(Dr Saimon Ambi)

The ‘closed shop’ nature of specialties is one that overseas doctors work out and adjust to. Adjustment entails various ways of working around the constraints. For example, the greater numbers of weekend and night shifts that the overseas doctors worked was negotiated to suit their needs. This is a quote from Dr Farokh Mostofi, a young Iranian doctor and filmmaker, with an extensive publication record and a passion for poetry, music and great novels that he read in French, Turkish, Persian and English:

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

(Dr Farokh Mostofi)

Dr Farokh Mostofi spoke later about having a short term and a long term future – the
short term goal was to get permanent residency and registration, accepting as part of 
this psychiatric night shifts, and the long term goal was to be able to work in his area of 
interest, nephrology. He was shifting his goals within his employment options. For 
some, this meant accepting limitations, such as Dr Surekha Sadafule who told me ‘for 
IMGs it is better to stop thinking about getting into a specialty’. Others found space to 
insert their previous experience into their nocturnal or ‘anti-social’ shifts. One day, I was 
sitting next to Dr Elena Radulescu when a crying child was carried past the unit. I 
commented that it must be hard for her not being able to work in paediatrics. She 
agreed that it was very hard. When she did paediatrics in Hospital Y she said that often 
children would be sent home and that ‘it’s hard because you have to do what the 
registrar says’. However, when she was the night resident, she was able to investigate 
more fully, and thus when a child came back with a reoccurring stomach pain she was 
able to send him for investigations. Otherwise ‘it was just frustrating’. Dr Elena 
Radulescu found a way of coping with her night shifts, of adjusting to these hours and 
weaving some of her own previous practice into the night.

**Things come up from time to time**

Overseas doctors found various ways to work around and within the limitations on their 
practices, within the ambiguities of a complex inclusionary/exclusionary registration 
process. Most overseas doctors were constantly working out the ways they could 
secure visas, use their visas, change temporary visas into permanent visas, get onto 
accreditation programs, obtain registration and find jobs. There was constant 
movement according to changes in the system as they unfolded. Doctors diverted their 
flow, moved with the times. One doctor in a large study group described this process of 
adjustment:

*I came here in 1988. I had done paediatric surgery. I was very involved in the activities 
here [observing] and after three years I was allowed to work – I did 150 operations*
without supervision — allowed to work for 16 months — "there is an appendix here you do
it". I was already involved in getting my specialty recognised — this is five to ten times
worse than GP. Then I tried the OSCE [objective structured clinical examination] but
because my English is not so good, I didn’t pass. I worked for four years on a temporary
visa then because I didn’t pass my exams that stopped. I was happy. I wouldn’t have to
see any more books ... then the GP college gave the scholarship ... [and he went back to
study again] ...

(Study group member, name unknown)

But it is not possible in short quotations such as this one to give an indication of the time
and energy that many overseas doctors invested in negotiating this system. Each
change and corresponding adjustment required effort and perseverance, aspects of the
social labour entailed in their movement between settings of practice. Dr Yang Fuquan’s
story in particular highlights this and is quoted at some length here to give enough detail
to his adjustments.

Dr Yang Fuquan: I just took one year leave [from his job in China]. I come here, I enrolled
in an English course, so I can, I can do three things. One. I can improve my English.
Second I can train, work experience, further degrees, study, whatever, when I go back.
Thirdly, I might have a chance to stay here, so I thought I have nothing to lose. But when
I just came, half a year after I came, ahh, Beijing massacre happened, bad, very bad, so
the Australian government keep along with the other western countries, US government,
they give us first half a year extension visa and then later a year visa, they call that a
protective visa and ... lots of people speculation, says, probably we can stay here, so I
thought, why not, give it a chance [laughter]. Then after four years things getting more
severe, and another four years and then we just apply for permanent visa, and even
before we got permanent visa, at the time, AMC’s policy was that you couldn’t take the
AMC exam —at the time they said - too many in the medical course, too many people
come in, and they even impose, say even if you pass the exam, ahh, they only take the
Registration

top 200 people in each exam, to go to next step, and ahh, so at that time I wasn’t able 
to, to, sit the exam, because of English. So I just try to improve my English and get 
prepared for one day when I can get the permanent residency visa, and um, the AMC 
exam, but things changed because things come up from time to time and sometimes 
they are unexpected and I got my permanent residency visa in 1994 ... I passed my OET 
[Occupational English Test] test in 1995, and then time for MCQ [multiple choice 
question]. At that time I thought that because people keep saying it is a very hard 
course, it was very hard to pass the AMC exam at the time, I thought why not? At the 
same time I applied for university, to do the [medical] course and because I can start 
from second year - one year exemption, so, if I got a degree from here it would be a 
better qualification than back home. I applied for university, medical faculty, in all of 
Australia, and most of them rejected my application, one from Perth university, they said 
that, already had enough from overseas, and the others say no, or alternatively I do full 
VCE [Victorian Certificate of Education]. At that time I had done VCE English, but I had 
not done many subjects yet so it seemed not immediately possible. So the only exception 
is Tas[mania] Uni[versity] and when they got my application some time later they sent 
me a letter and said, because they only got 60 places there, 60 places, they said how 
many for local Tasmanians, how many for interstate, and some for international 
students ... The university would encourage to, give more preferences, because I only put 
down medicine, to enhance my chances to get into university. At that time I look at the 
whole list of the categories, from the maths, physics, and they are not very useful, so I 
thought I would put down law and ahh engineer, and they offered me a place in law 
school, in 1996.

Anna: You started in 1996?

Dr Yang Fuquan: You were in the same year?

Anna: Yes that was the year I started medical school. We would have been in the same 
year!

At this stage I could not help but compare Dr Yang Fuquan’s story to mine, especially
considering that he would have been in my year in medical school at the University of
Tasmania had his application been accepted. I reflected on my own smooth progression
to employment; taken for granted. I did not have to face the changes and uncertainties
that Dr Yang Fuquan did. My experiences were different because I was a local medical
graduate and I did not have to exert the same energy that Dr Yang Fuquan, as an
overseas doctor, had to expend to work in medicine in Australia.

In saying this I am not making any comment on the need for overseas doctors’
qualifications to be checked or upon the need for their assessment. Rather I have
argued that because the overseas doctors have been trained elsewhere they are
regarded as less competent and their skills as inferior. This means they are ‘allowed’ to
work here yet rarely are included. It means they need to adjust to these constraints if
they want to work in Australia. Returning to Dr Yang Fuquan, he is now up to the part in
his story where he finished law school and then worked for several years in the
Department of Discrimination.

And then I went back to China and come back and my friends give me, the federal
government advertisement, for overseas doctors, I sent it to you? And I decided just to
ah, change my plan, my original plan, I had to change it, otherwise, the situation might
change again because 16 years ago there were too many doctors, now there is not
enough doctors, if I miss that, say four or five years, they might say too many doctors
again, until the next sixteen years [laughter], or maybe it will never happen again? So I
decided, just get this opportunity first, and then ever in the future if I want to go back to
legal studies I can in the future ... Some stage in 2005 my friend, actually my sister’s
university classmate, ahh, got a friend who is overseas trained doctor working in Victoria
in the program, in 2005 – she said at the time she can work in a remote area, she said
they really need doctors —even tried to go back to China to recruit doctors, then my
sister’s friend said, quickly pass the MCQs and then you can get a job here. I said OK, so I
finish in 2006 March, and then I rang her, and she said it is too late, the situation has
Registration

changed, now you need to pass the MCQs and have experience, or you pass the clinical as well, and I thought OK, things keep changing, we can’t change the thing or but we can try to adapt, so I try to pass clinical and yeah I believe that things come up from time to time as long as you are ready ...
(Dr Yang Fuquan)

Summary

Overseas doctors adjusted, constantly, to the ever-changing policies and accreditation requirements of the registration process they found themselves part of. These were particular types of adjustments, modes, that involved filling in paperwork and job applications and sitting for exams. Employment conditions for skilled migrants are notoriously unstable (Syed 2008, p31), and the ways in which they adjust to their attempted management has not been well researched previously. In this chapter I have provided an analysis that is imbued with the voices and practices of the overseas doctors themselves.

Registration was a complex patchwork of a number of different interrelated actors. Various researchers find particular influence exerted by the state, or by medical professional organisations, or recognise that it as an interrelated and complex process (Williams 2007, p36). Few study the ways that overseas doctors negotiate such regulations. Those that do include the voices of overseas doctors in their studies, often position them as powerless in the face of the credentialing process (Shuval 1997, p14). Instead, in this chapter I have shown that overseas doctors have ways of adjusting to ambiguous limitations and the management of their medical work.

It is precisely their ability to adjust that worries ‘the managers’ and has led historically to further restrictions on employment. Many researchers and commentators have used fluid metaphors to describe the overseas doctors, discussing the pool of doctors, the
inflow of overseas doctors, an absorptive capacity being reached. I am slightly reconfiguring these metaphors by focusing instead upon the fluid behaviour of overseas doctors in their adjustment to change. As I have emphasised, these adjustments were not effortless, they did not happen easily.

When overseas doctors came to Australia to work they had certain expectations and hopes. However, they soon come across the registration requirements which they had to complete before starting work. Perceived as limitations, in the context of the workforce shortages, the system thus appeared to overseas doctors to be simultaneously inclusionary and exclusionary. In a recent report from the OECD (2007, p131), attention was given to the mismatch that skilled migrants often find in new countries, when the value of their degrees are viewed differently. This chapter has empirically highlighted the uncertainties of many overseas doctors negotiating the process of registration in Australia.

In adjusting to registration requirements, overseas doctors highlighted the dynamicism of the accreditation system. The writing of this chapter, with constant, ongoing additions as changes in the process continued to evolve, is also testament to the complexities of these processes. The overseas doctors' adjustments revealed inconsistencies and discrepancies concerning registration. These are issues that many skilled migrants face. Others have also argued that by studying overseas doctors we can learn more about broader national politics. Kunz (1975) argued that the treatment of refugee doctors in Australia in the 1950s was a reflection of the ways in which all migrants were considered in Australia at the time. Raghuram and Kofman (2002, p2073) found that their study of migrating doctors highlighted the shifting geographies of skilled migration in Europe, and the roles of the state and regional legislation in reshaping British labour markets. Groustis suggests that her study of the process of qualifications accreditation for overseas trained professionals highlighted the difficulties the state encounters in fulfilling its objectives in relation to skilled labour. She writes, ‘the
experience of overseas trained doctors from NESC[s [non-English speaking countries] features the disparity between the groups' reality and the state-driven policy rhetoric' (Groutsis 2003, p81).

Overseas doctors have adjusted in their different ways to what are arguably, and in many cases necessary, constraints on their practice. In this chapter I provided some international, historical and contemporary context to the registration process following an interconnected arrangement of actors. The next chapter continues this study of adjustment by looking at how overseas doctors adjusted to paperwork in hospitals. The chapter is about how overseas doctors negotiated the documents that are often implicated in the ruling relations of the hospital and which carry invisible traces of institutionalised social relations (Quinlan 2009, p628). Stitching these two chapters together is a sensory interlude of about food, and about how we are constantly threading, in embodied ways, from the past to the present.
Interlude Three: One Evening in an Indian-Chinese Restaurant

Food. It was everywhere during fieldwork. There were microwaved dinners in the cafeteria, birthday cakes, free coffees, drug company lunches, lunches on the run, parties and homemade biscuits with the Sunday study group. In the rehabilitation ward tearoom, where most of the action takes place in Chapter Eight, staff laid homegrown chillies on the tables to share, cooked curries that were not too spicy for Dr Nikolai Nagorsky and compared cabbage recipes. The staff on this ward connected through the food and through the food, they adjusted to each other and to their workplace.

On what I thought was the last day of fieldwork I went to a restaurant with Dr Surekha Sadafule, her husband and her son. I had heard a lot about this restaurant from Dr Surekha Sadafule during my time with her. It specialised in Indian-Chinese cuisine. The Sadafule family longed for this food, which was their favourite in India, and had found a restaurant which they regarded as one of the best in Melbourne.

The food was pre-ordered because Dr Surekha Sadafule’s husband was on a late shift that night. For entrée we had chicken corn soup (except for Dr Surekha Sadafule who was a vegetarian). They had asked for it to be mild because they thought I would not be used to spicy food. For the main dishes we had American Chopsy, Manchurian chicken, Manchurian broccoli and a fried noodle ‘special’. All of the dishes were ‘Chinese’ but with sauces that tasted Indian in flavouring. The family told me that they did not actually like Chinese food – they found it too bland and preferred some spiciness with it. Over a dessert of hot Gulab Jamun with cold pistachio Kulfi we talked a little about the food and they reflected on their time working in Australia.

The Sadafule doctors were particularly preoccupied that night with the Administration department. They felt that Administration tried to get all of the medical staff to do extra shifts or gave them a hard time, but the difference was that the local doctors knew what
they could and could not get away with, they knew the system, whereas the Sadafules thought that international medical graduates did not know the system. The Indian couple considered overseas doctors to be in a more precarious position and that administrators knew this, knew that the overseas doctors really needed and wanted their jobs, and thus took advantage of this. Dr Surekha Sadafule emphasised that not all of the Administration department was like this, only perhaps 20%, but it was this 20% they had come across recently that coloured their thinking. She and her husband said that they had been learning the system from ‘the local grads’, who reiterated that they should not have to do the night shifts or have to fill in for someone who had given more than 24 hours notice about a shift. Before they knew these hidden rules, the Sadafules had always happily obliged with Administration requests because they had ‘not known better’.

Soon our desserts were finished and it was time to leave. Before departing the restaurant we had some mouth freshener from a little dish on the main counter. Dr Surekha Sadafule’s husband said that once he saw an ‘Australian’ woman finish her meal, have some of the mouth freshener and then go back and put her finger through the butter chicken so that the sweet sauce was the last taste in her mouth. He mused that ‘different people have different tastes’. For example he said that they were getting used to the order of wines that were given to them in wine tasting sessions. He gave me a handful of the freshener which tasted a little of candy, mint and caraway seed.

People adjust their tastes when they travel, but food preferences are always combined with past likes and dislikes, smells and flavours we have grown up with. As we travel we find ways to incorporate the past in our new environments. Travelling expands our habits and exposes us to different ways of doing things. Adjustment always takes something from the past into the present. We learn from our new contexts, are exposed to new things, through tasting, bit-by-bit. Similarly the Sadafules had learnt from the local doctors, over time, about how to ‘deal with’ Administration, adjusting in
the process.
Chapter Four: Paperwork

Administration with a capital A is a beige-carpeted place in the hospital that seems to be held together with paper. The novelist and physician Jed Mecurio describes this department well in his fictional account of a hospital, *Bodies*:

> The long, long corridor slips behind me and I pass through the swing doors at its end. There are no windows and my eyes are mole's eyes under the crackling strip lights. Arrows point into a set of steps and I follow them down to a pair of oak doors. When I push through them the floor under my feet becomes carpeted and around me I don't see any more uniforms, only suits, and the smells aren't hospital smells but those of offices.

(Mecurio 2002, p321)

In the previous chapter, the paperwork that infused the lives of the overseas doctors concerned visa applications, written exams and job applications. Often this paperwork side of 'the system' was encapsulated within the walls of Administration, a department that required significant negotiation, not only for employment opportunities and certification requirements, but also throughout their work in the hospital, as the Sadafules spoke about in Interlude Three. There are other places in the hospital that seem to be made of paper, such as the medical records department where columns of patients' files await digital transcription. These are places where hospital paperwork is more visible. In this chapter I examine less visible, though incredibly pervasive and mundane forms of paperwork: the everyday documents that were written on, read and used as forms of communication by the overseas doctors in the hospital. This is administration in the lower case.

Whilst computers are a growing presence in the daily life of hospitals, doctors' work is still heavily reliant on paper. Paperwork finds its way onto most reception desks and pin
boards, into pigeonholes and patients’ files. Hospital staff deal with this paperwork everyday. Pieces of paper are signed by patients, written on by doctors, handed between PSAs and hurtled through pneumatic tubing systems in plastic tumblers to pathology and radiology departments. During ward rounds, notes are scribbled in patients’ records by doctors balancing folders on bed rails. Referrals to other medical and allied health departments are made on slips of paper torn off pads lying about the ward and hard copy discharge scripts are still sent to the hospital pharmacists. Over time, some papers grow old and yellow and many are shredded or burnt in the large incinerators at the back of the hospital.

Paperwork was a material part of the environment that the overseas doctors adjusted to. This aspect of the system is what helps to tie the hospital institution together (Mol 2002, p82). Paperwork is considered important in medical work for many reasons concerned with accountability and communication. I have highlighted it as an aspect of the overseas doctors’ new environment in this thesis not only because of its pervasiveness and importance, but also because there are many practices tied up with paperwork that those familiar with a system often take for granted. The overseas doctors’ negotiation of administrative tasks often helped to reveal the social norms and rules of engagement inscribed in the documents. In doing so, they simultaneously revealed the ways in which every practitioner adjusts to the ‘constraints’ of forms and requests slips. Throughout the chapter, the overseas doctors’ pasts are also held in greater relief, as are their diverse ways of adjusting to administrative tasks.

Three ethnographic stories concerning three pieces of paper illustrate these points. The stories are prefaced with a discussion of the differences that overseas doctors found in their paperwork in Australia and a theoretical basis from which to think about paper in this chapter. Then the first story follows an overseas doctor with a radiology referral slip, to show how paperwork ties departments together, and how overseas doctors had difficulties knowing the right ‘codes of conduct’ by which to communicate information.
Paperwork

this way. The second story unravels through a more protracted moment of miscommunication concerning a discharge script, during which an overseas doctor works with those on her ward to adjust the paperwork required by the pharmacy department. In the final story, an overseas doctor nearing retirement is introduced, whose work is immersed in paper. He recalls a significant point in his early career in Australia concerning paper, which was a pivotal moment of adjustment. These stories of adjustment accumulate to allow a better understanding of how overseas doctors negotiate their new work environments and the social labour involved in moving their embodied practices between clinical contexts.

The significance of paperwork to the overseas doctors

On numerous occasions during fieldwork overseas doctors would make the observation that one of the most obvious differences they found between their medical work in Australia and elsewhere was the emphasis placed on paperwork. Dr Surekha Sadafule for instance was surprised to find that her medical work was only 50% clinical work, with administrative duties making up the other 50%. This was significantly different from her work in India. She found that in some departments, such as emergency, the clinical work was only 20-30% of the work. The emphasis placed on paperwork in their new workplaces was often contrasted with a procedural emphasis (explored in Chapter Seven) in their previous experience. As Dr Pham Ba Hung explained:

*I learnt the system. On the ward rounds I take notes, check the computer, blood tests ... in Vietnam, everyday I do five endotracheas [see Medical Glossary], I did some everyday, and lumbar punctures [see Medical Glossary] ... the biggest difficulties [here] are in writing the referral letter, on the phone. The difficulty is in not knowing the system.*

(Dr Pham Ba Hung)

For Dr Pham Ba Hung, the little attention that he had previously paid to employment
paperwork had already had significant consequences on his first few months of working in Australia. He had been in Vietnam until the day before he was due to start work. However, because of a misunderstanding with the Administration department, he had not completed the appropriate paperwork. This meant that he could not start work until three weeks after his term had started. By then, Dr Pham Ba Hung noted, the other two (locally trained) interns on his unit had ‘learnt the system’, which made it hard for him and hard for the nurses to understand his ‘newness’. He told me: ‘I could see the upset on [the nurses] faces’.

Whilst spending time with Dr Pham Ba Hung it was soon evident that he found the documentation necessary for his job a less familiar practice than the other two interns on his unit. Performing a procedure was much more straightforward for him than documenting it, and therefore the procedural work was prioritised. For example, one morning he swiftly, but gently and neatly, inserted some sutures to anchor a patient’s drain (though it had taken some time to set up because he did not know where the required instruments were and had sent a PSA to look for the packets and suturing kit; more of this in Chapter Seven). After the procedure was finished he left the ward in a hurry without notation of what he had done in the patient’s file. Documentation was not an ingrained practice, and so not considered when he was rushed. At other times, when he had to fill out paperwork to order tests or complete drug charts, Dr Pham Ba Hung often laboured over the forms. He would take time to fill out the information, regularly asking for help from the nurses. It was Dr Neelan Tiruchelvam who clearly expressed the frustrations that Dr Pham Ba Hung and many overseas doctors had with documentation:

*Here you do the paperwork. Mainly you are not practising medicine as an HMO – you are doing clerical jobs.*

(Dr Neelan Tiruchelvam)
Dr Neelan Tiruchelvam was told on numerous occasions by both his registrar and consultant to tidy-up his paperwork and improve his documentation. His consultant, Dr Mladen Mück, had developed his own complex relations with administrative tasks. Whilst Dr Mladen Mück spent a lot of time complaining about the emphasis on record-keeping in the Australian system and his frustrations with midwives who wanted everything ‘written down’, I would later hear him tell Dr Neelan Tiruchelvam and other junior staff about the importance of making adequate notes. He also warned his younger resident/registrar Dr Rudrangshu Mukherjee to be mindful of the medico-legal aspects of his work and the necessities of making careful notations. On other occasions Dr Mladen Mück complained to me about what he viewed as the extremely litigious nature of Australian medicine. Working in 'the system' now for 'some time', he had become very aware of the need to ‘write things down’ and had developed his practice accordingly, yet remained critical of these processes. He commented, however, that he had little choice but to change according to 'the system'.

_"I give my opinion, put it in writing. There are pros and cons, but this is the most efficient. You may think it is better to do it another way ... you learn not to be judgemental, not to give your own opinion ... I have changed, not 100%, but I have changed according to local habits."_

(Dr Mladen Mück)

Paying attention to the differences that overseas doctors noticed and their various ways of adjusting to paperwork in the hospital highlights the relative abundance and the prevalence of documentation in the local system they found themselves in. The relatively fewAdministrative offices, personnel and volume of administrative work in ‘foreign’ hospitals have been noted by sociologist William Glaser (1963, p39) in his cross-national comparison of the institution. ‘Writing things down’, taking notes, writing the referral letter and other clerical jobs are all more or less accepted practices of local staff, however begrudgingly. Local medical students are increasingly being inducted into
administrative procedures during university, in electronic and paper-based forms. Many students and doctors, both local and overseas, find documentation cumbersome and not the 'real medicine' that they had dreamed of practising. Dr Surekha Sadafule told me that as a medical student she thought that doctoring was about finding a diagnosis and had not envisioned the administrative side. She expresses the opinion of many doctors, wherever they are trained.

However, Dr Surekha Sadafule also believed that learning the administrative side of medicine in Australia was harder for overseas doctors because the local doctors had been coming to the hospital for years, and so were more aware of these bureaucratic procedures. Perhaps it was not so much that locals were more aware of the paperwork, but rather that they took administration tasks for granted in their work in hospitals. As Mecurio writes in *Bodies*, these are embodied practices:

> My next night on call evolves in slow motion. The clock in Casualty creeps round from one to two to three while my hand writes two pages of notes, four blood forms and an X-Ray request for every patient I admit.

(Mecurio 2002, p100)

Learning what, where and when to write becomes an embodied practice and the hand can write pages of notes almost without thinking, *in familiar settings of practice*. For the local doctors these habitual techniques were inscribed in their paperwork practices. Dr Hossein Youssefian thought that the local medical graduates were ‘good’ because they were organised and documented things better. The difference between those trained in the local system and those trained elsewhere, was exemplified by the practices of two doctors, one trained locally and another trained overseas, during a medical team ward round. The local doctor appeared extremely organised; her folder full of forms ready to bring out whenever required, such as pathology slips and drug charts. On the other
Figure 7: Medical education in India
hand Dr Marian Munteanu, a gentle paediatrician who could often be found with patients’ stickers running down his arm, appeared much less efficient in this regard. He had to spend some time finding and filling out forms. Later in the day, I asked him what he would take from the Romanian system, where he had predominantly worked in orphanages, and transplant here. He replied, very definitively and with a smirk; ‘less paperwork!’

Whilst overseas doctors’ unfamiliarity with paperwork is often noted, particularly in regards to legal aspects of documentation (Whelan 2005, p177; Gastel 2006; Porter et al. 2008, p38), this chapter examines in greater depth how overseas doctors adjusted to paperwork in situated, embodied ways that drew upon their past practices. These were adjustments that happened in the midst of practice. Thus this chapter departs from the focus of many orientation courses upon administrative departments in Australia such as Medicare and MBF (a private health insurer), which have a structural yet little practical influence in the overseas doctors’ day-to-day paper-based work.

Paperwork is intended to enhance communication, as becomes evident in the following ethnographic story. Sociologist of science Marc Berg (1996, p501; 1997, p514), whose work I draw upon throughout this chapter, argues that paperwork mediates and transforms the relationships that act and work through paperwork in the practices of reading and writing. Paperwork links together departments and carries with it important information. It structures the everyday gathering of medical information, facilitates communication between staff and allows for comparison of patients over time. It performs all of this by reducing detail, by being abstracted, selective and a structured representation of more richly textured work practice (Berg 1997a, p408).

The paperwork’s rules of engagement help to define whose role it is to use the paperwork, where it needs to be submitted and exchanged, and in what ways this takes place. Dr Pham Ba Hung was in the early stages of his work in Australia when I met him.
He was never fully confident of the necessary information required to put down on paper or to hand-over to a colleague, yet his role carried with him certain responsibilities that required this negotiation with paperwork. The story that follows examines how he negotiated a referral to the radiology department.

The radiology referral

It was the middle of a busy morning on Ward A in Hospital Y. Dr Pham Ba Hung and I waited for the two volunteers pushing a tea trolley with cylindrical funnels of hot chocolate, sugar and coffee to pass. As they did so, they left in their wake an aftermath of weak teas, gossip magazines and dog-eared Reader's Digests. We moved around the trolley to check on a medical student attached to the unit, who had been asked by Dr Pham Ba Hung to book an ultrasound. The student had misunderstood which patient required the ultrasound so Dr Pham Ba Hung helped him fill in the form for a diagnostic test. It took them both a long time to realise however that the patient's notes indicated it might actually be a therapeutic ultrasound (see Medical Glossary) that was required. During, this process, Dr Pham Ba Hung became increasingly confused. He looked further through the notes and the student wandered off, apparently no longer interested in this task.

Dr Pham Ba Hung briefly filled in the form and set off for the radiology department to deliver it by hand. Even though he was only in his first few weeks of the job, he already knew from his fellow interns that this was a more assured way of getting the test done, rather than sending the form by the pneumatic tubing system or with a PSA. Very soon, however, Dr Pham Ba Hung became confused about where to go (as was I); each time we asked for some guidance to radiology we were led in opposing directions. We finally found the radiologists. They sat in an internal pocket of the radiology department, in a dark film reading room, their skin illuminated eerily by the X-Rays on their computer screens. The radiology registrar was sitting at the desk, studying an image. Dr Pham Ba
Hung gave the referral slip to him, and the following conversation ensued:

Dr Pham Ba Hung: We would like to have an ultrasound to drain this patient’s abscess

Radiology registrar: [looked from the computer screen to the referral slip then up to Dr Pham Ba Hung] How do you know they have an abscess?

Dr Pham Ba Hung: CT.

Radiology registrar: The CT shows it? [the registrar looked at the patients UR [unit record] number on the referral slip and by typing it into his computer brought up the patient’s CT scans on his screen].

Dr Pham Ba Hung: [pause] Yes.

Radiology registrar: We can’t tell whether this is an abscess. Do they have Crohn’s [see Medical Glossary]? 

Dr Pham Ba Hung: [pause] Yes.

Radiology registrar: So they have Crohn’s. Have they had an op ... sorry I can’t understand you; I have to speak to my boss ...

[we waited for a man lounging back in white overalls to get off the phone and stop talking to the nurse. He wheeled over and the radiology registrar gave him a very short, concise presentation of the case]

Radiology consultant: The CT is dated two days ago. So why is this patient only being referred for drainage now?

Dr Pham Ba Hung: Because if you can’t drain it we have to have an operation.

Radiology consultant: Yeah I know that ... hmm [looking at CT] who’s your registrar? [an extended conversation ensued about which team Dr Pham Ba Hung belonged to] ... and how sick is this patient?

Dr Pham Ba Hung: He is on antibiotics.

Radiology consultant: No, how sick? It doesn’t matter, we’ll do it OK!

Dr Pham Ba Hung: [hesitantly] So ...

[the registrar and consultant just looked at him]

Dr Pham Ba Hung: When?
Radiology consultant: *We don’t know when, OK!*

As we left the reading room there was another intern waiting by the door with a radiology referral slip in her hands. I wondered how well she had prepared her paperwork and story, and what kind of interaction would play out. Walking away from the radiology department I could see that Dr Pham Ba Hung was upset.

Anna: *Going to radiology is very stressful huh?*

Dr Pham Ba Hung: *Yes, everywhere in Australia it is the same. I don’t understand it. In Vietnam it is very easy to get a test because the doctor makes money from it. Patients get these commonly, for minor things. The radiology companies are outside the hospital and they get money for the patients. Here, very hard.*

Dr Pham Ba Hung had never had to ‘sell’ a patient to radiology before and subsequently had only included the briefest clinical notes on his referral slip. He was new to this paperwork system, confused by the form and what was required when filling it out. When Dr Pham Ba Hung took the piece of paper to the radiology department to deliver it in person, one local technique he had already picked up, he became lost - the hospital’s rabbit-warren-like architecture heightening and allegorically representing his confusion and the stress of the situation in an unfamiliar place. When he arrived in the radiology department and presented the case to the registrar, he once again did not give the expected performance, and his awkward case presentation made the registrar quickly frustrated and Dr Pham Ba Hung further confused and nervous. The registrar made little effort to try and understand what Dr Pham Ba Hung was saying. The local doctor wanted an efficient transfer of information, of the kind he demonstrated when he presented the case to his consultant.

There is a style of discourse expected between those wanting radiological tests and those who can authorise them, a social norm ingrained into how the forms should be
filled out and the oral performance that is attached, when the request is presented verbally in person. A novice cannot always meet the radiology registrar’s or consultant’s expectations, whether they are trained overseas or locally. It is a form of discourse that has to be learnt and in the process there are situations of friction. During the latter years of medical school and during internship, locally trained doctors begin to learn ways to ‘deal with’ radiology and other departments. They learn the tricks of presentation for the radiology referral forms so that when they present these forms and the case to the radiologist, they have an increased chance of having the test done when their consultant demands it to be done. These relations gradually become more seamless and taken for granted over time, as they are refined and learned. It is how the institution runs smoothly.

Studying paperwork provides a useful lens into the work practices of an organisation, and what makes them run smoothly. Each form or referral letter in the hospital has been constructed from a line of articulation work or negotiations (Berg 1998, p235) that imprints the norms of the institution (Gerson and Star 1986, p257). Paperwork is thus embedded with social hierarchies (Berg 1998, p236) and plays an active role in medical work as part of the socialisation of doctors (Berg 1996, p501). When Dr Pham Ba Hung submitted the referral slip, his heightened confusion as a novice overseas doctor in the system, and his difficulties in negotiating the situation, revealed aspects of the paperwork’s required style of delivery for a smooth handover, as well as the fraught nature of inter-departmental relationships in the hospital. In the event, something was also learnt about Dr Pham Ba Hung and the economic environment in which he had previously trained. Throughout this process, the referral slip became more prominent, and aspects of what Akrich (1992) has described as its ‘script’, were revealed.

The forms that overseas doctors constantly had to fill in during their hospital work demanded ‘certain’ discourses and ‘certain’ words for seemingly seamless action. If they were not filled in the ‘right way’, if the form’s script was not followed, the overseas
doctor encountered a moment of miscommunication, to which they tried to adjust. The form’s script was learned through these adjustments, as doctors tried to minimise the time they had to spend writing the form but maximise their chance of getting the specialist referral or radiological test that was required. After each resistance encountered, overseas doctors slightly changed, to varying degrees, how they wrote the next referral. They incorporated their accumulating experiences of the local system into each bit of paperwork just as they also incorporated the remnants of their past working lives. The next ethnographic story explores these adjustments in the midst of practical engagement more closely, focusing on a pharmaceutical discharge script. Once again the overseas doctor, as a novice learning the system, revealed the underlying tensions in what appears to be a seamless paperwork trail between hospital departments.

The discharge script

*The scene starts in the rehabilitation ward tearoom with a birthday cake. I was in the midst of spending the week with Dr Elena Radulescu, who had sent me into the tearoom to drink coffee because I was looking a little tired. Whilst I sat at the table with the coffee warming my hands [it was a cold day], a nurse walked into the room and put a vanilla slice [an Australian mille-feuille] in the fridge, telling me it was for one of the patients, Mrs White, who turned 83 that day. Soon more nurses gathered, one finding a candle that sang happy birthday in a warbled kind of way. They carried the ‘birthday cake’ out to Mrs White’s shared room, staff gathering along the way, including Elena, all singing happy birthday led by the candle.*

(Recreated from fieldnotes)

It is not incidental that Mrs White turned 83 that day.

*After the birthday cheers died down, Elena sauntered back to the main part of the ward and sat behind the large desk, which also served as the front reception, facing a pile of*
patients' folders. Elena told me that her task for the morning was to “sort out” three possible discharges (patients who were most probably going to be discharged from the ward soon). Sorting out translated to completing a lot of paperwork. For example, one patient needed Rehabilitation in the Home (an ongoing community health service), which required some “considered organisation”, such as filling out of forms, ringing around, speaking to allied healthcare workers in the hospital.

(Recreated from fieldnotes)

All three overseas doctors that I spent time with on this ward needed to negotiate an interdisciplinary realm of referrals and follow-ups that were significantly different to what they were used to. Rehabilitation is a particularly striking example of the breadth of supposed interdisciplinarity in medicine in Australia, though it is certainly experienced in other units. The mass of paperwork required to make these referrals was a significant part of the rehabilitation resident’s job, and one that the overseas doctors adjusted to in varying ways.

Nose in the folders, Elena grumbled about the amount of paperwork needed to be done in these three discharges and how annoyed she was by the number of “outstanding” discharges which had not been completed by the resident in the job before her. Part of the documentation required was a discharge script for each of the three patients.

(Recreated from fieldnotes)

The discharge script is a list of the medications that the patient is taking at the end of their hospital stay, that once filled by hospital pharmacy, usually gives the patient enough medication to take for another week or two after leaving hospital, until they can visit their GP again. Writing discharge scripts is a routine, regular and mundane part of junior doctors’ work in hospitals. Constantly hassled by the nursing staff to complete them, the doctors do everything to avoid problems with both the nursing staff and pharmacy, making sure that the scripts are clearly written and have all of the required
information. These scripts are also filled with the potential for miscommunication.

I asked Elena about her method for writing her discharge scripts and she said that she preferred to check the old drug charts herself rather than the photocopies that the nurses provided for her, because sometimes things were left off the photocopies. She pointed out that for example a drug called Warfarin was left off the current drug chart she was copying into a discharge script. As Elena transcribed the pharmaceutical details from drug chart to discharge script, she also consulted a website to confirm the doses of the drugs and to find out how many tablets were in each packet. This is information commanded by the form, which she liked to “obey fully”. Elena told me that she liked to write clearly on all forms, charts and notes. She did write very neatly, though later there was some confusion with a nurse about whether she had written “hold fluids” or “had fluids” in one patient’s notes. After the nurse approached her about this misunderstanding Elena had turned to me and said that this made her realise just how important it was to write even more clearly. Elena talked about how you had to respect the form and what was required by it. She said that she had often seen doctors not write in capital letters for example [all of her drug charts were written in capital letters]. She told me the story of a nurse who had thought that four units of insulin, which was written “4 u”, were actually 40 units of insulin, and she raised her eyebrows up at me. Since then she said, she had been so much more aware of what she wrote.

(Recreated from fieldnotes)

Dr Elena Radulescu tried very consciously to avoid errors when filling in the discharge script. She was proud of the lengths that she went to, to ensure the accuracy of the script; by using the originals rather than copies, referencing information on the Internet and writing clearly in capital letters rather than lower case. Her heightened surveillance of this routine task highlights the range of possible miscommunications or mismatches that can occur, that she tried very self-consciously to avoid.
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Elena finished the discharge scripts for the three patients and rolled them into a plastic tumbler that she placed into a little chamber in the wall of the ward. After pressing a numerical combination for the pharmacy department, the package hurtled off down the pneumatic tubing system of the hospital. When this task was done, we went back to sit behind the reception desk. A cold draft came through the ward and we both put our jackets on. Elena went back to the patients’ files and started filling in a Centrelink [an Australian government statutory agency] form. She had trouble completing a section that asked how long the patient was going to be incapacitated. She went into the tearoom to ask some nurses for help. They reiterated how confusing the form was and showed her how to fill it in. Elena told me later that they do not have forms like this “back home”.

(Recreated from fieldnotes)

The staff on this ward helped Dr Elena Radulescu to navigate the unfamiliar paperwork as they knew more about how ‘it worked’, having been more ingrained in the system. They did so in the rehabilitation ward tearoom, a place that appears again more prominently in Chapter Eight. The Centrelink form is one of the many types of forms that the overseas doctors needed to fill out for medical insurance companies and other organisations. Many overseas doctors were not familiar with these connections to organisations outside the hospital. The forms that they filled in were sent out to these external bodies as well as down pneumatic tubes and to PSAs. There were forms flying all around the hospital system and outside its sliding doors.

The discharge script must have arrived at pharmacy, for a pharmacist appeared on the ward to ask Elena about a drug called Fosamax that she had prescribed. There was a discrepancy between the dosage of Fosamax on the discharge prescription she had just sent down and on the drug chart, for the-soon-to-be-discharged Mrs White. After having looked up the dosage of the drug on the Internet, Elena had changed the fortnightly dosage written on the drug chart to a weekly dose which she had written on the
discharge prescription. The pharmacist said that he had occasionally seen this drug prescribed fortnightly but that it wasn’t standard. However, he said that the most important thing was that the drug chart and her discharge prescription matched up. He said that legally they had to give whatever she had written on the prescription but that it was his job to check that they matched or if they didn’t, to look into why they didn’t. They talked further and she told the pharmacist that she would sort it out. She came over to me and said that now she was even more confused.

(Recreated from fieldnotes)

The discrepancy between the paperwork disrupted the smooth running operation between the rehabilitation ward and the pharmacy. Dr Elena Radulescu was required to adjust to this administrative mismatch.

Elena went to find her registrar to talk to him about this Fosamax dilemma. Her registrar, Dr Denzil Gunaratne, another overseas doctor, recommended ringing the GP to find out the Fosamax dose Mrs White had been taking prior to admission. Elena asked if he could do it and Denzil picked up the phone. Another cold blast came through the ward. Someone had left the ward doors open again and I got a chill down my spine. Elena pulled her jacket in tighter. Denzil then got off the phone and told Elena that the GP couldn’t remember the Fosamax dose and that his computer wasn’t working. Denzil wondered whether they should not just change the drug chart so that there would not be any hassles with pharmacy. Elena turned to a nurse and asked her what they should do and it was suggested that they could talk to the patient. Elena turned to me and said that this is why she liked being in a multidisciplinary team, although she never did go and speak to Mrs White. Instead, Elena looked up the patient’s old notes where she found it documented that the patient was on a fortnightly prescription upon admission. Denzil then recommended that they just cancel the prescription altogether. Elena looked at me with a quizzical expression as he crossed this out and she asked him to sign his squiggle to take responsibility. Denzil said that the GP could review the dose of the drug.
Dr Denzil Gunaratne tried to create a match between the drug chart and discharge script, to patch-up the discrepancy, first correlating the doses, then cancelling the drug on both chart and script. His actions revealed that not only did he want the GP to take ultimate responsibility for the patient’s care but also the hierarchy of social relations between himself and Dr Elena Radulescu, between the medical profession and pharmacy, between the doctor and the patient (who in this case was not heard). These numerous social hierarchies were wrapped up in the paperwork, embedded in its material form, tied up with who can write on what, where and when and who can authorise what, where and when (Berg 1996, p512; Berg and Bowker 1997, p526). Paperwork reproduces these hierarchical relations and shapes the interpersonal relations in the hospital (Berg 1996, p501). These aspects of documents are revealed most clearly by newcomers, like overseas doctors, in moments of miscommunication.

The GPs’ involvement had led to further confusion because he could not confirm the Fosamax dose, and rather than ask the patient, the doctors’ queries were also not confirmed by her old notes. It was not clear whether the doctor who created the drug chart upon admission was following on from the patient’s previous prescription or formulating a new one. Each moment of resistance forced the two overseas doctors into a form of adjustment, whether this was ringing the GP, changing the dose or cancelling it altogether.

At this point Denzil then also explained that in the studies he had read on bisphosphonates [the group of drugs that Fosamax belongs to], that these drugs were not effective for patients over 90 and that most of the studies had been done on patients between 65 and 70. Elena commented that perhaps Fosamax needed to be prescribed and taken weekly for the therapeutic dose to be reached but Denzil said that it didn’t matter with Fosamax. Elena continued to muse that if the patient wasn’t on the proper
dose of the medication it might have been the reason she had had the fracture in the first place [she had been admitted to hospital for a fracture of the head of the humerus].

(Recreated from fieldnotes)

At the age of 83, Mrs White was older than the participants in the trials and so it was difficult to apply the results of these randomised controlled drug trials (RCTs), published in the leading medical journals, to her situation. In hospitals, doctors have to adjust evidence-based medicine in the form of RCTs everyday to the moment-to-moment care they give to patients. They also adjust the information they hear in grand rounds, read in textbooks and that they gather from the Internet. These are all everyday adjustments.

When Elena told the nurse looking after Mrs White what they had done, the nurse replied that it would probably be cheaper for the patient to get Fosamax from the GP anyway because she already had her own prescription for it. The nurse sent the new prescription down the pneumatic tubing system, this time without Fosamax on it. I asked Elena if she had to prescribe this drug back home and she said “no”, that osteoporosis was not a condition that she had usually treated. She said that this could also be because she worked in paediatrics. She was more used to seeing rickets and prescribing calcium for this.

(Recreated from fieldnotes)

Before leaving this story, even more aspects of the local system are revealed. The conversation that Dr Elena Radulescu had with the nurse was in relation to the fiscal arrangements of the system, and the way funding was structured. Dr Elena Radulescu’s lack of familiarity with the drug also revealed the epidemiological profile of the disease and the underlying political economic conditions which affect this, providing more glimpses into her own past.
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The paper trail could continue, and reveal further aspects of the system if we followed the discharge script down the pneumatic tubes, back to the ward and into the ‘outside’ world with the patient. The Fosamax dilemma is interesting precisely because of what it opens up and the invisibilities it reveals. Through a mismatch between drug chart and discharge prescription, through Dr Elena Radulescu’s investigation and questioning and confusion and comparison, something is learnt about the system and how a series of relations and social norms normally make it run smoothly. The following, final story, provides details of another mode of adjustment to paperwork. It is from the point of view of a Sri Lankan psychiatrist near retirement, whose work was immersed in paper, and for whom paperwork represented a significant disjuncture in his practice.

The EEG

Dr Sarath Munasinghe’s rooms were in a simple suburban red brick house on a suburban street across from the hospital, with an old weathered sign out the front (the sort that they have in nature reserves, on old green decaying slabs of wood). The door had a wire-mesh screen and then a closed glass door upon which I knocked, and when there was no answer, walked away from. As I left, a woman came to the door and called me back into the main reception area where I waited until the doctor was free. Inside the reception, brown vinyl chairs were backed against one side of a large empty waiting room. There was a vase of artificial roses on the receptionist’s big table, which had an open appointment book on it and few other papers. Soon the psychiatrist emerged from his room with a patient and I was shown into his office by the receptionist.

In the diffuse midday light creeping through the almost closed blinds in Dr Sarath Munasinghe’s office I could see crammed bookshelves and an examination bench piled high with old files and psychiatry journals with yellowing covers. The doctor sat in a large cracked leather chair and in front of him was a desk piled with disordered files and unopened and opened letters. On the walls were framed certificates and a faded
postcard from Sri Lanka in a shell frame that seemed to be dated from the 1970s. Whilst Dr Sarath Munasinghe’s waiting room was sparse and empty, his office was filled with paper. Years of practice could be found in the musty journals and referral letters covering all work surfaces. Time seemed to have ‘stood still’ in his papery office, the work clock set at a different pace from the hospital’s next door. Here time ran on the psychiatrist’s schedule, the rooms often being closed whenever I visited on subsequent occasions, or that of his patients’, our interview being rushed towards its conclusion as a patient had arrived early for a consultation but needed to be seen quickly as they had ‘something in the oven’.

During our conversation, Dr Sarath Munasinghe spoke to me about his work in Sri Lanka, London and then Australia. When I told him about the research project (the informed consent for which he opened in ceremonial style with an ornate letter opener and then placed on a nearby teetering pile), he retrieved one of the yellowing journals from the bookshelf to demonstrate to me what he thought of research. He showed me a particular study and proclaimed that researchers never came to a conclusion about anything and that they were mostly ‘half-wits’. He sat back in his chair and waited to be interviewed. I asked him how he thought his practice might have changed by coming to Australia.

Dr Sarath Munasinghe: *The UK meant I could do anything I want without raising the eyebrows of the other doctors. Say ... if I treated a patient, and I thought that there were some physical problems, I could order an X-Ray, or order a CT scan and then, well, there was no CT scan then but there was tomography ...*

Anna: OK.

Dr Sarath Munasinghe: *So I can order any of those, and I can even order a lumbar puncture. Yeah, um, whereas here, in fact when I first came here I ordered, I ordered a lumbar puncture and an EEG [electroencephalogram] [he then got up and started rustling through a pile of overflowing papers at the back of his office]. I have got it here*
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with me because it is one of my special things [he continued to go through his papers and eventually brought out a large wad of paper that is the EEG and spread it out in concertina fashion on his desk]. I told the doctor I wanted to read the EEG because I was trained in Queen’s hospital of infectious diseases in London, so I knew how to read an EEG. I said I want to read the EEG. So he handed me the EEG, but before he did he asked the patient, “what does the psychiatrist want to do with an EEG?” You see. Things are different here... Here, I have to go through the man who is in charge ... I can’t go direct, because of the money or the practice involved so therefore that is one of the things I can’t do so I have to stick to psychiatry and nothing else. Which is very limiting ... The only way I have changed I suppose is to go my bit and palm off the difficult bit to the others, which is very unsatisfactory because I’m not helping the patient as I would like to, you see. So I will go and do my part, my half of it but actually I do about three quarters of what I should do, but I can’t encroach, so therefore I have to just wait till someone will have the sense to do the other half.

Anna: OK.

Dr Sarath Munasinghe: Yeah unsatisfactory, that is the argument. Otherwise, I’m quite happy here you see.

For Dr Sarath Munasinghe the EEG was a crucial marker of the beginning of his adjustment in Australia. It highlighted differences in the new environment. As ‘one of his special things’, that paperwork signalled when his status and opinion started to be questioned in regards to aspects of psychiatric practice he had normally been unquestioned about. It marked a need to reorient his boundaries of professional practice, a need that was raised by a local colleague, memorably, in front of a patient. Being questioned about his authority to read those reams of paper was a significant moment for the doctor and he kept the many pages of graph paper as a testament of crossing a threshold. His was yet another mode of adjustment, another way in which an overseas doctor had adjusted to the multifarious environment they found themselves in.
Not all change for the overseas doctors involved learning to adapt to more paperwork; for some it meant adjusting to severing relations with some forms of paper. For others it didn’t seem to involve paperwork at all:

Anna: *How do you find the system?*
Dr Saimon Ambi: *I don’t have to do many of the bureaucratic things – only those related to the cardiac surgery. I don’t have to know the whole system because of my level.*

These are all different modes of adjustment, including that of absence. What remained largely common however was that the overseas doctors changed in some way to accommodate to the system they were part of, something further detailed in the next section. In this process of adjustment, the overseas doctors brought with them a history of past practice. For Dr Sarath Munasinghe, it involved his relations with paperwork in Sri Lanka and the prestigious hospitals in London that he repeatedly mentioned. For Dr Elena Radulescu it concerned her meticulous checking and for Dr Pham Ba Hung it was tied up in his past relations with radiology companies in Vietnam. Each overseas doctor in the study brought with them a past set of relations to documentation and how they engaged with paperwork in the past influenced how they engaged with paperwork in Australia. These histories were inscribed, in bodily ways, in the movements of their pen, in the way they folded a form and in the scraps of memories they had of past patients.

**Splenomegaly instead of splenomegalia**

In the 1940s and 1950s a significant number of overseas doctors were employed in the peripheral margins of Australian ‘territories’ such as Antarctica, the ‘outback’ and PNG (Chapter Three). Dr Charles Haszler was one of these doctors. Schooled in the ‘classical gymnasium tradition with its emphases on the humanities and logical exposition’, he worked in PNG from 1950 to 1967, taking on the role of the first President of the Papua and New Guinea Medical Society. He is reported by S.C. Wigley (1967, pp41 - 42), in an
appreciation of his work in the *Papua New Guinea Medical Journal*, to have lived a life in Hungary 'in which music, books, theatre and political ferment were inescapable integral parts and overlaid by Magyar philosophy'. He was considered to be a doctor distinguished by 'the highest standards of performance', able to 'see things like the loss of a career in surgery, the Russian Front, and his experiences at General Motors Holden in their true perspective ... with quiet comment - continental and penetrating - always amusing, never arid or sterile'. In writing about his experiences in PNG, Dr Charles Haszler mentioned the differences he encountered concerning paperwork:

> Administrative procedures had to be learned by the New Australian doctors. We were soon to realize, after we started work, that sometimes it is hard to reconcile the Administration rules and health practice, at least as far as at that time the Continental way of thinking with war experience was concerned ... We who were specialists and were practicing for years on the Continent solely our specialty, had to relearn general medicine and remember our obstetrics, our dermatology, etc. We had to forget about the metric and the decimal system, and learn ounces, drams, grains and minims. We had to forget about the Latin diagnoses, which are commonly used on the Continent, and we had to learn to write in the Monthly Reports, English equivalents of the well known expressions. I was asked after my first Monthly Report that, in future, I should write in the Admissions and Discharged list "Splenomegaly" instead of "splenomegalia".

(Haszler 1967, pp37 - 38)

These are small details, but they are significant ones, and give some historical texture to the ways in which overseas doctors have adjusted since they started working in Australia. Like Dr Sarath Munasinghe, Dr Charles Haszler found differences between systems of paperwork and had to adjust his ways of doing things.
Overseas doctors learnt how to adjust in the midst of their practice in Australia. They adjusted to the requirements of the form, to the forms' terms of engagement, to the people with whom the paperwork was a medium in their relations. Overseas doctors learnt shortcuts, which words to emphasise and in what way to submit referrals. All of this happened over time; it took time. Rather than learning this in orientation classes and through manuals, overseas doctors learnt this in practice. They got a feel for how the referrals should be written, and learnt how to fill in a discharge script so as to reduce any misunderstandings. They learnt from the locals, for whom their own administrative practices were taken for granted.

**Ad hoc manipulations**

Local doctors not only incorporated paperwork more readily into their practice in ways which they too for granted but also demonstrated ways of ‘fiddling’ or ‘manipulating’ the paperwork to improve their efficiency and make the system run more smoothly. In other words, the locals knew how to adjust what they filled out on the forms, so as to get the required job completed as quickly as possible. An example helps to illustrate what I mean here. After a hurricane ward round with the colorectal surgical team, Dr Pham Ba Hung was left on the surgical ward with another of the locally trained interns. The two doctors did a handover, during which they discussed a patient’s referral to the gynaecology team. Dr Pham Ba Hung asked some questions of the other doctor, regarding the referral.

Dr Pham Ba Hung: *So is it PID [pelvic inflammatory disease]?*

Local intern: *No that’s been ruled out.*

Dr Pham Ba Hung: *So why are we getting a gynae[cology] referral?*

Local intern: *For abdo[minal] pain. Because we did before.*

Dr Pham Ba Hung: *It’s hard to make a referral about [something so vague].*

Local intern: *Yeah, I’ll just say that she’s sexually active, has abdo pain and query PID!*
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The local doctor knew how to make the referral form ‘work for him’ and was going to adjust his wording on the form to ensure the referral was ‘picked up’ by the gynaecology registrar, so that the patient was seen quickly, as requested by the surgical consultant. Trained in the system, the local intern knew ways in which to work both within the forms’ guidelines but also how to manipulate them, to make his job easier. It was the overseas doctor’s questions that revealed, momentarily, the hidden workings of this process.

Paperwork is often intended to behave in a uniform, stable and predictable way (Berg 1998, p234). However, as I have shown in this chapter, and as others have done so in their ethnographic studies of paperwork, such as Berg’s (1996, p515) study of the medical record, paperwork is also continually ‘worked around’ by people. Berg (1996, p513) emphasises that paperwork does not determine action, but is rather constantly reinterpreted and overridden. I have described this process as modes of adjustment whilst Berg (1996, p514) describes these ad hoc manipulations as ‘repair work’. Berg (1996, p514) extends this by arguing that flexible tinkering practices are essential to the paperwork’s functioning in getting medical work done. He does not prioritise these flexible practices over formal ones however, but rather argues that the informal and formal merge and interlock (Berg 1996, p515). Actors will always ‘fiddle’ requirements in order to get their work done (Gerson and Star 1986, p258). This is the way that systems run more smoothly.

Just as they revealed the mundane and often taken for granted presence of paperwork and its inscribed social norms, overseas doctors also revealed the everyday adjustments to paperwork made by locals in the hospital. They highlight the adjustments that practitioners made everyday with paperwork, in multiple ways with multiple forms, between different disciplines of practice. Through their adjustments to paperwork, overseas doctors help to reveal more about the formal and informal negotiations of the
administrative system of the hospital. They do this most obviously in events of miscommunication when they are in the process of fitting in with local norms.

Summary

This chapter has explored adjustment through three ethnographic stories. Collectively they have told us something about working in a multifarious environment, detailing modes of adjustment and the different ways in which the overseas doctors negotiated paperwork. I argued that paperwork was part of the seamless work of the hospitals, black-boxed and taken for granted by locals familiar to that environment. Interns educated in the Australian system learnt quite early to regard paperwork as just ‘part of their job’. Ingold (2000, p407) writes that it is when we use things without difficulty or interruption that they effectively vanish as objects of our attention. For many overseas doctors the administrative aspect of their work in Australia was something new and they were conscious of needing to learn this paperwork system. Their adjustments could be emotionally difficult and the miscommunications entail frustration and annoyance. Learning in practice demanded considerable effort.

As they learnt the system however, overseas doctors also started to take paperwork for granted. In doing so, they become folded into the system in a continually evolving way. Their adjustments will be ongoing because the paperwork will always change. Increasingly more forms will become electronic and prespecified, in the process changing the notions of hierarchy and other social norms in the hospital (Berg 1997a, p428). Once again we can ask: do the overseas doctors ever stop adjusting? In the next interlude Dr Nikolai Nagorsky reflects upon the stages of adjustment that the overseas doctors undergo, and whether or not they are ever able to receive their ‘full licence’ and become local practitioners. The chapter stitched on the other side of this interlude then explores, in more ethnographic detail, one crucial and unavoidable stage in this process: assessment.
Interlude Four: Getting Your Licence

[Rehabilitation ward staff room, middle of the working day. I am sitting at a small table with Dr Nikolai Nagorsky. A nurse enters the room]

Nurse: I won’t interrupt your lunch – can I just put this here for you to sign?

Dr Nikolai Nagorsky: Hmm.

Nurse: No you don’t have to do it now I don’t expect to interrupt your lunch, but it’s for a patient to get the equipment from ED, it ...

Dr Nikolai Nagorsky: Yes because I know him very well.

Nurse: Thank you.

Dr Nikolai Nagorsky: [something about a spot on the form to fill in]

Nurse: Don’t worry. I will fill that in, don’t worry about that, where do you sign?

Dr Nikolai Nagorsky: Leave it and I will sign there.

Nurse: And I’ll just put your name up the top.

[nurse leaves, apologising for interrupting and we return to the interview questions]

Anna: What does it mean to be identified as an international medical graduate?

Dr Nikolai Nagorsky: What does it mean to be identified, it is a good question [pause]. Generally speaking, it means, it means that you are like, like, when you drive a car, you are a learner and a probational yeah? You start as a learner, that is what we also have to impose onto the minds of international medical graduates, that you come here as a learner, and then you have P probationary, and then you graduate, yeah, because I see now, I see people who start like me from the very beginning as learners, probationary and I see those who are already in the consultant position and you can tell that this person is a consultant already, he is not a learner at all, not on probation, he is already a full blown medical practitioner here, who has the respect of his other colleagues although he speaks with accent, he is from a different background, religious or whatever, but he is already not overseas trained, he has passed all of these stages, he is already Australian, Australian made, because they made him out of this learning and probationary, yeah.
Anna: So he is no longer an international medical graduate?
Dr Nikolai Nagorsky: Who?
Anna: The doctor at the consultant stage.
Dr Nikolai Nagorsky: At the consultant stage? Yeah — no, they are already good.
Anna: OK, this is really interesting, so what other, what is the L stage and what is the P stage?
Dr Nikolai Nagorsky: L stage when you come here and you are not speaking English OK, even understanding the commands of the instructor, driving instructor, and still, doing, something which you are not supposed to do because you are learning. You come to the pedestrian crossing. In your country you would cross it without hesitating but here you must stop, or like Africans, they cross the intersection on a red light because they have different rules there. He could come here and he would do the same thing here, because he was doing it all his life, crossing on the red light, so the same with us also, so we have to be learners.
Anna: So what does it feel like to get your licence in one place and be on your Ls in another?
Dr Nikolai Nagorsky: [munching] I had a licence, a driver’s licence, driving on the right side of the road. Now I am driving on the left side of the road. It is upside down, so it takes time to change everything in your mind — the same rules, the same steering wheel, everything is the same — it is a good example by the way – but something is not the same yeah – you are driving according to the rules of this country. You know what? If you come, and you are not trained properly, you can actually forget where you are driving and go on the wrong side of the road and then have a head on collision – that is what is happening with us many times.
Anna: Can you think of a time ...
Dr Nikolai Nagorsky: Of course, like in Africa, when you think that you are still back home and trying to push your things and you collide.
Anna: So what is the P plate stage?
Dr Nikolai Nagorsky: The P plate stage is um, it’s again, it’s like you went through the
learning process, whether you went through internship, here, because some, they come and they say OK, that they would rather go back through the internship ... I think that I am still in the learning seat – probationary would be maybe near the fourth, fifth year of training here, that’s how long it takes.

Anna: And when you will consider yourself with a full licence?

Dr Nikolai Nagorsky: Yeah, the full licence will be, I believe, you know because it is always time, you do rotations, and again you do rotations, because after each rotation you have to have an assessment done on you, so that the instructor, the supervisor will write an assessment about your performance, and say, OK, this man is ahh displaying capacities, good capacities, display good nature, ahh, passionate about patients about the staff, always is polite, ambitious, and that is what is happening, and they would not give you good reference if you are not good – so it means if you don’t get it you have to go back and get more – if you are going OK then you just generate these things and you learn – because again it is like you are learning all the time ...
Chapter Five: Assessment

Most overseas doctors I met acknowledged the necessity of assessment, of needing to meet standards. Standards were viewed as a mark of competence and equivalence. The doctors had been conditioned to the importance of examination in their medical schools. When they arrived in Australia to work however, many were surprised by the number and nature of assessments that had to be completed to practice unconditionally in Australia. It took substantial effort to adjust to the style of these examinations, to learn what content was emphasised, and to balance the logistical details of when and where to sit the exam. This social labour is often not acknowledged in discourses concerning the assessment of overseas doctors or in the discussions of those proclaiming the need for standardisation in medicine.

In Chapter Three I highlighted how the assessment component of the registration process - the English (OET) exam, AMC written and clinical exams, specialist exams and on-the-job assessment in the hospital - were (and still are), ever-changing; that they were political, controversial and full of discrepancies. Exam formats changed, pass marks were redefined, quotas placed and removed, the permissible number of attempts extended and contracted (Hawthorne et al. 2007, p76), and more recently, assessment pathways opened or closed according to where you obtained your medical degree. The only consistency was the assessments' tendency to change. I discussed how overseas doctors adjusted to these ongoing changes in registration, part of which included assessment.

In this chapter I focus on the overseas doctors' study practices which entailed adjusting to assessments imbued with curriculum 'standards'. I explore the ways in which overseas doctors adjusted to these standards, highlighting the difficulties of assessment and the paradoxes entailed in this process. As previously defined, adjustment implies an attempted 'harmonisation of particulars', and in this chapter I pay attention to ways in...
which overseas doctors tailored past study and clinical practice and reconfigured them to be able to demonstrate their 'competence' in exam formats.

I begin with an outline of the AMC pathway, as this was the most common assessment pathway for the participants in this study. I then discuss the overseas doctors’ study practices by venturing into hospital libraries, cafeterias and tutorial rooms where this social labour took place. The chapter examines the overseas doctors' memorisation of old exam questions, the difficulties experienced doctors had with AMC MCQ format assessments and ways in which overseas doctors learnt the techniques of the AMC clinical exam. The analysis of this chapter concentrates on what these adjustments reveal about the standards embedded in Australian assessments and the many paradoxes inherent within this process. I undertake a critical analysis of the role of standards in contemporary medicine and dismantle notions of a standardised assessment process. Finally the chapter underscores the overseas doctors' efforts entailed in these adjustments, in trying to have everything in balance.

The AMC pathway

There have been a number of researchers who have extensively surveyed the landscape of assessment of overseas doctors in Australia, and Lesleyanne Hawthorne stands out as one of the leading scholars in this field. Throughout this chapter, I use statistics from one of her studies, completed in collaboration with Graeme Hawthorne and Brendan Crotty, to interrogate the argument put forward in this chapter. The sectioning off of this data into boxes is an invitation to the reader to alternate between the boxes and the main text, to adjust between quantitative analysis of patterns and qualitative research material exploring process (McDowell 2008, p502). It invites the reader to consider the place for connections between the quantitative and qualitative, their difference, and the space in between.
This section of the chapter deals with the AMC pathway, which as mentioned, was the most common assessment pathway for the overseas doctors in this project. The quantitative statistics in the box below show a comparative distribution of assessment pathways to those undertaken by overseas doctors in this study.

After surveying 1150 international medical graduates in Australia, Hawthorne, Hawthorne and Crotty (2007, p61) found that 85% of non-registered doctors were seeking registration through the AMC examination process, 8% through the Royal Australian College of General Practitioners, 5% through a specialist college assessment and 3% through other pathways.

At the time I was undertaking fieldwork, the AMC pathway was a progression from a written exam, to a clinical exam, then on-the-job assessment in the hospital, with the English exam needing to be completed sometime before employment. On the AMC (2006) website, the written exam is stated as being a test of the 'principles and practice of medicine', an assessment of the candidate's medical knowledge. On a long and exhausting day in an examination hall in one of Australia's major cities (and now in several off-site locations around the world), doctors had six hours to complete 250 computer-administered MCQs covering fields of medicine, paediatrics, psychiatry, surgery, obstetrics and gynaecology and general practice. The questions were designed by the AMC to be at an Australian medical undergraduate level (Gapper 2005, p417). This is an 'official' example of one of the questions on the AMC exam:

28. The most common arrhythmia in patients with hyperthyroidism is
A) sinus tachycardia
B) paroxysmal atrial tachycardia
C) atrial fibrillation
D) ventricular tachycardia
Chapter Five

E) atrial bigeminy


The AMC clinical exam consisted of a 16 station OSCE covering the disciplines of medicine, surgery, obstetrics and gynaecology, paediatrics and psychiatry. In the clinical exam, the overseas doctors role-played a doctor treating an actor role-playing a patient, whilst an examiner observed and assessed them. The overseas doctors had eight minutes at each station, the requirements of each differing but mainly revolving around taking a history, completing a physical examination and outlining plans for investigation, diagnosis and treatment. The AMC (2006) states that the aim of the clinical exam is to evaluate ‘clinical competence in terms of medical knowledge, clinical skills and professional attitudes for the safe and effective clinical practice of medicine in the Australian community’. This is an example of a station on the AMC clinical exam used during a Thursday evening tutorial for international medical graduates:

Information for candidate

You are the covering resident in a suburban hospital when you are called to see a 72 year old Mr. Jones who has suddenly become short of breath. He has had a fractured NOF [neck of femur] repaired 2 days ago, did quite well in the first 24 hours but became acutely short of breath about 30 minutes ago. The nurses are very concerned about him because of his acute wheeze, he looks sweaty, is restless and generally unwell.

Your task is to:

Assess the patient
Take further history as necessary
Order investigations
Discuss your diagnosis and management with the examiner
Assessment

The AMC exam was intended to mirror the final year assessments of an Australian medical student. It was intended to assess the knowledge and skills of a doctor who had trained elsewhere, using the Australian student as a 'golden standard'. However there are many differences between overseas doctors and Australian final year medical students, and the written and OSCE assessments become problematic measures of competence in this regard.

Dr Dumitru Bara: The locals here don’t have to do the AMC, do you?
Anna: [I shake my head]

Many overseas doctors felt like they were being placed under increased scrutiny, and had extra assessments, both before they worked and during employment. Dr Mladen Mück described this metaphorically when he said that:

*When you have a second hand car, it takes so much to register. They look at all the small cracks. But after you get your road worthiness, it doesn’t matter, all you need is updating. With a new car it is different.*

(Dr Mladen Mück)

The overseas doctors felt like they had to perform to prove their competence, as Dr Ashin Kuthala, a Burmese doctor who described his past career as 'floating on the Pacific', explains:

*Ahh yes, that is a small thing regarding the cannulation [see Medical Glossary] – when I was in Fiji island we called it Plastocaine. When I worked in New Zealand we called it lua or cannula, and when I came to Australia we call it Jelco. I say “what is Jelco?” ... a little bit variation from one place to another ... we have to have patience ... I had done thousands and thousands of cannulas in Fiji - nine years – acute case, myocardial infarction. I had to put them in myself, the nurses were so slow ... see this is small thing*
Chapter Five

cannula. We have to have patients and we have to be patient! Here, ahh I was asked so nice, “have you done before?” “yes I have done before” ... that is the usual question they ask, “have you done before?” ... a little bit asking in front of the patient, asking if you have done it before – a little bit that feeling ... after doing, after the performance of that procedure you feel better ...
(Dr Ashin Kuthala)

As I have argued previously, there is a sense in which the prior skills and experience of overseas doctors are devalued, and that they have to prove themselves in the Australian setting. Hage (1998, p62) argues that whilst nationals just have to be, migrants have to behave nationally to prove that they are nationals.

In this chapter I do not intend to critique the necessity of assessment, but rather highlight the ambiguities and paradoxes inherent in an attempt to standardise work across medical sites (Quinlan 2009, p638) and control for difference. I foreground the work that goes into adjusting to supposedly standardised assessments. The chapter highlights the modes of adjustment that overseas doctors undertake so that they can proceed through the stages of assessment, questioning whether these models allow a true reflection of their previous practice. The next sections step into the locations of these adjustments.

Studying in the hospital library

A library in Hospital Y provided a popular, widely accessed, central place in Victoria for overseas doctors to study for the AMC exams. On most days that I visited the library during fieldwork, there would be at least 20 doctors studying in the laminated carrels coated with pencil shavings and dust. At least several study groups of four or five doctors would also be sitting at tables in the designated discussion area. These tables would be piled high with photocopied pieces of paper and books. Doctors could often
be heard arguing in semi-hushed tones about the diagnosis of hyperthyroidism or the best investigations for acute pulmonary oedema. Timers would chime sporadically, marking the eight minutes that they had to complete the clinical station.

The hospital library was a place where overseas doctors could meet each other and engage in two practices considered by AMC candidates as necessary to pass the exams: obtaining and memorising past questions and learning exam techniques. On closer inspection, the paperwork on the tables were mainly old exam questions and the occasional recommended textbook. Some questions were those published officially as a resource set but many were also those copied out after being memorised by overseas doctors who had already sat the exam. These remembered questions were known by the overseas doctors as ‘recall questions’, a way of ‘paying it forward’ to your colleagues sitting the exam after you. Recalling questions was a well-recognised practice amongst overseas doctors. Recalls were either posted or downloaded from the Internet (e.g. aippg 2008) or passed between the doctors in the library, tutorials or other places.

Posted on www.aippg.net/forum: Sat Sep 30, 2006 12:57 pm
Post subject: AMC MCQ EXAM 2004 Melbourne

22. Patient playing game, squash court suddenly pain in ankle, no plantar flexion [see Medical Glossary], dorsal flexion [see Medical Glossary] limited and painful:

A/ rupture of medial ankle ligament
B/ complete rupture of Achilles tendon
C/ rupture of medial head m. solei [see Medical Glossary]
D/
E/
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Recently, two overseas doctors were investigated for posting answers on an Indian exam-preparation website and the AMC have threatened legal action for those caught publishing copyrighted material (Stark 2008). As many commentators have pointed out, the overseas doctors being investigated merely highlighted a practice not only common amongst the overseas doctors but also amongst local doctors. I remember copying out MCQs in medical school for the year below me, and studying from questions that had been provided by the years above, handed down in coffee-stained detail. In their study methods, and in ‘getting caught’, overseas doctors merely revealed a ubiquitous local custom. Their study practices revealed adjustments that were taking place everywhere in local hospitals, unveiling aspects of the local system that normally remain hidden from public view.

It was acknowledged that the easiest and most efficient way for overseas doctors to pass the AMC written exam, was to memorise both official and recalled questions. Dr Rudrangshu Mukherjee explained this to me:

Dr Rudrangshu Mukherjee: Well here you follow your own books and there is a standard set of questions. You can’t sit the AMC exam without knowing this set of questions, without knowing the status of the exam.

Anna: How did you find these out?

Dr Rudrangshu Mukherjee: It was by chance. I was at the Melbourne Uni[versity] in the photocopy room and there was a girl there photocopying a medical text book. She came up to me and said “Sir” and then my name – in India you call your seniors Sir [she had been in a year below him in medical school] – and she helped me find out where to get the exam questions from her cousin.

On the rehabilitation ward one day, Dr Elena Radulescu told me somewhat indignantly that ‘I know that doctors just memorise answers and get amazing results – but you can talk to them and see that their knowledge is not profound’. She highlights the
incongruency between what the written exams appeared to be assessing and what it did in fact assess: the study practices of overseas doctors, such as their ability to get hold of and memorise the questions. It is these study techniques that appeared more important in passing the written and clinical test than learning the knowledge it claimed to assess. This paradox also exists in many of the similar exam formats for local medical students.

**Studying in the hospital cafeteria**

Many overseas doctors passed the written component of the AMC quickly. Like Dr Rudrangshu Mukherjee they made connections, however serendipitously, and visited websites to obtain and subsequently memorise past MCQ questions. However not all overseas doctors passed the written exam so efficiently; there were different modes of adjustment. I met a large group of overseas doctors one Sunday morning in a hospital cafeteria, many of whom had been studying for the written exam for some time. I encountered the group accidentally that Sunday, having previously arranged to meet a participant in this staff cafeteria, passing the time by sipping and eroding my oesophageal lining on the bitter coffee that had regurgitated from the machine.

Dr Rudi van Aarde, a clinically retired doctor who had worked for 30 years as a GP in Johannesburg and still attended the Sunday group, told me a little more about its members. He told me about the leader of the group who had worked in Kuwait, Egypt, London, Ireland, Scandinavia and New Zealand before coming to Australia. He told me about the German psychiatrist, the Indian oncologist and an Eritrean GP – ‘so much experience’ – about a doctor from Sudan, an Iranian born Ecuadorian doctor who knew rural medicine as well, a pediatric surgeon who was working as a hospital cleaner, another working as a nurse (though ‘perhaps he was not working at the moment’). He said that there was an Afghani cardiologist there too and a doctor working as a night watchman. Many doctors in this group were a lot older than those I had met elsewhere
in the hospital, historically dense with years of previous clinical experience.

I believe that one of the reasons these doctors were struggling with the written exam was because they were finding it difficult to adjust their study techniques to an assessment designed to test the generalised knowledge of recent medical school graduates. Hawthorne, Hawthorne and Crotty (2007) tell a similar story.

Using age as a proxy for experience from data tabulated from AMC results from 1978 – 2000, Hawthorne, Hawthorne and Crotty suggest that the greater the period of time a doctor is away from graduating, the more difficult it is for them to pass the MCQ written examination. Their data shows that of those who qualified within four years of attempting the MCQ, 85% passed, for those qualifying five to nine years prior, 83% passed, 10 – 14 years prior, 80% passed, 15 – 19 years prior 78% passed, and for those who had qualified 20 years prior to attempting the MCQ for the first time, only 68% passed (Hawthorne et al. 2007, p39).

<table>
<thead>
<tr>
<th>Region</th>
<th>Age at 1st MCQ tertiled</th>
</tr>
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<tbody>
<tr>
<td>Australasia</td>
<td>82% 85% 90%</td>
</tr>
<tr>
<td>Oceania</td>
<td>94% 77% 73%</td>
</tr>
<tr>
<td>UK/Ireland</td>
<td>96% 96% 86%</td>
</tr>
<tr>
<td>North West Europe</td>
<td>87% 84% 66%</td>
</tr>
<tr>
<td>South East Europe</td>
<td>77% 73% 69%</td>
</tr>
<tr>
<td>East Europe</td>
<td>77% 71% 65%</td>
</tr>
<tr>
<td>North Africa/Middle East</td>
<td>89% 84% 73%</td>
</tr>
<tr>
<td>South East Asia –Commonwealth</td>
<td>90% 84% 67%</td>
</tr>
<tr>
<td>South East Asia – other</td>
<td>68% 74% 67%</td>
</tr>
<tr>
<td>North East Asia</td>
<td>86% 84% 79%</td>
</tr>
<tr>
<td>South Asia</td>
<td>87% 87% 82%</td>
</tr>
<tr>
<td>Central Asia</td>
<td>82% 69% 84%</td>
</tr>
<tr>
<td>North America</td>
<td>91% 93% 77%</td>
</tr>
<tr>
<td>Other Americas</td>
<td>78% 66% 59%</td>
</tr>
</tbody>
</table>
Years since graduation gave overseas doctors distance from answering broad medical questions in MCQ formats. They may have specialised, or never encountered MCQs previously. The ease of picking one answer was complicated by years of past experience. When writing about the IQ MCQs in his recent book about craftsmanship and skill, sociologist Richard Sennett (2008) argues that the craftsman with experience will want to *dwell* on questions. However time is of the essence in these exams. Therefore, Sennett (2008, p284) argues, intuitive leaps that might open up a question are impossible to test in multiple-choice formats. Overseas doctors with significant years of past experience had spent considerable time adjusting to previous medical systems in different ways. As Bourdieu (2000, p161) argues, it is those best adjusted in their previous field who often have the most difficulty adjusting to new social orders.

### Studying at the Thursday night tutorial

The study groups such as those who met in the library or in the cafeteria on Sunday were often formed from connections made in bridging courses and tutorials. I did not attend any of the number of fee-paying bridging courses that helped overseas doctors with clinical exam techniques, run publicly and privately in Melbourne, but I did regularly attend a free tutorial for overseas doctors held in Hospital Y. Each Thursday night an ever-expanding group of overseas doctors studying for the AMC clinical exam met in a small room near the hospital library to practice scenarios for the exam. During the tutorial, the tutor would pass around pieces of paper that gave an outline of a clinical scenario and asked for both a volunteer to role-play the exam candidate and for a volunteer to critique them. The tutor would role-play both the patient and the...
examiner. As was reiterated often by the tutor, the tutorial was not the place to cram facts or to learn medical detail but rather an opportunity to be walked through the technicalities of the exam ‘with some tips and tricks’.

There was a style to the clinical exam, and overseas doctors had to be able to know certain techniques to pass. Each assessment station was principally a single-diagnosis scenario and candidates needed to be able to recognise this, and to then be able to demonstrate, in eight minutes, their Australian style clinical practice. An article published on a website for international medical graduates, doctorsinaustralia.com, explains this focus of the exam:

This exam is NOT about being an excellent doctor who can manage all possible situations. It is NOT about knowing all the details about certain illnesses! It is NOT about specialist knowledge. It is NOT about physical examination or procedures. The main aim of this exam is to test for:
Communication with the patient …
Communication with the examiner …
Safety …
And only then:
Knowledge …

It will not help you one bit to read Harrison’s [see Medical Glossary] from cover to cover or if you know about pathogenesis of anything. The exam is not about specialist knowledge. It is about straightforward day-to-day situations that a GP or doctor in ED will encounter. Do not get sidetracked in your studies!

(Blum 2007)

The clinical exam, like the written exam, was not principally about knowledge, despite it being described as such by the AMC. I agree with Blum, that it was about interpersonal
communication and patient safety. Failure of overseas doctors to demonstrate 'appropriate' interpersonal skills (read here 'patient-centered care') could equate to failing the exam. Overseas doctors were made aware of the importance of demonstrating this clearly. Polite questions for patients were rehearsed, unfamiliar situations such as 'breaking bad news' were memorised, and the inclusion of families and other colleagues in decision-making emphasised during role-plays. The doctors wanted to demonstrate that they had made the adjustment to the 'Australian way' of practising medicine.

Adjusting to the Australian way

It is worth diverting here momentarily to consider in more detail what is being revealed in these assessments about the 'Australian style' of medicine. As I have argued, the overseas doctors now undertake mandatory orientation courses that focus on establishing Australian medicine as a defined and distinct set of defined features. One of the intentions of this thesis is to question these assumptions. By focusing on the efforts that overseas doctors made to adjust to assessments, to what was presented to them as the national standard in patient care, it is possible to further analyse the construction of this Australian style of medicine.

One way of doing this is to understand the aim of the overseas doctors' study methods as harmonising enough to the standard so that they did not stand out. One of Dr Mladen Mück's registrars, Dr Intaj Pathan told me, after completion of her obstetrics fellowship exams: 'the best advice I got was to try not to wake the examiner up – they only wake up if you do something really wrong or are really good'. All doctors, overseas or local, adjust to their examinations: surgeons adopt a surgical way of acting (confidently but with the 'right' degree of humility); medical registrars buy a plain conservative suit and 'serious looking' briefcase for their oral examinations, so that they appear competent and do not stand out from the other candidates. Just as these
doctors reveal what is expected from their intended specialty through their adjustments, so too do overseas doctors reveal the expected norms of practice in Australia.

Interpersonal skills are becoming increasingly documented as standardisable aspects of assessed clinical practice in Australia (as elsewhere). This is most clearly materialised in the newly designed Australian Curriculum Framework for Junior Doctors (Graham et al. 2007), which is discussed in more detail in the penultimate section of this chapter. Interpersonal skill is part of a more contemporary and nebulous understanding of 'skill', a word whose usage has expanded almost exponentially in most workplaces. Organisational studies researcher Jonathan Payne (2000, pp354, 356) highlights that it now includes 'a veritable galaxy of "soft", "generic", "transferable", "social" and "interactional" skills, such as "getting on with work mates and working as a member of a team", "getting information and advice" and "familiarity with social services"'. Payne, who has followed the changing nature of skill closely through policy documents, argues that these skills are often indistinguishable from personal characteristics, behaviours and attitudes, which in the past would rarely have been conceived of as assessable skills. He adds that 'moreover, the more skill shades over into desirable personality traits, behaviour, voice and appearance, the more it becomes bound-up with notions of traditional white "middleclassness"', which seemingly disregards difference (Payne 2000, p363). Payne raises critical questions in regards to how difference is assessed.

For overseas doctors the examination of interpersonal skills was thus often something of a performance, in their attempt to demonstrate good Australian practice, to demonstrate that they were competent doctors with a caring manner. As their own style of responding to patients was ingrained and embedded, entangled with past behaviours, personality traits, situational variants and cultural norms of previous contexts, it often appeared forced when they role-played what was considered 'patient-centeredness'. The author Don De Lillo describes the paradox of this performance when
Assessment

one of his characters reflects on ‘playing at being an executive’:

There’s a self-conscious space, a sense of formal play that is a sort of arrested panic, and maybe you show it in a forced gesture or a ritual clearing of the throat. Something out of childhood whistles through this space, a sense of games and half-made selves, but it’s not that you’re pretending to be someone else. You’re pretending to be exactly who you are. That’s the curious thing.

(DeLillo, p103)

Overseas doctors had often already adjusted to what was considered an appropriate way of interacting with patients in another context. They realised that something different was required in Australia. Yet what was required was underlined by similar duties of care: to try and be a good doctor. For many overseas doctors it was difficult to make their own sense of care explicit, to tease out the particulars of good practice for the examiner to assess. Because in doing so, they were having to pretend to be exactly who they were.

The style of assessment

One way to help the overseas doctors concentrate on demonstrating that they had good interpersonal relations with the ‘patient’ was to recognise the clinical case. Just as it was helpful to have good techniques to pass the written exam, such as memorising past questions, it was also important for overseas doctors to know the techniques of the clinical exam. One of the key components of the style of the exam was recognising the diagnosis and following this to its conclusion. It took me a long time to realise how the overseas doctors ‘sniffed out’ a case, how they learnt to quickly find and follow a single diagnosis. It was a newcomer to the group who highlighted what everyone else who had spent some time practising this style of examination already knew. It was also during
Chapter Five

this doctor’s role-play, which happened towards the end of my fieldwork, that I realised that as a researcher, I (however partially) understood the exam technique. In doing so, I realised that I had somehow become part of this Thursday evening tutorial group.

The tutorial had started with the usual settling into chairs, quiet chat and taking off of coats. After several role-plays the tutor asked for volunteers who were about to sit their exam. The doctor next to me was picked and when the tutor asked for someone to critique the performance, a new doctor to the group, Dr Jiang Lin, a lively Chinese doctor with a sparkle in her eyes, put her hand up. The tutor said that this was fantastic and that this was what they did in Australia – volunteer straight away. He thought that it put the others to shame. Dr Jiang Lin smiled. When it came time for her to give her critique of the role player's performance she went through the differential diagnosis in a way that categorised diagnoses first as systemic and then as local, proceeding carefully through each of the possibilities.

There was silence in the room.

After a pause, the tutor said to her that it was obviously her first time in the tutorial and that she was not familiar with how it was usually done. He remarked that she had great clinical skills and that he was quite amazed. He then analysed Dr Jiang Lin’s critique and said that he hoped that she did not mind him doing this but that really the exam was a ‘one-topic-type’ of exam. The other doctors in the tutorial room were nodding.

This seemed to perplex Dr Jiang Lin a little, but straight away it was her time to be the role-playing doctor/exam candidate and she busied herself with reading the handout. This case concerned a patient who had sudden searing pain in the back of his heel, and who thought that someone must have kicked him, though could not see anyone behind. Dr Jiang Lin read the question quickly and one of the doctors next to me said that this question had been on the exam in Adelaide and that they had done it in a previous
Thursday evening tutorial (the tutor had also apologised for the station being repeated). Dr Jiang Lin's eight minutes then started and she followed a line of questioning which indicated that she thought that the patient had a psychiatric condition. She persisted with questions relevant to this diagnosis even when the tutor tried to 'turn her around' with his answers (i.e. give her clues that she needed to change tact), a technique that examiners sometimes employ and which the overseas doctors are taught to be attentive to.

Soon the doctors around me started talking amongst themselves and murmuring about how she had the 'wrong line of attack'. Dr Jiang Lin continued and they started to talk louder and whisper under their breath. By the time that she had finished the case no one was watching her and the room was filled with chatter. The tutor asked the critiquing doctor what they thought the diagnosis was and when they said Achilles tendon rupture, Dr Jiang Lin looked a little confused. She said that she thought it must have been a psychiatric case and started defending her decision. The tutor reiterated that in three or four week's time she would realise 'what it was all about'. I sensed a pervasive feeling of pleasure in the tutorial group at seeing her make this mistake. One of the older doctors even joked that she 'was good, but not that good!' Most of them had already adjusted to this exam format to certain degrees. This was a significant moment for me during fieldwork because I saw the situation from the point of view of someone who had spent time in the tutorial learning the 'tricks of the trade'. I also felt quite smug, like the other overseas doctors must have, knowing the direction that the case should have taken and the technique of the exam.

The newcomer to the group had not fully grasped the style of the assessment, even though she thought that she did, even though she had learnt from her first mistake. She knew that the tutor had just advised her that she 'didn't have time to work out the complexity of the case' that she 'just needed to focus on one problem'. Changing from her first approach, in which she carefully considered the patient's differential diagnoses
(an approach ingrained in doctors during medical school), she followed one line of questioning. She decided that the case must be a psychiatric one and pursued this. Afterwards, the tutor told her that the history ‘didn’t smell like a psych case’. She had picked the wrong diagnosis.

Most of the other doctors in the tutorial, presumably those making the noise, seemed to know the right answer. They knew the case not only because it had already been practised in the tutorial and was on a past exam, but because they had also learnt the style of the exam. They had learnt what clues to pick up from the history and learnt how to follow the examiner’s lead if they were on the right or wrong track. Dr Jiang Lin, the newcomer, thought that she had adjusted her technique, but she had swung too severely in another direction. Even though in her own role-play Dr Jiang Lin seemed to learn from the previous case by going for a single diagnosis, her examination performance still needed adjusting. She needed to make finer adjustments, adjustments that could only be made over time, and after repeated practice, learnt amongst and from the other overseas doctors.

A newcomer’s performance revealed this style of the exam, just as the overseas doctors, as newcomers to the Australian hospital, help to reveal the system. After a number of Thursdays, I began to slowly see any newcomers adjust to the assessment style and give smoother performances when asked to provide a critique or role-play. In the tutorials and through study groups, the overseas doctors would quickly learn what a case ‘smelt like’, which was the right diagnosis. This reduction in complexity seems contra to good medical practice, to what is encouraged in doctors’ medical training. Through this newcomer’s story the discrepancies between the skills emphasised in medical school and those emphasised in hospital work, and the techniques overseas doctors needed to know for the AMC clinical exam, are once again highlighted.
The specialist

For overseas doctors with significant experience in their specialty, who were more aware of the complexities of patients’ presentations, the simplification of the clinical case in examinations was something particularly difficult to adjust to. In a study of novice medical students and senior doctors, researchers have shown that senior doctors have superior diagnostic skills because they are able to be more open to oddity and particularities in patients. In contrast the medical student goes more rigidly by the book and focuses on cause and effect (Sennett 2008). The format of the clinical exam meant that there was little time or space to be open to variety. The complex diagnostic skills entailed in the clinical work valued in hospitals remained hidden. This proved a particularly difficult conflict for many of the specialist overseas doctors, who effectively had to complete a clinical exam written at the level of a final year medical student. Whilst local medical students would be able to produce neat answers to cases, by focusing on cause and effect, overseas doctors found difficulties with this.

A related paradox also faced those overseas doctors sitting specialist exams. These doctors had ingrained years of prior clinical experience which were part of their clinical decision making process; their habituated practices. What they might have practised implicitly in previous hospital settings became difficult to articulate in the exam setting. The following passage is from an interview with Dr Mladen Mück, who, as we learnt in Chapter Three, was unsuccessful in his aim of passing the obstetrics college’s specialist assessment. Though able to demonstrate his skills in the workplace, he found it impossible to articulate, and make explicit, tacit practices that he had embodied in Bosnia.

For the initial assessment I was supposed to pass the Occupational English Test – the condition to be assessed by the college – in my case the college of obstetrics and gynaecology. Ahh, soon after a couple of months I managed to pass the Occupational
Chapter Five

English Test and there is a part of that English course that was work experience in the hospital of my interest and I got the opportunity to spend four weeks at the Royal Women’s Hospital in Carlton and in that four weeks everything changed drastically and the speed of my recognition drastically changed because I got the opportunity to have official ID and it was a tertiary hospital the same sort of hospital I worked at back home and similar design so it was easy for me to ahh, you know to figure out how it works and... I got opportunity then to mix and to figure out how to improve or what to improve to be part of that environment – it means that straight after that four weeks and having opportunity to ahh express what my strengths are I got opportunity to start to work... I used to work in obstetrics for 14 years before coming here. I was consultant for seven years and it was easy for me to demonstrate that ... in that field in the hospital I was accepted so well and after that success I got full time job and I continued in that hospital for the next five years...

(Dr Mladen Mück)

Dr Mladen Mück describes how he adjusted in the midst of practical engagement, how this was easier than adjusting to the exam. The remaining section of the transcript above has previously appeared in Chapter Three, and I repeat it here to give some sense of connection.

... In terms of assessment with the college I was assessed close to ahh Australian consultant and I needed to achieve the fellowship, of full recognition - the condition was to pass my membership exam and spend two years of advanced training and unfortunately I continued to work full time and I was good in that field but I could not ahh manage to ahh, achieve that goal you know, to pass the exam in that period of time required and that’s the reason why five years after working as a senior registrar at the Royal Women’s I needed to change the hospital and come, actually I came to Hospital X and ahh to work in what we called, a hospital in ahh an Area of Need ...

(Dr Mladen Mück)
In this quote Dr Mladen Mück describes the difficulties of sitting specialist exams. A different mode of adjustment was required for these than the AMC exam. Dr Mladen Mück told me later that he had problems in the obstetrics assessment because he had not thought about the details of the techniques for some time and could not explain himself well. He had difficulties in making his previous practice explicit.

The work of Polanyi (1958; 1966) on tacit knowledge helps to illuminate the complexities of this tension. Polanyi was an early philosopher of science whose interest was principally that of practice, and how, through skillful actions, a scientist shapes their knowledge. He called this tacit knowledge, a term which can be simply expressed in the dictum ‘we know more than we can tell’. Polanyi (1958, p54) argues that ‘practical wisdom is more truly embodied in action, than expressed in rules of action’. Herein lies the difficulty in making tacit knowledge explicit: it is difficult to tease out its particulars, as its very embedded nature defies easy codification. This creates difficulties when it comes to assessment, the difficulty in measuring tacit knowledge underscoring its slippery and elusive nature (Gertler 2003, p82).

In Dr Mladen Mück’s story there is evidence of how the particulars of practice can fall apart when we start to dissect them. Like a pianist who cannot separate what the right hand and left hand are doing but must play together to be able to play at all (Sennett 2008), Dr Mladen Mück could not adjust his implicit practice to an exam which required practices to be made explicit. The Bosnian doctor felt that he could adjust in the everyday of the hospital, but when he came to explaining his practice in assessment, things fell apart. Polanyi notes that it is difficult to make tacit practice explicit because normally we focus our attention on the action and only have subsidiary awareness of the details of our own movements and the instruments involved in the movement (more about these instruments in Chapter Seven). Being made aware of process ‘de-naturalises’ it and makes things, the performance, more obvious (Polanyi 1958, p56).
Richard Sennett proposes that ten thousand hours is often seen as a common touchstone for how long it takes for complex skills to become so deeply ingrained that they become part of our tacit knowledge. He writes that this number is in reality not an enormity, that 'the grueling conditions of a doctor's internship and residency can compress the ten thousand hours into three years or less' (Sennett 2008, p172).

Table 2: AMC CE pass rates
Source: (Hawthorne et al. 2007, p46)

The table above shows that increasing age (again equated somewhat problematically with experience) correlates with less success in the clinical exam (CE), implying a similar correlation between medical experience and tacit knowledge that Sennett suggests in the previous paragraph.

Another quantitative box tells a slightly different story.
Hawthorne, Hawthorne and Crotty (2007) found that the more times you sat for the written exam, the less likely it was that you will pass the clinical exam. For example those who had sat for the MCQ twice were 39% less likely to have completed the CE.

This interferes with the previous text. It tells us something about the nature of the assessment; that you need to grasp the style of both the written and clinical exam quickly to pass.

Of those who had failed the written exam, 75% reported that they had planned to sit for the exam again (Hawthorne et al. 2007, p64). Of those who had not passed the CE, 92% indicated that they were planning to sit again (Hawthorne et al. 2007, p66).

This tells us something about the perseverance of the overseas doctors, about their determination. And finally, another quantitative box complicates the story even further.

Interestingly those more experienced doctors who were able to pass the written exam on the first attempt fared the best. After adjustment of the figures, when compared with those who had recently qualified, those who passed the MCQ the first time then sat the CE with five to nine years experience were 17% more likely to pass the clinical, those with 10 – 14 years experience 48% more likely to pass and those with 15 – 19 years experience were 58% more likely to pass. Those with more than 20 years experience were no more likely to pass than recent graduates (Hawthorne et al. 2007, p49).

Again, this quantitative box interferes with the qualitative text in this chapter and tells something different about the combination of knowing exam techniques and experience.
that are not evident in the interviews with the overseas doctors. These boxes tell different yet connecting stories to the fieldwork data presented in this chapter, leaving points of ambiguity and preventing closure, opening to more questions, revealing more gaps. There is a need to adjust as readers, between the quantitative and qualitative information. The quantitative boxes highlight some of the further complexities and paradoxes of the AMC assessments.

Overseas doctors that I spoke to were aware of these paradoxes, recognising the performative aspects of the AMC clinical exam, where the particulars needed to be teased out to demonstrate competence equivalent to the standard of an Australian intern. Dr Rudi van Aarde shared with me his opinions on this style of clinical exam:

*You don’t see a patient! They just put a piece of paper up on the wall outside the room and then there is a role player. They have no idea if I can examine a patient or not. I just have to pretend to listen to the heart sounds but you can’t hear them! You just have to know the theory. It’s a performance.*

(Dr Rudi van Aarde)

Compare this to what Michael Polanyi writes about in regards to practice:

To become an expert wine-taster, to acquire a knowledge of innumerable different blends of tea or to be trained as a medical diagnostician, you must go through a long course of experience under the guidance of a master. Unless a doctor can recognise certain symptoms, e.g. the accentuation of the second sound of the pulmonary artery, there is no use in his reading the description of syndromes of which this symptom forms part. He must personally know that symptom and he can learn this only by repeatedly being given cases for auscultation in which the symptom is authoritatively known to be present, side by side with other cases in which it is authoritatively
Assessment

known to be absent, until he has fully realized the difference between them and can demonstrate his knowledge practically to the satisfaction of an expert.

(Polanyi 1958, p54)

Such clinical acumen differs remarkably from what was being assessed in the AMC clinical exam, as well as in the specialist exams. This is something long realised by the many educationalists, clinicians and administrators involved in the ever-changing design of the overseas doctors’ assessment. Lately there has been a heightened interest in workplace-based assessment in hospitals to address the inadequacies of the OSCE model (Polan 2009). Currently, this remains an idealistic possibility, with much debate in regards to the feasibility of its implementation in hospitals. This thesis contributes to the debate by reiterating that the current assessment of overseas doctors is highly problematic, with unresolved paradoxes based on study practices requiring memorisation, rote-learning and studying a clinical technique unrelated to the everyday context of hospital medicine.

In this chapter my intention has been to examine these tensions in the assessment of overseas doctors and focus on the ways in which the participants adjusted, or otherwise, to the exams. The overseas doctors’ study practices analysed so far are all ways of adjusting past experience to a standard. The doctors’ aim was to attune themselves to the requirements of this assessment, however briefly, so that they could have a ‘ticket’ to practice unconditionally in Australia. The next section touches upon what this meant to one overseas doctor before returning to a discussion of the role of standards embedded in the assessments.

Matching the vibration of the system

As may have become evident in the thesis so far, Dr Nikolai Nagorsky was something of a
philosopher. In one of our many long conversations he described to me, in metaphorical terms, what the process of adjustment meant to him.

Dr Nikolai Nagorsky: It is a fair system — it shapes us in three or four years — you understand the system [then]. I believe it's like learning a language. If you want to learn it you have to spend considerable time ... you speak with an accent [at first], you make mistakes, you're misunderstood, you misunderstand. This is the professional life. Even when you've passed all the exams [it's still like this]. But there needs to be a structural assessment. If you are abandoned, on your own, at the end of the day you could make a lot of mistakes.

So whilst Dr Nikolai Nagorsky underscores that learning happens in practice, like many of the participants, he still reiterated the need for assessment. I went on to ask:

Anna: Will passing the AMC exam make you feel different?
Dr Nikolai Nagorsky: Yes [pause] ... it is recognition, possibilities are widened, psychologically it means [you are] 'like one of us'.

The assessments prove competence and equivalence.

Anna: Do you then stop being an IMG?
Dr Nikolai Nagorsky: Yeah, I think so, yeah ... but then it depends on how you adjust and get yourself through this filter, yeah, it's like going through a filter, designed to stop certain elements coming through and unwanted from coming out – it is mind-setting of past conditioning ...

A movement from past habits to the present moment.

Dr Nikolai Nagorsky: ... a filter, or like coherence or incoherence – you think you are
coherent but you are not matching the vibration of the system here ...

Adjustment.

Dr Nikolai Nagorsky: ... but you have to voluntarily submit yourself to the purification. The system, which is a filter itself, will not allow you to come out with certain elements that will not allow you to function. The filter is a long process – you go through one, then another, finer, finer, then, like a language ... it takes some longer to get through the filter. Some get stuck, some have too much to change and are not able to get through ...

Modes of adjustment.

Dr Nikolai Nagorsky: ... we are placed in a solution, in a medium, we are not just an entity.

Quilted into their environment.

Dr Nikolai Nagorsky: We are placed in a buffer solution and we are meant to be dissolved. If you don’t allow yourself to be dissolved, that stuff will get stuck in the filter – and that is because you didn’t allow yourself to get dissolved in the solution – to get absorbed in the culture, in the medical culture [chuckling] culture, yeah ... that’s why we have these tests – that is why it is introduced into the curriculum ... ultimately the idea is that we become like one of you ...

Dr Nikolai Nagorsky’s philosophical account of the process of adjustment extracts many of the central themes of this chapter and the thesis more broadly. He highlights that the underlying goal of assessment is to ‘tune’ to Australian standards, to become ‘like one of you’. He describes adjustment as going through a filter, which requires reorienting past conditioning, over an extended period of time, with finer and finer adjustments. It is
these finer adjustments which are explored throughout the chapters in the thesis, as I 
examine how overseas doctors go about ‘matching the vibration of the system’ in the 
hospital. Dr Nikolai Nagorsky also pointed out that not all overseas doctors were so fluid 
in their movements, that not all doctors preceded through the assessment process 
easily. Some got stuck when they failed to pass an exam, coagulating on the edges, 
spending many Sundays in a disused cafeteria. Dr Nikolai Nagorsky described these 
doctors as having too much to change. It could be the case that they could not adjust 
appropriately to the standards, which were ultimately the filter, that they had 'too 
much' difference.

The filter

In the previous section Dr Nikolai Nagorsky used the filter as a metaphor for the 
standards in the system to which overseas doctors adjusted. He has not been the only 
one to make this analogy. ‘Standards act as filters mediating the relationship between 
evaluations and expectations’ sociologist Martha Foschi (2000, p24) declares in her 
check paper on ‘double standards’. In Chapter Three, the registration process could be 
re-interpreted as a historical and political ‘filter’ attempting to manage the influx of 
overseas doctors into the Australian workforce, a filter that was often couched in terms 
of standards. In this chapter, the focus has been upon standards embedded in 
assessments, and the same argument could be, and has been, made (Iredale 2009, p17). 
So far I have described how overseas doctors adjusted to this examination and 
performance standard. What exactly was this 'standard' and who decided what it was? 
What more does it tell us about how Australian medicine is being constructed?

Recently there has been a lot of interest in 'standardising' doctors in Australia. The 
Australian Curriculum Framework for Junior Doctors, launched in 2006, is a 
materialisation of this. The framework structure covers areas of clinical management, 
communication and professionalism that are considered key to what an Australian
doctor is all about. This framework is becoming steadily embedded into the curriculum of Australian medical schools, with national guidelines for its implementation. It is also becoming increasingly embedded in many of the assessment processes for overseas doctors, appeasing the need to define the core competencies of overseas doctors more clearly (Hawthorne et al. 2007, p127). The framework is considered to have the potential to 'improve' the integration of international medical graduates entering the Australian workforce (van der Weyden 2007, p332).

The Australian Curriculum Framework for Junior Doctors is indebted to the CanMEDs (Canadian Medical Education Directions for Specialists) model, which is one of the most pervasive standard concerning the definition of 'doctoring'. The impetus for the CanMEDs project began in the early 1990s within the Royal College of Physicians and Surgeons of Canada (RCPSC) (Frank and Danoff 2007, p642). This medical body, responsible for the training, examination and accreditation standards in Canada, felt a need to respond to the changing conditions of contemporary medicine (Frank and Danoff 2007, p643). Working groups developed a framework of 'key competencies' for all physicians, organised around seven 'physician's roles': medical expert, communicator, collaborator, health advocate, manager, scholar and professional. This framework was adopted as a foundational document for the RCPSC in 1996 and was revised, updated and re-adopted in 2005 (Frank and Danoff 2007, pp642 - 643).

It was not too long before CanMEDs was implemented into medical education through networked standards in curriculum, teaching and assessment. The RCPSC shared its intellectual property worldwide, with organisations such as the Accreditation Council for Graduate Medical Education in the USA, the Royal College of Surgeons in the UK, the Central College of Medical Specialists in the Netherlands and the AMC, adopting the model into their own frameworks. Other professionals such as nurses, chiropractors, physician's assistants, pharmacists, and veterinarians have adopted CanMEDs. CanMEDS has thus become imbedded into the fabric of not only Canadian medicine
This leads us to question the uniqueness, the ‘localness’ of the Australian standards embedded in the Australian Junior Curriculum Framework and embedded in the assessment of both local and overseas doctors. Standards which shape assessment processes have historical roots (Bowker and Star 1999, p6) and are the distributed work of many actors (Timmermans 1997, p288). It is often difficult to trace that which becomes, to use a term coined by Latour (cited in Bowker and Star 1999, p253), ‘black-boxed’. Currently the standards in medical education in Australia are more visible because they are in the process of significant reformation. Standards are ultimately idealised goals of practice and most likely are never perfectly realised (Bowker and Star 1999, p15). However they also have effect on the world (Timmermans 1997, p296).

Surprisingly there has been little critical debate about the Australian Junior Curriculum Framework in Australia and more globally about the transcultural capabilities of CanMEDs (with several exceptions such as ten Cate 2002, p603; Verkerk et al. 2007).

The paradoxes and efforts and failures of the ways in which overseas doctors adjusted to the AMC exams in Australia highlights some of the problems of standardised assessment. In many ways, the method of assessing overseas doctors’ practice that I observed during fieldwork viewed their skills not as complex processes, but rather as decontextualised attributes and competencies, which were carried with them, ‘luggage-like, from job to job’ (Payne 2000, p357). In their book Sorting Things Out: Classification and its Consequences, Bowker and Star (1999, p241) have argued that the push for standardisation is to render things comparable, so that each actor can fit a position in a standardised system. They write that standardisation has been one of the common solutions to issues concerning the movement of practices between contexts (Bowker and Star 1999, p293). However as this thesis has shown, and as Bowker and Star argue, there is a need for a richer vocabulary than that of standardisation with which to think through the heterogeneous and processural nature of adjustment (Bowker and Star...
1999, p293). The difficulties that the overseas doctors faced in assessment and the work that they put into adjusting, underscores the environmentally situated nature of medical practice and the impossibilities of creating ‘global’ doctors. This chapter has once again highlighted that practice is contextual. However, rather than consider the overseas doctors as completely unprepared for the Australian hospital, as having to learn and show competencies in Australian medicine, what I am suggesting is that there is more scope for the overseas doctors to adjust their own habitual practices to the multifarious environment they find themselves in. It can be difficult in exams to get everything coherent, harmonised and in balance.

**It’s so difficult to find that balance**

*Hamid seemed quite despondent. He had sat his English exam the day before, which he had failed. He said that this exam was ridiculous for he had passed the oral component with full marks one time whilst failing the written, and this time had failed the oral and passed the written.*

(Fieldnotes)

*Ashin tells me that he is about to have his third attempt at the clinical exam. On his first attempt he failed the O&G section and on the second, in February last year he passed the O&G and paeds and got a supplementary exam, but only passed five of the eight stations and he need to pass six.*

(Fieldnotes)

Overseas doctors were not always able to get their timing right. Success depended not only on *adjusting* to the exam questions and the exam techniques, and articulating practice explicitly, but also having all of that *in balance* for each station of the exam, each aspect of the assessment. Overseas doctors could spend years gathering in the cafeteria, days unpaid in a library, weeks attending tutorials, studying for these tricky exams. They not only had to have their performance in balance but also had to balance
when to sit the exam. Sitting the exams before you were ready could be costly and have impact on your motivation if you did not pass. Sitting the exam too late after arrival in Australia could also have negative implications. It could take too much energy to be a student again, as Dr Mladen Mück implies in this statement:

*It will be huge sacrifice and I don’t think so that at my age you know, 48 soon, that I am going to do that way and that I am going to do that effort. I tried to and working full time, and now I can’t afford not to work – that is the sort of the circle – it means to achieve that higher level I need to say be a full time student, not what I am now more than full time medical practitioner. As I said, I am just realistic in that field, and I don’t think so that I have enough energy at this stage to do that.*

(Dr Mladen Mück)

Overseas doctors delayed sitting exams for financial reasons such as Dr Mladen Mück, to support families in Australia or elsewhere. Those who had been out of work for some time accepted job offers in remote hospitals, or disciplines such as psychiatry, where they were not well supervised and received little clinical experience that would help them with their clinical exam. Overseas doctors could get lost in these positions for years and soon the cycle would become hard to break. It was difficult to know how to strike a balance. Dr Mladen Mück tells me about two of his registrars and their different assessment pathways:

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

Everyone says he's good, good, good but no membership, no exam ...

(Dr Mladen Mück)

Those overseas doctors who were able to find clinical work whilst going through the assessment pathway often felt themselves to be in a difficult position in regards to retaining their practical skills or getting paper qualifications. Dr Dumitru Bara concentrated on keeping his clinical skills up-to-date, though inevitably the fact that he had not passed the assessments worked against him. Conversely, doctors who did not work and focused on their assessments felt that their clinical skills became rusty. Kunz (1975, p104) mentions this dilemma amongst the refugee doctors from Europe, writing that there was a fear that every month of not working as a doctor could be used in arguments about further loss of professional knowledge and skill. A hospital HMO Manager lamented upon the overseas doctors' predicament:

And they're advised so many different things – they're advised, well, get all of your exams out of the way and then look for work, but then they might waste four years studying, not working, away from clinical practice and then when they apply for work, an employer looks and says, “well you haven’t worked as a doctor for four years”, or five years, or whatever it is, and that’s a bit of a barrier too. Because, umm, you lose your skills when you are not doing something. So it’s very hard for them I think, really.

(HMO Manager)

Overseas doctors need to maintain a balance between preparation for assessment and clinical work. At work they can demonstrate practical skills but they do not get the chance to study for the exams that are ultimately required for their registration, where they need to make their practice explicit. Overseas doctors studying for the exams reported feeling as if they were losing the practical skills that made them good doctors. To practice unconditionally in Australia they had to prove the existence of these tacit skills in the assessments. Once again the overseas doctors faced the conflict between
implicit and explicit knowledge, another of the many paradoxes of their assessment process.

Summary

Undertaking the assessment process in Australia to gain accreditation of previous work experience was not cheap. Each exam cost a considerable amount of money (over $AUD 4,000), and many of the bridging courses that the overseas doctors took to help them pass the exams were also costly (despite Commonwealth scholarships and assistance). Studying for the exams took the doctors away from their families and the hospital work they desired. It is not only the financial burdens of these assessments that were difficult. Adjusting to meet the Australian standard did not happen easily. As Polanyi (1958, p61) writes, 'the pouring out of ourselves into the particulars given by experience so as to make sense of them for some purpose or in some other coherent context, is not achieved effortlessly'.

This chapter has discussed the social labour that went into the overseas doctors various modes of adjustment to assessments in Australia. They were assessments during which the overseas doctors needed to perform a coherent self, a medical self that was congruent with a perceived ideal of Australian practice. The chapter examined how the overseas doctors arranged, as well as possible, their past practices, adjusting from previous standards and systems, to the expected Australian standard, embedded in assessments. In negotiating the assessment process, overseas doctors highlighted the practice of recalling exam questions, the difficulties of assessing ingrained tacit practices and a caring attitude, the need for workplace-based assessment and the particulars emphasised in Australian medical education such as 'patient-centered approaches'. Once again then, adjustments revealed aspects of the system that normally remain invisible. The next chapter follows the overseas doctors further into some of the places where they studied for exams, examining how they adjusted to the building itself. Interlaced between the chapters is an interlude about the exam room.
Interlude Five: The Exam Room Can Do a Lot of Tricks

After all their hard work, success in the AMC clinical exam could be thwarted by inconsistencies on the day. Here is an excerpt from some of the many recall exam questions posted on Internet forums (aippg 2008) for overseas doctors:

Posted: Wed Nov 14, 2007 8:44 am
Post subject: Perth Oct'07 AMC part 2 with comprehensive explanation

I have heard that Perth is not a good center. The questions were easy but we had some difficult examiners who had Parkinsonism face. 50% were not helpful and 25% helpful and 25% neutral. They asked some questions that were tough and the role players were ok.

The questions when you read might look very easy. The OA [osteoarthritis] hip station both examiner and role player were bad. In the swelling of arm station the examiner was pathetic. If by chance you get these as your initial stations you moral would be affected and will subsequently affect the rest of the exam. The main problem was most of the stations had normal variants. Its easy to detect disease, but difficult to call something normal. Looks easy but the exam room can do a lot of tricks.

Here are some more detailed excerpts from his list:

11. Visual acuity [VA]. Pt 17 yrs old and c/o blurry vision. VA was 6/24 both eyes and 6/16 with pin hole. Examiner said no need 3,4 and 6 cranial nerves. Looked like myopia. I said he needed concave lens. Did not have time to refer to Ophthalmologist. Moreover the fundoscopy was not working and I had to waste 30-40 sec[ond]s before examiner came to my rescue !!! Very
bad examiner who thought its my mistake the fundoscopy didn’t work!!!!. Keeping a faulty instrument.....

15. Renal colic in 20 yr ols lady. Finally a straight forward station with straight forward answers from role player. But the way the pt was wincing in abdominal examination it was hard to believe it was renal colic. She was very tender in LIF [left iliac fossa] abd and I also included Diverticulitis and Ectopic in diff diagnosis. U/A [urine analysis] blood +++. No leucocytes or nitrites. Beta HCG [human chorionic gonadotropin] not available. LMP [last menstrual period] 2 wks ago. The examiner made it up. I think he was not expecting ectopic in differential. This examiner was good and he told me that the diagnosis was indeed renal colic.

The assessment room had non-standardised, ‘messy’ conditions, which could thwart a doctor’s efforts at success. The examiner was not neutral (despite their best efforts), or they were ‘too’ neutral and had no expression on their face, not providing any clues. Similarly the role-playing patient may not have performed the symptoms convincingly, or the signs they described did not indicate disease, but rather were ‘normal variants’. Furthermore, instruments may not have worked. The order of stations may not have been optimal. The exam room could do a lot of tricks.
Chapter Six: Buildings

There was a late winter morning light seeping into the chemotherapy day unit which caught the bags of normal saline hanging from their rods; illuminating them so that they looked like eerie medical octopuses, clumped and dangling together.

(Fieldnotes)

The hospital seems like a strange world sometimes. For the overseas doctors the hospital buildings they found themselves in were both strange and similar (Chapter Two), familiar unknowns. In regards to the similarities, Dr Mladen Mück has previously described the Royal Women’s Hospital as ‘the same sort of hospital I worked at back home and similar design so it was easy for me to ahh, you know to figure out how it works’ (Chapter Five). In recalling his visit to a Peruvian hospital the surgeon and essayist Richard Selzer (cited in Fox 1989, p144) writes, ‘what a far cry it is from my sleek and spanking hospital in New Haven – all glass and pre-stressed concrete. And yet, so like’. For the overseas doctors, the differences were sometimes harder to describe or articulate. It could have just been a slightly disturbed feeling or overwhelming sense of change. One day, during a ward round, Dr Nikolai Nagorsky turned to me and talked about what it felt like to walk into ‘an Australian hospital’ for the first time. He described how the moment he stepped into the building he was overcome by a feeling of immense awesomeness...

He paused, and then suggested that an important question I ask the other overseas doctors would be: ‘what different feelings do you have when you walk into a hospital here?’ Dr Nikolai Nagorsky found it hard to elaborate upon his own question and was silent for some time afterwards.

This feeling of ‘awesomeness’ is beautifully captured in an illustration from The Arrival (Tan 2006). An anonymous migrant, upon reaching a nameless new land,
Chapter S\textsuperscript{\textdagger}

Figure 8: The familiar unknown
Source: (Tan 2006)
Buildings

eventually finds a place to stay on his first night. After collecting the key, he walks up the stairs and opens the door to his room. A large illustration shows him in the doorway, looking upon a room with a table, a desk and a ladder to his bed. It looks like a mundane scene, but within this familiar layout are details of unfamiliarity; hoses coming from the ceiling, knobs of strange shapes, odd bits and pieces that are scattered around the floor. It is a ‘migrant moment’ that the illustrator Shaun Tan (2008) wanted to capture on a single page. He wanted to draw that instant when someone has just stepped over the threshold into a new terrain, a new terrain that has remnants of the old. Within that moment is an immediate, fine threading between partial remembering and a simultaneous feeling of newness, for some perhaps awesomeness, felt through the body.

This chapter is about the embodied ways in which overseas doctors adjusted to the hospital buildings they found themselves in. Buildings were another part of the doctors’ new environments of practice, another aspect of the system. The word ‘building’, being both noun and verb, implies not only the materialities of the hospital but also a process by which places are made by their inhabitants (Brand 1994, p2). In this chapter I focus upon a number of ways in which the overseas doctors adjusted their practices to the unfamiliar known hospital architecture. They adjusted from their past ways of doing things, from their past ways of moving about hospitals. As the buildings they found themselves in changed, they continued to adapt to its evolving form.

Whilst the built environment has been recognised as a significant feature of educational settings (Peim and Hodkinson 2007, p389), little has been studied about how migrants adjust to the architectural dimensions of their workplaces. In this chapter I draw upon discussions in the STS and human geography literature that recognise such materialities in workplaces, using architectural discourses to flesh this out further. In the literature directly relating to overseas doctors, the newcomers’ relationship with hospital buildings goes almost unrecorded. At the most, it might be noted that they would need
Chapter Six

a tour of the hospital during orientation. As I have already begun to discuss however, and will do so in much more detail in Chapter Nine, such notions of orientation which distance the person from their environment, and consider learning as something that happens either outside of, or before, practice are unsatisfactory.

To study the ways in which overseas doctors adjusted to the hospital buildings in greater ethnographic detail, places that have already appeared in Chapter Five are revisited here. They are the rooms in the hospital where I have discussed how the overseas doctors negotiated adjustment to assessments: the library, cafeteria and tutorial room. Although the discussion concentrates on these three places, I also look briefly at other places and pathways in the hospital. The chapter begins by discussing how hospital architecture has been theorised in medical sociology as contained and structurating, before introducing more ecological and phenomenological perspectives on place. I then re-introduce the case studies, after which I discuss the various meanings these places had for the overseas doctors, and the role they played in reinforcing their sense of professional identity. I look at ways in which the participants adjusted to what seemed to be the many rules and regulations of these places. This analysis is furthered with a discussion of the overseas doctors’ pathways in the hospital such as their routes through corridors between study places. Examining these practices highlighted ways in which other hospital inhabitants adjusted everyday to the ever-changing buildings; aspects of hospital institutions so rarely documented. Finally, the chapter examines the affective dimensions of place, and considers how this can be told in a visual key.

The hospital

Hospital buildings have been long considered as replicating and reiterating the structural discipline, constraint and social order of biomedicine. In The Birth of the Clinic: An Archaeology of Medical Perception, Michel Foucault (1963) studied how hospitals shaped and were shaped by the professional changes in medical practice at the end of
Buildings

the 18th century in France, often using the structures of hospitals to highlight pervasive disciplinary social orders. Strongly influenced by Foucault's work, much of the analysis of hospitals to date has tended to replicate a model of hospitals that imposes order through architecture which 'enables' the clinical gaze (Radley and Taylor 2003, p77). For example, sociologist Lindsay Prior's (1988) close historical analysis of the architectural plans of 19th and 20th century hospitals suggests that the spatial organisation of hospitals was underpinned by then current conceptualisations of disease, hierarchies of labour and gender. Prior (1988, p93) argues that 'the architectural plan lays bare the spatial expressions in which medical knowledge and therapeutic practices are constituted'. Similarly nursing researcher Jenny Littlewood (2007) emphasises the reproduction of social order in the microcosm of the hospital, with physical structure and position of material objects reflecting status divisions. Categorical allocation of physical space is also viewed as regulating biomedical activities (de Laine 1997, p157) through enclosure, segregation, classification and ultimately power (Gieryn 2000, p475). The hospital building is viewed as acting to 'restrain, control, treat, "design" and "produce" particular and supposedly improved versions of human minds and bodies' (Conradson 2003, p1976). On a broader scale, historian Charles Rosenberg (cited in Fox 1989, p143) found the hospital to be a didactic microcosm illustrating the interdependence of health and order in the world.

These analyses stress not only the oppressive and coercive potential for architecture to shape peoples' lives (Dovey 2005, p291) and to enforce the dominant discourses of medicine, but also the ways in which biomedical structures are replicated and reiterated in design. Whilst this may often be the case, this chapter departs from this commonly held view to consider the hospital building as part of a local environment to which individuals adjust in surprising ways; in ways which are not necessarily bound within the limitations of an imposed structure or hierarchy. Thus, rather than relying on an analysis that coordinates the relationship between people and place as a purely dialectical exchange, where places shape people and people shape place, this chapter forwards an
argument which accommodates the potential for individuals to adjust to place. It is an approach that pays attention to ways in which the overseas doctors actually negotiated and used place in their everyday life, an ethnographic perspective which is surprisingly missing from the aforementioned sociological analyses of hospital environments. Previous focus has been on the goals of hospital design rather than the material and fleshy details of how work and movement is socially arranged (Brown and O'Hara 2003, p1569). Many of these past studies have also reinforced and reiterated medicine as a contained, ordered system. In this chapter I subsequently present an alternative 'system' that was not contained, but rather one that was more open, open here to adjustments and ongoing change. The next section provides more theoretical detail on how this fits into the thesis' overall framework.

**Theorising buildings as ‘places’**

Literature on ‘place’ in fields such as geography, architecture and STS has grown considerably in recent years. When utilising the concept of place in this chapter I am drawing upon the framework of sociologist of science Thomas Gieryn (2000), to provide some level of concreteness to the term, for there are many abstract alternatives. From his overview of place-sensitive sociology, Gieryn (2000, pp465 - 467) argues that ‘places’ have three necessary features. First, they are unique spots in the world, distinctions between here and there; in this case, a building. Second, places have physicality, a material form that is designed, built and used. Third, Gieryn states that places have meaning and value placed upon them by ordinary people, that is they are interpreted, narrated, perceived, felt, understood and imagined. This meaning is labile, flexible in the hands of different people, malleable over time. Gieryn argues that these three features are interwoven so that the plenitude of place loses analytical strength if they are unravelled, or one forgotten. Therefore place, according to Gieryn, is simultaneously location, materials and peoples’ interpretations and identifications.
Buildings

To Gieryn's definition I would add that place is something which we have an embodied relationship with. The body was the vehicle by which overseas doctors perceived their new environments. The doctors also carried their past forms of dwelling in their bodies, (Ingold 2000, p186), evident in the way they moved through places. Their modes of inhabiting the hospitals entailed a constant threading between habitual places of practice and the ones they found themselves in. The ways in which we engage with buildings or dwellings in bodily ways has been further studied by Bourdieu (1979) in his famous study of a Kabyle house, by Seamon (1980), Ingold (2000) and others such as urban planner Jean Hillier and philosopher Emma Rooksby and colleagues (2005a) in the edited collection Habitus: A Sense of Place.

Tying these theoretical perspectives together, in this chapter I focus on the hospital's location, its material details as well as overseas doctors' interpretations of, and ways of moving in, the hospital, subsequently incorporating a blend of observational, textual and interview data. This methodology extends much existing ethnographic work about hospitals which tends to view the hospital building as a backdrop for the social action of human-to-human interaction. Most hospital ethnographies leave out the materiality of hospitals from their accounts, paying little attention to the physicalities of place, to the building itself. In many ways these are ethnographies that I would argue are set in hospitals rather than being of hospitals.

This is a common criticism of much work in anthropology, sociology and geography, particularly from researchers who use ANT inspired methodologies sensitive to both human and non-human aspects of the environment. However, studying the ways that overseas doctors negotiated places does not entirely fit within an ANT focus that stresses the symmetry of human and non-human relations. As I have emphasised in Chapter One, the focus of this research is very human-centred. That is, in the context of place, I am studying how overseas doctors adjusted to the building rather than, as others have done, suggesting that the building is an equally important actor. For example, in
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her work on renovations, drawing from both architectural theory and STS, Albena Yaneva (2008, p23) considers the building an active participant in the course of building renovation. In arguing my position however, I do acknowledge that the hospitals changed over time, as a consequence of the inhabitation of overseas doctors, and explore this in more detail later in the chapter.

Of course there is exceptional sociological/anthropological work that recognises materialities of hospital places that has informed and inspired my analysis. Surgical ethnographers for example, do often pay attention to the layouts of surgical theatres, documenting how sterile boundaries and physical barriers enable social action and organise the movement of bodies and instruments (Fox 1992). Computer science researchers Jakob Bardram and Claus Bossen (2005) designed an elegant study of the spatial context of cooperative work in a Danish hospital which looked at the mobility of medical workers. Alan Radley and Dianne Taylor’s (2003, p77) phenomenologically informed study of patients’ perspectives of hospital spaces using photo-elicitation techniques highlighted, surprisingly to the researchers, the material and technical aspects of the hospital ward. And finally, anthropologist Debbi Long and colleagues’ (2006) work on hospital corridor conversations is one of the few studies, alongside Rapport’s (2004; 2008a; 2008b) work on hospital porters which I examine later in this chapter, to explicitly highlight the less structured use of place in hospitals. Using video ethnography, Long and colleagues examine how linear and liminal corridor spaces facilitated more fluid communication in multidisciplinary teams. They argue that, in essence, corridor conversations represent what is ironic, contradictory and complex about hospital-based clinical communication. These studies provide glimpses into the extraordinary richness to be found in an ethnographic analysis of hospital buildings. The next section now returns to the hospitals in my research.

Re-introduction of the case studies
For overseas doctors in this study, hospitals were part of the ‘core cartographic feature (s) of (their) subjective cityscape’ (Gieryn 2000, p472). Some knew few other places in Melbourne. They were locations of immense pragmatic purpose, more obviously for the overseas doctors who worked there but also for unregistered doctors who used the hospitals as a place to meet and place to study. Whilst there are a number of rooms, wards and units in the hospital that could be analysed, which the overseas doctors inhabited and dwelled, the following sections of this chapter look in most detail at the places that have already been introduced in Chapter Five. This is to tease out more of their pragmatic functions and the ways that overseas doctors moved within them. After close examination of the library, cafeteria and tutorial room, the chapter moves to other places in the hospital, such as pathways the overseas doctors created, revealing more pockets of improvisation and change in what is normally considered a disciplinary and rigid institution. These corridors and shortcuts also link the library, the cafeteria and tutorial room, highlighting the hospitals’ interconnections and the ways in which the system is quilted together.

The hospital library

In the last chapter, the hospital library appeared as a popular place for overseas doctors to study for their AMC exams. Amongst the smell of old dusty journals, a scattered assortment of textbooks and the screech of someone taping boxes, overseas doctors studied for assessments in the designated study areas. Study tables framed the neatly stacked journals and textbooks arranged by standard library filing systems. Between the shelves were skeletons and anatomical dummies with their brightly coloured organs fitting neatly together. Around the library were signs denoting where doctors and students could and could not study, what they were allowed to bring into the library and what they were not, what could be left on carrels and what could not. Hours of library usage were delineated clearly. When it was closing time the librarian would announce that those without staff passes such as medical students and AMC candidates had to
The hospital library was a convenient and publicly accessible place for overseas doctors to meet. In this place the librarians were friendly and allowed the overseas doctors to talk quietly in groups. There was a photocopier handy and textbooks nearby. Because so many overseas doctors studied there it was a great place to connect and share resources and to learn study practices. It was a place mainly inhabited by overseas doctors who were not employed at the hospital, doctors who have been called the 'medical underground' (Irigoyen and Zambrana 1979). These were the doctors who Australian doctor Ranjana Srivastava (2008, p218) describes as wearing 'their medical degrees like ill-fitting overcoats – too awkward to parade but too warm to discard'. Srivastava refers here to a sense of professional identity that was in flux, as the overseas doctors studied for the accreditation assessments in Australia. These doctors were not employed as doctors, a profession to which much of their sense of identity was bound.

The hospital library was an important place for overseas doctors to renegotiate their sense of belonging in the hospital. By studying in the library, in meeting other overseas doctors there, the unregistered physicians could be part of a medical world that they could not participate in through medical employment. It was a place where they felt like they belonged, however partially. It was a place similar to those they had previously belonged to, the library filled with familiar medical signifiers with historical links to their past practice and study. Amongst the textbooks and teaching models, the overseas doctors had a heightened sense of medical identity, similar to that experienced by a Ghanaian doctor in another study who told the researchers ‘as soon as I stepped out of the hospital [where he was training in the UK], I wasn’t a doctor anymore, I was a black man’ (Hagopian et al. 2005, p1755). This is an embodied identification with place that Mecurio describes well:

I experience a sudden hunger for the interior. I miss the concrete and brick
Buildings

and glass. I miss the constant weatherless climate. I miss the bodies of the old with their bits added on and bits taken away. I miss the rhythm of machines and the smell of antiseptic and the secret vaults that taste of healing. My body aches for it all in the way it's never craved cigarettes, never even craved heroin ...

(Mecurio 2002, p349)

As a place, the hospital library was not just a section of the E Block in Hospital Y, not just the textbooks and photocopiers and not just an emplacement of professional identity and past medical memories, but all of these three aspects intertwined and embodied.

The hospital cafeteria

On a floor below the library, on the ‘staff only’ floor of the hospital, was the basement cafeteria. Its kitchen had closed during the first few months of my fieldwork to make way for the bright green café upstairs and was now no longer filled with people making over-cooked staff meals. The kitchen stood there like a ghost ship behind silver screens, bathed in the fluorescent blue-black light of a plug-in insect repellent. With a ceiling of congested white tubing that looked like monstrous tentacles from a 1960s science fiction horror film, the empty kitchen gave a haunting aura to this basement space.

The cafeteria itself was filled with grey metal chairs with apricot plastic vinyl seats, and long tables. There were un-used extension cords hanging from the ceiling, big square blocks of fluorescent light, cards on the tables saying ‘please!! Do not leave dirty dishes on the table put them on the conveyer belt and leave tables tidy for the next person thank you’, all in one breathless sentence. The conveyer belt, now stationary, occasionally had a lone plate lying on it, never to be rolled into the kitchen. A phone might ring but no one would answer it. I was surprised that the clocks still worked down there. The stainless steel benches were overhung with urn taps; there was motley
carpet, empty power points in the walls, large garbage bins, nurses’ union posters, the hum of a generator, the foul taste of cheap coffee.

Overseas doctors used this abandoned hospital place as dining hall, meeting place and study room, alongside other fringe-dwellers and the occasional local medical doctor during lunchtimes. We have already met the overseas doctors who would gather in this cafeteria on Sundays, to study for the written AMC exam. There were also regular groups of overseas doctors who came there before the Thursday tutorial, heating their dinners in microwaves in takeaway food containers, which they then shared with each other. The atmosphere was often quite jovial and overseas doctors would move about the groups to hear news and other gossip. One evening there was a group of local doctors there. They were wearing mostly pale pastel shirts, eating and drinking snacks from the vending machines. I could hear them compare stories of drunken nights and trips away. They seemed out of place in this cafeteria. Downstairs had become the domain of the unregistered doctors.

The cafeteria was one of the places, a fringe-dwelling site in the hospital, where overseas doctors studied with paperwork and instruments and with each other. It was a place where they could be comfortable with their initial stages of adjustment within the local system, where they adjusted their repertoire of past practices to new ways of doing things in a new hospital context. The temporarily unused hospital space seemed a fitting location for these overseas doctors to meet, as they were doctors on the peripheral edges of the system. Again this place was more than location, furniture and meeting place, but as Gieryn argues, an interrelation of all three, an inhabitation of a seemingly unlikely hospital location in a creative way, weaving materials and relations into a surprising and novel arrangement (Conradson 2003, p1982).

The tutorial room

The tutorial room where overseas doctors studied clinical stations for the AMC exam
was another important place for unregistered doctors. It becomes the third case study in this chapter. Each Thursday night, overseas doctors studying for the AMC clinical exam met in a small room near the hospital library, lined with portraits of nurses and cabinets of antique medical instruments. They arrived from the library, from the basement cafeteria after microwaved dinners, from psychiatry wards and the ED - many before night shifts - from other outer metropolitan hospitals and from rural posts three hours drive away, to attend a tutorial where they practised scenarios for the exam. Attendance seemed to happen by word of mouth, with doctors often first coming to the group within days of arriving in Melbourne from overseas. Sometimes over sixty doctors were crowded in the small room, male doctors often giving chairs to females, leather Harley Street bags crammed under seats.

One tutorial participant told me that he felt comfortable in this place, that it was not a threatening environment. Another doctor told me 'you don’t feel as if you are in a foreign place in this tutorial group - you feel immediately at ease and everyone wants the same thing’. I did often sense a feeling of trust within the group and a feeling of openness and willingness to do anything that was needed to pass the exams, including the intimidating task of volunteering to role-play in front of the group. The tutorial room was a place in the hospital where the overseas doctors were allowed to be in control of the clinical case and have room to demonstrate their knowledge of the scenario or act on their feet and improvise. There was room to make mistakes as they adjusted to the style of the exam. This adjustment was not always free from audience criticism however, as was evident in Dr Jiang Lin’s scenario (Chapter Five).

Overseas doctors who passed their exams came back to share experience of the stations and sometimes ended up staying for the whole tutorial. There was a sense of achievement when these doctors came back, which worked quite naturally because the doctors returned on their own accord. They were proud of their achievements and wanted to share this with the group in that tutorial room. The overseas doctors
planning to sit the exam saw some incentive for the hard study, evidence that you could pass. Like the library, the tutorial room was another legitimate space for the unregistered doctors within the hospital, one that was imbued with materialities and cultural meaning. Watched by decades of Australian medical history captured in the acrylic gaze of nurses in starched habits, the overseas doctors were learning to meet an Australian 'standard'. Like the library and cafeteria, this room was a significant meeting place for the overseas doctors. In the next section I discuss how overseas doctors adjusted to these three places in the hospital building.

Gaps in the rhythms of everyday life

Each of the places outlined in this chapter so far were in some way configured by constraints and limitations. The hospital library and cafeteria were filled with signs, rules and regulations. Renée Fox was also struck by the omnipresent nature of signs in hospitals, which she views as a result of the hospital being a public/private space with a complex bureaucracy. She writes that 'their quantity and the nature of their messages infuse the hospital with a depersonalized, “Alice in Wonderland/Through the Looking Glass”/“Big Brother is Watching You” atmosphere all of its own’ (Fox 1989, p159). The library's skeletons and anatomical dummies with their brightly coloured organs fitting neatly together, the ordered filing systems, and carefully delineated places and times of study, can even be viewed in this way to reiterate forms of regulation.

As I have indicated at the beginning of the chapter however, the overseas doctors adjusted to these arrangements. In the library, usually five minutes before the announcement came over the loudspeaker that the library was closing for AMC candidates and others without authorised access, the study areas were already empty, doctors having dispersed home or descended to the cafeteria where they would heat up their leftover dinners or have another free coffee from the vending machine. In the cafeteria, overseas doctors ignored its staff-only designation, hospital security guards
accepting this with a shrug of their shoulders. In the cafeteria, the unregistered doctors made the place their own, making use of handy facilities such as the coffee machines and the staff's microwaves. In the tutorial room the overseas doctors learnt to move around the room, amongst the paraphernalia, squeezing more and more participants in the tiny space as the year progressed. Those who had been attending the tutorial for some time knew to get there early, to secure a front seat which would give them a better chance of obtaining copies of the scenario handouts.

These are yet more modes of adjustment to the environment, each overseas doctor having a different attached meaning or way of moving in these places. They were ways in which overseas doctors on the fringes of employment negotiated their circumstances and ways of being in the hospital. Thrift (2003b, p105) suggests that it is through creative ‘gaps in the rhythms of everyday life’ that people make improvised responses to the ‘arrangements of things’. He writes that:

Using talk, gesture and more general bodily movement, (people) can open up pockets of interaction over which they can have control. Clearly an important part of this process is that spatial awareness we call place. For places not only offer resources of many different kinds (for example, spatial layouts which may allow certain kinds of interaction rather than others) but they also provide cues to memory and behaviour. In a very real sense, places are part of the interaction.

(Thrift 2003b, p103)

Hospital buildings were part of the multifarious environment overseas doctors found themselves within. Their adjustments to the materialities of place were situated and embodied, evident in their movements and how they made themselves at home. It may have been glimpsed in the way a doctor walked through the hospital corridors. Or it could have been glimpsed in a gesture.
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Such minutiae was revealed one day in the hospital cafeteria. In this place, life orbited around the illuminated instant coffee machines standing erect in the middle of the room. The hot drinks were free and once you had pressed a button the machine softly grr'ed inside and a waxy paper cup plopped down onto the grill, magically mixing a bittersweet cappuccino. I showed Dr Abdul Karim Razavi and Dr Hamid Reza Salimian, who had recently arrived from Iran, how to get this free coffee and afterwards we met there fairly regularly. These two doctors loved to joke and our conversation topics often wandered onto Persian poetry and classical music. One evening after coffees and conversation, we headed off to the tutorial and deposited our empty cups in the rubbish bin by the microwaves. I threw mine in, not thinking, and Dr Abdul Karim Razavi scrunched his in his hand and threw it in as well. He then turned to me and asked why I did not scrunch my cup. I asked him why he scrunched his and he replied that it was so that no one else drank from it. The next time we had coffee he did not scrunch his cup.

This was a small detail. It was a simple contraction of his hand muscles, a small arc into a plastic bin, in that re-appropriated cafeteria. It was a gesture however that revealed a larger crack of difference between systems. In his reflexive action Dr Abdul Karim Razavi revealed something of his past, an alternative hospital setting, thousands of kilometers away in Tehran. These are the communicative registers of the body that Thrift argues we are often blind to in our studies of places. He urges us to pay attention to: ‘the subtleties of body language, the sensibilities of balance and posture, the sensory orientations of motion... [to the] “small” spaces which can have “large” effects’ (Thrift 2003a, p202). Dr Abdul Karim Razavi’s reflexive movement in the hospital cafeteria seems ‘small’ but it was in such gestures that difference was more evident and it was through such gestures that adjustment took place.

In his hospital ethnography, Rapport (2008b, p100) finely details how hospital porters’ liminality was manifest in their bodily gestures, in their postures and comportment in public spaces in the hospital. It may have been ‘a bored and uninterested slouch’ that
expressed how they coped with their liminal inhabitation of place, their bodily gestures revealing much about their existential mobility. Another anthropologist, Michael Herzfeld (2009, p132) has recently attempted to highlight the power of the role of gesture in maintaining or subverting formal structures, or what he terms ‘the political dimensions of meaning-making through gesture’. As overseas doctors moved between hospital places, as they made their pathways through the wards and corridors and stairs they were also adjusting to the system in embodied ways.

**Corridors and pathways**

Pathways link together hospital places. There cannot be places without paths and there cannot be paths without places (Ingold 2000, p204). The following excerpts from Mecurio’s (2002, p19) novel highlight the way in which we learn routes in buildings, and how pathways in hospitals signal a sense of belonging:

At the end of my first day as a doctor, my first First of August, I descend the stairs from my home ward and find myself in a long white corridor that looks the same as every other one in the hospital. I don’t ask anyone the way. I’m a white coat now. I’m expected to know these things. But it takes me ten minutes to find the exit signs.

(Mecurio 2002, p19)

And later ...

In the lift I fall five floors to the long sloping pastel corridor, the spine of the hospital that steers me out from its interior of wards and departments. I turn corners and mount steps and pass through doors. In minutes I reach the atrium. I peel off my white coat and cross into daylight. I do it all without thinking because now I know the way.
Following the overseas doctors’ tracks in the hospitals, such as those between the places which have provided case studies so far, reveals further adjustment to the building. In hospitals, corridors and stairs and lifts and PA systems and pneumatic tubing systems thread together to physically interconnect places. There are also unorganised, disordered pathways made by the inhabitants. In adjusting to the system, in learning the ropes as newcomers, overseas doctors developed their own informal pathways through the building; shortcuts from the free parking to the library, from the tutorial room to the train station, from the library to the cafeteria. As they started working in hospitals further shortcuts become a way of learning and adjusting to their new workplace.

In his study of hospital porters, Rapport (2008b, p96) tracks his informants ‘on the move’, between parts of the hospital plant, their well-being, he argues, being a matter of satisfactory progress through certain perceived environments. Rapport (2008b, p97) studies the porters’ ways of accommodating between ‘on the one hand, certain life-rhythms they felt happy with, and, on the other, the regime, the rules and the site of the hospital’. He writes that the porters turned the hospital into their own microsocial space (Rapport 2008a, p71), moving in and around the hospital in their own ways, ‘ways they had determined to be the best for themselves ... having favourite, idiosyncratic, possibly secret routes and shortcuts (and long-winded diversions), proud to know the best places to “get lost”’, hide, smoke, waste time’ (Rapport 2008b, p98).

Overseas doctors share a similar liminality to porters, both inhabiting the fringes of hospital life. The pathways of these fringe-dwellers through the hospital call to mind the work of philosopher Michel de Certeau (1984, p97), for he writes that it is intertwined paths that give shape to place as people ‘weave places together’. In The Practice of Everyday Life (1984) he proposes ways in which people escape rule-bound models
through tactics of evasion and escape (Napolitano and Pratten 2007, p3). Contra to Foucault ([1963] 2003), his aim is not to make clearer how the violence of order is transmuted into disciplinary technologies but rather to highlight the tactical creativity of groups of individuals ‘already caught in the nets of “discipline”’ (de Certeau 1984, pxiv). A tactic is part of, and depends on, the environment. It is about watching for opportunities that must be ‘seized on the wing’ (de Certeau 1984, pxix).

Importantly for this chapter, de Certeau is interested in how one insinuates into an imposed system with their own ways of dwelling, in how people find ways of using places in creative ways. It is those, he writes, who ‘by an art-of being in between’ draw ‘unexpected results from [their] situation’ (de Certeau 1984, p30). The overseas doctors could adjust to place creatively precisely because of their liminality and marginality. However, in making pathways and maneuvering around the hospital building I do not believe, as de Certeau has suggested, that the overseas doctors were resisting. Rather, in their adjustments they were learning how to become attune to the hospital’s ‘particular rhythms’ (Thrift 2003b, p102).

**Changing places**

In attempting to match the vibration of the system (Chapter Five), the overseas doctors threaded between previous architectural histories ingrained in their muscles and tendons and proprioceptors, their ‘arms and legs ... full of torpid memories’ (Marcel Proust cited in Urry 2000, p137), to the environment they found themselves in. In doing so, they changed along the way. This is how someone becomes an insider in a place, to feel part of it, by participating in daily performances through bodily practice (Cresswell 2004, p34). It was something that happened gradually over time and in the process of adjusting the overseas doctors accumulated more experiences in places in Australia which helped to shape their comportment. Better than any hospital ethnographer in the social sciences, the fictional writer Will Self describes how the hospital becomes
Yes, Shiva Mukti was a snaky changeling; a bilingual, first-generation immigrant who stuck one of his tongues out at his elders, while employing the other to lick the ice cream the world had given him. He bowed down to novelty, worshipping American movies, Japanese gadgets and Italian cars. He was a small, fastidious man, with lustrous blue-black hair which grew densely on the slopes of his mound of a brow; and his extended lobes – widely believed, in India, to be a mark of divinity – were covered with a filigree of black hairs. When he was a young man, breaking away from his family, charging towards life with his arms wide open so as to grab as much as he could, Shiva Mukti’s countenance had been at once chirpy and engaging, but with time had come overwork and thwarted expectations, which like swing doors slammed back into him, bruising and distorting his face ... As Mutki sat opposite David Elmley in the staff canteen at St Mungo’s, and ranted for the hundredth time that year about how ill-served he was by the local NHS trust, his smile, at one time charmingly lopsided, was now set in a permanent grimace of burnt-out dissatisfaction.

(Self 2004, p8)

And as the doctors changed, so too did the system, because they were part of the environment. Some of these changes were a direct result of the overseas doctors’ practices. For example, sometime after fieldwork had finished, the hospital library instigated new rules which limited the number of overseas doctors allowed to study in the library. There was an attempt here once again to manage their movements. Other changes were part of the hospitals’ evolving adaptation to the growing needs of its inhabitants. Again, on a return visit to the hospitals more recently, the tutorial room had turned into a computer laboratory, and the downstairs cafeteria had been cleared out to make way for an endoscopy suite. The overseas doctors, forever resilient, were
finding other places to study, such as in the nearby university medical library.

All buildings grow (Brand 1994, p10). Considering the rapid evolution of medical technology, hospitals are usually already outdated by the time they are built. This means that they need constant modification not only to accommodate technology but also the ever-changing actors who inhabit the place. There has been a contemporary movement in architecture to embed flexibility into the design of buildings, a kind of ‘determined indeterminacy’ (Sarkis 2001, p83), a philosophy long held by Japanese architects. In other parts of the world, this architectural focus can be found in styles of buildings often referred to as ‘mat buildings’ (Sarkis et al. 2001). Mat building design can be viewed however as maintaining a contradictory ideological position regarding flexibility (Sarkis 2001, p84). Places lose something when they are designed to promote such activity (Gieryn 2000, p477). Over-determined design could be seen to rule out the ‘crinkled fabric of buildings that allow little start-up businesses, and so communities, to grow and vibrate. This texture results from underdetermined structures that permit uses to abort, swerve, and evolve’ (Sennett 2008, p43), aspects of design I tie into my program recommendations in Chapter Nine.

In the hospitals where I did fieldwork, following the overseas doctors allowed glimpses into the crinkled fabric of the buildings, where the inhabitants adjusted to their surrounds and changed them in the process. The hospitals were filled with people adjusting constantly to their environment, evident in numerous pockets of architectural creativity throughout the hospital. During the course of fieldwork I held interviews with Dr Mladen Mück in his office with curtain tracks in the ceiling which would have usually overhung a patient’s bed, with a gynaecological examination lamp giving light to my notepad. I took fieldnotes in a nurses’ staff room with computers and whiteboard, as well as an empty hospital bed and the ubiquitous sink and hand cleansing bottles. I had a conversation with Dr Marian Munteanu in sections of old wards turned into kitchens. I visited the interpreters in their large room that seemed to have been an old treatment
room; the spatial dynamics meaning that the interpreters had their desks lining the walls, like lab scientists, with large vacant floor space between. Patients also adjusted to their hospital spaces. On a ward round with Dr Elena Radulescu we visited a Vietnamese patient whose room was brightly decorated with paper cranes that his daughters had made. The cranes were tied up together with the small ones falling down in string necklaces and the larger ones tied together to make garlands. Several religious figures were laid out by another patient’s chair in the chemotherapy day unit.

Following the overseas doctors into their study places, down corridors and into various rooms also revealed other peripheral members of the hospital, those who are little studied, though appear occasionally in research (Fox 1989, p161), such as the domestic staff, clerical employees, security staff (Patterson et al. 2008) and hospital porters (Rapport 2004, 2008a, b), who used the hospital building in creative ways. These fringe-dwellers of the hospital, the inhabitants of its empty spaces, are the workers whose labour often remains invisible in any study of medical practice or hospital life.

Overseas doctors’ adjustments to the building were thus part of everyday adjustments happening everywhere in the hospital. Thrift (2003b, p103) writes that: ‘when the minutiae of everyday interaction are closely looked at what we see is not just routines but also kinds of creative improvisations which are not routine at all’. Following the overseas doctors revealed this, as well as the peripheral places at the edges of the system, connected through informal pathways, part of an ever-changing architectural history. These places highlight the dynamic nature of the system. Ingold similarly reflects on the nature of this:

As people, in the course of their everyday lives, make their way by foot around a familiar terrain, so its paths, textures and contours, variable through the seasons, are incorporated into their own embodied capacities of movement, awareness and response – or into what Gaston Bachelard calls.
their “muscular consciousness”. But conversely, these pedestrian movements thread a tangled network of personalized trails through the landscape itself. Through walking, in short, landscapes are woven into life, and lives are woven into the landscape, in a process that is continuous and never-ending.

(Ingold 2004, p333)

If the term ‘familiar terrain’ is switched for ‘familiar unknown’, this passage of Ingold’s work underscores the phenomenological and ecological nature of the overseas doctors’ adjustments, where it is not about people shaping place and vice versa but about the two folding into each other.

In their adjustments, overseas doctors provide glimpses into their own past as well as the system they are becoming part of. This is revealed in gestures, in ways of moving through and interpreting places. We have already been provided with some sense of a hospital system in Tehran. There were other glimpses throughout fieldwork. In an operating theatre one day, Dr Neelan Tiruchelvam compared it to those he was more used to in Sri Lanka, where operations were run simultaneously, the consultant going between them and the medical students assisting. One afternoon in a small staff tearoom on the rehabilitation ward Dr Surekha Sadafule’s thoughts drifted back to India, comparing the tearoom to the size of a waiting room in a public Indian hospital, where she described how the doctor can treat a very large number of patients in a day, with queues of patients waiting at any one time. These comparisons of place highlight differences in the structural details of the doctors’ past and present work, providing glimpses into the health inequalities that the overseas doctors were witness to, though rarely discussed. These memories and comparisons highlight aspects of their previous practice as well as the system in Australia. However some differences were not so easily described. These were the affective dimensions of place.
Operating on a financial shoestring, a surgical team at the Jamkhed project’s only hospital can’t rely upon state-of-the-art equipment. But this facility still handles everything from hip replacements to ruptured bowels. Having a hospital as part of the program helps bolster village health workers’ credibility.

Figure 9: An operating theatre in India
Source: The National Geographic Magazine, December 2008, p74 - 75
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Affective dimensions of the hospital environment

A sense of affect is found in the awesomeness that Dr Nikolai Nagorsky remembered from his first day in ‘an Australian hospital’ and in the eeriness of the normal saline octopuses. Psychologist William Caudhill (cited in Fox 1989, p166) observes that the “rhythm of the on-going life” in a Japanese hospital seemed different from that of an American hospital. Similarities and differences vibrated simultaneously in the rhythms of the hospital buildings overseas doctors’ found themselves in. They were the affective dimensions of place, thread through the building to which the doctors adjusted. Gieryn (2000) concludes his overview of the sociology of place by musing that there is often much which is difficult to write about in terms of place, aspects which some might describe as ‘non-representational’ (e.g. Conradson 2003; Lorimer 2005). A focus on gesture is one way to explore some of these dimensions of our relations with architecture that are less explicit. Another way is to give more attention to the immaterial, affective dimensions of place, which are often missing from sociological, anthropological, geographic and STS discussions of the built environment (Conradson 2003, p1982). Thrift aptly describes affect, and its relation to place, as:

An impersonal force resulting from the encounter, an ordering of the relations between bodies which results in an increase or decrease in the potential to act. Place (understood as a part of this complex process of embodiment) is a crucial actor in producing affects because, in particular, it can change the composition of an encounter by changing the affective connections that are made. Thus, as we all know, certain places can and do bring us to life in certain ways, whereas others do the opposite. (Thrift 2003b, p104)

All of the places that have been analysed closely in this chapter are imbued with affect. The library had a dusty, night-time feel to it; the cafeteria, science-fiction peripherality;
Renée Fox’s hospital, an Alice-in-Wonderland quality. As the overseas doctors met in these environments, there were ripples of feeling. There was a sense of communality in the cafeteria before a tutorial, during the sharing of food. In the tutorial room the feeling could change quickly, from attentiveness to those who had passed the exams, to smugness when someone did not perform well, to shared laughter instigated by the tutor. In one part of the hospital, the affective dimensions of place were particularly acute for the overseas doctors. It was a place where many worked and where most negotiated their early stages of adjustment to the hospital. It was the emergency department.

One busy day, heading up to the wards, I passed through the ED waiting room with Dr Hossein Youssefian. He stopped for a few moments and recounted how he had a lot of memories from there because it was the first place he worked in, in Australia. He was lost for a moment in the feelings that this produced. The emergency department waiting room smelled like cleaned-up vomit, the familiar odour clinging to the plastic seats and dated gossip magazines, following us as we then made our way to the plastic seats and dated gossip magazines, following us as we then made our way to the ward.

Returning to the ED during a ward round there was a gentle restrained chaotic tension in the air, with the knowledge that there was a waiting room full of people to be seen. The department itself was quiet because there were no hospital beds to put the patients in, due to bed closures. After lunch they must have stopped being on bypass (see Medical Glossary) because there were patients on gurneys in the corridors and ambulance drivers with portable laptops by their side. Later I heard that there were six ambulances in the loading bay waiting to deliver patients to the department. A locuming overseas doctor walked past me and said that he had a headache, not from the work, but the underlying tension of the day, due to the fact that they were on bypass. Dr Mara Radovanovic, a tall, slim Bosnian doctor who migrated from Bavaria, Germany, described to me how this chaotic feeling was not only about bypasses and the
size of the hospital but also about the architectural layout of the emergency departments. She complained that you could not easily see the telemonitors of the cardiology patients in one particular hospital and that everything always felt ‘far away’.

The body-ballet (Seamon 1980) of the ED was shaped by the physicality and materialities of the unit, by the staff and instruments and waiting ambulances, by the way that everyone moved, embodying past practices and present moment tensions. To better understand these aspects of hospitals there is a need to pay attention to affective dimensions of the negotiating interactions that happen in EDs, in cafeterias and in tutorial rooms. The hospital building is an important part of the story; it is what is related to, adjusted to. Philosopher David Kolb (cited in Latham 1999) writes that, whilst
Buildings

often buildings only repeat or narrow the forms and possibilities we already live, architecture can also offer us new ways to hold ourselves, to move and to be. He states that 'buildings are not neutral containers; they shape the way we stand and move, the way we feel, the way time and space come to us. The dense reality of a building can affect us on more levels than our analyses provide' (David Kolb cited in Latham 1999). The affective dimensions of place are difficult to evoke. My own difficulty in describing the feeling of the ED is evidence of this. Gieryn (2000, p483) suggests that the way in which we might better understand place is not through a set of empirical findings at all, or even an explanatory model, but rather through a visual key. In the following section of this chapter I briefly discuss the power of the visual in understanding overseas doctors' relations with place.

A photography of surfaces

Throughout this chapter I have drawn upon novels and children's literature because these texts often are more effective at evoking the affective and material dimensions of hospitals and hospital life than the social science literature. Such insights from the arts and humanities have been noted as importantly lacking from our discussions of place in the social sciences (Gieryn 2000) and there is certainly more room to include non-social scientists as ethnographers of hospitals (Harris 2008). Gieryn (2000, p483) argues that there is much that is lost in translation in the description of a building in social science disciplines that rely upon words to grasp the social. He suggests that sociologists need to become more adept with maps, floor plans, photographic images, bricks and mortar, landscapes and cityscapes, in their stories of place. To this we could add smells, soundscapes, videos and touch.

At the end of this chapter is a photographic essay, or a narrative montage of images, which evokes the places discussed in this chapter and in Chapter Five, where many unregistered overseas doctors spent their time. These photos are not of the research
participants. They are of physical and material places. They are of meeting places, places of pragmatic usefulness, of memory and belonging. They are also imbued with affective layers that are difficult to capture in words, as well as visual imagery, the latter possibly coming closer to the former. The images need to be read on different terms to the text that they interfere and intersect with, in the chapters on either side of the interlude. The images attempt to constitute a ‘photography of surfaces’ (Soja 1989, p23), with gaps in between, many of them alluding to the ‘night-side’ (de Certeau 1984) of the hospital.

In this chapter I have also included architectural sketches of the fieldsites. These sketches not only tie in with the architectural theme of the chapter but also resonate
thematically with the idea of ‘place in process’ which underscores my argument. Hand-drawn architectural sketches are unfinished, unlike a computer-aided drawing. Sennett (2008, p40) quotes a young MIT architect who says that through drawing the details, the counter lines and trees ‘you get to know a terrain by tracing and retracing it, not by letting the computer “regenerate” it for you’. Sennett argues that these sketches are pictures of possibility, that ‘in the process of crystallizing and refining them by hand, the designer proceeds just as a tennis player or musician does, gets deeply involved in it, matures thinking about it. The site “becomes ingrained”’ (Sennett 2008, p40) in the architect’s hand, the building ingrained in the bodies of overseas doctors as they learn it, like Dr Mutki’s lopsided smile. Comparing drawing to writing, Sennett believes that:

The tactile, the relational, and the incomplete are physical experiences that occur in the act of drawing. Drawing stands for a larger range of experiences, such as the way of writing that embraces editing and rewriting, or of playing music to explore again and again the puzzling qualities of a particular chord. The difficult and the incomplete should be positive events in our understanding ...

(Sennett 2008, p44)

In discussing how overseas doctors adjust to the hospital building they have similarly revealed the dynamic incompleteness of place, of hospital buildings, of the system and their environment. It appears unbounded like the yo-yo quilt, with gaps and empty spaces. Incompleteness, like multiplicity and difference, is a key characteristic of medical practice (Mort and Smith 2009, p226), helping to explain its richness, pervasiveness and ongoing change.

Summary
Chapter Six

In this chapter I have argued that overseas doctors adjusted to the hospital building in various ways, highlighting a system that was more open and fluid than the rigid institutions with delineated departments, spaces and roles, with formalised and standardised control and organisation of access that often pervade social analysis of hospitals. I have addressed the lack of research on the materialities and physicalities of hospital buildings in hospital ethnographies by paying attention to how the overseas doctors moved about their architectural environment. In engaging with the literature on place, this chapter has also moved beyond what is often considered a two-way relationship where place is considered to shape the person and vice versa (Casey 2001, p688), to argue that the overseas doctors adjusted to place, in embodied ways, incorporating movements developed in previous clinical places. This highlighted neither ‘spaces of prescription’ nor ‘spaces of (fluid) negotiation’ (Cummins et al. 2007, p1828) but rather something creative that lies in between, revealing a hospital in continual evolution (Fox 1989, p160).

In teasing out the ways that overseas doctors adjusted to hospital buildings the physicality, materiality and cultural meaning of place needed to be addressed as well as its embodied and affective registers. To do so the chapter incorporated a visual key, as well as scenes from novels and children’s books, to help evoke the ways in which hospitals can be a kind of ‘architectural aide-memoire’ (Gieryn 2000, p481) that provides a kind of ‘half-remembered poetics’ (Entrikin 2001, p139) for the overseas doctors. Their adjustments may only be able to be articulated partially, in things like bodily dispositions, gestures and off-centred spaces (Thrift 2003a, p2023). In the next chapter I explore bodily adjustments from a different perspective, in relation to how overseas doctors adjusted to the tools and instruments in their new environments. Once again I analyse what this reveals about the doctors’ own past bodily practices and the contours of the technical system they encounter. Before doing this however, I have stitched in the photographic interlude ...
Interlude Six: A Photographic Narrative
Interlude Six
A Photographic Narrative

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Interlude Six
Interlude Six
All photographs by Thomas Fuller
Chapter Seven: Tools

It was Rudrangshu’s 17th caesarian section. As he slapped the surgical gloves onto his large hands, the locally trained resident with red hair finished inserting the woman’s catheter. Rudrangshu’s registrar, who was assisting, hurtled into the room, falling into her small gown. She was known in the unit as ‘the dynamo’. I stood back, to the side of the OT with the resident. He commented to me how the ultrasound equipment was much different in Victoria than in the Queensland hospitals where he had trained and worked as an OT ‘techie’. I nodded and turned my attention to the operation before me. Rudrangshu had made his incisions and was now reaching for the baby’s head. He was struggling with the child’s position and with his bulky hands in the small opening. His registrar was pushing with all her tiny weight on the upper part of the woman’s abdomen. There was more cutting, more pushing. The forceps were required, which took some manoeuvring ...

(Recreated from fieldnotes)

This excerpt from my fieldnotes sets up much of what this chapter is about. I proceed to examine the various ways in which overseas doctors adjusted their procedural work in the midst of practical engagement with instruments. The excerpt hints at institutional notions of status relating to instrumental practice: it was the resident’s job to do the mundane procedure (catherisation) and the senior staff’s role to perform the surgical procedure. However in this instance, it was the junior registrar who was operating, supervised by his senior registrar, a situation marked specifically by it being Dr Rudrangshu Mukherjee’s ‘17th caesarian section’. This overseas doctors’ liminal position within the obstetric unit is discussed in more detail later. Finally there were lots of instruments in the story; instruments which were part of the doctors’ adjustments. Instruments change between hospitals, even within Australia. And dealing with instruments needs to be learnt in the midst of practice.
In this chapter I argue that these adjustments become most evident in moments of ‘mismatch’, whether this is a mismatch between practitioners’ bodies, a mismatch between previous and current practice with a tool or a procedural mismatch concerning status. My argument assumes that instrumental technique is an embodied activity and the chapter initially examines how procedural skill becomes ingrained in fleshy habits, through observation, repetition and mimicry, with instruments that become extensions of the body. I then extend this further to look at how skillful practice is learnt in medicine in the midst of practical engagement. The various ways in which overseas doctors adjusted their technical work is subsequently introduced, first through one of my own stories regarding my use of a slightly different tool in an alternate medical context. This section examines what happens when the apparent seamlessness between the habituated human-tool-environment is ruptured. The story provides empirical material for study of the tactile dimensions of adjusting and sets me up as an object of analysis, alongside the overseas doctors in the project. Further modes of adjustment are discussed through ethnographic stories and the experiences of two overseas doctors on the obstetrics unit, which concern adjusting roles and status and responsibilities. In the chapter I argue that in circumstances of breakdown or mismatch, something further can be learnt about the mechanism of adjustment. In the process, once again, more is learnt about the overseas doctors’ past contexts of practice and the system they negotiated in Australia.

Thoom! Thoom! Thunk! Thunk! Tup! Tup!

In an obstetrics outpatient clinic, Dr Rudrangshu Mukherjee used his palms and fingers to feel the growing soft/bony contours of the unborn child; then his fingertips, intra-dermally rich in sensory nerve endings, to feel the woman’s slowing, stopped, then bounding pulse when taking a blood pressure reading; then his arm and hand to touch

\[1\] A version of this chapter has been accepted, upon the provision of making revisions, by the Sociology of Health and Illness
the woman on the shoulder, gently, when the results were not what she expected. Back
on the obstetrics ward a woman was admitted because her blood pressure was raised.
Dr Rudrangshu Mukherjee assessed for pitting oedema (see Medical Glossary) in her
ankles by pressing firmly into the woman’s flesh; assessed her reflexes by pushing her
foot quickly towards her leg, waiting for the reverberations signaling hyperactivity of the
nervous system; then performed a pervaginal (PV) examination to check for cervical
dilation. Later, when delivery seemed imminent, and the woman in pain, the
anaesthetist arrived and felt the bony nobules of her spine to find the soft place to insert
the needle so as to deliver an epidural anaesthetic.

These clinical skills are learnt and performed through the practitioners’ bodies. The PV
examination for example, performed by midwives and the medical team, is a routine
way of assessing the status of imminent deliveries. Learning to find the woman’s cervix
and subsequently assess the degree to which it has extended is an embodied practice
where the clinician remembers previous bodies and uses this bodily memory to help
them interpret stages of labour. Plastic charts on the wards with holes cut out help
novices by letting their fingers feel what 5cm or 8cm dilation resembles. A woman’s
body however is not a perfectly symmetrical cut-out plastic circle. Dr Rudrangshu
Mukherjee told me that it takes practice to know what to feel for. He said for example
that beginners often make the mistake of thinking that the cervix is long and closed
(meaning that the woman is not in labour), when in fact they have not found ‘the right
spot’.

The PV examination is a skill learnt and sensed through the clinician’s body with
repeated practice. The process of learning clinical skills, of training the body, requires
author and overseas doctor working in the USA, describes learning percussion as a
medical student, practising on his own body:
I was taught how to percuss the body so long ago: it was the first day of June 1972. That night, like tonight, lying flat on my back, the sheets pulled away and the lights off, I percussed my liver. I started just above my right lung, high, at the level of my nipple, pressing the middle finger of my left hand against my skin. I cocked my right wrist and let the fingertips fall like piano hammers: *thoom, thoom*.

“Resonance” I said to myself, picturing the air vibrating in a million air sacs, a million tiny tambours.

I moved down an inch: *thoom, thoom*. Farther down and farther still, and then suddenly, *thunk! thunk!* — dullness. I had reached my liver, airless and solid.

I returned to my nipple: *thoom, thoom, thoom, thoom*, and then *thunk!* I lightened my stroke: there was no longer any sound but there was still a vibration in my stationary finger — the pleximeter finger — which told me where the air sacs ended and where, high under my rib cage, under the domed diaphragm, my liver began.

I traversed my liver, following its dull note into the belly until the *thunk! thunk!* was replaced by a sharp and high-pitched *tup! tup!* — “tympany!” It was the air that had been trapped in the loops of my bowel. No longer confined to little sacs, it was free to vibrate like the air in a conga drum — *tup! tup!*

As a young medical student, I percussed everything in the joy of discovery. I percussed table tops, to find the stony dull circle where the leg joined the underside. I percussed plaster walls, looking for studs. I percussed tins of rice flour and the sides of filing cabinets. But in the dark, just as tonight, it was my own body that I percussed. As I drifted to sleep I saw myself as if transparent, my viscera, both hollow and solid, shining through my skin.

(Verghese 1994, p337)
Verghees describes how clinicians practice examinations on themselves and on each other, their hands learning what bodies feel like in the process. As Merleau-Ponty ([1945] 2008, p367) writes in relation to touch, one hand is functioning as object, the other as subject. Prosthetics and plastic models and skills labs certainly aid this process but it is not until the student then reaches the ward that their bodily learning truly develops, through their fleshy encounters with patients in teaching hospitals.

Practitioners highlight the importance of touch in hospital work. It has been suggested that the role of touch in medicine, although fully realised in practice, is not sufficiently recognised in social research (Moreira 2006, p81). However this neglects important work by Foucault and medical historians, for whom touch has been a topic of considerable debate. Foucault ([1963] 2003) suggests that touch was a marker of change in clinical medicine, delineating an era of observation from an era of examination. Others argue that Foucault’s thesis might be somewhat over-determined (Howes 1995, p133), and that physical examination such as taking a pulse and palpation was not absent from ‘Galenic (humoral) medicine’ (Nutton 1993). Whilst these debates are quite detailed, importantly for this chapter touch can be viewed as being considered an implicit part of medical practice for some time.

During tactile examinations, the physician’s hands are considered ‘tools’ in their own right. Polanyi (1966, p15) assumes the centrality of the body to the performance of all skills, considering it the ‘ultimate instrument’. Dr Mladen Mück, staff specialist in obstetrics and gynaecology certainly viewed his body as his instrument. Also an established tennis player, the doctor was proud of his athletic abilities, often comparing his surgical skill to sportsmanship. Occasionally he could be seen doing squats before an operation, like he was limbering up for a tennis match. Dr Mladen Mück considered bodily and procedural skill some of the most important aspects of medical practice, telling me ‘it’s easier to train someone who has practised for five years, to train them with language. It’s easier to train them than a local doctor with two left hands’. In many
ways, touch was a more easily transportable aspect of overseas doctors' work, part of their repertoire of embodied practice that could be translated across contexts. Whilst there are numerous cultural nuances and differences in regards to touching during the clinical encounter, when it came to procedural practice, overseas doctors largely considered the skills ingrained in their hands to be easily transferable. Clinical touch however no longer concerns only flesh-to-flesh contact between the doctors’ hands and the patients’ body.

**Instrumental extensions**

Since the 19th century, following apprehension about the bias inherent in purely tactile medicine, tools have become a common part of medical work. Historically there was concern about relying only upon touch because ‘who knew what the doctor heard, saw or felt; or how events of the previous day, the nature of previous medical training or even the mark of heredity influenced the perception?’ (Reiser 1993, p266). These questions return as a crucial dimension of procedural adjustment discussed later in this chapter. Technology, in the form of tools, was viewed as resolving this documented bias, and thenceforth became a more established part of clinical work. Many historians lament that at this time technology replaced touch, that the two became separated (Reiser 1993, p262; Howes 1995, p130). This section of the chapter blurs this distinction and regard tools and touch as being intertwined, extensions of one another. It is for this reason, that when material differences in equipment are found in an unfamiliar environment, that those perceived transportable skills can suddenly fall apart.

A conversation with Dr Rudrangshu Mukherjee reinforces how tools start to become ingrained in doctors’ bodily habits. One afternoon we were sitting in the obstetrics staff room talking about his career trajectory. He had studied medicine in India and then moved to Australia to study for his Masters to improve his chances of working in the USA. He had ended up staying in Australia, after stints in nursing and the hospitality
industry. The younger doctor considered Dr Mladen Mück as his mentor, listening closely to what he said and observing closely what he did. Dr Rudrangshu Mukherjee wanted to work in obstetrics and keenly volunteered for any evening and weekend shifts, eagerly attending all emergency procedures, wanting to be involved in as much as possible, to get as much practice as he could. Unlike the other registrars in the unit, he was not on the obstetrics training program as he had not yet obtained a seat in the AMC clinical exam, and needed to finish his AMC exams before commencing obstetrics training. This resulted in Dr Rudrangshu Mukherjee assuming a rather liminal position between resident and registrar. He hoped however that this current experience would not be wasted. Dr Rudrangshu Mukherjee had learnt about being an apprentice from his father who owned a mechanic store in India. He told me that his father would not let someone repair a tape recorder who did not know how to take the lid off properly; that you had to prove yourself capable in his eyes before you were allowed to do things, such as proving you knew how to work a screwdriver. Dr Rudrangshu Mukherjee appreciated the value of tools and needing to use them 'properly'.

As we talked, he played with a pair of artery forceps in his hands. He was practising a way of holding the instrument that he called a 'palmar technique'. Over and over again he would repeatedly open the forceps by unhooking the latch with his palm then closing them again. Through his repetitive practice, Dr Rudrangshu Mukherjee was attempting to make the surgical instrument an extension of his own hands. Polanyi (1958, p59; 1966, p7) views tools as an *extension* of ourselves, as a part of knowing. Polanyi (1966, p16) writes that we make things (objects) function at the proximal end of tacit knowing, that they are incorporated into our body, that we extend our body to include them, 'so that we come to dwell in [them]'. Similarly drawing upon the notion of dwelling, Ingold (1996, p179) writes that 'in the flow of action, the body itself becomes transparent, as do the tools attached to it, which – like the body – are as much a part of the used as they are used'. Ingold evidently draws here from Merleau-Ponty, who regards instruments as absorbed into the body. Merleau-Ponty ([1945] 2008, p165) writes that just as a blind
Figure 12: Obstetrics instruments including artery forceps
man’s stick extends his radius of touch, so ‘a woman may, without any calculation, keep a safe distance between the feather in her hat and things which might break it off. She feels where the feather is just as we feel where our hand is’. The feather in the hat is no longer an object but an extension of the woman’s body. Objects as such become incorporated into the body (Merleau-Ponty [1945] 2008, p166), become bodily auxiliaries (Merleau-Ponty [1945] 2008, p176). The tools then do not replace touch but rather practitioners develop an alternative sense of touch through/with the instruments (Zetka 2003, p18).

Tools, although considered an important part of medical practice by clinicians, are often ignored as the focus of analysis in much medical social science literature. Actor network theorists, STS scholars and anthropologists of material culture give the most prominence to tools and instruments in their work. Mol (2002) for example views the microscope as an integral part of the practices that ‘enact’ atherosclerosis (see Medical Glossary). Identifying as a praxiographer, Mol has studied how medicine interacts with and shapes the disease atherosclerosis through its various sociomaterial practices. She emphasises how realities are enacted, simultaneously blurring Foucault’s ([1963] 2003, p167) divide between the knowing subject and the object as known, because the object is enacted through practices as well. Her ethnography of atherosclerosis explores difference, the coordination of difference and multiplicity into singularity, and ultimately, the inclusion of these practices into each other. Drawing upon Mol’s work, STS scholar Tiago Moreira (2006, p87) argues that surgical touch is mediated by technological artifacts, looking at how neurosurgical instruments replace hands as haptic (see Medical Glossary) tools because of the limited access that the surgeons have in their anatomical fields (Moreira 2006, p85). In the area of obstetrics, Madeleine Akrich and Bernike Pasveer (2000) argue that whilst the discipline has been fraught with political debates concerning tools and technology, rarely is this discussion about technologies. They regard obstetrics practice as a chain of devices, techniques and procedures which are part of the unfolding change taking place in the discipline (Akrich and Pasveer 2000). Finally, in
their work in anaesthetics, Dawn Goodwin, Catherine Pope, Maggie Mort and Andrew Smith (Pope et al. 2003; Goodwin et al. 2005; Mort et al. 2005, p2037) focus on anaesthetic practice as technological mediated and demonstrate how in some procedures the human-machine interface is completely blurred (Mort et al. 2005, p2029), becoming like Donna Haraway's 'cyborg' (Goodwin 2008). These researchers explore how, as part of their learning, anaesthetic trainees must learn how to feel with a needle (Mort et al. 2005, p2033), their work, like mine, and much of the STS work mentioned here, reiterating how tools and touch become closely intertwined. The next section further examines how this becomes ingrained in the midst of practice.

Learning skillful practice

Because of their bodily nature, procedural skills are often thought of as being learnt in bodily ways. Surgical instruments such as the one Dr Rudrangshu Mukherjee handled as we talked, must be learnt to be held in a way that is comfortable for the clinician, whilst allowing flexibility of movement in the internal architecture of the patient's body. The instrumental technique needs to be ingrained so that the clinician can be quick and responsive in their procedural work. Dr Rudrangshu Mukherjee tried to explain the palmar technique to me and talk through a demonstration. He said that he had been trying to find something written about the technique but could not find anything (neither could I). A description of the palmar technique that Dr Rudrangshu Mukherjee was learning was difficult to find in written instruction because it must be learnt in practice.

Like Polanyi, Foucault ([1963] 2003, p61) suggests that tacit knowledge such as medical skill needs to be passed on from 'body' to 'body', doctor to doctor, 'from master to disciple ... transmitted beneath the level of words'. This concept has been reiterated in much work in medical sociology that adopts the apprenticeship model of clinical learning (e.g. Merton 1957). These ethnographers focus on medical skill passed on from senior
doctor to junior doctor, through a process of medical socialisation that assumes that there is a set body of practice to be imparted. As Foucault ([1963] 2003, p72) himself has written, ‘the clinic was concerned only with the instruction, in the narrow sense of the word, that is given by a master to his pupils. It was not in itself an experience, but a condensed version, for the use of others, of previous experience’.

Observation and mimicry is certainly part of how practitioners learn procedural skills. In their new hospital contexts, overseas doctors often observed and copied techniques of their local colleagues. On a tram one evening a doctor spoke to me about the difficult time he had when he first started working in a hospital in country Victoria. He said simple things such as taking blood were different. He felt as if he should know how to do these procedures, especially considering that he was hired as an HMO2. So he managed by closely observing other people doing simple procedures and sometimes replicating these exactly; in his words ‘pretending he knew what he was doing’. In an adult rehabilitation ward I watched Dr Elena Radulescu, who had specialised in paediatrics, observe her intern take blood from a patient. She said to me that this locally trained doctor ‘took blood much better than her’ and she wanted to learn his technique. Another doctor in an orientation program for overseas doctors went to the venepuncture (see Medical Glossary) clinic and asked them if he could observe how to put in cannulas and how to take blood. Staff at the venepuncture clinic were used to medical students doing this and said that it would be fine. The doctor told me, ‘the medical students, they know the environment and can learn easily this way’.

These overseas doctors were learning techniques by observing local practitioners. However their learning was not just about observation and mimicry. For these overseas doctors had already learnt ways to do many of these procedures, ways that had been ingrained in contexts elsewhere. They were not starting ‘from scratch’. It meant that what they were engaging in were modes of adjustment, adjustments that continually formed and moved on from their own previous practices, rather than those of their
Chapter Seven

‘masters’ or those they were observing and copying. These were adjustments situated in the midst of their environment, in embodied ways, entailing threading from habitual practices to those required in that moment.

Dr Rudrangshu Mukherjee, who appeared earlier in the chapter, was in the process of learning an instrumental procedure. There remains a crucial component of his technique however, which is important in any sensory study of learning, which I did not record: its tactile dimension. These details are not always observable to the ethnographer. They are little changes in how things feel for the participant. These details, such as the haptic nature of fine-tuning, the perceptual registers of proprioception (see Medical Glossary) and pressure exerted by instruments, are the kind of sensory information that Thrift (2003a) argues is missing from many accounts of practice. It is difficult to describe these in print, let alone if you have not performed them yourself.

To address this difficulty, two theorists on skill/craft, Ingold (2000) and Sennett (2008), use descriptions of their own playing of musical instruments, as examples of what it is like for humans to dwell in/with instruments (Bourdieu (2000, p144) also points out the richness of understanding about practical engagement that is to be found in studies of playing musical instruments). Because tactility was difficult to study from interview or observational material there is much to be gained from analysing a personal anecdote. Thus, like the theorists on skill and craft before me, in the next section I draw upon prior first-hand experiences to help understand further how overseas doctors adjusted their skills, in the midst of practical engagement in a different environment.

In brief summary, this and the previous sections of the chapter have set up how in technically mediated medical work, the body and instrument are intertwined, extensions of each other. The following section then separates the two, arguing that in unfamiliar contexts, a gap appears between person and tool. I subsequently argue that it is
because of the entanglement of person and tool in familiar settings of practice, that in moments of breakdown or mismatch in unfamiliar environments, the two become separated, revealing their knotted nature when taken for granted. The remainder of the chapter then examines various ways that overseas doctors adjusted to these moments of separation, how they negotiated tools and instruments within altered contexts of procedural practice.

On inserting a cannula

When I finished my internship in Australia I went to work as a locum junior doctor in a small cottage hospital at the edge of a Royal Oak forest, on the outskirts of a village in West England. At the end of my shift, at the end of my first week in the hospital, I was asked by a nurse to insert a cannula before going home. There were no other doctors in the hospital, and none of the nurses on-duty were experienced in cannulation. I did not hesitate to start preparing for this simple task. If there was one procedure I had ingrained during my year as an intern, it was cannula insertion. The cannula had become a natural extension of my hand, a skill I had learnt, like all interns, to perfect quickly so as to make the job easier. It had become ‘second nature’ to be able to find a ‘good vein’ in a patient and I had spent the year of internship sizing up the veins of my friends outside the hospital which bulged in comparison to the patients’. It is the feel of the patient’s vein that is important when inserting a cannula, for it to happen as quickly and painlessly as possible for the patient. Touching happens first without gloves, so that the tactile receptors in the fingertips can judge qualities of the vessel such as the depth and the pressure required for the introducer to puncture the rubbery vein hidden under the skin; then quickly onto gloves. Quickly, so that your fingers do not forget what the vein felt like. There is one vein in the body, just near the wrist, that is called the ‘intern’s vein’, because it is a good spot to strap in a cannula and is considered ‘hidden’, and not so obvious to other blood collectors in the hospital. It is called the intern’s vein as if the intern owns this part of the patient’s body!
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Figure 13: IV cannula

a: introducer tip
b: flexible cannula tube
c: hub of cannula
d: wings for securing cannula in place
e: valve for fluid injection
f: protection cap
In the Nightingale-style ward in that cottage hospital, the patient was sitting in her chair, next to the bed. After briefly introducing myself to the patient I brought out the equipment trolley onto the ward and started preparing the tools for the procedure, which I very quickly found were different to what I was used to. I was not expecting this. I thought the British system and the Australian system would be the same. The difference in the equipment was not large, in fact quite minute. Somehow the body of the instrument did not move as easily as the device I was used to. It meant that on my first attempt of inserting the cannula in the intern’s vein, it did not work smoothly, the introducer going through one side of the vessel wall and out the other (a very common mistake made by medical students). The procedural skill I had previously performed fluidly, of entering the vein at the ‘right’ (not 90 degree) angle, with a small angular change milliseconds later so that the pointy introducer did not pierce the other side of the vessel, was suddenly incongruent. Like the piano player who started paying attention to their fingers whilst they were playing a difficult piece, got confused and had to stop (Polanyi 1966, p56), I was brought into a self-consciousness that had started to make obvious what previously I had taken for granted. I became conscious of a procedure that I had normally been unaware of, that had previously been habitual.

When I attempted another insertion, this time near the inside of the patient’s elbow, I missed again, puncturing the vein once more. A bruise started to appear under her soft skin. She looked at me then, in a concerned way: one miss is perhaps forgivable, but not two. The patient said nothing but her eyes asked ‘does this girl know what she is doing? Where is she from anyway? She doesn’t have a British accent. Why did she take so long to assemble the equipment? Did she not know where everything was?’

I started to get a little panicked. The patient needed the cannula for antibiotics that were due in half an hour and if I could not finish the job, the nurses would have to call in a doctor from the larger hospital half an hour’s drive away. I inspected the equipment again and practised in the air, away from the patient. I tried to get more of a feel for
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how the equipment moved. I decided I had room for one more attempt. I would have
to go for an obvious vein that I knew would not last more than a day. The patient would
have to have another cannula, but that would be tomorrow and not that evening when
my blouse was soaked through with sweat and all I wanted to do was go home. I felt the
patient's arm gently, looking for veins and found a large wobbly one on the back of her
hand. This time blood flushed into the chamber and I slid the tubing into the vein whilst
removing the introducer. The cannula was inserted and the patient received her
antibiotics, some dressings over the other punctures in her skin and an apology from
me, before I burst out of the hospital into the less suffocating forest air.

During this unfortunately protracted experience for the patient, I had to adjust my
technique to be able to insert the cannula. What had previously been a smoothly
embodied action, where I had incorporated a tool into my work, became disjointed
when the equipment changed, however slightly. I did not follow what Akrich (1992,
p208) would call the cannula's 'script'. Paraphrasing Ingold (2000, p414) who describes
something going wrong in a cello performance, I had become painfully aware of myself
and the instrument, and the distance that separated us. The unfolding self-
consciousness further inhibited my abilities and I was only able to complete the task
after compromising on the positioning of the device: a rather crude form of adjustment,
though fitting considering my novice status as a skilled practitioner. During this moment
of mismatch, both the habits developed in my environment of past practice and the
ways of doing things in the environment of the moment were brought into some relief.
Differences in the ward setting, how the instruments were stored, relationships with
nurses and consultants and patients were made more obvious. I felt underqualified to
be the only doctor in the hospital considering my junior status. The discrepancies
seemed to expand, gathering weight.
A moment of mismatch

Cannulation was a practice I had learnt from repetition and mimicry. I did not learn the technique by memorising written instructions or studying illustrations, for as Dr Rudrangshu Mukherjee has pointed out, this is a difficult way for such techniques to become embodied. Instead, I learnt first on sections of pigskin in skills labs at university, with well-used instruments. Later, as medical students, we practised on each other, leaving tutorials with bruises and dressings. In this practice my hands learnt what other bodies felt like and I got used to the equipment. It was not until I reached the wards however that my bodily learning truly developed during fleshy-technological interactions with patients in the midst of the hurly burly of the teaching hospital. My hands started to remember these bodies, to develop a historical density (Merleau-Ponty [1945] 2008, p277). As medical students, we were taught by interns and other medical students, but it was mostly through practice that we developed our technique, skills honed through repeated trials. The learning curve increased exponentially when we became interns ourselves, and cannulation became a routine, mundane activity.

The ingrained and embodied procedure of intravenous cannula insertion, in which tools had become almost natural extensions of my hands in a familiar context, became disjointed when I encountered minute differences in equipment in a different country. Rather than having someone to copy and mimic, I had to undergo my own bodily adjustment and be attentive to minute differences in sensations, the patient's body and the equipment. Ingold (2000, p356) would view this as a subtle response and coordination of visual/haptic perception with action. The key to such 'tuning', he writes, is not in the movements themselves but in the ability to adjust the movements to evolving change in the surrounding conditions (Ingold 2000, pp359, p353). This adjustment happened through the body as I got a measure of the instrument with my hands, incorporating myself into the new dimensions of the tool (Merleau-Ponty [1945] 2008, p168). As a practitioner I was in active perceptual engagement with my
surroundings rather than just being an observing, copying subject. As Ingold has highlighted, the skill was not a property of the individual body but rather of a total system of relations, within a richly structured environment.

At the beginning of this chapter I explored the embodiment of procedural technique, including the use of tools, through ongoing environmentally situated practice. Overseas doctors learnt techniques through their hands and tools, incorporating a bodily memory of past patients and a host of other environmental factors in which they dwelled. The person-tool-environment becomes inseparable in a familiar medical setting where the technique becomes ‘second nature’, part of a habitus formed in, and rejuvenated in, that environment. All is taken for granted.

When the context changes, this is disrupted. Working in new environments, overseas doctors found equipment that was slightly different and as such became aware of objects which had previously disappeared from their consciousness. Merleau-Ponty (1945] 2008, p160) writes ‘a movement is learned when the body has understood it, that is, when it has incorporated it into its “world”’. To understand is to have harmony between the intention and the performance (Merleau-Ponty [1945] 2008, p167). When the body has ‘ceased to be a knowing body’, when it cannot draw everything together in its grip, he writes that world becomes atomised (Merleau-Ponty [1945] 2008, p329). Once we start to analyse an event further, the unified experience in which we are normally given over to the object, further breaks up (Merleau-Ponty [1945] 2008, p277).

These are some of the few instances in *Phenomenology of Perception* in which Merleau-Ponty discusses an atomised world, being generally more interested in how one develops and retains a grip on the world, rather than loses it. Similarly, in *The Perception of the Environment: Essays on Livelihood, Dwelling and Skill*, Ingold (2000, p414) only discusses losing grip briefly, when he describes something going wrong during one of his cello performances. Of those theorists concerned with practice that I
have used in this thesis, it is Bourdieu (2000, p159) who has written most substantially on what he has described as a ‘mismatch’ of bodily dispositions. However, his concept was arguably under-realised (Noble and Watkins 2003; Waterson 2005, p339), with much empirical and theoretical work needed to flesh it out further. The next section explores mismatch further, extending upon these theoretical ideas by illuminating, using the empirical data from this project and my own previous experience, what happens when things became incongruent and an overseas doctors had to adjust their procedural work.

**Adjusting during mismatch**

In Chapter One, I argued that adjustment was a movement between what Merleau-Ponty described as two layers of the body: the habit-body, developed from past practices, shaped in medical schools and hospitals; and the body-in-the-moment which similarly entails a practical engagement with the environment that one finds themselves in at any one time. I argued that in familiar environments, the habit-body and the body-in-the-moment are often closely aligned, leading to tacit practices. In the unfamiliar environment, the body-in-the-moment is situated within the unexpected and one finds themselves somewhere, however slightly, ‘strange’. I suggested that the two layers of the body were often seen more obviously to be separate with overseas doctors because of past practices developed in environments elsewhere. I am extending that here to explore what happens in moments of mismatch, concerning instruments and tools.

Tools are part of this habit-body and in the process become ‘black-boxed’ and taken for granted (Clarke and Fujimura 1992, p10). Both the habit-body and Bourdieu’s extension of this, the habitus, help us to understand how procedural skills become ingrained and learnt in familiar contexts. As stated, the body-in-the-moment is similarly a practical engagement with the surrounding environment. In the moment, on that Nightingale ward, I had to get a measure of the instrument, to feel its tactile contours, to be
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attentive to the patient and the texture of the environment in which I found myself in, in that cottage hospital at the edge of the oak forest. Adjustment was the movement between the habit-body and the body-in-the-moment, the two more obviously separate because of a difference that I have suggested is made more obvious in the work of overseas doctors in new hospital environments.

By examining these ruptures of context more is learnt about the mechanisms of adjustment. Akrich (1992, p207) writes that if we want to describe the elementary mechanisms of adjustment, we have to find circumstances in which the inside and the outside of objects are not well matched. We need to find disagreement, negotiation, and the potential for breakdown. Interestingly, whilst Bourdieu has been criticised for developing an idea of the habitus as reiterative, he argues that it was around such instances of mismatch, observed during fieldwork in Algeria, that he developed his thinking of the term. Just as objects or infrastructures become more visible during breakdowns (Star 1999, p382; Latour 2005, p81); just as minor disruptions in organisations make the articulation process temporarily visible (Strauss 1988, p171); or the body becomes more visible in times of disease (Leder 1990, p87); so too do overseas doctors, moving from one context to another, reveal the taken for granted, seamless relations in their new environment. In paying attention to adjustment the contours of the subject and object are further revealed (Pickering 1993, 1995).

There are few talented newcomers who learn the rules of a game without mismatches or friction. Insight develops from experience, from working out what is possible and what is not, working out how to work effectively in a new environment. Focusing in this chapter on moments of mismatch is something very different from spotlighting mistakes, as sociologist Charles Bosk (2003) did in his hospital ethnography. Too many discourses about overseas doctors also focus upon mistakes. Too many orientation programs are designed around avoiding mistakes. Using the term mismatch highlights instead ways in which overseas doctors adjusted, moving constantly between their past
practices and the situation they found themselves in. So far I have highlighted the tactile nature of adjustment to tools. There were other modes of adjustment that overseas doctors undertook in relation to their procedural work, adaptations also revealed during mismatches.

**Shifting roles**

Dr Neelan Tiruchelvam found it hard to adjust to the procedural differences in his work in Australia compared to Sri Lanka. As one of the residents on the obstetrics team, it was his job to perform many of the menial jobs in the OT and on the wards. Cannulation was one of them as was catheterisation (see Medical Glossary). After inserting his third catheter during a morning’s operating list, he could not have made it more obvious to me how boring it was for him to be doing this job. With his arms crossed, leaning back on the surgical stool, he told me in a loud whisper that this job would not be done by a doctor in Sri Lanka. It was a job for the nurses or medical students. He believed that his allocation to this job was a sign of how Australia and other rich countries wasted their resources. He told me that he had trained to be a doctor and to do ‘certain things’ and that ultimately here he was doing ‘other things’:

*In our country you train to be a doctor to do doctors’ duties ... being IMG we see the difference ... at home we totally do the true medical stuff. Here the HMOs mainly do the menial jobs. It’s a waste of training. When you become a medical student in Sri Lanka you have done 100 episiotomies. But I hardly get a chance to perform practical aspects here. I don’t want to criticise the system here. What I want to tell you is the difference ...*  
(Dr Neelan Tiruchelvam)

Pointing to the operation in front of us, Dr Neelan Tiruchelvam told me with a smirk, that he could assist lying back in a chair operating with his toes! For him, the catheter and catheterisation was so routine and dull it was beneath him. He demonstrated to me
nonchalance towards his requisite procedural tasks with an arms-crossed-feet-back-laissez-faire attitude. It was a demeanour which the other doctors in his team interpreted as laziness. Catheterisation was part of a long ago past, a previous practice that he had surpassed in his 20 years of working as a GP in Sri Lanka and when he had performed these skills, the environment was very different. He noted that ‘here you are alone. You have to find instruments, gloves ... this was hard in the beginning. In Sri Lanka you are like a king’.

Rather than a haptic adjustment, Dr Neelan Tiruchelvam was negotiating an adjustment of his perceptions of his role as doctor. This was because of a mismatch between the procedural work he was trained to do, and that which he was required to do in Australia. Because of his catheterisation duties, the world for Dr Neelan Tiruchelvam was ‘smaller than before’ (Winance 2006, p62). For many doctors, their professional identity is tied up with techniques and procedures (Goodwin et al. 2005, p683). A doctors’ status within a medical team or within a hospital is often developed, achieved and defined through their participation in instrumental work (Goodwin et al. 2005, p868), leading to the age-old conflict between physicians and surgeons (Katz 1985, 155). Procedural work helps to define their status in a work setting, helps to define their role as a doctor.

Medical practice, along with the status and roles tied up with it, is environmentally situated. Instruments and tools are stitched into this context. For many overseas doctors whose identity was heavily tied up in their procedural work, there could be some significant adjustments that they needed to make when they changed settings of practice. These weren’t always about acquiring new skills. Often orientation programs presume that overseas doctors arrive from systems that are less technologically sophisticated than the Australian one. This may sometimes be the case. However Dr Neelan Tiruchelvam didn’t necessarily consider himself adjusting to perform more technologically advanced procedures. In fact, he perceived his adjustments as ‘downgrading’ to a system he found imperfect, or rather resource-rich, and therefore able to
have doctors perform duties that others could do in Sri Lanka. For many overseas
doctors like Dr Neelan Tiruchelvam, cannulation and catherisation were routine activities they did as medical students, but moved quickly on from in their work as qualified clinicians. In Australia, such tasks are taken for granted aspects of junior doctors’ roles. There was thus a considerable amount of work that many overseas doctors needed to do to reconcile their performance of these procedural tasks with their previous roles in their hospitals ‘back home’.

Dr Neelan Tiruchelvam told me that he did not really care about obstetrics and that he was working in the HMO position as part of a required supervised year in the hospital before heading onto GP work. His adjustments were about coping with the circumstances, biding his time. Often between catheters, he would tell me stories of how many cesarean sections he could do in a day in Sri Lanka, or the time he saved both his son and his wife by checking her blood pressure when she was pregnant (using the all powerful tool, the stethoscope), then using his status as a doctor in Sri Lanka to get her the treatment she needed. These stories highlighted aspects of his past and widened the discrepancies between his previous procedural work and the tasks awaiting him in the Australian operating theatres. Being an IMG he saw the difference. He saw the discrepancies between his past and current work highlighted in the rupture between his perceived abilities and competencies and the procedural work he was required to do as a junior doctor in the obstetrics team. This highlighted larger differences between the system in which he was trained and the system where he found himself, discrepancies shaped by economic resourcing and political frameworks.

**Different environments of practice**

Dr Neelan Tiruchelvam’s consultant, Dr Mladen Mück, did not have to perform menial tasks such as pre-operative catheterisation or cannulation. However, because of his lack of local registration status (Chapter Three), his practice was limited in that he was
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restricted to work in a public teaching hospital, where he had to spend much of his time, frustratingly for him, teaching his junior staff how to perform procedures. Many of these registrars would soon ‘overtake’ him and become locally recognised consultants. Dr Mladen Mück had to adjust to these constraints, these adjustments revealed in his procedural work. He would often recount how procedurally superior he felt to his locally trained colleagues:

\begin{quote}
It means that my main strength was the clinical skills ... I was privileged to operate a lot and to do what some people here in the training program ... ahh they have not the opportunity to perform that kind of or that number of ... if I can tell what during six months of training, what I used to have in a different ... of course once you perform that a thousand times you are more confident and I believe that that was a big advantage of what I had in comparison to my colleagues at the time and ahh yeah, there are so many other disadvantages [laughs] but as I said that was the main advantage. It means procedural skills, much more procedural skills during the training program than they perform [here].

(Dr Mladen Mück)
\end{quote}

Dr Mladen Mück told me about the environment in which he was able to practice his procedural skill:

\begin{quote}
I got an opportunity to be trained in a bit more relaxed environment where you can practice a lot. You are responsible to your college. Of course it means complaints and litigation but all complaints are sorted out with the medical board and your college without involvement with lawyers... it means, that learning certain techniques and performing more complicated trials, it was a bit easier... I said my advantage was doing that and practising that in an environment that was not threatened with litigation and of course I changed my practice here when I realised that ahh, that that was the way how to go [here]. You are completely covered by litigation guidelines, by the protocols and
\end{quote}
Dr Mladen Mück describes how he adjusted to the new litigious environment he found himself in, in Australia. He highlights the difference in the systems of his past and the present, and once again underscores how the environment is so much part of doctors’ procedural work. Dr Mladen Mück’s story also highlights the pragmatic nature of adjustment; the necessity of adjusting practices in new work contexts. Organisational studies scholar Jawad Syed (2008, p37) writes that there is evidence that migrants do not feel settled in their new labour market until they are employed in jobs related to their experience. Dr Mladen Mück was unsettled in his ambiguous and tentative position in Hospital X. He was unsettled about his registration status which restricted his procedural work, and led to a sense of occupational stasis.

Both Dr Neelan Tiruchelvam and Dr Mladen Mück were making adjustments to their roles as doctors in the hospital. Their adjustments to procedural work were different from mine; they were other modes of adjustment. The two doctors in the obstetrics team underlined the different priorities that overseas doctors had in their work, and the different expertise which were valued. Not all overseas doctors considered procedural work the most important part of their clinical practice. Dr Wassan Khalid Al-Ameed, the young doctor from Iraq, had difficulties with the procedural work that was required of her in ICU, needing to repeat many arterial lines. Dr Sheng Qi, the Irish trained doctor and acupuncturist, had never put a chest drain in, and we took some time from his work in the busy ED to check up on his first patient on the wards. In contrast, some overseas doctors with considerable specialist experience had never had to learn what were considered simple intern procedures in Australia, such as putting in IV cannulas, whilst others, such as Dr Ashin Kuthala found them routine (Chapter Five). For all of these
overseas doctors, having to do arterial lines, chest drains and cannulas all entailed different modes of adjustment. The next section examines how these are part of everyday adjustments happening in hospitals.

Revealing everyday adjustments

New devices, techniques and procedures are instrumental to the changing nature of hospitals. New wards, units and suites are built around them, such as the endoscopy unit in Hospital Y, and clinicians constantly have to adjust to this change. Practitioners have to adjust when they move between hospitals in different states in Australia, as the local intern pointed out in the beginning of this chapter, or between hospitals in the same state or city. In a weekly O & G meeting, an argument ensued between the midwives and doctors as to how to perform sterile PV examinations. Some argued that the vagina was a non-sterile field anyway. The group decided to ‘agree to disagree’ and concluded that practices were different across hospitals. Doctors also need to adjust between disciplines and across departments, where tools can vary dramatically. In one interview, Dr Farokh Mostofi talked about the different adjustments his rotations would entail:

Adapted to working here? Umm, I have not been working anything more than psychiatry and I have been adapted in psychiatry. Yep, I don’t have any more problems in psychiatry but I don’t know if I start my career in emergency I would have any problem or not. You know, because it is quite different and you need different, you know experiences, need more skills ... taking IV cannulas, intubation, some things like that.

(Dr Farokh Mostofi)

Each department requires a different mode of adjustment. Not only are there differences between departments but also within departments. The reason why Dr Rudrangshu Mukherjee was learning the palmar technique highlights this well. The red
haired obstetrics intern told me that Dr Rudrangshu Mukherjee had been scolded 'unfairly' by one of his consultants for not having the right technique with the artery forceps and that he should be using the palmar technique. The intern thought that this demonstrated just how individualised medical practice really was. In the obstetrics department, each doctor had a different way of doing things procedurally in the OT. The intern told me that one consultant told him to do something one way and his partner consultant, when observing the technique, said 'where on earth did you learn that?'

Practitioners also need to adjust to each patient they treat. It means, using the example of cannulation, that during the procedure the practitioner must respond to individual differences in patients such as co-morbid disease, previous drug use, pregnancy, needle-phobias and the weather, as well as other environmental conditions, all impacting on the technique used, to which practice is slightly, tacitly, tactically adjusted in response. In the Surgeons and the Scope, sociologist James Zetka (2003, p10) similarly details how surgeons adjust to the variable nature of the raw material of the patient's anatomy and other unexpected eventualities. He writes, 'the traits of a mature surgeon are acknowledging an obdurate, complex, and uncertain environment; adapting one's work routines to manage this environment to the best extent possible' (Zetka 2003, p11). Pope (2002, p377 - 379) also documents how surgical techniques have to be constantly adjusted in each case, as surgeons learn to make do, drawing upon their past experiences and responses.

Any local medical system is a richly textured, multifarious environment made up of a vast number of patients, tools and techniques which are constantly changing. As a consequence, hospitals are filled with practitioners adjusting their ways of doing things to these environmental conditions that they find themselves in. These are the adjustments that Bourdieu (2000, p138) regards as necessities of the field, a process that happens almost tacitly in familiar contexts, in moments of minute improvisations during the evolution of procedural skill. In the development of techniques we often
become unconscious of the actions and processes by which we achieve the result. Polanyi (1958, p62) describes this as feeling our way to success without knowing how we do it. Dr Mladen Mück demonstrated this all too painfully when he failed his specialist exams because he could not explicate the process of techniques that had become part of his tacit knowledge (Chapter Five). In the process of familiar adjustments, tools become 'black-boxed' and no longer questioned or viewed as problematic, but rather taken for granted (Clarke and Fujimura 1992, p10).

As newcomers to the system, overseas doctors highlight these everyday practices of adjustment because of their movement between hospital contexts, when they are confronted with conditions of actualization different from those in which their habitus were produced (Bourdieu 2000, p161). They have to put more working into their adjusting. They reveal the smaller details of adjustment. Zetka writes:

> It is not the abstracted principles that enable an occupational group to move from one technology to another but the more microlevel, seldom-accounted for adjustments to sedimented behavioural routines. The outcomes of these adjustments must be accounted for in our scholarly reports of technological change ...

(Zetka 2003, p180)

In moving from one context to another, overseas doctors reveal the minute, 'micro-level, seldom account for' taken for granted relations between clinician-tool-environment that develop through everyday adjustment in hospitals. As overseas doctors negotiated their procedural work they were also becoming part of the system; the overseas doctors changed and were part of the system's change.

Adding to the flora of medicine here
Whilst the overseas doctors were adjusting their practices within their new environment, they were also bringing into the hospital their own ways of doing things, their own techniques. I asked Dr Rudrangshu Mukherjee what doctors brought with them to Australia and he replied that they:

*Add to the flora of medicine here. Everywhere though there is resistance to what you bring in – ideas need to be dynamic – we all think the same – if you have a bright idea – a new surgical procedure for example – [it needs to be dynamic] – I think it is the west - I'm not talking just about Australia – that people are fixed on this as the best medicine – I don't believe that this is true – if an idea is not dynamic though it doesn’t flow – it has to mold to the air pressures – if you want to migrate you have to adapt.*

(Dr Rudrangshu Mukherjee)

It was difficult for the overseas doctors to instigate new procedures or introduce new devices into the Australian system. For example Dr Saimon Ambi had recognised the limited success he would have in introducing the saphenous vein endoscopic harvesting technique he had perfected in Malaysia into the local cardiothoracic unit. There were subtle ways however, that overseas doctors began to change the system. This became evident to me on one afternoon that I spent with Dr Pham Ba Hung on the surgical ward. He had been given the task of supervising a medical student inserting a cannula. He was very patient with her, advising her to do the final preparations in front of the patient so that they knew everything was sterile and appropriate. Whilst she made her preparations, Dr Pham Ba Hung talked a little to the patient who was nervous about the upcoming operation, providing him with words of reassurance. As the medical student inserted the cannula, she repeatedly asked Dr Pham Ba Hung about an air embolus in the tubing and he continually assured her that it was alright. After they left the patient’s room, Dr Pham Ba Hung took the student aside and showed her his technique for inserting IVs through a piece of paper. He demonstrated a very gentle manoeuvre and made it look very simple. In teaching the local medical student in this way, Dr Pham Ba
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Hung demonstrated how he was becoming part of the system to which he was adjusting, that he was a teacher as well as learning the system himself.

One of my own thesis supervisors, an overseas doctor from Germany, also taught the newcomers about the local system. Dr Rudrangshu Mukherjee spoke of his mentorship.

[Supervisor], you must have taught thousands of doctors how to do procedures – it was part and parcel of your medical expertise how to do certain things and that will reflect in your students and that will reflect in persons under you. It is not necessarily an Australian way of doing things. There is no right or wrong way and I think that overseas trained doctors would have contributed to teaching in Australia and your experience will come in and it is not necessary that it will go to waste and I think that there will be a confluence of different experiences – that is what I think...

(Dr Rudrangshu Mukherjee)

Dr Rudrangshu Mukherjee raises a crucial point. As overseas doctors became part of the system, they blurred clear definitions of what were ‘Australian ways of doing things’. They became part of a ‘confluence of different experiences’. As Dr Nikolai Nagorsky told me, ‘you start to see more and more how the system works and you start to feel more part of the system’. Through adjusting to a system that they were part of, the threading and tailoring became finer and finer. The overseas doctors became more ingrained into the system they were changing. As I have consistently highlighted in this thesis, overseas doctors were part of their context, they were the situation, not encountering the situation (Clarke and Fujimura 1992, p17). We are in our environment, not separate from it.

Summary

I believed that obstetrics is the same all over the world and so I thought that this is
Tools

certain knowledge that is the same all over the world and you put it in your suitcase and transfer into every country... but it is not exactly the same...

(Dr Mladen Mück)

Like me, few travelling doctors considered the technical difference of procedural work in advance. Medicine was presumed to be with a capital M, a uniform abstract body of technical skill that could be transported in a suitcase from place to place. Upon migration however many doctors found themselves in places where patients' bodies were different, where economic resources might be more bountiful, where nurses had a different role and where there was a slightly different configuration of the cannula. In this different environment, the overseas doctors had to adjust their practice. My story showed this to be a haptic process of minute change upon encountering small differences in tools. It highlighted the importance of tactility in the embodied work of overseas doctors. Dr Neelan Tiruchelvam and Dr Mladen Mück's stories showed how adjustments also needed to take place in terms of roles and status in relation to procedural tasks. All of these modes of adjustments, tied up with the minute and the mundane, reveal not only something about the doctor and the vestiges of their past but also about the new system that they are steadily becoming part of. Once again, the stories highlight the environmentally situated nature of medical practice.

This chapter challenges the common perception that overseas doctors need to acquire better procedural skills to adapt to the Australian system. As an alternative, I have argued that overseas doctors adjusted their own ingrained, environmentally shaped, bodily skill constantly, to an unfolding, ever-changing instrumental environment. This acknowledges that overseas doctors come to the Australian workplace with their own pasts, their own embodied skill, and gives scope for change in practice. This is precisely what they feared in the 19th century, when the call was made for technology because who knew what previously the doctor had 'heard, saw or felt', how the previous days' events, previous training and even upbringing impacted on their practice. Conversely l
have implied in this chapter, and throughout the thesis, that it is precisely this historical
density which defines practice. Adjustment is a temporally emergent process that
evolves, not through the transmission of rules or instructional illustrations, nor through
sole observation and copying, but rather through perceptual engagement within the
context of practice. The next chapter follows how overseas doctors attuned to their
human environment, with an intervening interlude that gives a little more detail about a
doctor’s past in obstetrics and his journey half way to Australia.
Interlude Seven: Dr Nikolai Nagorsky's Story

Every participant had a different constellation of stories connecting them to their past. Here is a glimpse into some of these stories:

We sat down opposite each other at the table in the rehabilitation ward staff room after I had buttered my roll and Nikolai had heated up his leftover chicken. I asked him whether he went straight into medical school after high school and he said that first he had served the compulsory three years in the Russian Soviet army in a nuclear submarine in the North Sea. "I then decided to go into medicine – for I was not that strong in maths! Once I was in medical school I decided to go into obstetrics". "Why O&G?" I asked. "Because in Russia spouses are not allowed into births, so when I saw my first birth as a medical student it was like a supernatural experience, I had never seen anything like it before ... and then the appearance of the head! It was supernatural". After graduating, Nikolai worked in the Ukraine for 15 years in a hospital by the Black Sea, near a resort by a river. His family loved it there but soon had to leave because of the difficult political situation they found themselves in.

"We decided to leave and sold the house for 2,000 US dollars. We were lucky to get the money for the house in German marks because the person who bought the house was a currency dealer. US dollars were much more valuable than the Russian currency. But you couldn't leave then with large amounts of money". So when they boarded the train Nikolai rolled up the money and hid it in the curtain rods in their train carriage. The kids were scared and he told them to sleep. When they did their rounds the customs officers were suspicious because the Nagorskys were a family 'going on holidays' but after their things were searched - they had to pack as if they were going on a summer holiday, including tennis rackets - they were let through. The family arrived at Budapest train station. "What did you do when you got there?" Nikolai said they just sat on their luggage and looked around the station in amazement. All the children wanted were
Interlude Seven

Coca-Colas. A couple came up to them who spoke German and English and helped them find a place to stay. Soon they were given UN passports as political refugees and stayed in Budapest for six months. Although they did not have enough for the airfare, they somehow found their way to South Africa where Nikolai heard they were looking for doctors ...

(Recreated from fieldnotes)
Chapter Eight: People

One afternoon on a ward computer, Dr Nikolai Nagorsky showed me a PowerPoint presentation he had given during a conference in Adelaide on overseas doctors. He had only four slides. The first was a map of Russia showing the town where he came from. The second was a picture of his hometown in summer and the third a picture of his hometown in winter. The last slide was then a list of all words connected to or meaning ‘flexibility’ that he had resourced from the dictionary, including the words ‘bendability’, ‘adaptability’ and ‘compliancy’. He had learnt the significance of the word flexibility in South Africa when his American employers asked about its meaning in a job interview. He said that his English was not very good then but that he had just learnt the meaning of the word, so he used his hands to make a motion of bending something and the American doctors laughed and said that he had it. In the following section of interview transcript, the Russian doctor gives an example of his ‘flexibility’, what many overseas doctors considered was a fundamental requirement of adjustment, when he describes his work in South Africa:

Initially I was trying to impose contradictions into the system, trying to impose my values, and thinking that the way they run medicine there is not right - because sometimes the level of the patient was at stake. For example you say, “we have to take this patient to theatre for caesarian section, emergency, because she has got placenta abruption [see Medical Glossary], she is bleeding”, and the nurse will tell me “we can’t take her now because we have to put a suprapubic catheter [see Medical Glossary] in first and shave her pubic area”, and you tell her “we can’t do this because we will do it while we give her an anaesthetic while I am scrubbing, so that we can save time”. And this is my way, but not their way, that’s it. Of course it is different here, but that was in Africa, that was their way and ahh, you had two options, either take everything in your hands, and spoil your relationship with the nurses, with the matrons, matrons! [laughing] Or you can just try to find the optimal solution. Say, “I’ll take the trolley”, you say, and
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"you try to shave while we are going to theatre", and they were doing it, OK. So I drove and she was shaving. It is primitive in South Africa yeah, but the same applies here, different levels of management here in the system, of course there are some differences but we have to, find the compromise ...

(Dr Nikolai Nagorsky)

Dr Nikolai Nagorsky found a way to collaborate with the nurses in South Africa, to reconcile their differences concerning a procedure. He adjusted from his habitual ways of doing things to a practice more fitting with his circumstances. The last chapter foregrounded the ways in which overseas doctors adjusted to tools and instruments in their procedural work. This chapter focuses on the ways in which overseas doctors adjusted to people in the hospital, including nurses, patients and other work colleagues. I focus upon the nuances of these embodied, interpersonal negotiations, upon adjustments which were often prosaic, and which blurred traditional hierarchical relations within the hospital.

The chapter begins with a brief discussion of how the interpersonal relations of overseas doctors in Australian hospitals are either assumed to be problematic or enable a good ‘cultural fit’ within a multicultural community. In this chapter I offer an alternative to these approaches by focusing upon how the doctors adjusted in situations, concentrating upon the subtle nuances of interpersonal interaction in hospitals as they happened. By empirically studying the interactions of overseas doctors in the hospital, the chapter contributes an understanding of their interpersonal engagements not as problematic, or ‘manageable’, but as something constantly negotiated, day-to-day, in the midst of practice. Whilst language fluency was certainly a very important aspect of how overseas doctors attuned to their new environments, I have chosen to focus on more understudied aspects here; those subtle, embodied adjustments which arose in the course of ethnographic fieldwork. In a subsequent section I then introduce a piece of interpersonal interaction captured on digital tape, between a social worker and an
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overseas doctor, which raises many of the key concepts of the chapter. The remaining sections of the chapter analyse small details of interaction; the minutiae of social engagement, including gesture, facial expression, accent and single words. I then discuss how the overseas doctors, as newcomers to the hospital, reveal the everyday way of adjusting during interaction that locals take for granted. The chapter concludes with a brief examination of meeting places, tying in with previous chapters and interludes on buildings (Chapter Six) and food (Interlude Three), and prefacing the remaining interlude (Interlude Eight) about a meeting place created as an outcome of this research project.

Cross-cultural communication

Interpersonal interaction in medical settings has been described by Paul Atkinson (1995, p31), as one of the most consistently studied topics in sociology. He writes, ‘the medical encounter has been taken as a microcosm for the complex division of labour and its interactional consequences in modern society’ (Atkinson 1995, p31). By focusing on interpersonal relations here, I am analysing them as part of the ecological environment that the overseas doctors found themselves in. Unlike many other hospital ethnographies, I do not privilege them as the sole form of social interaction, but rather some among many of the heterogeneous social relations the doctors were negotiating.

As well as being a popular focus of study in hospitals, interpersonal interaction is also a well-documented area of interest for those concerned with the ‘integration’ of overseas doctors into the Australian system. Generally, in this literature, the social interactions of overseas doctors in new hospital environments are presumed to be problematic. Overseas doctors have been described by many researchers based in medical faculties or postgraduate medical organisations in Australia and elsewhere, as having ‘inferior communication and clinical skills’ (Sullivan et al. 2002, p614) and ‘deficient’ communication competencies (Hall et al. 2004, p120; Porter et al. 2008, p38). They are
argued to have *inadequate* patient-centered interviewing skills, with *deficiencies* in peer interactions and attitudes towards different religions or convictions (Hall et al. 2004, p122; Tromp et al. 2007). Others have described language and cultural issues that *impinge* on overseas doctors’ consultations (Duncan and Gilbey 2007). Overseas doctors are often categorised as coming from systems with lower degrees of ‘patient-centeredness’, and as having ‘poor’ relations with interdisciplinary staff (Porter et al. 2008, p38), particularly nurses (Whelan 2005, p177). Often solutions are provided for these problems that revolve around training and orientating the internationally trained doctors in regards to better ‘cross-cultural competence’, ‘cultural awareness’ and ‘cultural safety’ (Whelan 2005, p176).

Whilst recognising that language fluency certainly impacted upon all of the overseas doctors’ relations in the hospital and is an important part of any learning process (Williams and Baláž 2008a, p27), in this chapter I depart considerably from the aforementioned perspectives on the interpersonal interactions of overseas doctors. First, I do not take as a starting point that the overseas doctors’ interactions are problematic, nor that there is ‘an Australian style’ of patient-centered interaction (Chapter Five). Also, I do not presume that the system of interpersonal interaction in a hospital is shaped around a rigid, well-defined division of labour with firm role differentiation, hierarchy and means of communication (Coser 1962, p12). As discussed in Chapter Six, rather than a rigidly defined institution, I regard the hospital as being filled with ongoing negotiations occurring in practice. The argument of this chapter also departs from the views of researchers, educationalists and hospital practitioners (both local and overseas) who presume that there is ‘cultural compatibility’ between overseas doctors and patients from similar ‘ethnic’ backgrounds. It is suggested that there should be fruitful overlap between a ‘diverse’ workforce and a ‘diverse’ patient population (Kagawa-Singer and Kassim-Lakha 2003, p580; Steward 2003, p83; OECD 2007, p199). I explore this further in the next section.
Diversity for diversity

One day a locally trained registrar told me that 'it's good that we have overseas trained doctors, especially here where there is such a migrant community: Bosnian, Polish. It's good having doctors from other cultures because they can relate to them'. One of the Bosnian doctors in this study, Dr Mladen Mück, said that 'ethnicity is all about trust. If your team has one Muslim and one Vietnamese, this is the way you have full cooperation from the patients. It is so easy to pass on the message then'. In a similar vein, in a recent apology from the American Medical Association in The Journal of the American Medical Association, the immediate past president admitted the association's prior refusal to recognise African-American physicians amongst their ranks, recommending to now increase 'the ranks of minority physicians so that the workforce accurately represents the diversity of America's patients' (Farwell 2008).

'Recognition' of overseas doctors implies power dynamics which situate the recogniser apart from the recognised. It is reminiscent of the 'valuing diversity' discourses which Hage is critical of (Chapter Three), whereby overseas doctors are recognised and valued for their diversity, but are not allowed just to be diverse. The local medical community in this regard can be viewed once again as attempting to be managers. The push and emphasis on cultural fit echoes a 'management of diversity' discourse (e.g. Brief 2008), which many in the social sciences are now starting to move away from (Healy and Oikelome 2007, p1922).

Whilst several researchers and organisations have raised the potential difficulties of this approach of 'cultural matching' (Taylor 2003, p558; OECD 2007, p199), few however have critiqued these commonly held perspectives in relation to overseas doctors. More markedly, few have empirically examined the social interactions of overseas doctors as they happen in hospitals. In this chapter I do not analyse participants' interactions with the lens of 'valuing' diversity nor as a celebration of multiculturalism in the hospital.
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Rather, through a collection of ethnographic stories, I argue for developing an understanding of the overseas doctors’ various ways of subtly adjusting in day-to-day negotiations, in the midst of practice.

A conversation in a tearoom

The section of transcript opening this chapter was a fragment of a much longer conversation I had with Dr Nikolai Nagorsky one day in the rehabilitation ward tearoom. The following lengthier section of transcript is part of this conversation, and captures an interaction between two staff members in the hospital.

Dr Nikolai Nagorsky was taking a break from his morning work and had made time to answer some of my questions. We were sitting at one of two little tables in the room, the room itself a small diverticular sac off the main corridor smelling of antiseptic hand wash and floral air freshener. It was the ‘official-unofficial’ staff congregational area on the ward, with a toaster, a microwave, fridge and phone, into and out of which nursing staff, medical staff, social workers and physiotherapists continually weaved. I spent time in that staff room with three different overseas doctors working as rehabilitation residents at various times of the fieldwork year (Dr Nikolai Nagorsky, Dr Elena Radulescu and Dr Surekha Sadafule). All of them interacted differently with the other staff, brought different layered histories to the two tables.

For my interview with Dr Nikolai Nagorsky I had positioned the digital recorder amongst the gossip magazines, tissue boxes, apples and homegrown chillies on the table. Dr Nikolai Nagorsky was smartly dressed in a pink striped shirt and pastel tie. His cream coloured trousers had a few drops of blood by the knee, evidence of early morning procedural work, perhaps cannulation. We were sipping on some green tea he had brought from home, in mugs taken from a random crockery ensemble in the cupboards - a museum of items tagged with the names of past and present ward nurses and the
occasional fleeting resident - and were munching on his daily snack of walnuts. He had started talking about his first impressions of working in Australia, when not long after, the rehabilitation ward social worker entered the room.

Dr Nikolai Nagorsky: ... because here you can say I want this procedure or you say I don’t want this procedure and that’s what we were lacking back home, so I believe – do you have any questions?

Anna: Yeah.

Social worker: Oh it is very interesting. Sorry I shouldn’t be intruding on your interview but, it’s just very interesting to hear you say all that Nikolai.

Anna: You might have some better questions than me for Nikolai.

Social worker: Oh, what are you trying to do? I don’t even know what you are doing.

Anna: I am doing a project that looks at the work experiences of doctors who have received their medical qualifications overseas.

Social worker: Right.

Dr Nikolai Nagorsky: Anna is writing a PhD dissertation to try and help overseas doctors...

Social worker: Integrate.

Dr Nikolai Nagorsky: Integrate.

Social worker: Into the country.

Dr Nikolai Nagorsky: Into the system, yeah – because there are so many hidden ... [Dr Nikolai Nagorsky talks a little of the hurdles for overseas doctors and his experiences in Russia and the Ukraine]

Social worker: But that is so beautifully expressed, what you are saying, because language is only the beginning – and understanding all of the cultural nuances and values ... I’m, I’m amazed that there is that difference, because that’s what we hear about but I didn’t realise that it was sort of true. Like we’ve got this perception that things are much more severe in your country, but to hear you say that so clearly, that’s quite interesting, yeah, yeah.

Dr Nikolai Nagorsky: It’s like for example when you have a group meeting, with the
overseas trained doctors Anna, and the nature of the question would be like this: what do you think about the language barrier, and would language improvement help you perform better as a medical doctor or for example, if you don’t have any problem with the language, if there is no such thing as language barrier, what do you think would be other barriers that you should overcome? Because some people think that there are no other barriers, that it is only language which is a barrier and ahh, and that would be a good discussion.

Social worker: Even cultural barriers are a big thing.

Dr Nikolai Nagorsky: Hmm.

Social worker: But you can probably only overcome that by being with people, and socialising with others, working and socialising with the other people, you gradually absorb the different values ... do some things make you mad Nikolai, like some things you disagree with in our system?

Dr Nikolai Nagorsky: Of course I can see the differences between my system and your system, but again, as I said from the very beginning, the attitude of the international medical graduate should be like this - you are coming to a different ... it is like coming as a guest to someone’s house ...

Social worker: When in Rome, do as the Romans.

Dr Nikolai Nagorsky: Yeah, that’s it.

Social worker: Hmmm.

Dr Nikolai Nagorsky: Whatever you think is appropriate for you back home, is not appropriate here, and it means that you have to make an effort, to ...

Social worker: Yes.

Dr Nikolai Nagorsky: Ahh ...

Social worker: That’s the bit that would be really, challenging I think being international medical graduates.

Dr Nikolai Nagorsky: Absolutely!

Social worker: Because you have to continuously get out of your comfort zone to connect with people.
Dr Nikolai Nagorsky: *Yeah exactly, and the point is here.*

In this captured conversation, Dr Nikolai Nagorsky and the social worker both spoke about and enacted the process of negotiating with others in the hospital, of adjusting through interpersonal social interaction. I chose a rather long section of dialogue to also highlight the meandering, prosaic way in which the overseas doctors negotiated with other people in the hospital.

In speaking about this process Dr Nikolai Nagorsky described adjustment. First the social worker rephrased this as a process of assimilation into the country and Dr Nikolai Nagorsky corrected her, into the system. They spoke about how this happened not only through language, but through non-verbal means, by being with others, what the social worker described as ‘absorbing’, but what I argue is more about ‘adjusting to’ others in the midst of practice. Dr Nikolai Nagorsky described how overseas doctors saw the differences between systems, just as Dr Neelan Tiruchelvam noted in the previous chapter. Dr Nikolai Nagorsky highlights how the process of adjustment involved getting out of one’s comfort zone – habitual practice, habitus, the habit-body - to connect, central themes of not only this chapter but the overall thesis.

Interpersonal interactions in hospitals are negotiated processes. Some other studies also have highlighted the everyday, nuanced nature of negotiated adjustments between hospital staff. Mol (2002) studies this in relation to those concerned with the diagnosis and treatment of atherosclerosis. Drawing upon a similar theoretical framework, Moirera (2006, p76) describes the coordination he observed in a surgical theatre between surgeons and anaesthetists as a negotiated process of mutual adjustment. In his ethnographic study of an ICU ward, Simon Carmel (2006, p162, p172) noted that medical work is characterised by convergence and incorporation rather than competition, with blurred occupational divisions of labour that contrast the organisational division of labour which is enforced. Carmel argues that staff overcame
tensions as a result of close, routine and collaborative interaction, which emphasised the importance of trial and error. These ethnographic studies also highlight, by studying interactions in the workplace, that colleagues negotiate their work, daily, in prosaic ways, in practice.

The meandering tearoom conversation introduces many aspects of interpersonal interaction which are further teased out in this chapter, simultaneously highlighting the methodological richness of studying overseas doctors’ work in the hospital ethnographically. The conversation flags the shift this chapter takes from focusing on language barriers and language fluency, to an emphasis on non-verbal means of communication.

The subtleties of interactions

The first intimation to us that we are really in a different place may be the look of incomprehension on the faces of our interlocutors, or the pained censure by others of our newly inappropriate behaviour. Having crossed a boundary, we have to think ourselves in our transformed identity which is far more subtle, far more individualized than its predication on status.

(Cohen 2000, p67)

In their interpersonal interactions in their new environment, overseas doctors found minute differences in social engagement that could not so easily be categorised as ‘cross-cultural’ problems or ‘deficits’ in communication. Difference was subtle or unexpected, realised in the midst of interactions, as highlighted by Dr Mladen Mück:

You know I am more than happy to recall that, in the first weeks, there are some things that are the same in every hospital, it means that here the key is the same, the only difference was that the doctors did not use the right code that we were used to and ahh,
sort of not calling the doctor by surname what we used to do, just calling the doctor with the first name and that was sort of the difference and if you are talking to me about what is the difference in the medical field – there are a lot of things and ahh, and how introduction between doctors and patients and midwifery staff, that is a bit different ...

(Dr Mladen Mück)

Other staff noticed subtleties too.

It’s not just to do with language... it’s about not functioning at that level ...he [a previous overseas trained registrar on the ward] had emotional problems ... it was also to do with where he was trained [smirk], you know, where you pay for it – where it is known not to be of high quality. I’m not sure where. You could ask the girls ... He had no concept of what it meant to be a rehabilitation registrar and sometimes his behaviour to patients or patients’ families was just inappropriate. He had emotional difficulties but there was also something else, another part I couldn’t get a handle on ...

(Nurse Unit Manager)

For the overseas doctors the subtleties of interactions may have been wrapped up in a single word.

Today I attended a mini-case meeting on the rehabilitation ward. The patients came individually into the quiet room, where Surekha, Denzil, a nurse and I sat. Surekha sat behind a desk with wheels, upon which the patients normally ate their meals, writing in the notes, whilst her registrar questioned the patients. One of the patients was a young girl who was upset that she had been faecally incontinent during her weekend leave, on her mother’s birthday. She became quite worked up and the nurse and Denzil tried to pacify her and say that they would talk about this issue another time. She seemed to calm down and then showed signs of becoming angry again, at which point Surekha said “now we’re over this topic”. This flared a passioned reaction from the patient and she
was very upset until she left the room. I realised that Surekha’s emphasis on the word ‘over’ had a different meaning for the patient, one which probably seemed, unintentionally, quite dismissive.
(Fieldnotes)

A middle-aged man came into the surgical outpatient clinic this afternoon to have a biopsy taken. He appeared anxious. Hossein asked him some questions. One of them was “are you supportive in your family?” The patient was visibly taken aback until Hossein reiterated that he was asking whether he financially supported the family.
(Fieldnotes)

[later] On the ward Hossein went to see a patient who had mentioned to the nurses that she had leg pain. Hossein told her that this could be a complication of the surgery she had had the day before. At the word “complication” the patient looked quite shocked and then made a nervous joke about “complications”.
(Fieldnotes)

‘Complication’, ‘support’, ‘over’. Each of these words had a significant and important effect. Each time they were uttered by the overseas doctors there was a change in the affective dimensions of the social interaction. They were commonly used words spoken on the wrong occasion. Speaking the right words at the right time is a nuance of being familiar with an environment, aspects of language which one learns over time, though of course never fully grasps. Overseas doctors often had difficulties in ‘reading’ the behaviour of their colleagues and patients. Organisational researcher Karola Decker (2001, p49) suggests that the distress that many overseas doctors experience in their interpersonal relations may spring from some of these ambiguities embedded in the fine grain of communication. This fine grain difference was not only evident in the use of single words but also facial expressions. Two of the pastoral carers in Hospital X recounted such a story, from their perspective as the self-proclaimed ‘cultural brokers’
Pastoral carer #1: One woman came to me in tears and said that a doctor with an Asian accent had come to her father and stood at the end of the bed and just looked at her and said “you need a tracheostomy [see Medical Glossary]”, and she was just so cold.

Pastoral carer #2: I’ve had another similar complaint – was it a couple of days ago? Hmm, I think we need to follow this up.

Pastoral carer #2: [later] also, here at Hospital X we have a lot of Asian psychiatrists, and the patients tell me that the psychiatric doctors have such impassive faces – and the patients go absolutely spare!

Pastoral carer #1: I think that they are not aware of the cultural nuances.

Facial expressions are part of our embodied ways of interacting with others and of displaying emotion. In the hospital, facial expression is a critical aspect of fuzzy terms such as ‘empathy’ and ‘patient-centredness’. Because of differences in ways of interacting, practices developed in environments elsewhere, overseas doctors often had different facial expressions. This could lead to feelings of frustration at being misunderstood. Dr Wassan Khalid Al-Ameed explains:

*Sometimes the way you say an expression might be slow or you didn’t catch up and feel yourself an idiot. Your conversation, if you are with your group of people it would be very fast and very different.*

(Dr Wassan Khalid Al-Ameed)

Dr Wassan Khalid Al-Ameed continued to describe how overseas doctors could sense these perceptions of incompetence from locals through subtle facial expressions:

*When people do not understand what you mean – that is frustrating, when people do not know you and judge you – they judge you from things you do. They do not give you*
the chance, they judge you as, as your background, they judge you as your gender, but they do not of course, because it is illegal. But you can tell, they judge you so, even if they are nice, they smile at your face, but you are an intelligent person, you know that smile, although you have a different language, you have a different body language.

(Dr Wassan Khalid Al-Ameed)

As well as facial expressions, differences were found in gestures. In Chapter Six, I examined how gestures reflected ways in which overseas doctors related to buildings. Here I am interested in gesture as a point of contact between people, reiterating both difference and connection. Dr Abdul Karim Razavi, the doctor who scrunched his cup in the bin, had other observations of gestural difference. He recounted how ‘here the nurses pick up on very small things’, discussing an incident when he did not give the patient a tissue after administering eye drops and the nurse made a big deal about this. ‘In my country this would be such a minor thing’. Dr Pham Ba Hung explained how in a meeting he observed an intern lean over in his chair to give one of the consultants a piece of paper. He said that in Vietnam this would not happen and the doctor would have to get out of his chair and walk all the way around to give the paper to his superior.

Dr Pham Ba Hung: *In Vietnam there is 100% respect.*

Anna: *So it is different here?*

Dr Pham Ba Hung: *No it is the same, but the doctors go about it in a different way [makes a motion with his hands, one going one way and the other another way].*

Gestures reveal familiarities of the new setting which are simultaneously strange; familiar things just gone about in a different way. Two participants, Dr Mladen Mück and Dr Nikolai Nagorsky, also noted that touching a patient or a nurse was different in Australia compared to Bosnia and the Ukraine, and that this could have significant impacts upon interactions. Dr Abdul Karim Razavi asked me about how far he should
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stand away from a professor. In Iran, he said, he would stand up very straight and not talk very much. These are all subtleties of how to position the body, how to move, subtleties that require adjusting when a practitioner moves from context to context.

In the final part of this section I want to examine the minutiae of accents. Several overseas doctors spoke about their accents to me. Dr Abdul Karim Razavi described his accent anatomically, and told me how his facial muscles were formed in such a way that they made certain phonetics and he would never be able to change that. Dr Wassan Khalid Al-Ameed also described her accent:

_I do not look very dark. If I do not talk I do not look Asian - you know what I mean. Like one of my friends she is Asian, she is a local graduate, she is a second generation, so not just a local graduate. She speaks Australian and I say “you speak exactly the same, you don’t have any problem at all” ... With the patient for example – if I talk with them two words fluently – once I start to talk with them more with my accent, they say “oh where do you come from?”, no not the patient, the patient is different, but the doctors, “where are you from?” I wouldn’t say that they are ... I dress the same thing, I look maybe like the same thing – but once I start to speak I realise that they change. They do not speak with as before. They speak to me but in a superficial way._

(Dr Wassan Khalid Al-Ameed)

Whilst Dr Wassan Khalid Al-Ameed’s English fluency skills no doubt impacted upon her interactions with patients and her colleagues, I have used her quote to emphasise the importance of accent, as she has done herself. Accents are a way of delineating the overseas doctors as different from the local practitioners who may ‘look’ different but speak ‘the same’. They are a way of classifying ‘overseas-ness’. Accents had an effect on the overseas doctors’ interpersonal interactions. Dr Mara Radovanovic said that as soon as doctors heard her accent on the phone they reacted differently, ‘there is a different atmosphere’.
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In *Phenomenology of Perception* Merleau-Ponty ([1945] 2008, p174) points to the affective significance not only of individual words but also of accent, intonation, gesture and facial expression, which reveal not only the speaker’s thoughts but also the source of those thoughts. Whilst verbal and non-verbal language comprehension presupposes a commonly perceived world (Merleau-Ponty [1945] 2008, p226), differences highlight alternative environments. Merleau-Ponty writes that ‘the gesture presents itself to me as a question, bringing certain perceptible bits of the world to my notice, and inviting my concurrence in them. Communication is achieved when my conduct identifies this path with its own’ (Merleau-Ponty [1945] 2008, p215). Because the overseas doctors’ communicative registers were developed in hospitals elsewhere, and their difference could be non-concurrent with locals, they had to adjust. Through the case studies I have presented in this section, I have shown that this happened in practice, through an engagement with the people in the overseas doctors’ environment. These accommodations were not purely cognitive but also bodily. Once again, as Merleau-Ponty reiterates, ‘it is through my body that I understand other people, just as it is through my body that I perceive things’ (Merleau-Ponty [1945] 2008, p216).

The overseas doctors in this section described differences in embodied reactions concerning the affective, accented, expressive and gestural components of interpersonal interaction, which often lie beyond the level of the words spoken. These are aspects of social interaction often missing from the literature on overseas doctors. They are the surpluses that Connolly was quoted as discussing in Chapter One, the traces, noises, stutters, gestures, looks, accents, exclamations, gurgles, bursts of laughter and rhythmic or irrrhythmic movements that inhabit, punctuate, inflict and help to move the world of concepts and beliefs (cited in Thrift 2004a, p71). The next section explores how the overseas doctors adjusted these subliminal aspects of interaction over time, as they became more and more part of the system.
Modifying exchanges

Like birdsong, human interactions are learned rather than innate. They can be modified, either through new elements or the modification of existing ways of interacting.
(Grosz 2008, p38)

Dr Zhou Jiaying, the doctor we met at the very beginning of the thesis, who had travelled with her husband from Shanghai, where she had a position in a ‘well respected’ hospital, told me about her first few months in a hospital:

When I first started I didn’t have much reaction to the nursing staff — didn’t have much expression. But then I learnt to have expression on my face when people talk to me, to be more social.
(Dr Zhou Jiaying)

Several other participants, Dr Elena Radulescu and Dr Nikolai Nagorsky also described learning the importance of the smile, then smiling more. The overseas doctors observed how locals did things and tried to integrate it into their own practices. Dr Hossein Youssefian described how everyday he thought ‘how can I be like one of [the local doctors]?’ He wanted to sound more like a natural speaker and tried to copy the accent. He watched local doctors use different words, different gestures. He told me ‘I try and catch them, but I can’t’. He found interactions in Australia so different, such as presenting a patient to a consultant, or speaking to the patient. Another doctor, Dr Marian Munteanu, recognised that changing the subliminal aspects of engagement with others in the hospital was a process that took time and shared history.

Dr Marian Munteanu: [quietly] In my country, speaking my language – sometimes you can say only by the intonation in your voice, you know how to make jokes and with
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whom. Here, I don’t feel like I belong to this place, so I don’t make jokes where at home I would make the jokes and know when it was appropriate. It’s a cultural thing. It needs a long, long time to know when and where ... it’s not only with me – even if they don’t say it in this way – I notice that some [other overseas doctors] are closed up – you rather shut up than say an inappropriate thing.

Anna: Does this change?

Dr Marian Munteanu: You start making friends with medical practitioners and you start to know who is on the other [telephone] line – and he asks you more questions. It’s normal. It is about humour, but not only humour, other details too. You use humour to detense - is that the right word? – a situation. In Romania if I feel a situation is building up, I make a joke – and in Australia can I do that? As an IMG, from the point of view you have to defend yourself, not yourself but your position.

Anna: What did you mean by the other details?

Dr Marian Munteanu: If you want to use the generic term it is humour – but not only humour – it’s all – maybe sports, it’s cultural.

Anna: Is this important with the patients, your colleagues, or both?

Dr Marian Munteanu: Well you never get close to the patients, it’s not appropriate. So it’s probably more amongst the medical practitioners. It’s harder to make friends with the other medical practitioners because of this barrier. You keep a certain distance – because you don’t barrack for the same football team, have coffee on the weekends, go fishing together – you are from different worlds. In my country it is common for my best friend to be my colleague. You talk about other things at work, not just the patients. But here it is just about the patients, it is superficial, not deep. Here you just keep the façade. This other sort of relationship you build over years and years.

Dr Marian Munteanu emphasises how it is the subtleties of intonations in your voice and humour which can effect an interaction. Knowing how to ‘detense’ a situation takes time to know when and what to say at the right moment. The local doctors not only shared football teams, caffèlattes and fishing trips but had also spent years together
learning these interactional nuances, having been gradually exposed to this environment in hospitals. Dr Marian Munteanu, as a newcomer, described what goes unsaid for many doctors educated and trained and working in the same system, revealing a tacit understanding in social relationships that becomes ingrained over time. For the overseas doctors, sharing experiences with colleagues helped in filling in some of these details and realigned what Merleau-Ponty has called the perceived world that leads to comprehension. The longer they were in the system, the more they got a sense of the game, with greater ‘awareness of and responsiveness to the play of all the actors involved’ (Hillier and Rooksby 2005b, p23). As Bourdieu (cited in Hillier and Rooksby 2005b, p23) points out, this ‘requires improvisation and flexibility and above all, it requires use of anticipation as to what one’s team-mate/s and one’s opponent/s will do’. These are adjustments learnt over time.

Each of these negotiations were shaped by the overseas doctors’ own pasts, every doctor adjusting in a different way. For example, Dr Nikolai Nagorsky was very well regarded by the staff in the rehabilitation ward, and found ways to connect to them. In this section of the transcript, which preludes that presented earlier in the chapter, the nurse unit manager of the ward has just poked her head around the door.

NUM: So do you want me to tell you my joke, my heaven joke?
Dr Nikolai Nagorsky: Later.
Social worker: Because he is having an interview.
Anna: We can stop for the joke.
NUM: I’m going now – I will tell you later [laughs].
[door closes]
Social worker: I just want to say, that Nikolai has actually been an asset, when I remember when you first started, and I said, well I don’t know how long it was and I said something about “how do you like working here?” and he said “I love it”. Now I’ve never had that response from anyone, they’re always like, oh yes, isn’t that hard, I mean it’s
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*alright, but not with the sort of, with your passion. So I think you’ve, there is something about you, that has made it easier for yourself.*

Dr Nikolai Nagorsky: Thank you.

Social worker: I’m not very expressive, but that’s what I perceive.

Anna: Were you like this when you first arrived in South Africa, and when you got to New Zealand?

Dr Nikolai Nagorsky: Maybe that is how South Africa moulded me, I mean...

Social worker: Ahh.

Dr Nikolai Nagorsky: Because, [laughing], yeah, it is really moulding, because I met different, you know the nurses were all, in hospitals in Africa, they were in charge and it was very difficult for me to understand this ahh, no one told me, no one told me what to expect. If they had told me that they have certain values here, our nurses are running the hospital, they are in charge, and you also, because you are a doctor, you have to become like equal with them, you have to display respect because they are not like the nurses back home. Back home they were doing some injections and some procedures and that is all, yes, that the differences, aha. And sorry what were you ...

Anna: You said that you weren’t the same – what did you mean by that? [Nikolai goes on then to recount the story that this chapter opens with]

The overseas doctors adjusted by threading between their past ways of doing things and the new environments they found themselves in. What the overseas doctors described and enacted was not learning about these relationships in orientation courses but rather negotiating them everyday in practice, in tearooms, on the wards and in corridors on the way to theatre. They learnt from other local doctors, copying, replicating, improvising upon the interactions that they overheard.

A nurse answers a phone and says that it is for Zhou – it is a district nurse wanting to clarify the dose of a Clexane order. Zhou spends some time speaking to the nurse but says that she does not know about this patient and that she thinks that it is best for her
to talk to the haematology resident. He is a large guy in trendy clothes, sitting writing in some notes. The nurses say he is hiding and he responds that he isn't, dismissively. The haematology resident then gets on the phone and curtly tells the nurse he knows nothing about this patient and can't clarify the order and that he will put them through switch to speak to the actual doctor who wrote out the order. As Zhou and I walk back towards the patient that she is about to see, she repeats what the haematology resident said on the phone under her breath and comments that she should have said this.

(Fieldnotes)

Adjusting is about observing and copying, 'testing the waters', learning from the reactions of others, and reacting to their responses. Dr Charles Haszler documents this experience in PNG:

The orders and instructions to the sisters (in the few hospitals where we had sisters from Australia) were sometimes misunderstood, ridiculed, or ignored with an expression of horror. So it happened to me when, after one of my first operations at Port Moresby, I ordered the patient on the night of the operation - according to our Continental custom - to take icy cold tea without sugar and with a few drops of lemon, the Australian sister looked at me as if she did not believe that such an order could be given by any reasonable human being. She only shuddered and gave the patient cold water.

(Haszler 1967, p37)

Dr Charles Haszler learnt to adjust his treatments to the local customs, just as they learnt to compromise to his orders. Negotiating interactions with other people in the hospital meant that each interaction needed to be approached differently, drawing from the overseas doctors' past practices in Australia and elsewhere, responding to the specificities of the moment.
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In settings of more than two other people, it could be difficult for the overseas doctors to juggle these various interactions and multiple forms of engagement. For example, interdisciplinary team meetings were challenging for the overseas doctors because of the range of social interactions they were thrown into. Many regard the difficulties that overseas doctors have in undertaking interdisciplinary work as concerning their unfamiliarities with this practice (Decker 2001, p50). It is stated that they are, for many, 'an annoying waste of time' because as one overseas doctor said in a study, they are used to only 'justifying my decisions only to my senior colleagues' (Decker 2001, p50).

Whilst this may certainly be true, what I am emphasising here is that engaging in interdisciplinary work highlights and complicates the many modes of adjustment that the overseas doctors are learning and negotiating at any one time. Dr Nikolai Nagorsky describes how he negotiated interdisciplinary encounters, just one mode of adjustment amongst many:

You have to listen to other people, what they are saying, yield to the other suggestions from other health professionals. Like today for example, in this meeting ya [pause], somethings were, not so smooth there, some staff wanted to push a little bit their way, about a few things, but you felt that to argue about these things, or you make a probe, like you probe, OK you say, alright, well ah, if you make a probe, they will say OK, I think it's alright, like you make a probe and that person say, no, no, it's not going to work this way, and no it's not going to work this way again, and then you try to come back to the same problem but from a different approach and say OK maybe we can do these changes and maybe that will shift us from moving towards the goal, that seems, not direct impact ... you have to understand the situation, the stress, the intensity of the situation.

(Dr Nikolai Nagorsky)

Probing back and forth, threading from past ways of doing things to the present, interacting in new environments filled with diverse social exchanges, reveals something
of the contours of both the overseas doctors’ past settings of interaction and the system they become part of. The next section explores this further.

**Revealing social norms of interaction**

Overseas doctors, as newcomers, reveal social norms of interaction. In the workplace, organisational researchers Rick Ledema, Carl Rhodes and Hermine Scheeres (2005) argue that worker identities are increasingly being shaped through engagement with colleagues who make claims about each other’s conducts, identities and work practices. They write that these interactions are being made more prominent by ‘others who are increasingly other, as a consequence of their social mobility, cross-cultural interaction and inter-occupational/professional networks, and so forth’ (Ledema et al. 2005, p333).

Overseas doctors reveal social hierarchies and the little ways of adjusting that locals take for granted. This happened more obviously when overseas doctors tried to insert their own ways of doing things into the ‘status quo’. For example, Dr Mladen Mück revealed the way the more relaxed appointment system worked in Hospital X, and the expectations of the doctors to work around this and to take whatever time was required to respond to patients’ enquiries.

*There was the frustration for me when I came in to an overbooked outpatient clinic. I was a bit different from others in the field. I am sort of as an organised person. My way was to come into the waiting area and, “excuse me you are rostered every 15 minutes everyone has just 15 minutes allocated time”. “I will give you warning after 10 minutes” or something like that. But this was not an acceptable way. We should answer all the questions you know. I thought this was an unrealistic expectation and I raised this issue so many times. For me it is actually making the patient unhappy, it means not telling them exactly what’s our plan and what’s our roster and what they can expect ...*(Dr Mladen Mück)
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As he clashed with the system, contours of difference were made more obvious. Dr Mladen Mück was a doctor who had numerous clashes with other people in the hospital. On a number of occasions he told me about ‘encounters’ with administrative staff, midwives, his junior staff and patients. On the ward, he tried again to instigate change and his similarly unsuccessful attempt once again revealed how the system worked.

*It might be that the democracy is so high that it is counterproductive. It is so democratic that you get stuck.* There was another registrar from Yugoslavia once on this unit, from Belgrade, and there is another registrar with a PhD in public health and we wanted a more communist way of doing things. We wanted a handover at 0800 and the ward round to then start at 0830. Do you think we could arrange this? No, never! They midwives, they are not like on a button. The woman is on the phone, or there are hundreds of things they do rather than have the lady ready for induction at 0830.

(Dr Mladen Mück)

Despite having a comrade-in-arms, Dr Mladen Mück could not change ways of doing things in this volatile ward of the hospital. Relations in many obstetrics wards are historically fraught, political and complex (Akrich and Pasveer 2000). In the hospitals where I did fieldwork there were controversies and clashes between medical staff and midwifery staff. They were everyday encounters and negotiations and as Dr Mladen Mück himself said ‘it is not a matter of being overseas or being from the local culture’ that these interactions arise. However, he adds, ‘but they tend to use these things’.

The doctors’ ‘overseas-ness’ often highlighted to the midwives and nurses their struggles with medical dominance. In this frictional space, local doctors quickly learn ways to work with, and move around, the midwives, from the time they are medical students, just as they learnt the social norms of radiology departments (Chapter Four). Dr Mladen Mück tried to adjust to the midwives, for as he said, ‘this is the system and you have to adjust to this way’. He would have preferred a more hierarchical social
structure, where the roles of the healthcare workers were clear and where the juniors obeyed their superiors without question. Dr Mladen Mück thought that his juniors argued too much about things, and that everyone had opinions on matters; that it took forever for anything to be done. He opined that there were a lot of things that could be done better but he had to bite his tongue because he wanted to ‘work within the system’. In his adjustments he constantly collided against the others, these instances revealing much about the social norms embedded in his human environment.

By revealing tacit ways of doing things embedded in local systems, the overseas doctors not only highlighted some of these taken for granted aspects of the local environment but also more about themselves. In the process of adjustment some aspects of the overseas doctors’ past were revealed. There have been glimpses of the communist order, ways of standing and when to smile. These histories cannot be neatly categorised into national types of ‘cultural practices’ that require training and cross-cultural management. Rather, what the overseas doctors engaged in were moment-to-moment interactions in practice. As has become evident in this chapter, these interactions and connections often happened in ‘meeting places’ (Massey 1994) something explored further in the next section.

**Only connect**

A meeting place is somewhere like the rehabilitation ward tearoom where Dr Nikolai Nagorsky, Dr Surekha Sadafule and Dr Elena Radulescu all spent time as residents. Meetings in this room between people in the hospital – overseas doctors, social workers, nurses – were bodily, sensory, affective ones. When Dr Elena Radulescu was having a tea break one day a Serbian nurse, who had previously translated for a Polish patient, entered the room. I asked what language they were speaking. She said that the patient knew some Serbian because the patient had a friend who was Serbian, and that this was better than her English. Dr Elena Radulescu was nodding in the background and
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said ‘yes, they are both Slavic languages’. The Serbian nurse rested her hand on my shoulder as she spoke and then on Dr Elena Radulescu’s shoulder. Dr Elena Radulescu turned to her and said ‘I guess you cook with lots of cabbage too? I made Anna a cabbage dish today’. I asked the nurse if she would make similar dishes? Dr Elena Radulescu described it and the nurse nodded. They began talking about how they would make layered cabbage dishes with mince meat too and then the physiotherapist, who had entered the room, said ‘ah Eastern European food ...’

These women ‘met’ through bodily contact and cooking, demonstrating how meeting places could happen beyond shared language, in other ways. They adjusted to each other in that room in a similar way that the Serbian nurse and the Polish patient adjusted their language. In her hospital ethnography *Woman in the Surgeon’s Body*, anthropologist Joan Cassell (1998, p38) argues that difference - in her analysis something primarily bound up with gender - is produced through social interactions and altered, resisted and negotiated in them. Her book on the participation of women in a male-dominated profession, surgery, focuses analytically on the importance of embodiment in these social interactions. Often the literature on overseas doctors and their interactions with others can be disembodied, devoid of the gestures and utterances and facial expressions which colour their exchanges, filled instead with a list of behaviours, attitudes, values and categories (Cassell 1998, p39). I have argued in this chapter that learning when and where and what to say and do was rather a process that happened through the body.

In meeting places, embodied points of intersection were found which enabled the doctors’ adjustments. As Cassell argues, difference was both produced in these interactions and adjusted for. It is the paradox of the frontier (Interlude One), whereby the points of difference between bodies are also their points of contact. Rooms and other places in buildings were part of this interaction and facilitated interactions (Chapter Six). Long and colleagues (2006) suggest that interprofessional agreements in
hospitals (what they call collaborative action) depend on informal negotiations that occur in liminal areas such as in corridors and car parks (and I would add here tearooms). Much negotiation of difference occurs at this very local level, through everyday experiences and encounters. Amin (2002, p959) suggests that the ideal sites for coming to terms with difference, for negotiating the micropolitics of everyday social contact and encounter, are where these prosaic encounters are compulsory, in micropublics such as the workplace.

In the rehabilitation ward tearoom, a significant part of the doctors', social workers', physiotherapists' and nurses' workplace, they interacted in ways that transcended circumscribed notions of 'culture' and the institutional arrangements that caused separation of the doctors and nurses and allied health staff as 'us' and 'them'. This revealed complexities beyond presumed simplistic doctor-nurse, medical-allied, overseas-local, cross-cultural differences often detailed in relation to overseas doctors. As Rapport (2008a, p64) writes in relation to porters and doctors, it is in 'meeting places' that 'the hospital division of labour transmogrifies(s) into a field of social possibilities that range beyond the logic of the institution as such'. Adjustments in interpersonal interactions happen minutely, bodily, serendipitously, over time. These moments encompass a wider social awareness of a generically human communion that possibly transcends institutional and cultural differentiation (Rapport 2008a, p69) and offers greater hope for engagement than by considering the social interactions of overseas doctors as inherently problematic.

**Everyone adjusting everywhere**

Interpersonal engagements and adjustments through interactions occur in the hospital everywhere, everyday. As Ingold (2000, p401) writes in relation to speaking, it is 'closely attuned and continually responsive to the gestures of others, and speakers are forever improvising on the basis of past practice in their efforts to make themselves understood
in a world which is never quite the same from one moment to the next’. It is through such negotiations that things *get done* in hospitals. As staff and patients constantly change, this remains an ongoing process. Renée Fox (1989, p145) regards the hospital as a choreographed continuous day-and-night procession of human actors who enter and exit. She identifies patients, visitors, professional staff, technicians, administrative, clerical and housekeeping personnel, volunteers, delivery persons, messengers, vendors, police, clergy and undertakers. There are almost endless varieties of interaction that happen between this cast of characters, within any hospital. However, I would argue that the kinds of interactions that happen in hospitals are not all choreographed, with a plethora of serendipitous intersections and missed connections too, knots and tensions and loose threads in the yo-yo quilt of hospital life.

Everyday, prosaic encounters amongst people in the hospital were happening all around me when I did fieldwork, both involving the overseas doctors but also in places in my peripheral vision or wandering glance. One day, on a ward before going to grand rounds, Dr Marian Munteanu resited a cannula which he did quickly and easily. There was a cleaner in the room who was complaining to the patients about her working conditions and about how she did not have access to the right cleaning equipment ‘so how am I meant to do a proper job?’ She had a duster in her hand that was attached to a long handle and was wiping the tops of the rails where the curtains ran around the edge of the patients’ beds. One of the patients, an elderly Greek man, pointed out to her that his lights were full of cobwebs, and looking up, indeed, they were filthy. The cleaner reached up, and the patient tried to help her and together they swept out the cobwebs and dust from the light fixtures. She said that it was because of the throwing up of the sheets and the patient’s wife remarked that now they had twice as much light! When I walked out of the ward with Dr Marian Munteanu the patient in the next bed said that she would like her light cleaned as well.

The cleaner, the patients and the patients’ families were all interacting in prosaic ways.
The hospital is one of those places where there are interweaving connections and random encounters and simultaneously a place where people can 'coexist or cohabit without living together' (Marc Auge cited in Cresswell 2004, p45). Overseas doctors' interactions were part of this patchwork of human interaction. The overseas doctors were the newcomers, adjusting to become part of the system in their negotiation with the hurly burly of their human environment.

In their interactions, people connect with past histories and adjust a response that incorporates an ecological background of prior practice. The histories of the overseas doctors were made up of their histories of previous interactions and threads of interconnecting environmental factors. The locals had developed their interactions in familiar settings and often took ways of connecting to others for granted. It was the overseas doctors who revealed aspects of social reproduction that the local doctors implicitly assumed, through their clashes and more obvious adjustments. The interpersonal interactions of overseas doctors are often viewed as problematic in bureaucratic and research literature, but in the hospital melted into any number of negotiations of difference. These improvised interactions happened in the meeting places of corridors and tearooms and cafeterias. By looking at the overseas doctors' interpersonal interactions, their everyday prosaic nature was revealed.

**Summary**

I began this project, like many others, presuming that there were a set of social relations which the overseas doctors must learn to adapt to, when negotiating the system.

Anna: *And were there any enlightening moments when you gained insight into this is how the hospital, this is how the Australian system works?*

Dr Farokh Mostofi: *Hmm, ahh, actually I learnt it gradually here, so it was not a point that I can tell you, you know it was really, the right moment that this is how Australia*
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behaves the patients or something like that ...

Instead the overseas doctors adjusted to diverse and ever-changing forms of interpersonal interaction that happened in practice, defying easy categorisation. Whilst many researchers of overseas doctors have focused on differences in language fluency and spoken competency, this chapter focused on the subtleties and minutiae of language experienced through the body, in the form of introductions, single words, gestures and facial expressions. I focused upon the nuances of adjustment, upon the connections, or misconnections, that overseas doctors had with other people in the system they were very much part of. Not all overseas doctors engaged in subtle and responsive ways with those they worked with, just as not all local doctors did either.

In the story opening this chapter, recorded during a tearoom conversation, this system was revealed to be a dense arrangement of social relations, aspects of which are foregrounded separately in each chapter of the thesis. There was the story about procedures, shaving and surgical operations, which Dr Nikolai Nagorsky negotiated with adjustment. The story detailed relations with nurses and patients in South Africa, and in its telling, an interaction with a social worker. Place was another relation, the tearoom facilitating these conversations as a ‘meeting place’. In the background was Dr Nikolai Nagorsky’s pathway of registration and assessment. I was part of the interaction too, as a researcher sitting there with my digital recorder and notebook. This was the multifarious environment that the overseas doctors were part of, aspects of which have accumulated in ethnographic stories throughout this thesis.

In this chapter I have emphasised how adjustments were everyday and prosaic, and occurred in the midst of practice. I have emphasised how in such instances, in such places, identities were fluid. The following interlude examines the fluidity of overseas doctors’ identities in more detail. It explores an outcome of this research that provided an opportunity for overseas doctors to showcase their past experience in meeting places
People within the hospital. Following this interlude is the final chapter which sews up, incompletely, some hanging threads of this thesis.
Intlude Eight: Expand Your Horizons

Whilst writing in patients’ notes one day, Dr Nikolai Nagorsky turned to me and suggested that there should be more opportunities for overseas doctors to present their expertise in the hospital. He came up with the idea of having a lecture series designed to explicitly showcase the prior research and clinical work of overseas doctors in Australian hospitals. He also came up with a title: Expand Your Horizons. For him this term had two meanings: both an expansion of the presenters’ horizons and also the horizons of those who would attend the lectures. I submitted an application to DHS for funding for this project and started to organise the program together with Dr Nikolai Nagorsky. We decided that the objective of the project was to provide an opportunity for participating overseas doctors to engage in a dialogue with other overseas doctors and the local hospital community about their prior research and clinical work. The purpose of the project was not only to facilitate this exchange but also to allow greater recognition of the overseas doctors’ previous experience in a meaningful way.

After funding was granted for the project, a call for abstracts was distributed through various email networks to all overseas doctors in Victoria, both those employed and unemployed. Ten lecturers were selected to present over five separate Mondays in one of the fieldsite hospitals. The lectures were advertised extensively by email, posters (see Appendix), hospital e-newsletters and in person on the day of the lecture, with a free lunch provided beforehand to entice the busy hospital staff to attend.

Over those five Mondays, audiences heard about diverse research endeavours and clinical experience, including: 3D vectorcardiographic studies conducted in Sweden; a study of the radiological features of intervertebral vacuum phenomenon conducted in Japan; a discussion of the methods, complications and management of abortion and Malaria in Burma; and an epidemiological study of suicide by burns in Iran. All of the presenters completed evaluation forms reflecting on their experiences of lecturing.
They reported that it was important for them to have the opportunity to present a lecture in the hospital and appreciated being able to discuss their topics with peers and colleagues, an opportunity that they otherwise hadn’t had before. Many felt that they were able to start to develop better professional networks. Almost all of the doctors indicated that they would be highly likely to present another lecture in the future if given a chance, and similarly, would recommend the experience to others (Fuller 2009).

Seventy-five people who attended the lecture series also completed evaluation forms. Of these virtually all were overseas doctors, reflecting the demographics of the audience more broadly. Overall, attendees responded very positively to the lectures. Most found the presentations to be enjoyable, interesting and professionally relevant. Eighty-three percent of respondents indicated that the lecture series had changed the way they perceived the role of overseas doctors in Australian hospitals. Attendees also made comments reflecting a new understanding of the existing and potential opportunities for overseas doctors within hospitals (Fuller 2009).

Giving overseas doctors a chance to share their prior work experiences in an Australian clinical setting enhanced their sense of belonging, achievement, and recognition. It strengthened their professional identity and alleviated feelings of occupational stasis. The lecture was also a ‘meeting place’ where the overseas doctors’ identities were not single or fixed, but rather multiple, where they could showcase aspects of their past work as doctors. It was a place where the overseas doctors stitched some of their own experience into the system, where they became part of the ever-changing hospital fabric, potential creators of some of its change.
Chapter Nine: Conclusions

One of the critical challenges for the social study of biomedicine in the 21st century is to capture and explore transformations of medical practice (DelVecchio Good 1995b, p469). DelVecchio Good (1995b, p462) has suggested that the fertile areas for this research are local-global exchanges. However, as I have argued in this thesis, notions of global or universal medicine are mythical and what we find empirically instead are many locales. Transformation in medicine occurs as practices travel from one local context to another, either with practitioners, as foregrounded in this thesis, or in other forms such as instruments, standards or styles of management. International migration is by no means the only source of change, but it is one that has been underexplored.

By focusing on locality rather than a global, or national, arrangement of things, there starts to appear room for politically and practically relevant initiatives for negotiation, experimentation and accommodation of difference (Akrich and Pasveer 2000, p80). It is when we start to look closely at the ways in which overseas doctors negotiated their new hospitals that the adjustments integral to adaptive medical practice and the contextual complexities of medical work are highlighted. The social labour involved in moving practice between contexts, something too often hidden in the quest for universalisms, is made more visible through the work of the overseas doctors.

In this thesis I have concentrated on the ethnographic details of these sensory, situated, embodied adjustments. Rather than assuming that the process of moving practice from one context to another was inherently problematic and thus requiring ‘managing’, the thesis opened it up as a research question. This research also departed from many current discourses on medical migration into Australia by recognising that not only did overseas doctors have different ways of adjusting (modes), but that in doing so they drew upon past practice rather than starting ‘from scratch’. The past they brought with them was not only documented officially in their curricula vitae, referee reports and
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accreditation certificates from previous universities and hospitals, but lived in their bodies. The system the overseas doctors became part of and changed in the process, was not learnable outside of practice, but rather emerged as multifarious and dynamic, their adjustments embedded in this varied set of social relations. Focusing on the overseas doctors' attunement to the system revealed that there were adjustments happening in the hospitals everyday. The overseas doctors' adjustments were more obvious than the locals because the overseas doctors had a repertoire of past practices developed in hospitals elsewhere, from which they were constantly threading back and forth.

Each overseas doctor who appeared in this thesis negotiated new hospitals, through their own mix of social relations. Each chapter came as a loosely bound set of these interpersonal, material, technological relations; different clusters building on the same argument, different textures and colours of the system brought to the fore each time. Within each chapter were a range of characters, stories, theoretical perspectives and various texts. Each of these was intended to have an accumulative effect, to tell something in their quilting together about the nature of adjustment in medical practice. The argument thus emerged through a stitching together of a patchwork of stories, events, themes and theoretical perspectives. They were arranged in a particular way but could have been done so otherwise, highlighting different connections and gaps between elements of the ecological terrain the overseas doctors found themselves in. This thesis has by no means fully mapped a system. There remain a lot of loose ends ...

The next section provides an overview of the chapters before I move on to consider the contributions of this research.

Overview of chapters

In Chapter One I introduced the overseas doctors and the argument. I positioned the
thesis amongst the most significant existing literature on the topic and within a theoretical framework. The bulk of the chapter was divided into three sections which outlined the assumptions of the thesis, namely that: overseas doctors were different from local doctors because of practices developed elsewhere; that the system they were becoming part of in Australia was multifarious; and that they negotiated differences through modes of adjustment, threading from the past to the present.

Chapter Two discussed the fieldwork setting and method, providing a reflexive viewpoint on adjustment through my perspective as a researcher in the hospital. I described how as a novice anthropologist I was also learning in practice and making situated adjustments. The ethnography developed through a tacking back and forth, from the past to the present, as adjustments were made in recruitment, observation, interviewing, analysis, during writing and in ongoing engagements in the field.

Chapter Three gave shape to the registration process that the overseas doctors adjusted to, though always within limits. I argued that the overseas doctors adjusted to a 'policy of patches' which often left them confused and frustrated, yet which they persevered in negotiating through sheer necessity. In doing so, they highlighted a system, overflowing with differences and discrepancies, despite claims of standardisation.

In Chapter Four the overseas doctors' relations with paperwork were followed. Through three ethnographic stories, events unfolded which showed various ways in which the participants adjusted to the mundanities of the administrative system. Their adjustments highlighted social norms inscribed within the systems' documents and the ways in which practitioners adjust to forms everyday. As the overseas doctors learnt the hidden rules of practice, they became ingrained into the paperwork trails themselves.

Chapter Five then presented a closer look at the assessment process. I focused upon the paradoxes of the overseas doctors' assessments to a slippery and supposedly
standardised system. As years of prior practice had become ingrained and embedded, the overseas doctors' tacit knowledge was difficult to make explicit for the examiner. New exam techniques had to be learned and for some overseas doctors, examinations alone were a distant memory. The matter of when to do the exams was a question of timing, choices possibly jeopardising success and potential futures. These were all modes of adjustment that required effort and perseverance.

In Chapter Six, the hospital building took center stage, and the nature of the overseas doctors' adjustment to the materialities of place was analysed. In this chapter I moved away from viewing the hospital as a rigidly structured institution, to analyse ways in which overseas doctors adjusted to its physical form. The chapter also revealed the ways other peripheral members of the hospital used space in creative ways and highlighted the affective and ever-changing dimensions of the overseas doctors' new environments.

Chapter Seven studied the process of adjustment concerning the overseas doctors' procedural work. In this chapter I incorporated one of my own stories as an overseas doctor and the stories of two doctors in an obstetrics unit, exploring some amongst many of the overseas doctors' different modes of adjustment to instruments. In the chapter I argued that by studying moments of mismatch something unique is learnt about ways practitioners negotiate between different work contexts and the environmentally situated nature of this work.

Chapter Eight examined interpersonal interactions in the hospital and how overseas doctors adjusted to their colleagues and patients. Focus was upon the subtleties of interpersonal adjustment in hospitals, such as gesture or accent, and how overseas doctors adjusted over time to an environment filled with nuanced negotiations amongst staff. The chapter showed that by studying the overseas doctors' interactions as they happened, we learn more about the prosaic nature of adjustment in the midst of
practice.

Quilting these chapters together were a number of interludes. The last concerned an outcome of this research. Further contributions of the thesis are now examined in greater detail in the remaining sections of this chapter. These sections are divided up to consider the contributions of the research theoretically, methodologically and practically.

**Theoretical contributions of this research**

In this thesis I have drawn from a range of theories to provide further insights into my analysis of the ethnographic material. Whilst falling broadly within an ecological framework of understanding derived from the work of Maurice Merleau-Ponty and Tim Ingold, the chapters include a range of theories developed and utilised in a diverse array of disciplines. One of the theoretical contributions of this research is this patchwork approach. By using a range of theories, points of connections are highlighted, as are differences. This yo-yo quilt of theory has allowed the overseas doctors' stories to be examined in richer, textural detail. Whilst contributing to multidisciplinary ways of using theory, the thesis has also contributed more specifically to theoretical ideas in three disciplinary areas: science and technology studies, organisational studies and medical education.

**Science and technology studies**

There is a long running dialogue in STS that draws from ANT concerning the symmetry of agency. To this debate I have contributions to make drawn from an understanding of the ways in which the overseas doctors negotiated their work in their new human and non-human environments. From studying their practices, I have understood this
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relationship between humans and non-humans to be asymmetrical, yet very much intertwined. That is, focusing on the human actors, I have emphasised that the overseas doctors *adjusted to* their human and non-human environment rather than *with it*. This was the result of not only constraints on their practice, and their marginalisation leading to adjustments of necessity, but also due to their newcomer status within the hospitals.

Like any addition to an ecological context, overseas doctors needed to tune themselves to the vibration of the local setting. It was through their tuning into the environment, that it gradually changed. The overseas doctors were thus part of the system’s adaptation, consequently blurring any clear separation between them and the environment. The overseas doctors’ social relations needed to be understood in more subtle ways than merely considering them as two-way interactions, where one shapes the other and vice versa. Rather, change happened as each aspect of the environment was enfolded into the other. This theoretical contribution draws very much from the work of Ingold and Merleau-Ponty and adds to a lively discussion in STS about the relationship between humans and their environment.

**Organisational studies**

Whilst there is a current trend in organisational studies to go back to its former reliance on ethnographic methods (Yanow 2006, p1744), there remains nonetheless a lack of detail about the embodied, situated, sensory and affective nature of work and workplaces in this discipline (Conradson 2003). This thesis has demonstrated how a detailed look at the work of practitioners provides greater understanding of the contextual nature of workplace practice. Ethnography highlights the mundane and the routine, the practices which are often taken for granted, providing valuable insights into how organisations and institutions work.
The thesis also contributes to what appears to be a significant gap in our theoretical understanding of how skills are transformed from one setting to another, in new occupational contexts (Syed 2008, p31; Williams and Baláž 2008b, p1924). With 200 million people now estimated to be working outside their countries of birth (Williams and Baláž 2008a, p5), this is an issue relevant for many workplaces. Researchers have recognised the need for more ethnographic work studying the nature of knowledge transfer of skilled migrants (Williams and Baláž 2008b, p1933) and learning in the workplace (Yanow 2006, p1744). This thesis is embedded within an ethnographic understanding which has enabled theoretical insights of overseas doctors' adjustments in hospitals.

There are theoretical insights here for other workplaces as well, where practitioners come together to negotiate difference. Bourdieu (2000, p144) has argued that there is much to learn about practice from studies of musicians (Chapter Seven). Detailed studies of musical practice such as sociologist David Sudnow's (1978) ethnomethodological study of learning jazz improvisation through the body is a good example. I believe that there is also much to learn about practice from those working in hospitals, who are engaging in a range of heterogeneous relations to get their work done. The thesis particularly highlights the need to acknowledge that all practitioners in workplaces come to their work with a wealth of past practice and experience, which they constantly adjust, to the changing shape of the organisation, a change which they are very much part of.

Medical education

In this thesis I have theoretically interrogated contemporary changes in medical practice and learning in medicine by highlighting the role of difference, the modes of adjustment that doctors underwent, and the environmentally situated nature of this learning in local contexts. I have highlighted the sensory nature of learning in hospitals, for in their
adjustments overseas doctors had to pay attention to how things felt, how they looked or sounded. They had to notice ‘those subtleties of texture that are all-important to good judgment and the successful practice of a craft’ (Ingold 2000, p416), yet are all too often overlooked in medical education research.

Using an ethnographic approach, this thesis has enabled a study of medical education as it happened. Doctors’ learning in ward-based environments is an under-researched area in medical education (Bleakley 2002, p9). Existing research tends to have a bias towards a psychological model of information transmission and uniform teaching methods that strips away the cultural complexities of learning (Bleakley 2002, p11). In this thesis I celebrate contextual complexity and offer ways in which to understand this further, using empirical observations and various theoretical models. As researchers in the field of medical education move towards utilising more diverse disciplinary approaches, particularly those engaging with literature such as Jean Lave and Etienne Wenger’s (1994) ‘communities of practice’ and ‘situated learning’ work, this is a timely contribution to make.

The thesis also contributes towards a critical understanding of recent change in medical education such as the role of standardised medical curricula. Whilst the push for standard global practice is prominent in the medical education literature (e.g. Harden 2006; Karle 2006), there are simultaneously growing voices of concern and critique (Ringsted et al. 2006; Del Bigio 2007; Verkerk et al. 2007) and this research provides ethnographic details which emphasise the local nature of medical learning.

**Methodological contributions of this research**

Throughout this thesis I have drawn not only from the rich observational and interview material gathered throughout fieldwork, but upon a range of other textual material that I have incorporated within and between the chapters. As previously argued in Chapter
Two, this material was not intended to have a triangulating effect, but rather to highlight the multiplicities of the research topic and method. Methodologically, the thesis has contributed to ways of thinking about incorporating non-academic material into academic discussion.

Too often academia holds a narrow view of who are the ethnographers of medical practice, privileging the work of sociologists and anthropologists. Academic accounts often do not adequately capture the sensory or affective dimensions of medical practice, something which writers and artists outside the academy may be more attuned to (Harris 2008). For example, novelists are open to creative possibility for their characters and to documenting the medical world in evocative ways. Those working within the visual key, such as contemporary artists, illustrators and photographers are also often more comfortable than academic researchers with presenting their work in ambiguous and incomplete ways. Artists are attentive to the aesthetic poetics of everyday hospital life, many having already opened up fascinating areas of cross-disciplinary exchange that explore hospitals in new and exciting ways (e.g. Robb 1999; Booth 2000; Cizek 2007; Wainwright 2007).

In Interlude Six, photographs allowed another reading of the research site which hinted at the creative potentials of working with artists in hospitals and other workplaces. Photography is one way in which to explore human and non-human relations and the environmentally situated nature of medical work, but there are of course other media. There is more scope to include video (e.g. Iedema et al. 2006; Cizek 2007) and sound artists (e.g. Wainwright 2007) in telling stories about hospital life. Engaging with artists-in-residence, novelists and illustrators and their work means expanding our notions of who are hospital ethnographers, recognising the methodological richness in the stories that non-academics have to tell about this fascinating workplace.
Practical contributions of this research

One of the reasons for undertaking this study was to have some positive, transformative effect on the ways in which overseas doctors are supported through the transition process from their previous work environments to new hospitals in Australia. The situated knowledge generated from the research methods utilised in this thesis has much to contribute to this area, and the results need to be taken back to the domain of the overseas doctors, and those concerned with their work situation. It means having a say about program design and being part of the discussion of the best ways in which to create a smooth transition for the growing numbers of overseas doctors in Australian healthcare systems.

The recommendations that I outline below are built on several principles. First, using a principle very similar to that adopted when sewing a yo-yo patchwork quilt, the programs are about using materials that come to hand. This not only makes transitional programs last longer but also means they are better designed for the local environment of practice and the changing needs of its practitioners (Brand 1994). This does not mean, for example, pooling all resources into expensive orientation courses external to the overseas doctors’ work settings but rather looking within organisations to see who and what is integral to the process of transition. This includes not only involving overseas doctors in the process – often a remarkable oversight - but also local staff. When we consider the involvement of local staff, we need to broaden our definition of supervisors beyond that of doctors to consider nursing staff, porters, medical students, psychologists and patients.

Transition programs need be locally designed, for it is the local environment that the overseas doctors are adjusting to. The greater the distance from the locus of design to the locus of practice, the more reworking needs to be done on the ground (Mort and Smith 2009, p225). Again, this involves incorporating overseas doctors into their own
learning, as well as leaving space to accommodate the contributions of future overseas doctors. The aim is not to over-design programs, but rather allow room for flexibility and change (Brand 1994). As changes happen, responsive action needs to take place locally, rather than being mediated through remote command centres. Integral to this is ensuring that hospital managers and others involved with funding and resource allocation have a close relationship with overseas doctors, so that they can respond in a timely way to change.

There is a considerable amount of funding currently being directed towards the orientation, training and assessment of overseas doctors in Australia. In Victoria alone, the 2007 – 2008 State Budget set aside $AUD 7.8 million over four years to establish a national assessment process and to enhance orientation programs, education, training, supervision and workplace based assessment for overseas doctors (DHS 2007; 2009, p2). The practical recommendations which I have discussed, and which I now consider in more detail below, concern not only using these resources wisely, but also thinking more experientially, using what comes to hand, and considering learning as it happens in environmentally situated practice.

**Involving overseas doctors in their learning**

There are already a number of good examples of ways in which overseas doctors are starting to be included in their own teaching and learning. For example, several bridging courses now ask overseas doctors who have completed the course to return and teach (e.g. Victorian Medical Postgraduate Foundation (VMPF)). In the Thursday evening tutorials at one of my fieldsites, overseas doctors also learnt from each other, both when they critiqued each other’s performances and through more informal means (Chapter Five). Despite a surprising lack of recognition of overseas doctors’ contributions to the transition process in the past, they are starting to be acknowledged. They could matter more however. There is much more room to involve overseas
doctors in their orientation so that newcomers can learn from those who have gone before them, a powerful pedagogical tool.

One commonly recommended way of doing this is to establish mentorship programs, so that those who have become more established in the system can orientate incoming overseas doctors (Curran et al. 2008, p167). Another way in which to involve overseas doctors further is to have the newcomers teach themselves about the system they are entering, as they are entering it. This could be through reflexive group meetings, where overseas doctors share with each other their own observations about their new settings of practice, learning from each other's critical reflections². In many ways overseas doctors were ethnographers of the hospital, with revealing observations of the system they were becoming part of. There was very little room for the overseas doctors to engage in systematic reflection or consolidate this learning. Once in the hospitals, they were largely left to themselves. However, as Dr Nikolai Nagorsky highlights, there is a need to reflect upon these stages of change:

Dr Nikolai Nagorsky: ... desire, willingness to learn and adjust, persistence, determination. If a person comes here with a consultancy background, that person could fail easily, making big mistakes, trying to impose your own expertise – they could be polar approaches – you have to go through the mincer.

Anna: The mincer?

Dr Nikolai Nagorsky: [he makes a grinding motion] If you think this is the same as it was before, without knowing the process, then you will suffer even more...

Reflexive group meetings in the hospital would allow room to discuss this process, in the midst of the overseas doctors being part of it. Researchers Pope and colleagues (2003, p654) have shown in their ethnographic studies with anaesthetists, that medical practitioners benefit from thinking critically and systematically about their own practice.

² An application for funding for such a project was submitted to DHS by myself and Clare Delaney in October 2009
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They argue that encouraging the doctors to focus upon their observations also extends and refines the skills of clinical observation.

There has been one orientation program in the USA which has focused upon easing and deepening the learning of overseas doctors by ‘intensifying their attention to their new social environment’, what ecological psychologist James Gibson (cited in Ingold 2000, p167) would call ‘an education of attention’. The anthropologist involved in this American project - who wrote up his own ethnographic observations of his time with a participating Vietnamese doctor into a separate case study (Rittenberg 1987) - explains how each participant was assigned ethnographic exercises such as interviews and ward observation to help study aspects of their everyday situations. After their assignments the overseas doctors met with an anthropologist to reflect on the lessons they had learnt about American culture (Rittenberg 1987, p151).

This seems like an excellent way for overseas doctors to engage in ongoing reflection about their learning. Reflective practice is important for newcomers, with a richness inherent in being able to combine the ability to both engage and to distance, to view an enterprise as an outsider, whilst becoming an insider (Wenger 1998, p217). The learning of migrants is enhanced by their role as social outsiders (Williams and Baláž 2008a, p182). Williams and Baláž (2008a, p182) argue that this makes skilled migrants more open to reflexive understandings of particular settings than insiders ‘who have been deeply embedded within the values of that system, often from birth’. There is a role in such reflexive meetings for the inclusion of anthropologists, sociologists, psychologists and ethicists, to facilitate discussion and prompt in-depth exploration of the overseas doctors’ observations.

Narrative-based focus groups with foreign medical graduates have also demonstrated the richness of reflecting on work experiences with others. Kevin Fiscella and colleagues (1997) used critical incidents in a focus group format to discuss ‘transcultural challenges’
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raised by overseas doctors in relation to their work in America. The focus groups also had American medical graduates who reflected on similar issues, which prompts the possibilities of including local interns, also undergoing significant adjustments, in such sessions in Australia. Dr Nikolai Nagorsky recommended having such focus groups concentrate on times of conflict, similar to the critical incident, because, he told me:

*Sometimes it is silent, and we must recognise that silent conflict. Because that silent conflict between the system and the newcomers, it can grow into something bigger if it is not resolved because they can bottle it up, us, I am sorry we are talking about me, I can bottle it up, I can think OK OK you tell me whatever you want, but I still do my way I used to do, and that is how it will be, that’s what silent conflict is about, so I am not, not open to the changes, not acknowledging that there must be changes that must be done, it means that I can kind of create a conflict within myself and the system which could actually lead to some, ahh, some hazardous consequences, sometimes, yes? ... And that’s where the truth will come out, so because, because there is differences, when there are difference there is always this conflict ...*  
(Dr Nikolai Nagorsky)

Studying conflicts and tension can be a useful tool through which to explore boundaries and scales of social membership (Permezel and Duffy 2007, p362). Dr Nikolai Nagorsky recommended that as a researcher I could ask participants in these groups questions such as, ‘as a newcomer, what do you feel is different? Assertiveness? Putting in IVs? Treating kids different? Doctor-patient-nursing staff relations?’ These questions highlight that any facilitator of sessions in which overseas doctors reflect on their learning process would need to be mindful of the multifarious nature of difference that the overseas doctors find in their new environment, and prompt such discussion, whilst letting it evolve at the same time. Time and space needs to be given for such groups, during what some hospitals call ‘protected time’. In doing so, overseas doctors would have the opportunity to reflect and learn from each other outside of the pressures of
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their job but still within the hospital context. Such opportunities would acknowledge the work that goes into the overseas doctors’ adjustments.

Whilst face-to-face methods are considered by many to be the most powerful means by which to learn and reflect (Mulroy et al. 2007, p537), there are also other ways in which overseas doctors could learn from each other. Dr Surekha Sadafule recommended an orientation book covering such things as ‘how to follow a protocol’ or ‘how to notify a consultant about patients’ that could have ‘words of wisdom’ by other overseas trained doctors. There is certainly little in the written literature available to the overseas doctors which outlines what others have experienced in ‘their words’, though more recently media resources have appeared such as DVDs (Woodward-Kron et al. 2009), containing overseas doctors’ stories.

Another way in which overseas doctors can learn from each other is through on-line formats. The Internet forum www.aippg.com (2008), set up by one of the overseas doctors I met during fieldwork, has now grown into a considerable resource for overseas doctors around the world wanting to work in Australia, the UK, Canada and the USA. Whilst this forum mainly deals with overseas doctors sharing information on assessment and registration matters, there is room to use the format in other ways, to discuss overseas doctors’ learning in hospitals. Another tool would be a wiki (Fabri, personal communication), or a similar web 2.0-based apparatus, which remains ‘live’, and open for overseas doctors to continually contribute to.

Finally and importantly, there is also a need to involve overseas doctors in the research design and implementation of projects concerning overseas doctors. By involving the doctors more fully, they can direct project focus and outcomes to better fit their needs. This kind of action research is currently sadly lacking and will hopefully take place in the

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3 Another planned outcome of this research is to produce a booklet for overseas doctors and those concerned with their employment, which details some of the experiences of participants in this research. The booklet will use, as much as possible, the participants’ own words.
future. Having outlined the room for overseas doctors in research design, and in their learning, I now want to highlight the role of other staff members in the hospital, in the overseas doctors’ transition process.

**A broader definition of supervision**

Currently there is much emphasis and a significant amount of funding being directed towards the role of ‘supervisors’ to monitor and further the learning of overseas doctors in hospitals, with the aim to enhance patient care and provide trainee support. Whilst I think that the role of supervisors is important for overseas doctors, particularly in regards to their on-the-job assessment, I nonetheless believe that our current definitions of supervision are somewhat limited. Almost universally, supervisors are considered to be medical staff, predominantly senior medical staff, vocational trainees, prevocational trainees and also medical students (McGrath 2009). Already, research has shown that there are problems with this model, with gaps between what information supervisors consider themselves to have delivered and what overseas doctors regard as having been delivered in terms of supervision. There are also difficulties related to time constraints, especially of senior medical staff (McGrath 2009). The solution to these problems is largely considered to be further building of the supervisory capacity of the medical staff (McGrath 2009).

I suggest another alternative, one that broadens our definition of who has supervisory capacity. As has been evident in this thesis, overseas doctors learn from a full cast of characters, including nurses, medical students, other overseas doctors, locally trained doctors, porters, phlebotomists pharmacists and PSAs. Nurses helped Dr Pham Ba Hung and Dr Elena Radulescu with their paperwork (Chapter Four) whilst Dr Zhou Jiaying learnt from the resident how to speak on the phone (Chapter Eight). Dr Surekha Sadafule and her husband learnt from the other interns about how to deal with Administration (Interlude Eight) and a doctor in the pre-employment program learnt
from the staff at the venepuncture clinic about how to insert cannulas and take blood (Chapter Seven). Dr Pham Ba Hung learnt about drugs prescribed in the hospital from a Vietnamese pharmacist on the wards, whilst Dr Abdul Karim Razavi and Dr Elena Radulescu observed and copied other doctors in regards to their procedural work (Chapter Seven). Researchers have also highlighted the role of pharmacists (Hawkins 2009), Clinical Teaching Associates (CTAs) (Musk 2009, p46), the hospital chaplain and medical records personnel (van Naerssen 1978, p200) in the overseas doctors’ learning, and the role of patients in the learning of medical students more broadly (Becker et al. 1961, pp8, 11; Stacy and Spencer 1999; Bleakley 2002, p11). Wenger (1998, p100) reiterates that there is often little recognition of the role of what he terms ‘old-timers’ in situated learning processes. He recommends recognising these efforts, encouraging them and otherwise facilitating the process. This seems like good advice when thinking about overseas doctors’ learning in Australian hospitals.

So far I have only mentioned the human aspects of the overseas doctors’ environment. As this research as shown, the overseas doctors adjusted to a multifarious environment. Supervisory programs need to recognise this as well as realising that adjustment happens in practice, that it is situated in an environment. I examine this further by suggesting that the findings of this ethnographic research push us to reconsider current emphasis on the ‘orientation’ of overseas doctors.

**Transition rather than orientation**

In Chapter One I discussed how there is currently much emphasis on the pre-employment orientation of overseas doctors, critiquing briefly how this is often considered as something which happens outside the setting of practice. I have now argued in every chapter, that the overseas doctors learnt principally in the midst of practice, in their environment. Thus, I believe that it is necessary to reconsider orientation, as something that happens over time in the workplace. It is not that current
orientation programs are inappropriate, but rather that I consider them merely a starting point rather than the totality of learning; they address one but not all stages of adjustment.

There are many excellent features of existing programs and manuals for overseas doctors that come under the umbrella term of ‘orientation’. In the hospitals where I conducted fieldwork there was a six-month orientation program for overseas doctors which was modelled on what the local students did in their pre-internship years in hospitals. The overseas doctors involved in the program were able to have student registration so that they could be involved in ward practices and be covered medico-legally. This enabled them to have ‘legitimate peripheral participation’ (Lave and Wenger 1994). The program involved the completion of logbooks, tutorials, teaching by nurse clinical educators, case presentations with PowerPoint, and sessions in a simulation centre. The overseas doctors in this study who undertook this course found it very useful, as Dr Nikolai Nagorsky told me:

*The bridging course was helpful, because, it was, I was already on the field and seeing what was happening around, already noticing that OK that is already different, how you talk to the kids as well, you talk to the kids like they are adults, explaining them what is going on and what is going to be done and asking them how they feel about it - I believe in many countries that we came from that is not the case.*

(Dr Nikolai Nagorsky)

Other orientation courses have been cognizant of the need to have ongoing orientation work in hospitals (Curran et al. 2008, p168), the need to attend to the minutiae of documentation and everyday practical skills (van Naerssen 1978, p200; Porter et al. 2008, p39) or have recognised that there are critical time periods when instructional support is most needed (Hoekje 2007). Many organisations recognise that their orientation manuals are merely points of resource rather than orientation in its totality.
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(e.g. PMCV 2009). Others recognise that the overseas doctors have diverse needs in terms of orientation and support (The Royal Children's Hospital 2009). In Victoria, bridging courses are now thinking beyond just assessment preparation and including discussion and observation of hospital work practices in their program (e.g. VMPF). There are therefore many important aspects of current programs which I believe need to be strengthened and better financially supported, each addressing different aspects of orientation, including learning in the environment, attention to the mundane aspects of medical practice, the use of manuals as mainly resource material and the inclusion of overseas doctors as educators.

However there are orientation practices that could be improved upon. On the whole ‘orientation’ continues to be presented to the overseas doctors as something which happens prior to hospital work, whereby the system is constructed as learnable outside of practice (Horvath et al. 2004, p493). In his work on situated learning, Wenger warns against this and suggests that:

We would do well to be suspicious of any training scheme that is purely extractive in nature. By this I mean schemes that “extract” requirements, descriptions, artifacts, and other elements out of practice, transform them into institutional artifacts (courses, manuals, procedures, and the like), and then redeploy them in reified form, as if they could be uprooted from the specifications and meaningfulness of practice. This kind of extractive training ignores an organization’s most valuable learning resource: practice itself. (Wenger 1998, p249)

I have asserted in this thesis, as Wenger does here, that learning happens in the midst of practical engagement in an environment. There has been a model in medical education for sometime which posits learning as a novice’s acquisition of an expert’s skills (Bleakley 2002, p10). Similarly, much teaching about the system in orientation courses and
manuals posits learning as something externalised, leaving the nature of the doctor, their environment and their relations underexplored. This is a model of transmission, absorption and assimilation (Lave and Wenger 1994, p47). It implies codification of knowledge that concentrates on the purely cognitive, rather than the embodied nature of learning, creating the illusion of a simple, direct, unproblematic relationship between learners and the elements of their subject matter (Wenger 1998, p264). This does not recognise, as I have done in this thesis, and as others such as Alan Bleakley (2002) have also highlighted in his work on the educational interactions between consultants and junior doctors during ward rounds, that learning is an active sensitisation to the ecology of the working environment.

Rather than continuing to replicate the current model of orientation, I propose greater recognition of the stages of learning that happens in the midst of practice and reformulating this as a time of 'transition'. Whilst there are periods of transition for all medical practitioners, especially when they go from medical student to intern, or intern to registrar (Zukas 2009), the overseas doctors' transition can often be more difficult because it is not an officially sanctioned time of transition. The nurses and other staff on the wards expect the new interns to be newcomers, but not the overseas doctors. Overseas doctors are given less space for transition, are less tolerated. Their adjustments are also more obvious. As an HMO Manager said:

*I think we need to improve, at a unit level, the support structures that we have, and actually not just for the IMGs but for all the junior doctors ... but it becomes glaringly apparent with an IMG [laughs], I mean I was just talking about it this morning, that you know, the gaps become glaringly apparent when it's an IMG involved.*

(HMO Manager)

Despite it being one kind of transitional period, the first few weeks, months, years of overseas doctors' work in hospitals were not the only time they had to adjust. Many
researchers comment that international medical graduates who have been in the system for five years or more are perceived by local staff to have 'integrated successfully' (Narasimhan et al. 2006). I argue instead that there are *modes of adjustment*, that as Lave and Wenger (1994, p36) argue, there are ‘multiple, varied, more-or less-engaged and inclusive ways’ of adjusting. Adjustment was ongoing, to a system that was constantly changing. Every practitioner had their own trajectory. Learning was not an object to be handed down, but rather was an ongoing, interactional/relational process.

*You can do a three month course – but in order to perform, you have to go through these dramatic hard years of learning* ....

(Dr Nikolai Nagorsky)

As Ingold (2000, p230) writes, ‘we know as we go, not before we go’.

The current emphasis on orientation programs seems to meet the political requirements of larger government and medical organisations who need ‘evidence’ of overseas doctors’ competencies. There is a strong argument for introducing overseas doctors to the elements of the system that they will soon become part of, prior to their employment, so that they are not left ‘floundering’. However, as I have already argued, this kind of orientation needs to be seen only as one resource rather than the totality of learning. It needs to supplement rather than substitute for the learning that happens in practice (Wenger 1998, p250). There can be dangers in considering orientation as completed before practice has even begun in the new work context. Reconsidering orientation as a period of transition may enable funding to be redirected to longer-term programs in hospitals, that are adaptable to the changing needs of the overseas doctors.

Transition programs must respond to the emergent (Wenger 1998, p267). Overseas doctors' adjustments cannot be encapsulated in orientation manuals or courses because they happen on the fly, making use of the material and architectural arrangements at
hand, changing quickly. The heterogeneous nature of this learning is rarely raised in current orientation practices. From this research I advocate for transition programs that are more sensitive to the manifold elements of overseas doctors' working environments, and the various situated, embodied, sensory ways that the overseas doctors adjust. I advocate for programs that are sensitive to the changes in the system, that roll with the movements of the doctors; programs that better reflect the overseas doctors' everyday ways of tuning into the system; programs which appreciate the range of social relations that the doctors' negotiate within their hospital environments. The system cannot be presented as something coherent and contained, as something to be learnt in brief pre-employment orientation programs. It needs to be appreciated as part of an ongoing relationship between dynamic institutional arrangements and people with personal trajectories that temporally unfold in the place of practice.

Incorporating the overseas doctors' pasts

"Every man", wrote Chateaubriand, "carries with him a world which is composed of all that he has seen and loved, and to which he constantly returns, even when he is traveling through, and seems to living in, some different world".


A central tenet of this thesis has been that overseas doctors had modes of adjustment, and that they adjusted constantly from their past to the present situation they found themselves in. When considering transition programs for overseas doctors this needs to be better recognised. The overseas doctors in this study had various ways of negotiating the system that reflected differences that could not be defined in categorical ways, nor integrated in any uniform way. Whilst essentialised notions of classic sociological categories are no longer adequate, at the same time, our politics cannot fail to recognise differences. There is a need to problematise difference in new ways, which considers
differences within differences and differences which are not always so obvious. It means considering difference in productive rather than non-productive ways, as potentially enriching rather than always problematic. Transition needs to better accommodate the ‘multiple overlapping learning trajectories’ (Goodwin et al. 2005, p860) of overseas doctors and their threads of previous practice. It needs to reconsider overseas doctors’ role within the system, a role that is not defined merely as ‘gap-filling’, but that instead acknowledges the doctors’ wealth of past experience, thus strengthening their own sense of professional identity.

In their recent International Migration Outlook report, the OECD (2007, pp134, 150), detailed the difficulties migrants have in using their human capital in the labour market and questioned the extent to which skilled migrants are being best employed in their new countries. Whilst programs are being developed in Australia, as in other countries, which attempt to improve the placement of overseas doctors in their areas of expertise, in hospitals, the past experiences of overseas doctors are often ignored in the focus upon the doctors’ integration into the Australian system and acquisition of new skills. Overseas doctors experience this lack of acknowledgement of prior work experience as a barrier to career advancement (Rosenthal et al. 1997, p128; Health Workforce Queensland & Rural Doctors Association of Queensland 2005, p10).

The contributions of overseas doctors to national healthcare systems has been better recognised outside Australia, in countries such as the USA, where they have celebrated notable contributions of overseas doctors to improvements in clinical practice, biomedical and health service research and medical education (Cohen 2006, p517). Often these are rather notable researchers, rather than the ‘everyday’ overseas doctor, but it nonetheless demonstrates some publicised recognition of the work of overseas doctors in widely disseminated journals. Australia has maintained a historically disappointing approach to the recognition of overseas doctors’ previous work. Kunz (1975, p112) writes in relation to the post World War II period that ‘the neglect to utilize
their wide experience, skills, and challengingly different outlook, was in economic terms an expensive and wasteful folly'. It seems that little has changed and that it is time to consider alternatives.

The multidirectional nature of learning and knowledge transfer of skilled migrants is an underexplored area of research (Williams 2007, p32; Williams and Baláž 2008b). Migrants are seen as coming to learn rather than to co-learn, let alone transfer knowledge (Williams and Baláž 2008b, p1925). There have been glimpses of overseas doctors teaching others in this thesis, such as when Dr Pham Ba Hung taught a medical student cannulation, or the conversation between the social worker and Dr Nikolai Nagorsky. More explicitly, overseas doctors were able to share their prior clinical experience and research work in the lecture series, Expand Your Horizons (Interlude Eight) (Harris et al. 2009). This lecture series project began to address the gaps identified in the academic and broader migration and public health literature, as well as the needs of overseas doctors working and studying in Australian hospitals. Expand Your Horizons was built on a premise that overseas doctors were able to engage in knowledge transfer just as the locals were. It assumed that the overseas doctors arrived in Australia with past practices, rather than starting from scratch. We need more programs of this sort.

Recognising the expertise of overseas doctors in Australia, and incorporating their wealth of previous practice will ultimately depend on how open organisations are to embracing these terms of social engagement (Amin 2002, p973), on how open hospitals are to embracing external reference standards and methods (Williams and Baláž 2008b, p1926). The transfer of knowledge across contexts is often constrained by such institutional barriers, where, as Gertler (2003, p95) argues, what are described as cultural differences are rather concrete differences at the macroinstitutional level. The mood at a recent conference on international medical graduates in Victoria, at which the lecture series project was presented, indicated that organisations are becoming more
open to considering overseas doctors in Australia as educators. Organisations need to maximise connectivity and openness amongst workers to leverage knowledge transfer (Williams and Baláž 2008b, p1926). This may involve providing opportunities to overseas doctors to speak within existing lecture series or educational programs within hospitals such as grand rounds and in-house conferences⁴. These are ways to create openings for contact and dialogue with local hospital staff as equals, so that new identities form from the engagement (Amin 2002, p972).

These measures are largely recognising and facilitating what is happening already: that the overseas doctors are changing the environment that they are part of. As de Certeau writes:

Renters make comparable changes in an apartment they furnish with their acts and memories; as do speakers, in the language into which they insert both the messages of their native tongue and, through their accent, their own ‘turns of phrase’, their own history; as do pedestrians, in the streets they fill with the forests of their desires and goals.
(de Certeau 1984, pxxi)

The goal of the practical contributions that I have outlined in this section is to not only recognise that this is happening, but also to exploit the richness of these changes happening in medical practice at the local level. My suggestions aim to embed this perspective in the well-funded orientation programs for overseas doctors. The practical contributions have concerned using materials that come to hand, involving overseas doctors and other hospital staff in a process of learning through transition.

⁴ Two speakers from the Expand Your Horizons series have been invited to present at medical grand rounds at Hospital Y
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The final stitches

Before closing, I want to reiterate the emotional work that went into the overseas doctors’ adjustment. It is difficult to be a newcomer again, when you have already gained membership elsewhere. Learning in a new environment is a process imbued with precariousness, uncertainty and vulnerability. It can be a rewarding but also a very painful and lonely time. Too often these aspects of the overseas doctors’ stories have been neglected.

The overseas doctors I spent time with were often under scrutiny. Judgements were made about the mundane, because it was mundane. Earlier in the thesis Dr Mladen Mück used the analogy of a second hand car that is examined for all its small cracks before it gets road-worthiness, compared to a new car (Chapter Five). As the overseas doctors had to put more work into their adjusting, in the process, they taught us something about it. In essence, these adjustments were inherently pragmatic. They were not largely about resisting local norms nor insisting on taking control, but were rather about getting the job done. Often, of central importance to the participants was improving their English language fluency, sorting out their visas, making sure their families were settled and that they had a decent salary to support them.

There was also however the tremendous desire to belong to the local medical profession. Their identities as doctors were integral to this. For identities are always relational (McDowell 2008, p504) and becoming part of the system was about belonging. The overseas doctors’ identities were constituted through practices within and between medical contexts, local and elsewhere. They were formed in places where they were called doctor, rather than overseas doctor, and continually shaped in the familiar unknown/unfamiliar known hospitals they found themselves in. Bowker and Star (1999, p295) write that membership is about resolving interruptions between the strange and the taken for granted. It is such gaps which arguably feed into the strength
Conclusions

of medicine (Berg 1997b, p168) driving it constantly forward. These are not gaps between the global and the local but rather gaps between local contexts of practice.

With this thesis I have contributed to a discourse which questions universalisms in medical practice. But I have done more here than deconstruct medicine as a universal. I have detailed some of the social labour that underlies this myth, examining the work of adjustment that goes into moving medical practice between settings. In doing so I have begun to problematise these settings of practice as ‘local’. Law writes that:

The idea of the universal transportability of universal knowledge was always a chimera. But if the universal disappears then so too does the local – for the local is a subset of the general. Instead we are left with situated enactments and sets of partial connections, and it is to those that we owe our heterogeneous responsibilities.

(Law 2004, p155)

It seems that the increasing number of migrating health practitioners inadvertently redefine and reshape hospitals as ‘local’ institutions shaped solely by the society and culture in which they are embedded. Hospitals are becoming places, as anthropologist Ulf Hannerz (2003, p210) writes, where ‘there are no real natives, or at any rate fewer of them, sharing a life time’s localized experience and collectivized understandings’. The system becomes instead ‘a bricolage, of geographical elements, environmental characteristics, material features, shifted and reorganized fragments from a number of milieus’ something constantly reconfigured and reorchestrated (Grosz 2008, p47). It becomes a yo-yo quilt of stories, moments, events, partial connections and gaps, and it is within this multifarious patchwork that the overseas doctors become enfolded.
List of References


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Health Workforce Queensland & Rural Doctors Association of Queensland (2005). *'The other side of the equation': issues that impact on overseas-trained doctors in..."
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Medical Glossary

AMC orientation guidelines

Consent forms for overseas doctors

Expand Your Horizons advertising flyer

Table of participants
Medical Glossary

**Arterial line:** A thin catheter inserted into an artery, used to measure blood pressure or obtain samples for arterial blood gas readings

**Atherosclerosis:** A condition in which the artery wall thickens as the result of a build up of plaques

**Bypass:** A two hour time period when ambulances bypass a specified ED at the request of that ED

**Cannula:** A flexible tube which, when inserted into the body, is used either to withdraw or insert fluids

**Cannulation:** See cannula

**Catheterisation:** The introduction of a catheter into a body cavity to inject or remove fluid, used in this case to empty a patient’s bladder

**Crohn’s:** An inflammatory bowel disease

**Cold calling:** A way of approaching prospective employers, typically via telephone, who were not expecting such an interaction

**Dorsal flexion:** Flexion of the ankle

**Endotracheas:** See tracheostomy

**Haptic:** The sense of touch, involving movement

**Harrison’s:** *Harrison’s Principles of Internal Medicine*, a large comprehensive medical textbook

**Humidicrib:** An ‘incubator’ for newborn infants

**Lumbar puncture:** A diagnostic or therapeutic procedure performed in order to collect a sample of cerebrospinal fluid for biochemical, microbiological and cytological analysis

**M. solei:** A muscle

**Pager:** Called a beeper or bleep in some places, this is a simple personal telecommunications device for short messages
Appendices

**Pitting oedema:** A medical condition whereby fluid builds up in the patient's limbs so that when gently pushed with a finger, a depression remains

**Placenta abruption:** A complication of pregnancy, wherein the placental lining has separated from the uterus

**Plantar flexion:** Extension of the ankle

**Proprioception:** The sense of the relative position of neighbouring parts of the body

**Therapeutic ultrasound:** A procedure that uses ultrasound for therapeutic benefit

**Tracheostomy:** A surgical procedure on the neck to open a direct airway through an incision in the trachea

**Skills labs:** Houses training equipment for students and clinicians to practice procedures

**Suprapubic catheter:** An indwelling catheter that is placed directly into the bladder through the abdomen

**Venepuncture:** Taking blood
AMC orientation guidelines

In guidelines released by the AMC (2007), they state that orientation should include, but not be limited to, the following:

A) Orientation to the Australian healthcare system
   - Structure and funding of the healthcare system in Australia
   - Medicare Australia
   - Commonwealth Department of Veteran's Affairs
   - Pharmaceutical Benefits Scheme
   - Provider and prescriber numbers
   - Interface between private and public health services

B) Communication and cultural safety
   - Cultural awareness; safety; respect and competence
   - Australian society incl multiculturalism; status of women, children and elderly
   - Aboriginal and Torres Strait Islander culture
   - The Australian patient
   - Cross-cultural communication
   - Communication strategies

C) Orientation to the local jurisdiction
   - Registration and standards bodies
   - Medical education and training
   - Professional support
   - Government and non-government referral agencies
   - Rural and remote health services and supporting organisations
   - IT systems; e.g. prescribing, pathology and radiology ordering and reporting
   - Patient safety and safe medication practice
   - Infection control
   - Occupational health and safety

D) Legislation and professional practice
   - Legislative framework governing practice in the particular jurisdiction
   - Litigation and indemnity
   - Patient rights and responsibilities
   - Patient complaints
   - Patient consent
   - Substituted health care decisions
   - Adolescent autonomy
   - Death and the Coroner’s Act
   - Child safety
   - Organ transplantation and autopsies
   - Access to health/medical records and confidentiality
Participant Information and Consent Form
For international medical graduates working at Hospital X

Project Title: Working as an International Medical Graduate in an Australian hospital

Student Researcher: Anna Harris, PhD Candidate, University of Melbourne
Centre for Health and Society, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne

Participant Information Version 2 Dated 10/01/2007 Site: Hospital X

This Participant Information and Consent Form is 6 pages long. Please make sure you have all the pages.

1. Your Consent
2. Purpose and background of the project

You are invited to take part in a research project entitled Working as an International Medical Graduate in an Australian hospital.

This Participant Information contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible what involvement in this project would entail before you decide whether or not to take part in it.

Please read this Participant Information carefully. Feel free to ask me questions about any information in the document. You may also wish to discuss the project with work colleagues, friends or family.

Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand the information and that you give your consent to participate in the research project.

You will be given a copy of the Participant Information and Consent Form to keep as a record.

3. Purpose and background of the project

The purpose of this project is to look at the professional experiences of doctors who have migrated to Australia and to attempt to understand this in the context of their current working lives in an Australian hospital.

Doctors who have obtained their medical qualifications outside Australia now make-up a significant proportion of the Australian medical workforce, yet little is known about their current or previous working experiences. Prior research in this area has provided
Appendices

detailed numerical information, and alluded to the complex ways that recently migrated doctors enter new hospital environments. However, there is a gap in our in-depth understanding of the work experiences of migrant doctors. Research in the social sciences on hospital doctors which uses ethnographic research techniques (where the researcher follows, observes and talks to participants during their everyday working lives) has proved to be a particularly valuable way to study doctor's work experiences. This project aims to use this ethnographic research method to attempt to help understand the professional experiences of international medical graduates.

The research will examine the working lives of international medical graduates at two Melbourne hospitals and those they interact with in the hospitals. From this research it is hoped that we may acknowledge doctor's prior experiences and to explore how best to enhance work experiences and inter-professional relations in hospitals.

You are invited to participate in this research project because you have obtained your medical qualifications outside Australia. Your involvement is sought because your life story and experiences in Australia as a migrant doctor are valuable and informative. Around fifteen to twenty international medical graduates will participate in this project (from Hospital X, Y and Z). Other hospital staff working with you will also be asked to participate.

This research is being conducted as part of my PhD at the University of Melbourne. I am studying at the School of Population Health in the Faculty of Medicine, Dentistry and Health Sciences. This research is fully supported by the university and by the health network.

4. Procedures

Participation in this project will mostly involve being shadowed by me during your working day at the hospital. I will be interested in observing your work activities and interactions in the hospital with other staff and patients but am not interested in the details of your clinical management of patients. I will not be evaluating how well you perform your clinical duties. I may shadow you initially for one week, and then we can talk about what further involvement you consider is appropriate. During the shadowing period, you will be asked to participate in occasional informal interviews to explore certain issues, which may last around 15 minutes to half an hour. These short interviews will take place at a time and place convenient to you and will be tape-recorded with your permission. Your participation in the project will not extend beyond hospital working hours and should not impede upon your work duties. Overall, I will be based at Hospital X, Y and Z for approximately 9 to 12 months.

5. Possible Benefits

The possible immediate benefits of participating include the opportunity to discuss your
current and previous working experiences with someone unrelated to your employment in the hospital. In the longer term, results of the study should improve awareness regarding the working experiences of international medical graduates and their interprofessional relations in Australian hospitals and possibly enhance these in the future. I cannot guarantee or promise that you will receive any direct benefits from this project, and it is more likely to benefit international medical graduates commencing work in the future.

6. Possible Risks

The main possible risk of being involved in this research may be feeling excessively shadowed throughout the working day. I will make every effort however, to minimise the impact of my presence and if you ever feel uncomfortable, shadowing will cease. Potentially sensitive issues may also be raised in discussions and interviews with you. If sensitive issues are broached during interviews or discussions that requires further counselling, I will give you contact details of the hospital counselling service or the Victorian Doctors Health Program.

There is also a risk that despite all efforts to make the data anonymous, that your views or experiences may be recognisable to other staff in the hospitals.

There may be additional unforeseen or unknown risks. As a participant in the study you have a right to suspend or terminate your involvement in the project at any time if you feel uncomfortable or unduly inconvenienced.

7. Privacy, Confidentiality and Disclosure of Information

Any information obtained in connection with this project and that can identify you will remain confidential. Information will only be disclosed with your permission, in a non-identifiable form, except as required by law. No hospital staff will have access to the full fieldnotes or interview tapes. If you give me your permission by signing the Consent Form, I plan to share the research results with academic colleagues during seminars and conferences, discuss findings with the hospital and medical organisations and finally to publish results in the form of a doctoral thesis and journal articles.

In any publication, every effort will be made to provide information in such a way that you cannot be identified. Confidentiality will be maintained by using pseudonyms (fake names) for participants and the hospital in the recording and publishing of data. However, because of the small number of participants in this research, I cannot absolutely guarantee that you might not be identifiable in quotes in local presentations or in published material read by colleagues. All data will be stored in locked filing cabinets on University of Melbourne premises and in confidential computer files, with sole access by the researcher. According to university requirements, data will be destroyed after seven years. Paper files will be destroyed and computer files will be
8. Results of Project

As participants, you will be informed of the results of the project in a concise report disseminated at the end of the project. A completed thesis will be available from the University of Melbourne library in early 2009.

9. Further Information or Any Problems

If you require further information or if you have any problems concerning this project, you can contact me or my principal supervisor at the University (details were provided).

10. Other Issues

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact the manager of the research directorate (details were provided).

11. Participation is Voluntary

Participation in any research project is voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your employment with the hospital or your registration.

Before you make your decision, I will be available to answer any questions you have about the research project. You can ask for any information you want. Sign the Consent Form only after you have had a chance to ask your questions and have received satisfactory answers.

If you decide to withdraw from this project, please notify a member of the research team before you withdraw. This notice will allow that person or the research supervisor to inform you if there are any special requirements linked to withdrawing.

12. Ethical Guidelines

This project will be carried out according to the National Statement on Ethical Conduct in Research Involving Humans (June 1999) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.
The ethical aspects of this research project have been approved by the hospital’s Human Research Ethics Committee.

13. Reimbursement for your costs

You will not be paid for your participation in this project.

Thank you for considering participating in this project. Please contact me if you would like to participate or have any further enquiries.

Kind Regards,

Anna Harris
a.harris4@pgrad.unimelb.edu.au or (0420382337) mobile
CONSENT FORM

Project Title: Working as an International Medical Graduate in an Australian hospital

Student Researcher: Anna Harris, PhD Candidate, University of Melbourne
Centre for Health and Society, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne

I have read and I understand the Participant Information version 2 dated 10th January 2007.

I freely agree to participate in this project according to the conditions in the Participant Information.

I will be given a copy of the Participant Information and Consent Form to keep.
The researcher has agreed not to reveal my identity and personal details if information about this project is published or presented in any public form.

Participant’s Name (printed):
Signature  ......................................................... Date

Name of Witness to Participant’s Signature (printed):
Signature  ......................................................... Date

Declaration by researcher*: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher’s Name (printed):
Signature  ......................................................... Date

* A senior member of the research team must provide the explanation and provision of information concerning the research project.

Note: All parties signing the Consent Form must date their own signature
expand your horizons
lunchtime lectures by international medical graduates

mondays
may and june 2009

lecture theatre 2
1 – 2 pm (except 29.06 12.30 – 1.30)
lunch provided

This lecture series is supported by and the Faculty of Medicine, University of Melbourne and funded by the Department of Human Services
Enquiries: Anna Harris, a.harris4@pgrad.unimelb.edu.au
## Participants

<table>
<thead>
<tr>
<th>Nationality/country of medical education/countries worked in*</th>
<th>Prior employment</th>
<th>M/F</th>
<th>Department**</th>
<th>Employment level**</th>
<th>Length of time in fieldsite hospital**/Australia**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vietnamese/Vietnam/Vietnam</td>
<td>9 yrs as HMO</td>
<td>M</td>
<td>Colorectal Surgery</td>
<td>HMO</td>
<td>3 wks/6 yrs (3yrs in factory)</td>
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<tr>
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<td>6 yrs, 2 yrs as Paed Reg</td>
<td>F</td>
<td>Rehab Medicine</td>
<td>HMO</td>
<td>2 yrs/2 yrs</td>
</tr>
<tr>
<td>Indian/India/India</td>
<td>2 yrs as HMO</td>
<td>M</td>
<td>Obstetrics and Gynae</td>
<td>HMO/Registrar</td>
<td>2 yrs/4 yrs (1wk hospitality, 6mths PSA &amp; MPH)</td>
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<tr>
<td>Romanian/Romania/France and US</td>
<td>5 yrs incl PhD in Pharm</td>
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<td>Obstetrics and Gynae</td>
<td>Registrar</td>
<td>?</td>
</tr>
<tr>
<td>Bosnian/Bosnia/Bosnia, Germany</td>
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<td>Emergency</td>
<td>Registrar</td>
<td>3yrs/4yrs</td>
</tr>
<tr>
<td>Indian/India/India</td>
<td>?</td>
<td>F</td>
<td>Obstetrics and Gynae</td>
<td>Registrar/Fellow</td>
<td>?</td>
</tr>
<tr>
<td>Sri Lankan/Czech Republic/none</td>
<td>?</td>
<td>F</td>
<td>Rehab Medicine</td>
<td>Registrar</td>
<td>?</td>
</tr>
<tr>
<td>Iranian/Iran/Iran</td>
<td>?</td>
<td>M</td>
<td>Psychiatry</td>
<td>HMO</td>
<td>Less than one yr/1 yr</td>
</tr>
<tr>
<td>Burmese/Burma/Burma, Fiji and NZ</td>
<td>2yrs as GP, 9 yrs and 3 yrs</td>
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<td>Paediatrics</td>
<td>HMO</td>
<td>1.5 yrs/3 yrs</td>
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<tr>
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<td>?</td>
<td>M</td>
<td>General Medicine</td>
<td>HMO</td>
<td>6 wks/at least 6 mths</td>
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<tr>
<td>Iraqi/Iraq/none</td>
<td>5 yrs study in NZ</td>
<td>F</td>
<td>ICU</td>
<td>HMO4</td>
<td>2 yrs/2 yrs</td>
</tr>
<tr>
<td>Bosnian/Bosnia and UK/Bosnia</td>
<td>16 yrs, 8 yrs as consultant</td>
<td>M</td>
<td>Obstetrics and Gynae</td>
<td>Snr Reg/Staff Consultant</td>
<td>9 yrs/9yrs</td>
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<tr>
<td>No.</td>
<td>Nationality/Affiliation</td>
<td>Gender</td>
<td>Speciality</td>
<td>Institution</td>
<td>Years</td>
</tr>
<tr>
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<td>--------</td>
<td>------------</td>
<td>-------------</td>
<td>-------</td>
</tr>
<tr>
<td>13</td>
<td>Sri Lankan/Sri Lanka/Sri Lanka</td>
<td>M</td>
<td>Obstetrics and Gynaecology</td>
<td>HMO</td>
<td>1.5 yrs/2 yrs (2 wks in factory)</td>
</tr>
<tr>
<td>14</td>
<td>Malaysian/Malaysia and US/Malaysia</td>
<td>M</td>
<td>Cardiothoracic Surgery</td>
<td>Senior Reg/Fellow</td>
<td>3 mths/3mths</td>
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<tr>
<td>15</td>
<td>Australian/Ireland/(none)</td>
<td>M</td>
<td>Emergency</td>
<td>Registrar</td>
<td>?</td>
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<td>Indian/India/India and ?UK</td>
<td>M</td>
<td>Endocrinology</td>
<td>Registrar</td>
<td>?</td>
</tr>
<tr>
<td>17</td>
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<td>F</td>
<td>Rehab Medicine</td>
<td>HMO</td>
<td>?</td>
</tr>
<tr>
<td>18</td>
<td>Indian/India/India</td>
<td>F</td>
<td>Medicine</td>
<td>HMO</td>
<td>6 wks/at least 6 mths</td>
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<tr>
<td>19</td>
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<td>Oncology</td>
<td>HMO</td>
<td>3 yrs/10 yrs</td>
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<td>Russian/Russia/Ukraine, S Africa &amp; NZ</td>
<td>M</td>
<td>Rehab Medicine</td>
<td>HMO</td>
<td>?</td>
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<td>Iranian/Iran/Iran</td>
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<td>Neurosurgery</td>
<td>HMO</td>
<td>?/at least one year (3mths before)</td>
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<td>Indian/?/?</td>
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<td>?/UK/UK</td>
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<td>Registrar/Resident</td>
<td>Less than 1 year/less than 1 year</td>
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<td>24</td>
<td>?/UK/UK</td>
<td>F</td>
<td>Medicine/ICU</td>
<td>Registrar/Resident</td>
<td>Less than 1 year/less than 1 year</td>
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<td>25</td>
<td>Sri Lankan/Sri Lanka/Sri Lanka and UK</td>
<td>M</td>
<td>Psychiatry</td>
<td>Consultant</td>
<td>20 years</td>
</tr>
<tr>
<td>26</td>
<td>Sri Lankan/Sri Lanka/Sri Lanka</td>
<td>M</td>
<td>Obstetrics and Gynaecology</td>
<td>Consultant</td>
<td>40 years</td>
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</table>

**Participants not working in fieldwork hospitals**

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<thead>
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<th>No.</th>
<th>Nationality/Affiliation</th>
<th>Gender</th>
<th>Speciality</th>
<th>Institution</th>
<th>Years</th>
<th>Notes</th>
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<tr>
<td>27</td>
<td>Burmese/Burma/Fiji, and NZ</td>
<td>M</td>
<td>Emergency</td>
<td>Registrar</td>
<td>3 yrs/3 yrs</td>
<td></td>
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<tr>
<td>28</td>
<td>Iranian/Iran/Iran</td>
<td>M</td>
<td>Not working</td>
<td>?</td>
<td>None/1 mth</td>
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</table>
### Table 3: Participants

<table>
<thead>
<tr>
<th></th>
<th>Country/Country/Country</th>
<th>Experience</th>
<th>Gender</th>
<th>Occupation</th>
<th>Work Status</th>
<th>Employment Status</th>
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<td>Few yrs HMO and research</td>
<td>M</td>
<td>Not working</td>
<td>?</td>
<td>None/1 mth</td>
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<td>30</td>
<td>Iraqi/?/?</td>
<td>?</td>
<td>M</td>
<td>Not working</td>
<td>?</td>
<td>None/?</td>
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<tr>
<td>31</td>
<td>Chinese/China/China &amp; Australia</td>
<td>6ys in Opthamology &amp; lawyer</td>
<td>M</td>
<td>Not working</td>
<td>?</td>
<td>None/Tas for at least 8 years (5yrs factory, law)</td>
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<td>32</td>
<td>Russian/Russia/Russia</td>
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<td>M</td>
<td>Pathology</td>
<td>Venepuncturist</td>
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<td>South African/South Africa/South Africa</td>
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<td>MD and MPH</td>
<td>F</td>
<td>Not working</td>
<td>?</td>
<td>None/?</td>
</tr>
</tbody>
</table>

*For some participants this includes countries they didn't work in but undertook medically related employment, for others it does not include countries they have spent time in before arriving in Australia

**At time of first meeting
Appendices
Author/s: HARRIS, ANNA

Title: Overseas doctors in Australian hospitals: an ethnographic study of how degrees of difference are negotiated in medical practice

Date: 2009


Publication Status: Unpublished

Persistent Link: http://hdl.handle.net/11343/37098

File Description: Overseas doctors in Australian hospitals: an ethnographic study of how degrees of difference are negotiated in medical practice

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