

‘To Stay or Not to Stay’: Migration Decisions and Professional Mobility of South African
Educated Physicians in Rural Alberta

by

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Abstract

Introduction: Rural communities in Alberta, Canada have faced physician shortages for decades. Attracting internationally educated physicians, including many South African physicians, is one way to address this problem. While much of the research on internationally educated physicians focuses on attraction and retention, I bring a fresh approach, framing the decision to stay in light of migration decisions and professional mobility, all within a life course perspective.

Methods: Data was collected via semi-structured virtual interviews with 29 South African educated physicians who have practiced family/general medicine across Alberta. Many participants were white men, while physicians of colour and women were notable minorities. This qualitative research was guided by abductive grounded theory, a methodology that encourages theory building and contributions to ongoing debates. Data was transcribed verbatim and analysed using open thematic coding.

Findings: South African educated physicians made the decision to leave South Africa and to come to Canada to pursue the prestige and opportunity that was inaccessible in South Africa. Instead of freely making decisions about where to live and the sort of medicine they wanted to practice, physicians were limited to work as rural generalists. This perceived lower prestige professional work meant South African physicians occupied low status positions while more prestigious work was reserved for Canadian educated physicians. The outcome of this stratification played an important role in South African physicians' ability to achieve what they were looking for and the professional opportunities that were available if they stayed in a rural community or migrated elsewhere.

Conclusion: Findings suggest that migration, or in this case physician attraction and retention, is an outcome of aspiration and capability, contingent on prestige and professional status. South African educated physicians have successfully and creatively managed their perceived lower status work, finding ways to bring their aspirations to life in rural communities and stay. Alternatively, when unable to stay in rural practice, South African educated physicians' decisions to relocate to an urban centre was a matter of lifestyle over professional prestige.

Preface

This thesis is an original work by Ashley Hadley. The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Research Ethics Board, Project Name “‘TO STAY OR NOT TO STAY’: MIGRATION DECISIONS AND MOBILITY OF SOUTH AFRICAN TRAINED PHYSICIANS IN RURAL ALBERTA,” No. Pro00122607, August 25, 2022.

Dedication

Dedicated to the South African physicians who made this study possible. I am honoured to have heard your stories, horrified by the toll years of rural practice have taken, and confident those searching will find their way. Thank you.

Acknowledgements

I owe a debt of gratitude to my supervisor, Dr. Nicole Denier, who repeatedly saw this research for what it was and what it could be and prodded me in that direction. I appreciate that you led me towards the information and sources that allowed me to make many of the decisions, while not shying away repeated revisions. Thank you to the other members of my supervisory committee, Dr. Sara Dorow, Dr. Sarah Stahlke, and Dr. Bukola Salami, for your time, energy, and input in seeing things to the finish line.

Thank you to those who travelled with me. Thank you for caring enough to ask and understand what I am doing and why it matters. Thank you also to those who reminded me of life 'outside' and urged me to remain a social participant. This research and I are better for it.

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Abbreviations

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| AMA | Alberta Medical Association |
| CA | Census Agglomeration |
| CaRMS | Canadian Residency Matching Service |
| CCFP | Certification in the College of Family Physicians |
| CCFP(EM) | Certification in the College of Family Physicians (Emergency Medicine) |
| CMA | Canadian Medical Association |
| CMA | Census Metropolitan Area |
| CPSA | College of Physicians and Surgeons of Alberta |
| ER | Emergency Room |
| IMG | International Medical Graduate |
| LMCC | Licentiate of the Medical Council of Canada |
| LMIA | Labour Market Impact Assessment |
| MCCQE | Medical Council of Canada Qualifying Exam |
| TDM | Therapeutics Decision Making |

Chapter 1: Introduction and Literature Review

Rural communities in Canada have faced physician shortages for decades. The problem is multifaceted; doctors must be attracted to rural communities and opt to remain there, and basic health services and infrastructure must provide care specific to rapidly ageing and geographically widespread populations. The ongoing shortages in communities across the country have been the subject of much policy discussion and have inspired targeted programs and policies to attract and retain doctors (Miedema et al., 2009; Hancock et al., 2009; Gilles et al., 2008; Bourke et al., 2013). One such effort relies on the recruitment of International Medical Graduates (IMGs) to critically buoy rural healthcare systems in many provinces.

In Alberta in particular, IMGs educated in South Africa have been part of the solution to the rural physician shortage. South African educated physicians practice in 83 towns and cities in Alberta (CPSA, n.d. (May 2022)). In Alberta Health Service's (AHS) rural North Administration Zone, one third of all physicians are South African (Fournier, 2023). A number of communities are staffed exclusively by South Africans, while a number of other communities rely entirely on IMGs from across the world (CPSA, n.d. (May 2022)). Actively practicing South African educated physicians have cared for Albertans since 1985, arriving in Alberta every year since then. Many of these physicians practice in a rural setting, often several hours from an urban centre. Yet, these international recruitment efforts have not stopped the shortage as Canadian educated physicians appear as disinterested in rural practice as ever and IMGs do not practice in a rural community indefinitely, as they are often expected to do.

This motivates two questions that together aim to understand why an IMG might stay in a rural community. First, how do South African trained physicians make decisions about migrating to or from rural Alberta? Second, what role does professional mobility play in South African

trained physicians' geographic mobility? The first question situates rural doctors' decisions to remain in rural Alberta in the context of their broader migration trajectory. The second question hones in on a particularly important dimension of professional migration, the ability to realise professional goals. As South African physicians' migration and professional trajectories are not universal, my research will consider how these experiences have been shaped by gender, race, marital status, migration context, and life course stage as findings permit.

I draw on migration theory and literature on stratification within the medical profession to guide my research, positioning findings within a life course approach that 'follows migrants through place' and considers migration alongside other life course events (Impicciatore and Panichella, 2019). Theories of migration help elucidate how people make the decision to stay or relocate, how migratory flows continue after they have begun, as well as who has the agency, or choice, to migrate (Massey et al. 1993; de Haas, 2021). International physician migration and the movement of other highly skilled professionals in regulated professions presents a unique case that requires special consideration within these broad theoretical frameworks, particularly as it highlights the tension between individual choice and best interest, and the structural constraints migrants come up against. When it comes to voluntary migration, as is generally the case for highly skilled labour migrants, theories of migration initiation posit that people move in pursuit of their own and their families' best interests (Massey et al. 1993; de Haas, 2021). Migrants often continue to move until they have found the right fit (White and Lindstrom, 2005). For many labour migrants the problem is that achieving what you came for is not always straightforward, but often complicated by professional regulation and other means that limit the work people can do (Ostrovsky et al., 2011). Furthermore, Canada as a receiving state targets immigration policy to address labour or population shortages, often targeting highly educated migrants for positions

and sectors where Canadians are unwilling to work (Massey et al. 1993; Ostrovsky et al., 2011). The outcome of this policy framing often results in a mismatch between immigrant's individual aspirations and labour demands. Jenkins (2020) found this to be the case for IMGs in the United States, where more prestigious positions were reserved for American educated physicians.

To understand how place and professional prestige shapes South African educated physicians' decisions to stay in rural Alberta, I conducted 29 semi-structured interviews with physicians in family or general practice in Alberta. This qualitative research was guided by abductive grounded theory, a methodology that encourages theory building and contributions to ongoing theoretical and empirical conversations and debates (Timmermans and Tavory, 2022).

Literature Review and Theoretical Framework

To understand and contextualise the problem of South African educated physicians' retention, I draw on diverse theories and lines of empirical research. First, I discuss migration theories and migration decision making process. I then turn to work that details IMGs as a policy solution to the rural physician shortage in Canada and review literature on rural physician attraction and retention, orienting it towards migration theory. Finally, I conclude with what is known about professional mobility in medicine. Together, the components of this theoretical framework create a foundation to explore how physicians' migration, aspirations and capabilities are linked to whether a physician is retained.

Migration Theory

Migration theories help to explain patterns in migratory flows by exploring how people make the decision to relocate, how migratory flows continue after they have begun, as well as who and how the choice to migrate is available to and under what circumstances (Massey et al. 1993; de Haas, 2021). Massey et al. (1993) summarized prevailing theories of migration, which continue to influence how migration is studied. The review identified two main currents: theories

that explain the “initiation” of a migratory stream and theories that explain “the perpetuation” of migration streams. Theories of initiation entail primarily economic explanations. Micro-level initiation theories highlight the cost-benefit analysis of people migrating in search of higher income, with a macro-level outcome of migration from a lower income to higher income nations. Theories of perpetuation suggest that the decision to migrate is birthed in more than economics. More specifically, migration may also be conceptualised in light of how a migrant’s social network may reduce some migration associated costs (i.e., social support, temporary housing, employment), how agents and recruiters assist migrants, and how migration contexts change as streams mature to induce further migration.

Adding to these established theories, de Haas’ (2021) more recently re-envisioned migration theory, introducing an aspirations-capabilities framework. de Haas (2021) began with the assumption that migration and geographic immobility, or going and staying, were equally reasonable choices depending on the person. The difference in who left and who stayed was someone’s aspiration and/or capability to migrate, the criteria of which point to structural factors in tandem with individual choice. Simply put, aspiration, or the desire to migrate is a product of someone’s cultural and social capital, and to some extent financial resources. Capability describes access to the resources, often money, education or occupational skill, that would ultimately enable someone to be able to migrate and exercise their full agency. People with access to fewer resources were understood to be generally immobile because they lacked aspirations and/or capabilities, while higher socioeconomic status may lead someone to stay because aspirations and comforts were more likely to be realised at home than internationally (de Haas, 2021). Although much of what makes aspiration and capability possible is related to status,

it receives minimal mention in de Haas' (2021) work and is not imbued with significant explanatory power for migration.

Some of the tension between individual choice and structural constraints in migration may be attributed to migration regimes and migration control. While most migration theories are directed towards the receiving nation, Lee's (2017) accommodating, facilitating, and directing sending state regimes conceptualise the role of the sending state in directing, influencing, and responding to migratory flows respectively to best meet their nations interests by how they craft various domestic and international policies. Within the receiving state, Triandafyllidou (2016) and de Haas et al. (2018) proposed that immigration has not become more restrictive or interested in limiting or reducing the number of immigrants, but rather more selective in managing who may enter and on what terms. The receiving states selectivity is implemented through immigration policy and practices, in addition to policies and practices around work and professional governance. These multi-level and layered policies and practices have implications for IMGs and the work they are able to do (Jenkins, 2020).

Some theoretical approaches to migration focus specifically on the migration of professionals. Encapsulated in the literature on the sociology of professions, highly skilled labour migration is largely viewed as a matter of international supply and demand where countries compete for workers to promote their own economic development (Iredale, 2001; Adams, 2018; Triandafyllidou, 2022; Czaika and Parsons, 2017). Labour migrants are often used on a temporary basis to fill long term labour shortages (Liu, 2019; Siar, 2013). The situation is more complex for those seeking work in regulated professions. This is the case when it comes to healthcare, as not only is an immigrant's ability to work in healthcare a matter of meeting federal immigration criteria, but also meeting the demands of professional regulators (Salami et al.,

2018). Furthermore, deskilling is both racialized and gendered, people of colour and women experiencing economic disenfranchisement or deskilling differently than men (Liu, 2019; Creese and Wiebe, 2012; Salami et al., 2018).

While together Massey et al. (1993) and de Haas (2021) paint a rich picture of the where, and why of migration, they differ in whether migration is a one-time move across national boundaries or if geographic mobility is more fluid. Migration is often complicated as people internally migrate within the receiving country, make repeated moves between the sending and receiving country (circular migration), and sometimes permanently return (Constant, 2019). In order to understand the decision to stay in a rural area, we must understand the full range of mobility and the reasons someone would choose to leave more broadly. Internal migration refers to local migration “within...(or) between labor markets,” as is the case when someone moves between Canadian provinces, from a rural community to a city, and less often, between rural communities (White and Lindstrom, 2005). Internal migrations are generally attributed to better employment opportunities elsewhere (White and Lindstrom, 2005; King and Skeldon, 2010). Circular migration refers to repeated temporary, voluntary migration between the sending state, receiving state, and a potential third country (Crush et al., 2012; Labonté et al., 2015; Constant, 2019; Constant, 2020). Circular migration may occur as “...a form of corrective migration due to unmet expectations...” or as a benefit-maximising strategy (Constant, 2019). The decision to return may be planned or unplanned (Triandafyllidou, 2022). Return may be considered a measure of success for migrants who met their goals, or of failure for those unable to accomplish goals due to a ‘miscalculation’ of costs and benefits (Cassarino, 2004; de Haas and Fokkema, 2011; de Haas, 2021).

As internal, circular, and return migration demonstrate, migrations are not always one-off, or simple, uni-directional moves that should be treated as separate and distinct events. Instead, migrations are part of a broader trajectory that should be conceptualised holistically and positioned within the life course (Impicciatore and Panichella, 2019; Schapendonk and Steel, 2014). The decision to migrate is made alongside other life course events, such as decisions around education, employment, and family. However, migration is not just a response to life course events, but life course events, in turn, shape the who, when, where and why of migration. A life course or trajectory perspective on migration “...implies a methodological shift from investigating migrants’ position in places towards the following of migrants through places” (Schapendonka et al., 2020).

The final theoretical consideration is how people make decisions about their migration destination. Czaika et al. (2021) and Lee (1966) pointed out that people usually do not have enough information about their destination to make a fully informed, rational decision, but instead base their choice on perceptions. Yet, migration is not random as “most migrants move along spatially clustered pathways between very particular communities in origin and destination areas” (de Haas, 2021; Triandafyllidou and Gropas, 2014). But these pathways change over time, varying with the economy and social networks (Masferrer and Roberts, 2012). Triandafyllidou and Gropas (2014) found that Greeks migrating to Europe did not consider one destination country, but a series of European destinations. Preferred destinations had access to job opportunities, a fair income, quality of life, and language. When it came to deciding on a specific international or internal destination, people were swayed by “more liberal regulations” and international entry routes that posed the fewest barriers (de Haas et al., 2019). Studies on Canadian provinces and similar research found that immigrants usually decide to migrate to

major urban centres, are influenced by high income earning potential, and low unemployment rates (Newbold, 1996; Ostrovsky et al., 2011; Ramos, 2018). Similar to economic based international migration theory, it appears people select the place that best maximises benefits, minimises costs, and corresponds most closely to their aspirations and capabilities. In Canada, this has most often been in urban centres, not rural and remote communities.

Rural Physician Shortage

Rural communities are desperate for physicians to make the decision to stay. Canadians across the country are unable to find a family doctor and it is estimated that almost a quarter of Albertans, some roughly 800,000 people, do not have a family doctor (Fleming and Sinnott, 2018; Roquette, 2023). The majority of those without access to a family doctor in Alberta live in a rural area. For decades, the number of physicians in Canada has increased, but the proportion of physicians who practise in rural communities has decreased (CMA (b), n.d.; McDonald and Worswick, 2012). Numerous researchers have used their scholarship to advocate for rural communities to attract and retain physicians through work that strives to understand the shortage in order to resolve it and introduce stable, suitable rural staffing and service levels (Pylypa, 2013; Joudrey and Robson, 2010; Grant, 2006; Groutis and Arnold, 2012; Bidwell et al., 2014; Grant and Oertel, 1997). Health authorities have implemented solutions that range from preferential billing codes for rural areas, financial incentives for rural medical students, new contract signing bonuses, and increased professional support (Barer and Stoddart, 1999; Barer and Webber, 1999). Despite little progress towards the resolution of this shortage, these measures continue to be offered as solutions. Beyond these policies aimed at making rural medical practice more attractive, arguably the policy with the most significant impact on the rural physician shortage has been a shift to reliance on IMGs. Alberta in particular has increasingly come to depend on

IMGs. The proportion of IMGs in the province increased from 25% in the early 2000s to 35.5% in 2020 (Benarroch and Grant, 2004; CMA, n.d.; CPSA, 2020).

The consequences of the physician shortage are felt on multiple levels from growing wait times, poor health outcomes, as well as in high levels of physician burnout and even an exodus from the profession as part of “the great resignation” (Kiran et al. (a), 2022; Kiran et al. (b), 2022; Lee, 2023; CMA (a), 2022). Burnout, or the “emotional exhaustion” that occurs when “demand is perceived as exceeding individual resources,” is primarily used to describe occupational stresses, although personal stresses may compound burnout (Varpio et al., 2018; Amofo et al., 2015; Lemire, 2018; Amofo et al., 2015). Physicians have been found to experience higher rates of burnout than other professions, family medicine being one of the highest burnout medical specialties (Varpio et al., 2018; Weidner et al., 2018). These high rates of burnout have been proposed to result in physicians reducing their hours, clinical scope, or leaving medicine altogether (Lemire, 2018). Due to unique stressors, rural family physicians experience burnout differently than their urban counterparts (Hansen et al., 2021). Subspecialised family physicians who provide inpatient care and obstetric services were found to be less likely to experience burnout (Weidner et al., 2018). Research on IMG burnout and mental health found IMGs to be less likely to experience burnout (St. Onge et al., 2022; Al-Haddad et al., 2023). Despite conflicting findings on the incidence of burnout amongst family physicians in Canada and the infrequency of IMG burnout, burnout should be considered in the creation of policies and practices intended to attract and retain IMGs who practice family medicine.

As important as it is to ask why South African educated physicians chose Canada and to consider these physicians’ perspectives in attraction and retention, it is also important to ask why Canada chose them. Indeed, provincial medical regulators have a (intermediate) preferential

recognition of South African medical credentials (Grant, 2006). The migratory stream of South African educated physicians to Canada did not arise spontaneously but emerged due to active recruitment campaigns to attract them, including Canadian health authority representatives traveling to South Africa and placing ads in medical journals (Grant, 2006). South Africans were generally selected for their English language skills, similar (post-)colonial medical education, and an awareness that many South African's were looking to escape the country in the years surrounding the legal end of Apartheid (Grant, 2006; Joudrey and Robson, 2010).

Given that early Canadian recruitment campaigns ran in the midst of a health crisis in South Africa, the South African government resisted the efforts of Canadian medical recruiters, but their requests to stop went largely unheeded (Rogerson and Crush, 2008; Labonté et al., 2010). Continued recruitment appears to be a highly effective means to recruit South African educated physicians and has played a significant role in shaping migration at both the international and provincial levels. Given decades of active recruitment campaigns and the formation of a migratory stream, the number of South African educated physicians in Canada has grown to exceed the number of physicians educated in any other country outside of Canada (CMA (a), n.d.). Conversations about the ethics of international recruitment continue (Walton-Roberts and Borgeault, 2023).

Although this migratory stream began some 50 years ago, the number of South African physicians in Canada quadrupled between 2000 and 2019, increasing from 602 to 2,454 (Grant, 2006; CMA, n.d.). Grant (2006) found that the number of physicians arriving in Canada around 2000 was almost double that of the early 1990s and attributed this difference to the effectiveness of active recruitment versus the push of Apartheid. Many South African physicians went to the Prairie provinces, including Alberta (Grant, 2006; Joudrey and Robson, 2010). Publicly available

data from the CPSA (n.d.) showed that 1,008 South African official language speakers (not English) were registered in 2022, 92.9% of whom spoke Afrikaans. 13% of physicians “outside of Edmonton and Calgary” and one third of all physicians in AHS’s North Zone trained in South Africa (Fournier, 2023). Yet, recruitment continues to play an important role in leading South African educated physicians and other healthcare professionals to Alberta (Babych, 2022; GOA (b), 2023). In 2023, the Alberta Government publicly and vaguely referred to exploring “international options,” while adopting “international recruitment campaigns” that target healthcare professionals from countries that include South Africa (GOA (b), 2023; GOA (c), 2023). They have placed ads with an international recruitment organisation (MCG, n.d.).

When it comes to what is known about who the South African physicians coming to Canada are, there are some common migration motivations and demographics, documented predominantly in a descriptive body of literature on ‘push and pull’ factors. Predominant emigration motivations include crime and poor working conditions (Arnold, 2011a; Grant, 2006; Labonté et al., 2006; Klein et al., 2009; Joudrey and Robson, 2010; de Haas, 2014). Historically, most South African physicians who migrated to Canada have been white and the majority of research about South African physicians in Canada speaks to the experiences of white physicians (Tankwanchi et al., 2013; Arnold, 2011a; Joudrey and Robson, 2010; Dambisya, 2003; Bidwell, 2014). More broadly, emigration from South Africa is often discussed as a matter of ‘white flight’ or as a racialized ‘brain drain’ that entails white physicians capitalising on racial economic privilege (Arnold, 2011 (a and b); Ragurham, 2009). Accordingly, South African physicians of colour are often excluded from the conversation and assumed to be immobile.

Participants’ medical school, sex, and age also help to shed light on the migratory flow. Research conducted in the 1990s suggested graduates of historically English medical schools

were most likely to be abroad, but more recent research found emigrating physicians to be more evenly divided between English and Afrikaans institutions (Weiner et al., 1998; Arnold (a), 2011; Van der Vyver and DeVilliers, 2000). Physicians from new or historically Black universities remained underrepresented. In terms of demographics, the majority of South African physicians continue to be men (CPSA, n.d.; Grant, 2006). The average age of physicians has decreased from the early to mid-forties to the late twenties and thirties (Arnold, 2011a; Van der Vyver and DeVilliers, 2000).

Rural Physician Attraction and Retention

Communities work incredibly hard for an IMG to choose to practice in their community. In large part, rural communities are made responsible for what is perceived as their individual failure to attract and retain physicians, instead of holding the provincial government accountable to provide “reasonable access” to “medically necessary” health services (Han and Humphreys (a and b), 2005; Cameron et al., 2010; RhPAP, 2019; Canada Health Act, 1985; GOC, 2011; GOA (a), n.d.; GOA (b), n.d.; GOA (a), 2023; AHCIA, 2000). Yet communities are not only made morally responsible for physician attraction and retention, but also financially responsible. Across Alberta, communities are investing tens, if not hundreds of thousands of dollars on physician attraction and retention incentives, building new healthcare facilities, and even owning and operating family practice clinics to cover overhead costs and reduce the entrepreneurial and administrative burden (Bay, 2022; Dalmar, 2022; Dubois, 2022; Cowley, 2022; Bellefontaine, 2023). Should a new CPSA proposed direct physician sponsorship model pass, even more responsibility would be placed in communities’ hands (CPSA (b), 2023). Accordingly, many research findings lead to suggestions, recommendations, guidelines, and insights into how rural communities could go about doing a better job.

The physician attraction and retention literature has identified a number of reasons why physicians are not interested in rural practice: (lack of) employment for spouses, a lack of amenities and privacy, opportunities for children, and more importantly, the demands and challenges of rural practice (Miedema et al., 2009; Cameron et al., 2010; Cosgrave, 2020; Gorsche and Woloschuk, 2012). Practice preferences, workload, access to support and resources, and relationships with colleagues all had the potential to contribute positively or negatively to physician satisfaction and retention (Cosgrave, 2020; Gorsche and Woloschuk, 2012). Increased rural income only appeared to have a small impact on younger physicians' choice, who were understood to only be interested in rural practice if they had grown up in a rural community or been 'exposed' to rural medicine during their medical education (Yang, 2003; Asghari et al., 2020; Cameron et al., 2010; Miedema et al., 2009; Scott et al., 2011). These reasons seem to provide little guidance on how to proceed and exactly how they are useful in informing rural physician attraction and retention is unclear.

The physician attraction and retention literature and de Haas' (2021) framework offer two contradictory understandings of retention. On the one hand, the physician attraction and retention literature assume retention is indefinite rural practice. On the other, de Haas' (2021) aspirations-capabilities framework conceptualises retention as a migration or mobility related decision. Just as someone might opt to leave a rural community, they might elect to stay. The difference being that mobility is not a static decision that is contingent on someone's happiness in a place, but their ability and/or capability to aspire and respond.

Stratification in the Medical Profession

It is worth taking a step back to understand what is known about IMGs geographic and professional mobility. There is a consensus that IMGs fill less prestigious family medicine positions in underserved rural communities, but for several years this outcome went without an

explanation (Labonté et al., 2006; Becker, 2022; Blacklock et al., 2012; McGrail et al., 2012; Hammett, 2013; Curtis and Dube, 2015). Jenkins (2020) pushed to expand the conversation to broader stratification within the medical profession. She found that IMGs in the United States must repeatedly prove their competency through a rigorous, complex, and multi-step process that takes years and thousands of dollars to complete, justified in the name of patient safety, but IMGs and their credentials remain untrusted (Jenkins, 2020). Residency programs would rather admit lower scoring candidates from known, but less prestigious institutions than high scoring IMGs. Furthermore, in addition to medical knowledge, IMGs must also prove their cultural competence, or their ability to act and behave in culturally acceptable ways with patients and colleagues (RhPAP, 2022; Clemens and Pettersson, 2008; Costae et al., 2018; Norman et al., 2014). These softer skills are often mandated and disguised as professionalism criteria. This highlights how the medical profession is stratified along multiple lines: education (i.e., South Africa versus Canada), place (rural versus urban), and within and between medical specialties. While we know IMGs are more likely to end up in rural practice, the implications on their professional mobility are unclear.

Understanding stratification within a medical speciality is useful to understand the relationship between South African and Canadian family physicians and how stratification extends along multiple lines. Jenkins (2020) has done exceptional work in understanding mobility and prestige in the medical profession. Years of ethnographic fieldwork amongst internal medicine residents at an academic and community hospital in the United States found that not only are some specialties more and less “IMG friendly” or accessible for IMGs to match into, but that whereas IMGs match into less competitive, less prestigious programs at community hospitals, more competitive and prestigious residency positions at academic teaching hospitals

were reserved for US medical graduates (Jenkins, 2020; Jenkins et al., 2019; Jenkins, 2018).

While family medicine is an “IMG friendly” specialty, it is also incredibly broad. The breadth of family medicine suggests there are a number of ways it could be stratified. Furthermore, we do not know what the implications of practicing a lower prestige specialty are.

Along these lines, but on a broader scale, the literature on highly skilled immigration has identified that some migrants are professionally deskilled (Ostrovsky et al., 2011; Creese and Wiebe, 2012). Deskilling refers to a migrant’s lack of economic integration and/or their downward professional mobility (Creese and Wiebe, 2012). Common forms of deskilling include jobs that require local experience or fail to recognize international credentials, thereby forcing migrants to accept positions they are overqualified for if they are to participate in the labour market. This is problematic as the highly skilled migrants selected by the Canadian immigration system on the basis of their perceived economic contributions are often relegated to fill positions that underutilise their skills and offer little room for advancement (Iredale, 2001; Adams, 2018).

However, as noted previously, stratification in the medical profession extends beyond an IMG/Canadian educated physician divide. Research offers some insights into why Canadian educated physicians are disinterested in choosing family medicine. Not only does it lack prestige compared to other medical specialties, it is also highly demanding and the lowest remunerated of the specialties (Scott et al., 2007; Vanasse et al., 2011; Collier (b), 2011; Beaulieu et al., 2008). Specialising in family medicine is often assumed to be a “back up” choice for medical students with less competitive applications, despite family medicine being the first choice in the majority of matches (Woloschuk et al., 2017; CaRMS, 2014). Strong applicants who expressed an interest in family medicine were viewed to be “limiting oneself” and directed towards more prestigious and competitive specialties (Scott et al., 2007). While family medicine held some personal

appeal, such as the ability to build patient relationships over the years, more structural causes like family obligations, need for an income, and coming from relatively lower socioeconomic status families, seemed to lead students to family medicine (Beaulieu et al., 2008; Scott et al., 2007; Collier (a), 2011; Scott et al., 2011). Canadian educated physicians who do specialise in family medicine are increasingly found to pursue additional training in order to offer focused family practice subspecialties that provide some of the benefits of more prestigious specialties (Collier (b), 2011; AlAteeq et al., 2020; Collier (a), 2011).

Physicians and the Covid-19 Pandemic

The recent Covid-19 pandemic has undoubtedly had a huge impact on migration and professional mobility. In addition to “...an often unmanageable workload, lack of personal protection equipment, distressed patients, fake news...” reduced incomes, and an uncertain future, doctors were often left to cope alone (Benson et al., 2022). Physicians have reported burnout, struggling with mental health, unhappiness with their work, and that they are likely to retire early, take multiple breaks, or leave medicine altogether (Kiran et al. (b), 2022; Kiran et al. (a), 2022; Johnson et al., 2023; Snelgrove et al., 2022). Early research and organisations that represent physicians have suggested that the pandemic experience was harshest for rural physicians who went without the resources and service redundancies available in urban centres (Anaraki et al., 2022; AMA, 2023; CMA (b), 2022). Rural physicians’ collective action, protest, and resignation were often ignored and denied (CBC News, 2020; Pearson, 2020).

Research Contribution

Given rural communities struggle to attract and retain physicians, the use of South African educated IMGs as a policy solution to address the rural physician shortage, and stratification within the medical profession, the role of geographic mobility in determining these physicians access to professional mobility is unclear. My research questions work to understand

the relationship between geographic and professional mobility in order strengthen rural physician attraction and retention, along with the needs and interests of South African educated physicians. This research is timely as rural physicians and communities need help now more than ever to sustain the delivery of rural health services. Rural healthcare needs physicians to stay.

My research will inform the ongoing search for solutions to the rural physician shortage by engaging a core group of physicians with experience in rural communities – South African educated physicians. Understanding South African educated physicians’ migration and mobility experiences in rural Alberta contributes to research on high skilled migration, professional status hierarchies, and migration theory, which are critical to informing policies that will allow physicians to make free and informed decisions about rural practice.

In regard to migration related contributions, research findings go beyond the traditional cost-benefit analysis and extends de Haas’ (2020) aspirations-capabilities framework to rural physician retention. Findings add to the literature on physician attraction and retention by suggesting that prestige plays an important role in shaping related migration decisions. This research lays a theoretical foundation for how destination decisions are made, along with the explanatory power of migration theory at the international, provincial, and community level. While it is understood that IMGs have been relegated to rural family practice, this research identifies the social mechanisms that make this possible, along with describing why and how some opportunities are within or outside of a South African educated physician’s reach.

Chapter 2: Methodology

To understand how geographic and professional mobility shape South African educated physicians' attachment to rural communities, I conducted semi-structured interviews with physicians. Throughout interviews I explored how physicians made the decision to relocate from South Africa to Alberta and the factors that influenced their decision to continue to practice in a rural community. I spoke with 29 South African educated family or general practice physicians who had practiced across Alberta. Participant interviews were analysed around themes of migration trajectories and professional mobility that ultimately led to the development of strong explanations for the questions at hand. I now turn to a more technical discussion of the methodological theory and process.

I used qualitative research methodology and methods, namely abductive grounded theory and semi-structured interviews, to answer research questions regarding how South African educated physicians make migration decisions and examine the interconnectedness of professional and geographic mobility. Migration and professional mobility are two very dynamic processes best understood through a life course trajectory approach, rather than as a singular event confined to a distinct period. Qualitative research methodology is particularly well-suited to examine these dynamic trajectories.

Abductive grounded theory falls under the umbrella of qualitative methodology. Abductive grounded theory is a modified, modern, and flexible conceptualisation of Glasser and Strauss' (1967) grounded theory (Deterding and Waters, 2021). Grounded theory was conceptualised to construct theory from the ground up, relying on a strong commitment to "...theoretical sampling toward saturation, strong inductive analysis, and full immersion in the research field..." Grounded theory findings should be entirely self-grounded and stand alone.

Abductive ground theory departs from grounded theory in that it is not entirely inductive, nor entirely deductive (Deterding and Waters, 2021). Abductive logic lands somewhere between deriving findings purely from the data, as is the case in inductive research, and wholly measuring research findings against selected pre-existing theory, as done in deductive research.

Accordingly, abductive researchers are encouraged to be “sensitised” to relevant research from the outset (Deterding and Waters, 2021; Timmermans and Tavory, 2022). Where grounded theory contributes new theory, abductive grounded theory research findings make new and surprising theoretical contributions by adding to pre-existing work and creatively engaging with ongoing conversations (Timmermans and Tavory, 2022). Abductive grounded theory uses ‘how’ questions to understand the processes that are these new and surprising contributions.

Accordingly, I selected abductive grounded theory for its orientation to and interplay with pre-existing theory, and openness to surprises or new findings and interpretations (Timmermans and Tavory, 2022).

Abductive grounded theory does not specify a number of interviews that guarantees saturation, but notes that the number of interviews required is highly specific to each research project (Deterding and Waters, 2021). I set out to conduct 20 to 25 semi-structured interviews with South African educated physicians, or to continue interviewing until saturation was achieved or all participant recruitment avenues had been exhausted. Semi-structured interviews are a method used to assemble theory and collect rich data shared through personal accounts, where the primary data interest is the verbal content (Creswell, 2013; Sandelowski, 1991; Rinaldo and Guhin, 2022). These interviews provided the balance needed to ask questions intended to answer the research questions, which were developed in relation to existing theories,

while giving participants space to answer in a way that let them lead the conversation in unexpected directions (Sandelowski, 1991).

I conducted 28 interviews with 29 South African educated physicians. Interviews began with questions about how participants made the decision to go to medical school, followed by a series of questions about how they made the decision to leave South Africa, how they decided on migration destinations, as well as their thoughts, experiences, and reflections on their practice (Appendix A). The complete interview schedule is located in Appendix A.

All interviews were conducted virtually over Zoom, ranging from 45 minutes to 2.5 hours, averaging roughly 70 minutes. One dual-physician couple was interviewed together. One interview was conducted in two parts, while all others were conducted over one meeting. Repeated themes and ideas emerged and developed, which led me to conclude that saturation was achieved (Sandelowski, 1995). While I conducted and analysed interviews on an individual basis, the interviews captured one very important example of South African educated physicians collective group experience (Rinaldo and Guhin, 2022).

Participant Inclusion Criteria

At the research outset, physicians were eligible for participation if they received their medical education in South Africa, had immigrated to Canada, and had practiced medicine as a general practitioner or family medicine specialist in rural Alberta for six months or more. A rural area was defined as any community apart from the seven census metropolitan area's (CMAs) and census agglomeration's (CAs) in Alberta (i.e. outside of Medicine Hat, Lethbridge, Calgary, Red Deer, Edmonton, Grand Prairie, and Fort McMurray) (Statistics Canada, 2022). CMAs and CAs refer to the spatial distribution of population size and require a threshold population "core" surrounded by a less dense population (Statistics Canada, n.d.). These population defining

measures may be understood in relation to AHSs Administrative Zones that have a CMA or CA in each Zone (Figure 1).

These initial criteria were selected to highlight the role of education and credentials in migration and reflected the dominant discourse that IMGs, physicians from South Africa in particular, were a solution to the rural physician shortage and only permitted to work in rural communities upon entering Alberta (Joudrey and Robson, 2010). Research was focused on general practitioners and family physicians due to Canada's regionalized healthcare system where family physicians offer the bulk of services in rural communities, the earlier noted discourse around the immigration, or 'import'



Figure 1: A map of Alberta Health Services Administrative Zones. Source: Rudmik et al., 2015.

of South African physicians to address rural physician shortages, and the reality that IMGs are more likely to practice family medicine than another speciality (Joudrey and Robson, 2010; Jenkins, 2020). However, as research progressed and new information and cases regarding South African physicians' immigration to Alberta were brought to my attention, participant inclusion changed slightly. In particular, while most participants fit the original criteria, three did not. One participant initially arranged to practice in rural Alberta, but the agreement fell through shortly before his arrival. He subsequently ended up practicing in two other provinces, but never in Alberta. A second participant moved from a rural community in another province to a regional centre in Alberta when he had not yet obtained general medical registration. The third participant

migrated directly from South Africa to an urban centre in Alberta via clinic sponsorship. While exceptions, I included these cases as they add a rich analytical complexity around the relationship between migration and professional mobility and challenge the prominent rural physician shortage discourse.

Participant Recruitment

Access to this highly specific group required creative solutions including clinic contact, personal contacts, contacting University of Alberta and University of Calgary Clinical and Associate Lecturers, snowball sampling, and engagement with professional associations/social media. Contacting physicians at their private family practice clinic proved the most fruitful recruitment means. I identified eligible participants via the ‘find a physician’ feature on the CPSA ((a), n.d.) website, which listed clinic contact information. In most cases I called the clinic, briefly explained the research to the receptionist and requested an email address where a poster and information letter could be sent. While many receptionists were willing to help, others were sceptical and preferred information be faxed or outright refused to share the information. In some exceptional cases when an email address was available on the clinic website, I contacted the clinic directly. In total, 85 clinics in rural communities and 123 clinics in Alberta’s CMAs and CAs were contacted in this fashion. I generally made contact with additional clinics every week between September 1, 2022, and December 2, 2022. A follow up message was sent two to three weeks following initial contact if a response had not been received from a physician at a particular clinic or if a clinic did not confirm forwarding research details. In some limited circumstances when a physician could not be reached at their clinic, I sent a private, professional Facebook message. In total, 15 of 29 participants were recruited in this way.

Other means of recruitment included personal contact and contact via the University of Alberta and University of Calgary. I had established personal contact with several South African educated physicians prior to research commencement, of whom five consented to participate. Seven of my friends and colleagues agreed to share the research poster on their social media and/or to introduce me to another colleague. This resulted in one interview. A number of South African educated physicians are employed by the University of Alberta and University of Calgary Family Medicine Departments as Clinical or Associate Lecturers and work with Canadian medical students on placements. 65 emails were sent to physicians in this capacity, which resulted in one interview.

Similar qualitative research has relied heavily on snowball sampling to access busy migrant healthcare workers (Wojczewki et al., 2015; Dahlke and Stahlke, 2019; Bidwell et al., 2014; Bezuidenhout et al., 2009). At the end of most interview's participants were asked if they knew anyone they thought might be interested in participating. A number of participants agreed to pass details along, requested permission to share details, or explained they had already forwarded research details to several friends/colleagues. These introductions resulted in three interviews. It is unclear if two interviews were the result of snowball sampling or clinic contact.

I contacted the following professional associations via publicly available contact information or with a kind introduction from a research committee member: The Black Physicians Associations of Alberta, RhPAP (Rural Health Professions Action Plan), CPSA, Alberta Medical Association, Society of Rural Physicians of Canada, Alberta College of Family Physicians, Alberta International Medical Graduate Association, Black Physicians of Canada, and the Canadian Association of Nigerian Physicians and Dentists. Four associations generously

shared research information on their social media, in a newsletter, or with a personal contact. This avenue resulted in two interviews.

Several attempts were made to engage with the South African community in Alberta. Permission was obtained to share a research poster in the ‘South Africans in Calgary (meetup and advice)’ and ‘South Africans in Edmonton’ Facebook pages. The same research poster was delivered to two South African stores in Edmonton, Alberta. I do not attribute any interviews to these means of recruitment. Participant recruitment was carried out in compliance with research ethics approval, which mandated that I could not contact physicians via any AHS facilities or staff.

Data Analysis: Transcription and Coding

I transcribed interviews verbatim within one to two weeks following the interview. Analytical, personal, and methodological memos were made throughout the interview and transcription processes to identify emerging themes and track shifts in the analytical process. Immediately following each interview, I memoed what had been done in preparation for the interview, what I had known about the participant prior to the interview, any conversation or logistical issues that occurred prior to the start of recording, the social setting or rapport, what was visible of the physical setting, any conversation that took place after recording stopped, and any immediate analytical memos at the top of mind. Analytical memos developed throughout the three months of interviewing, contributing to the codes and categories that were the earliest versions of the ideas behind the findings discussed (Deterding and Waters, 2021).

I used open-thematic coding to analyse interview data using NVIVO (released in 2020) software. I followed the coding principles outlined by abductive grounded theory, which suggests coding should move from broad themes to more focused codes (Deterding and Waters,

2021; Timmermans and Tavory, 2022). Following this logic, coding progressed from early descriptive codes to more substantial analytical codes throughout analysis. At its core, coding is intended to reduce data into manageable and meaningful units of analysis through a process of “defamiliarization by isolating observations” and “refamiliarization by putting observations in dialogue with each other and your ongoing reading” (Timmermans and Tavory, 2022).

Accordingly, the abductive codebook initially developed around the research questions, but progressed into a robust, largely specific, analytical codebook that supported two emerging themes, migration and professional mobility (Deterding and Waters, 2021). Codes were applied to chunks of text in an attempt to ensure as much meaning and context were preserved as possible (Deterding and Waters, 2021; Campbell et al., 2013). Several lines or chunks of text were coded to several codes to ensure the meaning was captured as fully as it was meant by the participant (Campbell et al., 2013). Interview data was compared to that of other participants in order to identify and generate insight from similarities and differences, particularly in relation to participant gender, race, and family status (Corbin and Strauss, 1990).

Validity Checks

I applied two qualitative validity checks, descriptive and interpretive validity, to ensure that I accurately captured exactly what participants said and came as close as possible to understanding and communicating what participants meant or intended to communicate (Maxwell, 1992). Descriptive validity measures deployed include verbatim transcription and continued interviewing until saturation. Interpretive validity measures strengthened research findings by introducing measures intended to accurately represent participants’ experiences and the meaning behind what was said during an interview, as well as aiding the inclusion of a strong participant voice (Creswell and Miller, 2000; Mays and Pope, 2000). Disconfirming evidence,

memos and rich description were used as four means of interpretive validity (Creswell and Miller, 2000). I actively sought out and included incidents of disconfirming evidence to ensure a series of experiences and outlooks were represented. Examples of disconfirming evidence include: interviewing 3 participants who did not fit the initial participant inclusion criteria, recruiting participants who practiced in rural and urban settings, and sharing conflicting perspectives when participant views and experiences differed. Findings below are presented alongside rich demographic descriptions of participants to provide readers with information and context they need to make their own credibility judgement (Creswell and Miller, 2000).

Ethics

I obtained research ethics approval (Pro00122607) from the University of Alberta, Research Ethics Review Board 1. The Canadian Tri-Council Policy Statement stresses three core ethical principles, respect for persons, concern for welfare, and justice, that guided research design (TCPS2, 2018). I adhered to these principles throughout the research process. Prior to participating, I provided participants with a letter of information that described the research, the types of interview questions to expect, and consent (Appendix B). Participants had an opportunity to ask questions before agreeing to be interviewed, before the interview recording began, and at the end of the interview. Prior to recording the interview, I reminded participants that the interview was confidential between us, that they were free to withdraw, and that they were welcome to share as much or as little as they would like. All participants gave paper or verbal consent. No one opted to skip a question or to withdraw from the study. A copy of the consent form is located in Appendix C.

While the perceived risk of harm to participants was low, the many challenges of migration and medical practice did not go unappreciated. Most participants appeared to enjoy the

conversation/interview, along with an opportunity to openly share the many challenges, frustrations, successes, and joys they had experienced along the way. No incidents of participant harm, emotional or otherwise, caused by the interview were reported. Regular check-ins with my supervisor and self-care practices helped me to manage any research related stress.

I stored interviews and participant data on my password protected computer. Participant names and place identifiers were removed from the transcript. Participant descriptions and quotes are not presented with any identifying information in order for participants to maintain public anonymity and confidentiality in the research process.

Researcher Positionality and Research Philosophy

At the interview end, when participants were asked if they had any questions about the research or if they wished to make any concluding remarks, it was common for participants to ask what had motivated the research or how the interest had developed. I always explained that the curiosity was born while I worked as a Primary Care Paramedic in rural communities and had encountered a number of South African educated physicians. Other times, participants asked if I had grown up in a rural community or assumed I was a “city slicker” as I was open about living and studying in Edmonton, Alberta. Not only did the answers to these questions matter to participants, but so did the other statuses I occupied, such as my race, gender, graduate student, and citizenship status. My social positioning and life experiences were influential to the way I conceptualised the research problem and sought answers. My work and rural upbringing uniquely positioned me to be aware of the tension between healthcare worker agency and a rural community’s struggle to attract and retain healthcare workers. As a white researcher, I can reasonably assume that the white participants who made racist comments about their emigration motivations might not have been shared had I been a person of colour. While the extent and

impact of my gender, graduate student status, and Canadian citizenship cannot be quantified, it is important they are identified. I felt like an equal alongside participants as someone with a university degree and security of citizenship.

Returning to my earlier research philosophy, I believe research was undertaken collectively and that knowledge construction was shared, particularly as participants brought up some topics most important to them and I made a strong effort to present participants perspective when my own differed (Welikala, 2007). It is my intent that the findings and discussion to follow are respectful of participants and those they spoke of, mindful of South African educated physicians' agency, while they also challenged and contested popular modes of meaning and common ways of thinking. I reserved responsibility for the direction and interpretation of research findings (Deterding and Waters, 2021).

Participant Demographics

Table 1 Participant Demographics - General

| Category | Frequency (n=29) | Percentage (%) |
|---------------------------|---------------------|-------------------|
| Sex | | |
| Female | 10 | 34.5 |
| Male | 19 | 65.5 |
| Current Age | | |
| 20-29 | 0 | 0 |
| 30-39 | 10 | 34.5 |
| 40-49 | 8 | 27.6 |
| 50-59 | 9 | 31.0 |
| 60-69 | 1 | 3.5 |
| 70-79 | 1 | 3.5 |
| Race and Ethnicity | | |
| White | 23 | 79.3 |
| Afrikaans | 19 | 65.5 |
| English | 4 | 13.8 |
| Black | 1 | 3.5 |
| Indian-Coloured | 1 | 3.5 |
| East Indian | 2 | 6.9 |
| Other | 2 | 6.9 |

Roughly one third of participants identified as female, while all others identified as male (Table 1). This proportion is roughly equal to what has been reported for South African physicians in Canada previously and is a reasonable estimation based on information from the College of Physicians and Surgeons of Alberta's (CPSA) website, particularly for those physicians who practice in a rural community (Grant, 2006; CPSA (b), n.d.). The number of women is low relative to the higher proportion of women primary care physicians in Alberta and the broader feminization of family practice across Canada (AHS, 2021-2022; CMA, n.d.).

Participant age ranged from early thirties to early seventies (Table 1). The average participant age was just under 46 years. The overall average family physician age in Alberta is 47, while the average age of family physicians who practice primary care is 45 (AHS, 2021-2022). This suggests participants are similar to physicians in the province in this regard.

Many participants identified as white, the overwhelming majority of whom were Afrikaans rather than English (Table 1). Six participants of colour identified as Black, Indian-Coloured, East Indian, or other. While the ethnic composition of South African educated physicians in Alberta or Canada has not been documented, Afrikaans speaking physicians in Alberta far outnumber physicians who speak other South African official languages including Zulu, Xhosa, Soto, Siswati, and Setswana (CPSA (b), n.d.).

When it comes to circumstances around the time of migration, I asked when participants had left, whether they were married, and if they had children (Table 2). Participants arrived in Canada from 1990 to 2020. The median year to arrive was 2007, while the mode was 2016 with four people arriving then (Table 2). Over 82% of participants were married/common law when they migrated, including six participants who were in dual-physician partnerships (Table 2). Most participants did not have children when they migrated. At the time of research, only one

participant was single following a divorce, while the majority of participants were still married or had found a partner. Many participants currently had children (Table 2). Most participants entered Canada on a closed work permit. In recent years, changes to the Express Entry program dictated a shift to that pathway. More recent changes announced for the Alberta Advantage Immigration Program, Express Entry Stream, may see the entry pathway shift again (Aldrich, 2023).

Table 2 Participant Demographics - Migration

| Category | Frequency (n=29) | Percentage (%) |
|-------------------------------------|-----------------------------|---------------------------|
| Year of Migration | | |
| 1990-1994 | 1 | 3.5 |
| 1995-1999 | 5 | 17.2 |
| 2000-2004 | 4 | 13.8 |
| 2005-2009 | 8 | 27.6 |
| 2010-2014 | 2 | 6.9 |
| 2015-2019 | 8 | 27.6 |
| 2020-2022 | 1 | 3.5 |
| Marital Status at Migration | | |
| Married/Common Law | 18 | 62.1 |
| Dual-Physician Partnership | 6 | 20.7 |
| Single | 5 | 17.2 |
| Divorced | 0 | 0 |
| Current Marital Status | | |
| Married/Common Law | 22 | 75.7 |
| Dual Physician Partnership | 6 | 20.7 |
| Single | 0 | 0 |
| Divorced | 1 | 3.5 |
| Children at Migration | | |
| Yes | 8 | 27.6 |
| No | 21 | 72.4 |
| Children at Time of Research | | |
| Yes | 25 | 86.2 |
| No | 4 | 13.8 |
| Entry Category | | |
| Work Permit | 18 | 62.1 |
| Express Entry | 2 | 6.9 |
| Provincial Nomination | 2 | 6.9 |
| Other/Unknown | 4 | 13.8 |

Most participants practiced in rural communities, while about a third practiced in an urban setting (Table 3). One participant routinely alternated between rural and urban practice. A minority of participants practiced outside of Alberta, in both rural and urban settings.

Table 3 Participant Demographics - Professional

| Category | Frequency (n=29) | Percentage (%) |
|---|---------------------|-------------------|
| Current Practice Location | | |
| Rural | 16 | 55.2 |
| Urban | 9 | 31.0 |
| Other | 1 | 3.5 |
| Other Province | 3 | 10.3 |
| Years of Practice in South Africa Before Migration | | |
| 0-1 | 0 | 0 |
| 2-3 | 16 | 55.2 |
| 4-5 | 6 | 20.7 |
| 5-10 | 4 | 13.8 |
| 11-25 | 3 | 10.3 |
| Medical School | | |
| Afrikaans | 17 | 58.6 |
| Pretoria | 8 | 27.6 |
| Stellenbosch | 6 | 20.7 |
| Bloemfontein | 3 | 10.3 |
| English | 10 | 34.5 |
| Cape Town | 6 | 20.7 |
| Witwatersrand | 4 | 13.8 |
| Other | 2 | 7.0 |
| MEDUNSA | 1 | 3.5 |
| Unknown | 1 | 3.5 |
| Contract Length | | |
| 1 year | 1 | 3.5 |
| 2 years | 12 | 41.4 |
| 3 years | 3 | 10.34 |
| 4 years | 0 | 0 |
| 5 years | 6 | 20.7 |
| None | 2 | 6.9 |
| other/unknown | 1 | 3.5 |

Although most participants emigrated shortly after completion of their postgraduate medical training, it was not uncommon for participants to have a number of years experience. In regard to medical education, just over half of participants attended an Afrikaans institution, some attended an English language school, while only one person attended what has been considered a Black medical institution (Table 3).

Participants were motivated to study medicine due to a childhood interest in the body, the direction of aptitude testing, and the pursuit of a professional career that would set them up for success in South Africa. However, the decision was also shaped by a series of socio-economic factors, as indicated by some participants' ability to study wherever they wanted or to follow in family footsteps, while others were proud to be the first physician in the family, having come to medicine later in life. Participants chose an institution on the basis of language and ethnicity, agreeing with previous research that South African postsecondary institutions remain divided along racial lines (Weiner et al., 1998; Arnold (a), 2011; Van der Vyver and DeVilliers, 2000). Only participants added that stratification along racial lines also indicates differences in prestige.

All but one participant claimed to have had a contract at the outset of practice in Canada (Table 3). While it was most common for someone to have had a two year contract, five year contracts appeared to be the norm more recently.

In summary, I conducted semi-structured interviews with 29 South African educated family/general physicians. Interviews and open thematic coding were guided by abductive grounded theory in order to generate rich understandings oriented towards theory building that lend to an understanding of the processes behind how physicians make migration decisions and the relationship between geographic and professional mobility. Descriptive and interpretive validity measures were deployed to capture participants meaning to the greatest extent possible.

Chapter 3: Pathways to Rural Alberta: The Aspirations of International Migration

South African educated physicians' decisions to leave South Africa and whether or not to stay in rural Alberta are not made in isolation. Rather, these decisions are often intertwined. A physician's reasons for leaving South Africa are commonly also their reasons for coming to a rural community in Alberta: migration decisions reflect aspirations and capabilities, or a physician's desire for a life they could not live in South Africa, and their goal to live that life, or to achieve prestige and opportunity, in Alberta. Place plays an important role in fulfilling aspiration. Yet, the choice of place may be constrained. In this chapter, I outline the pathways that South African educated physicians take to rural Alberta. In particular, I identify a series of policies and practices that limit physicians to practice in rural communities. I position these findings in relation to de Haas' (2021) aspirations-capabilities framework, classical migration theory (Massey et al., 1993) sociological literature on the professions (Iredale, 2001), and a life course perspective that considers migration trajectories and the importance of physicians' families in migration decision-making (Impicciatore and Panichella, 2019).

Emigration Aspirations: Reasons for Leaving South Africa

South African educated physicians' emigration aspirations, or their reasons for leaving South Africa, provide a window into not only why these physicians were dissatisfied with their work in South Africa, but also what they were looking for when it came to working in the profession in Alberta. Physicians were looking for a comfortable life relative to their peers, an improved socioeconomic status and stable political climate, and life away from South Africa's high crime rate. All of these aspirations refer to achieving the prestige, position, and opportunity that were unavailable to this group of general practitioners in South Africa and made possible by their shared definition of the "good life" and the "knowledge, awareness and perception of

opportunities ‘here’ and ‘there’” (de Haas, 2021). I begin with a glimpse into the kind of professional options that were available to participants in South Africa, which framed their reasons for leaving.

Opportunity in South Africa

To become a doctor in South Africa, students study medicine for six years, usually immediately following high school. Following this, medical students complete two postgraduate training years, a year of internship and a year of community service, after which physicians may begin independent practice and have the option to pursue a specialist residency. Roughly a third of participants spoke about never seriously considering specialising and/or a love of generalism or treating it all. As such, they were happy to begin their career as general practitioners.

Many participants, however, had an interest in specialising or were in the process of specialising in one of a number of fields at the time of emigration. Participants often intended to postpone specialising until they returned following several years of generalist practice in Canada. A few participants had plans to specialise stalled by family needs. Accordingly, both participants who were and were not interested in specialising considered the years between graduation and specialisation an ideal time to migrate as they were not committed to a practice and still maintained the opportunity to return to specialise should they choose.

I was gonna get into a program, but...a friend of mine said, ‘hey, I got this request to...go work in Canada, but I’m busy with my specialty, do you want to do it?’ And I was like not really ‘cause I’m about to enter my specialty, so I don’t want to go. Anyway, so the person that he was in contact with got in contact with me and said, ‘you know what? Why don’t you come for a few months. We’re kind of desperate here and you can go back and continue to locum and whatever.’ (male, 40-49, person of colour¹)

¹ It is not my intent to homogenise all participants of colour. I appreciate that participants represented multiple diverse ethnicities and contributed a number of perspectives accordingly. Unfortunately, South African physicians of colour remain a minority in Alberta, and I opted to ensure that participants of colour’s identities remained confidential by not identifying their ethnicity.

Adventure and Previous Travel

For the majority of participants who emigrated shortly after finishing their studies, the years between beginning independent practice and specialising provided a perfect window of time to adventure and do some travelling. Medical training was highly demanding, modestly remunerated, and left new physicians tired, broke, and as one participant said, “At that point I was young, and I just wanted to travel.” The end of postgraduate training was the first opportunity physicians had to do something new and take a break.

The desire to travel was more than youthful wanderlust. Travel was an opportunity to see and experience a world that had been largely denied to South Africans during the Apartheid years, but despite the end of international sanctions and domestic censorship most participants found themselves unable to travel as a result of a weak currency (roughly 13:1 South African rand to Canadian dollar exchange rate). A working holiday was a realistic means to “to see the world” and had become popular amongst recent graduate peers.

First of all, we grew up in Apartheid, so we were very isolated. And it was a fairly standard thing for doctors to do, to go two years to England and then travel and you know, make some money that's not South African [laughter] rands to see the world. So I did that. (female, 50-59, white)

Given this interest, a number of participants had made short-term international migrations prior to what ended up being a permanent move to Canada. Previously, participants had spent time on short-term locums in the United Kingdom and Canada, worked in Ireland, practiced on a cruise ship, spent time abroad on a gap year, and even completed international medical electives. Participants claimed they had never planned for these trips to be permanent and that they did not consider staying long term. Working abroad helped participants to accomplish their goals of adventure and earning a bit of money, while simultaneously broadening horizons.

Life Course Factors: Marriage and Children

Although many participants were young, recent graduates, a few participants were a bit older and had practiced for a number of years. I noted differences in their aspirations when it came to life course factors like marriage, children, and professional timing. While most participants had a partner at the time of migration, only one quarter had children (Table 2). At the time of the interview, all but one participant had a partner. Relationship and parental status allowed many participants the freedom to emigrate.

And for me it was, well, you know, I'd love to work a little bit internationally. And you know, there's a natural pause in your career where it makes a lot of sense because you're not tied to anything, I didn't have kids, I was married at the time. (male, 30-39, white)

Of the newly married recent graduates, many partners' early career positions made it the right time to take a temporary pause. Similarly, not having children allowed South African educated physicians the freedom to uproot their lives. While a few participants with preschool aged children found the timing right to leave, another shared how he and his partner had delayed their plans to emigrate when they got pregnant until their children were school aged in order to have access to family support.

Money

Whether looking to travel or capitalising on a personal and professional window of opportunity, money played an important role in the decision to emigrate for the majority of participants but was rarely the sole driving factor. Money came into play in two ways. First, physicians felt unable to get ahead financially in South Africa. Regardless of their professional income, physicians mentioned it was hard to make ends meet, or to pay for what they considered basic expenses despite working in excess of full time as most did, particularly when working in the state funded healthcare system. Participants' desire to get ahead, or their "notions of the

‘good life’” as de Haas (2021) might say, was linked to their “awareness” that people they knew who were practicing internationally were doing well financially.

I mean, me and my husband both worked at the time and we could barely afford two cars and a flat - just by doing two professional jobs and working the amount of hours that we did. So, financial incentive was a big thing. Like I mean, it can put you ahead so much faster. (female, 30-39, white)

Second, for the vast majority of participants who planned to return, funds saved working abroad were intended to be spent on a house, or used to buy into a costly, private family practice.

Socio-Political and Socio-Economic Factors

Despite the legal end of Apartheid and the introduction of restitution efforts, South Africa remains riddled with inequality where race is highly politicised and influential in shaping economic opportunity. Participants did not deny that racism motivated some white South African physicians to leave, but often framed their motives differently. Critical whiteness is a useful theoretical tool to help understand the socio-political and socio-economic emigration terms participants described. Writing in the early 2000s, Steyn (2001) noted that the white lament of ‘a changing white identity’ in an ever-changing South Africa was a more common expression of white South Africans' racism against South Africans of colour. In particular, some white participants perceived a lack of opportunity for white men and children, which they attributed to affirmative action, an employment equity policy that attempted to ensure proportionate participation and representation of historically marginalized ethnic groups. This perceived lack of opportunity and the lament of ‘a changing white identity’ was the lament of white racial privilege, and the subsequent perceived status loss that had previously offered a comfortable, prestigious professional position (Steyn, 2001).

White men explained that affirmative action had influenced which medical schools they applied to and the professional opportunities that were available to them in South Africa.

I actually applied to [pursue specialty] in South Africa - I applied and I didn't get in...And I'm not saying that [affirmative action] was the only reason, but it was a contributor and like the colour of my skin and gender kind of put me at the bottom rung to be honest. (male, 30-39, white)

White women physicians shared how their non-physician husbands perceived the same lack of opportunity. Given this perceived lack of opportunity, men often initiated emigration or were the partner most interested in leaving South Africa. Several male physicians noted their wives had taken time to come around to the idea or had been somewhat reluctant to leave, although for one man emigration was driven by an ultimatum from his wife. When not being led to migrate by their partner, women participants attributed their reasons for leaving South Africa to crime, adventure, or being unhappy with the working conditions in South Africa. White children were perceived subjects of the same lack of opportunity.

Some participants of colour noted they left despite good professional opportunities. However, better opportunity elsewhere was still a factor as these physicians cited a job offer or suggestion, adventure, and family reunification as their primary motivations.

In South Africa, white physicians continue to compose the majority of registered physicians, although the proportion decreased from roughly 56% to 45% from 2000 to 2019 (Tiwari et al., 2021; Khan et al., 2013). The proportion of Black physicians more than doubled from 14% to 29% over the same time, while the proportion of Indian physicians has held steady around 15% (Tiwari et al., 2021). There was a small uptick in Coloured physicians from 2014-2015. Although improvements in racial representation, white physicians continue to be significantly overrepresented and Black physicians significantly underrepresented compared to the population (Khan et al., 2013). Indian physicians appear to be slightly overrepresented and Coloured physicians the most closely represented.

The end of Apartheid also introduced professional changes through the expansion of publicly delivered health services to Black people and a rise in private insurance. This shift changed the kind of medicine people could practice and how they were remunerated for it. Given South Africa's two-tiered healthcare system, low resource public system, and disease burden, it was a hard place to be a physician. Participants had heard, or seen if they had practiced elsewhere, that medicine could be different.

Escaping high crime rates for relative safety was yet another reason that fed physicians aspiration to go elsewhere. Roughly half of participants in this study named crime and subsequently of safety elsewhere in their decision to leave South Africa, but apart from a few participants who had been crime victims, the others made brief, passing, almost obligatory comments or said something to the effect of 'I'm sure you've heard about crime from other people.' Crime did not appear to be a primary driver of emigration for most physicians, despite the emphasis previously attributed to high crime rates and victimization in the literature (Bezuidenhout et al., 2009; Arnold and Lewinsohn, 2010).

Intended Stay

Many of these aspirations could be accomplished with a short-term stay in Canada. As such, the majority of participants planned on temporary stays, such as a short-term locum or two years in Canada, before returning to specialise. While the timing was sufficient to realise aspirations, shorter stays also coincided with the two year contracts participants were asked to sign as a commitment to AHS and the sponsoring clinic from the early 2000s to roughly 2015. It is also worth noting that the bulk of participants came on work permits, some of which were shorter than the contracts

participants signed (Table 2, Table 3). In all cases, the length of contract influenced how long people planned to stay in Canada.

Many participants who hoped to make a permanent move had practiced for five years or more and had children when they migrated. These older, more experienced participants explained that their life stage and responsibilities dictated the move be permanent.

Cause remember our situation was a little different to some people that come. We immigrated. We sold everything; we didn't plan on going back. A lot of doctors come here and they like it and they stay, or they come for a certain period of time. We came to stay. (male, 50-59, white)

Yet, in spite of these predominantly temporary plans, South African educated physicians had spent many years, sometimes even decades in Canada. Whether physicians claimed adventure, a lack of professional opportunity, money, or the right life stage was at the centre of their reasons for leaving, each reason points to the inability to achieve the desired prestige in South Africa and the necessity of looking elsewhere. Findings related to why participants stayed will be discussed in relation to retention.

Migration Destination Decisions

Given participants' aspirations they had to make a decision about the place, the country, province, and community that would best help them to create the life they envisioned. Examining the destinations participants considered sheds light on physician attraction and retention policy and offers a window into physicians' aspiration by comparing the places participants considered reasonable choices.

International

Not only did participants aspire to a life that was outside South Africa, but countries across the world were also engaged in a competition for highly skilled workers, including South African educated physicians. When it came to choosing a county, physicians had several options

and most considered multiple international destinations. International competition was strong and a participant commented that Canada was no longer at the front.

Compared to when I first came, I think a lot of the other countries have caught up; it's quite competitive now. (male, 40-49, person of colour)

Given this international competition and the variety of options available, participants chose what they believed to be the best option for them (Table 4). The first criterion considered

Table 4 International Options

| International Destination | Benefits | Risks |
|---------------------------------------|--|---|
| England and Ireland | -Ease of entry -Clear pathway to practice | -Weather (too rainy) -No pathway to upward professional mobility |
| Australia and New Zealand | -Similar culture, weather, and lifestyle -Clear pathway to practice -Full scope generalist medicine -Friends and family | -Limited to practice in isolated rural setting -Inadequate remuneration |
| United States | -Knowledge of country from popular culture and/or global stage | -Only pathway to practice meant completing a residency -(Dysfunctional) two-tiered healthcare system |
| Saudi Arabia and United Arab Emirates | | -Cultural differences |
| Canada | -Friends and family -Reasonably clear pathway to practice -Full scope generalist medicine | -Cold climate/winter -Challenging pathway to practice |

was reasonable access to medical practice and the availability of career opportunities, such as being able to practice your preferred medicine in a place you wanted to work. Lifestyle factors also played a role in painting a picture of the life physicians could live in the country, like weather, lifestyle, and culture. Friends and family in the country played an important role both in

reducing associated risks of migration and increasing benefits, but also in giving participants a clearer idea of what sort of life they could live there (Table 4).

Canada was one country considered alongside England and Ireland, Australia and New Zealand, the United States, Saudi Arabia and the UAE (Table 4). While some of the appeals of other countries held true, Canada was overwhelmingly selected on the basis of the people participants knew in the country; the vast majority had friends or family members in Canada. In fact, only a few physicians claimed they knew no one in Alberta or Canada prior to immigrating, some of whom discovered acquaintances, such as a medical school peer, after they arrived.

Friends and family were influential in inviting participants to attend recruitment events in South Africa, telling people about job opportunities, sharing information about life and practice in Alberta, helping to navigate bureaucratic professional barriers, and even went so far as to host physician families they had never met in their homes while the new arrival searched for accommodation. Support began while participants were in the process of making a destination decision and typically extended into the weeks, months, and sometimes years that followed.

So one of your friends is chatting to the medical recruitment guy and mentions it to you and, you're oh, ok. And then you get in touch with him and the ball starts rolling that way. So, you know, it's also seeing your colleagues leave and seek those different and better opportunities. (female, 30-39, white)

Knowing someone in Canada did not appear to be gendered or racialized as the majority of both women and participants of colour knew someone in Canada. Given the international competition for these highly skilled physicians, they could choose the country that maximised aspiration and was within their capability. Because of their social networks, Canada was the participants choice.

Province

Participants had to make the same aspiration maximising decision on the provincial level as they did on the international. While immigration remains federal jurisdiction, provinces have a

role in attracting, particularly in the last decade as immigration programs have been targeted to meet province-specific labour demands (GOC, n.d.). Accordingly, participants usually decided on the province at the time they decided to come to Canada. Alternatively, some participants made the decision to migrate to Canada specifically because of friends or family in Alberta.

The competition that existed between countries was not as strong at the provincial level, or at least not until the Covid-19 pandemic and exacerbation of the healthcare worker shortage. Although a few provinces received brief mentions, participants generally went where they knew and where they could practice medicine most easily.

I think it depended on what we were aware of, where the needs were. I didn't even think there would be a need in any other provinces. (female, 60-69, white)

Participants generally considered the same destination criteria when debating between countries and provinces. In light of the provincial regulation of medicine, much of what made pathways to practice accessible was determined at the provincial level. While participants did not consider Alberta requirements easy to fulfil, relative to other provinces, Alberta was “the path of least resistance.” South African friends and colleagues who had navigated the same provincial requirements were particularly helpful. In the same vein, a participant mentioned not choosing a province because they did not know any other South Africans there.

While participants occasionally mentioned a recruiter presenting multiple countries as options, it seemed more likely that a physician would approach a recruiter when they had decided on a country, often selecting them because of their specialisation in placement for a specific county. Accordingly, agents played a larger role in provincial selection. Agents recommended provinces based on two factors, the path of least professional resistance and their colleagues and contacts in a particular province. Several participants named the same recruiter.

The lady that was involved with locating a place for you to work in Canada mentioned that it's a bit tougher to go to the bigger provinces like BC and Ontario and it's a lot quicker and easier to get into Alberta. So, she actually got me to liaise with a doctor that was out here already and he was like here in one of the rural cities, and he said, 'hey, we're really short here. Maybe you should think about coming rural.' (male, 40-49, person of colour)

Altogether, recruiters, social networks, and the structure of medical practice in the province made Alberta one of few accessible destinations for South African trained physicians by increasing awareness of life in Alberta and subsequently impacting aspiration, while also lowering costs and placing migration within reach.

Community

As participants' destination focus narrowed to Alberta, they began to work with a community, health authority/AHS, or clinic, to settle on a community where they would practice. South African educated physicians took one of two approaches to deciding on a community: they undertook a careful evaluation of the opportunities available in several different communities by making "site visits," or accepted a position in the first community where they were offered a position.

Around half of participants made a site visit, a trip to check out the practice and community, or completed a locum, prior to selecting the community where they would sign a contract. A South African physician in a recruiting community typically organised the itinerary that included hospital and clinic tours, meeting colleagues, sightseeing, and contributions from local government and business officials in particularly supportive communities. While site visits generally seemed to help participants make informed decisions about the realities of the work and living arrangements they were signing up for, one participant pointed out that despite relatively minor differences between rural communities, physicians were effectively getting the

same deal and site visits sometimes scared people off. Furthermore, site visits also provided communities with an opportunity to compete with each other for the visiting physician.

They had recently had a big split in the big clinic and there was a lot of animosity...And we had actually heard that not just from the [community one] crew, but from [community two]. You got the impression that each town was trying to play dirty with the others so they could recruit you. (male, 40-49, white)

Inter-community competition was not limited to site visits, but also included communities ‘stealing’ physicians from each other.

When it came time to make a decision, participants turned their attention to the different professional opportunities, working conditions, and lifestyle options available in each rural community. Work related criteria were undoubtedly the most important consideration. As one participant pointed out, work and income were a key part of the reason to leave South Africa. As the majority of households relied on a single income, that of the physician, they needed assurance that things would work out.

I think for all of us, our work is why we are here, why we come over, so I think that’s always the most important thing that people want to sort out... and then of course about the community and what’s around...but I think that’s second to the work environment and working circumstances. (male, 50-59, white)

It was even trickier for dual-physician couples to find the right professional fit. They sometimes ended up dividing clinical and non-clinical work by sharing a position to manage family obligations. Ultimately, couples identified that it would be entirely impractical and unsustainable for dual-physician couples to practice in some communities that could not offer the kind of balance and accommodation required. Still, in most circumstances if the work met a threshold of acceptability, the family would try to make the community work. Community decision making, like choosing a country, allowed South African educated physicians choice in

where they ended up and that choice was centred around professional opportunity and stability in order to realise aspirations.

The Pathway to Rural

While choosing a place, country, province, or community contributed to physicians' ability to accomplish their aspiration, or to achieve what they were looking for by migrating to Canada, de Haas (2021) defined capability as the “(freedom) to choose where to live” or the agency to make a choice and impose it on the world. There is a conversation in the literature around the practice of relying on IMGs to fill family medicine/generalist positions in rural communities (Jenkins, 2020; Grant, 2006; Hammett, 2013; Olsson et al., 2019; Schumann et al., 2019). As demonstrated above, South African educated physicians can exercise agency over their destination decision in many ways. Yet, the predominance of IMGs filling family practice positions suggests that these decisions may also be limited in some ways. To understand how South African educated physicians' agency was limited when it came to place, I explain what physicians would have wanted if they could choose freely.

Location Choice

While many participants grew up in an urban space, that did not always directly translate to a desire to practice and live in a similar environment. Some participants preferred or were open to rural settings. Others explained that if they had been given a choice about where to practice, they would have selected urban.

Despite any preferences, it was common knowledge that moving to Alberta meant moving to a rural community. South African educated physicians were attuned to the reasons so many South African physicians practiced in rural Alberta and how it was not so much about what they wanted or international labour supply and demand to correct a rural physician shortage, so

much as it was a matter of distribution and Canadian educated physicians' unwillingness to practice in rural communities. Accordingly, South African educated physicians explained how a rural practice had been the only practice available to them.

That's what the government offers us. We are deployed [laughs], used, and made useful. True...And [I have] no problem with where we are needed. I find it sad that it's necessary for people from outside to fill gaps where Canadians don't wanna go...It's that the one's here don't wanna go there. (female, 60-69, white)

Participants' preferences around where they wanted to live, coupled with their inability to practice in an urban centre, suggests that had South African physicians had the final say in their destination decision, many would have made a different choice. Yet, many physicians, including those who would have preferred to live in a city, ended up making the best of things and embracing rural practice and the community. In a humorous take with serious undertones, one physician highlighted the futility of physicians' limited agency over place.

Most South Africans were in small town Canada...So they could kill² rural Canadians, but they're not allowed to kill a city Canadian. So that's why they have to go rural. And then when they finally write exams and they go to a post in the city, then the Canadians complain that the South Africans don't want to stay in the boondocks. (male, 70-79, white)

While South African educated physicians' limited agency over place was obvious, exactly how it occurred was unclear. As the participant above hinted, professional regulation played a significant role, while ultimately several different contributors acted on the national, provincial, and community level.

On the national level, closed work permits, a lack of permanent residence upon entry to Canada, and contracts played a role in determining where South African educated physicians could and could not practice (Table 5). The majority of participants entered Canada on short-

² Never fear, your doctor is not out to kill you; medical errors are easily many physician's biggest fear. The burden of being responsible for someone's life sometimes introduces some dark humour about medical licenses as permission to kill people.

term work permits (Table 3). It was often the case that contract length would exceed work permit length. Participants were unable to apply for permanent residence for several years, except in the case of several participants who had landed as permanent residents through the Express Entry

Table 5 Pathways to Rural

| What | Role in Determining Place |
|----------------------------|---|
| International Level | |
| Closed Work Permit | Closed work permits were the most efficient and effective means of entering Canada for most participants. A work permit could only be obtained with a Labour Market Impact Assessment for a position that no Canadian wanted. Work permits meant South African educated physicians were in Canada temporarily and did not have permanent residence. |
| Contracts | Although technically administered on the provincial level, contract length generally exceeded that of the closed work permit. For a physician to fulfill their contract they either needed a second work permit or permanent residence. |
| Permanent Residence | Work permits and (a lack of) permanent residence worked reciprocally as obtaining permanent residence was the only way to be in Canada without a closed work permit. While Express Entry was not an easy pathway, it did mean physicians landed in Canada as permanent residents. Alberta Provincial Nomination Programs provided a pathway for some from work permit to permanent residence. |
| Provincial Level | |
| Provisional Registration | Physicians may either be on the general or provisional CPSA register. Provisional registration was granted in absentia of the CCFP or alternate examination route to the general register. |
| Community Level | |
| Position Sponsorship | For a rural physician post to be filled by an IMG a community clinic must request AHS “sponsor” the position. AHS then recommends the position for CPSA sponsorship. The clinic incurs the IMGs assessment cost. |
| Contracts | The sponsored physician is required to sign a contract that they are only eligible to practice in the community where they are sponsored. |

program post-2015. A lack of permanent residence reciprocally made South African educated physicians dependent on closed work permits that limited practice to one community. Work permits were achieved through a successful Labor Market Impact Assessment (LMIA) that found

no Canadian to do the job. The reliance on closed work permits was closely connected to contracts that functioned as a community level intervention.

Participants described how closed work permits had prevented them from working in other communities when they found themselves in a tough situation with colleagues, or when they wanted to locum in another community to help with coverage or allow a colleague to get away for vacation. Permanent residence was generally considered the only means to freedom from a closed work permit. The more recent shift to using the Express Entry program meant South African physicians arrive in Canada with permanent residence.

I was in [community] for quite a while and could not work anywhere else. Even though I had met some friends in [other community] and they needed help..., I wasn't able to cover any shifts over there until such time I was either on an open work permit or I had my permanent residency. (male, 40-49, person of colour)

Medical credential recognition, professional regulation, and credentialing also functioned to direct and limit South African educated physicians to rural practice. South African educated physicians were required to complete a series of medical knowledge assessments before being eligible to practice in Alberta. While many of these assessments were nationally administered requirements across Canada, the profession is regulated provincially by the College of Physicians and Surgeons of Alberta (CPSA). Some assessments had to be completed before a participant could migrate, others after, some following several years of practice in Canada. The assessments required varied significantly with the policy and practice of the day and to a lesser extent, the discretion of the evaluator. Required assessments can be found in Appendix D.

The provincial regulation of medicine meant that the CPSA determined the requirements to be a regulated member in Alberta. For example, one participant who had hoped to practice in Alberta explained the year of post-secondary training he received in the early 1990s before two years of training had been introduced made him ineligible. Instead of coming to Alberta, he obtained his licence in another province where one year of post-graduate training was sufficient. A participant who had completed two years of post-graduate training in South Africa had to complete an IMG stream residency in Canada when the province where they lived failed to recognize their second year of postgraduate training. Other participants gave examples of the

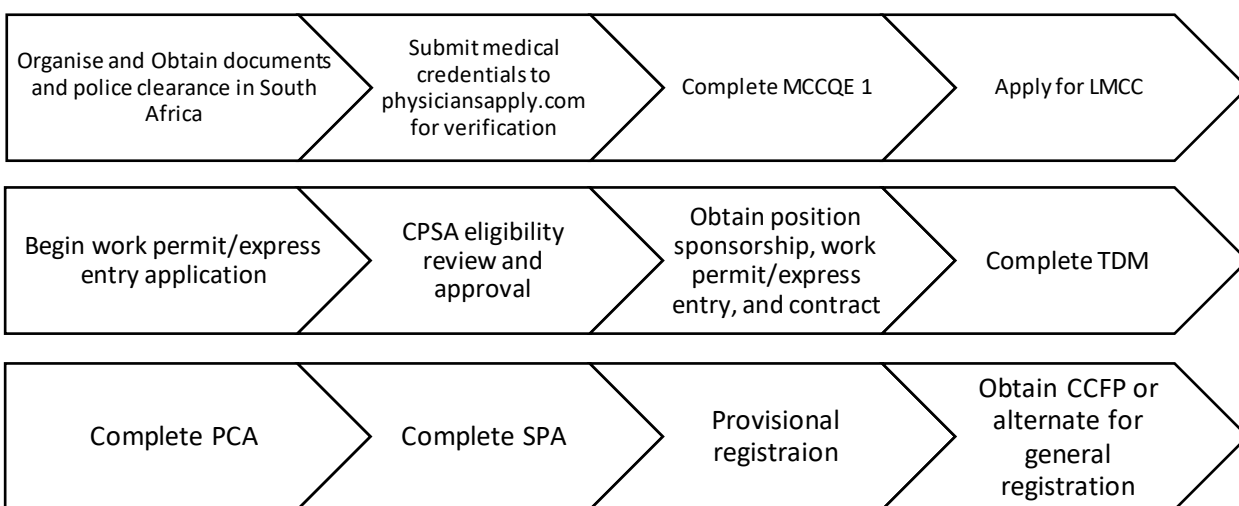


Figure 2 Pathway to Practice in Alberta, Canada. Source: CPSA (d), n.d.

CPSA's failure to understand how medical education was delivered in South Africa and the subsequent bureaucratic barriers this lack of knowledge imposed.

Rather than have IMGs proceed directly onto the general register as fully licensed, independent medical practitioners when they had been found competent to practice medicine in Alberta, around 2010 the CPSA introduced provisional registration. For generalist IMGs, provisional registration provides a means to practice medicine in absentia of Certification in the College of Family Physicians (CCFP). The reasoning behind provisional registration seemed to

have little to do with ensuring physician competency, providing oversight or support to new Alberta practice physicians. Rather, provisionally licensed physicians face more severe consequences should a complaint arise, and participants suggested its primary purpose was to get IMGs to rural communities and keep them there.

Provisional registration was obtained following the successful completion of two, three month supervised practice assessments, the first of which is unpaid and outside the community where they would practice (PCA, SPA) (Figure 2, Appendix D). In some cases, couples have been split and sent to opposite ends of the province (Sabo, 2022). To transition from the provisional to the general (independent) register participants had to obtain CCFP, which they were eligible for with several years of Canadian experience, or via an alternate assessment at the end of the permitted six years of provisional registration. If a physician chose to move to another province while on the provisional register, they would restart from year one.

Alberta came up with a rule that if working in rural Alberta and you stay there for five years, you will qualify for full registration without any restrictions. So, I didn't need to write any more exams. I was working [in AHS Zone] and I was like 'I'm not gonna keep on studying and doing all these things if I don't have to.' So I didn't. And that's another reason we stayed in [community] for a few more years. (male, 40-49, person of colour)

Several changes have been made to these provincial requirements in recent years. First, in the early months of 2023 the CPSA introduced a program that waived the first of the two, three-month clinical assessments for family physicians educated in Australia, Ireland, the United Kingdom, and the United States, but not South Africa (CPSA (a), 2023; CPSA (d), n.d.). Second, the CCFP changed its eligibility criteria to sit the exam for physicians in practice from three to five years (CFPC, n.d.) Effectively, this meant that CCFP no longer provided a means to obtain general registration that is faster than the six year alternate exam route. Regardless of contract length, this suggests South African educated physicians must spend at least five years in rural

practice. Furthermore, even if a physician obtained general registration via the alternate route, participants explained that without CCFP physicians were ineligible from practice in many urban areas depending on the Alberta Health directive of the day.

On the community level, participants understood they were eligible for employment in “communities of need,” all of which happened to be rural while the same ‘need’ was absent in urban areas (AHS (b), 2015). To work in (rural) Alberta, IMGs are only eligible to apply for sponsorship eligible positions. To obtain sponsorship a health organisation or clinic had to apply to AHS requesting sponsorship for a single physician position, demonstrate that there was a need and that no Canadian educated physicians had applied (AHS (b), n.d.; AHS (a), n.d.). If approved, the local clinic hired for the position and AHS recommended, or ‘sponsored’ the individual, to the CPSA for a practice readiness assessment. The clinic paid the cost of the assessments, \$34,885 per applicant and the CPSA’s second highest source of revenue in 2021 (AHS (b), n.d.; CPSA, 2021; CPSA (c), n.d.). Position sponsorship is a relatively new requirement, introduced around the time of AHS formation in 2008 (Church and Smith, 2022).

So they call it a 5-year sponsorship. Now, I’m not a hundred percent sure what they’re sponsoring, if that’s a reduction in registration fees or what all, although I doubt that. But basically, you’ve got a contract and that ties you to a community for that five years. (male, 30-39, white)

Many participants believed they were required to sign a contract given the costs incurred to sponsor them. Yet they also believed contracts served a purpose that went beyond working in a rural community, to staying there for an extended period.

Historically, the hope has been you’ll sign, and it worked with me, I signed for two and I stayed for nine. You know, so, the hope is once we get you, once we sink our hooks into you for two years, hopefully you’ll fall in love and you’ll want to stick around, and you’ll want to kind of build your life in this community. (male, 30-39, person of colour)

In recent years, the contract length changed from two to five years and was accompanied by a cut to the financial incentives offered. Participants had differing thoughts on the impact the increased contract length would have on South African physicians' agreeability to practice in a rural Alberta. While some physicians thought it would have no impact and noted that they would have signed a 10 year contract if asked, others viewed it as a largely detrimental move that would cause physicians to accept deals in other places where the obligations were lower and more favourable for the physician.

The circumstances when a physician could begin an urban practice upon entry to Alberta were extremely limited. Despite the capability to choose the specific rural place, South African educated physicians generally always had to choose a community in rural Alberta because of how a series of professional factors on the international, provincial, and community level prevented them from doing otherwise. Accordingly, physician's aspirations for leaving South Africa and coming to Alberta had to be possible in rural Alberta if a physician was to stay.

Conclusion

Given their aspirations, participants decided to move to the country, province, and community that offered them the best opportunity. This meant choosing a country, Canada, where people had support networks, where the requirements to practice medicine were relatively reasonable and aligned with practice goals, all while ideally while living comfortably with family. However, the sort of agency to freely choose where physicians wanted to build their practice and life was influenced by professional constraints that limited South African educated physicians to rural practice. The indicators of prestige, or social worth, are both material and immaterial. Physicians' quest for improved opportunity, income, and relative position by carefully selecting the destination that best helped meet that goal are these indicators. There is a

giant question left hanging. Since South African educated physicians placed great emphasis on improving their prestige, social position, and professional opportunity in motivating their migration to Canada, what they found in the country and their communities of settlement, weighed heavily on their aspirations to stay or to move onward. This is where geographic mobility meets professional mobility.

Chapter 4: Geographic and Professional Mobility: Place, Profession, and Status

Hierarchies

Given South African educated physicians' aspirations and reasons for coming to Canada, their ability to achieve the position and prestige they are in search of contributed to their choice to stay in a rural community. In this chapter, I examine how opportunities for professional mobility in rural Alberta are linked to physicians' intentions to stay in those communities. I connect insights about how South African educated physicians' aspiration and capability led them to rural Alberta, their intentions to stay rural, and show that these same limitations on place are also limitations to upward professional mobility. I find that practicing medicine in a rural community means practicing generalist medicine, where generalist practice stands in contrast to the work physicians would have preferred to do and that of many Canadian (family) physicians. Furthermore, the work physicians are directed to do shapes the status hierarchy, or differences in prestige, between Canadian and internationally educated physicians, just as theories of highly skilled labour migration suggest. I position findings within Jenkins (2020) work on status hierarchies in the medical profession and what is known about Canadian medical students' disinterest in choosing family medicine (Scott et al., 2007; Vanasse et al., 2011; Collier (b), 2011; Beaulieu et al., 2008).

With the intersection of place and profession in mind, I focus on South African educated physicians' position in the medical hierarchy and how they view themselves. Status hierarchies refer to differences in prestige, or positions of unequal status "in the social order" that indicate social worth (Jenkins, 2020). Although migration theory suggests IMGs are highly skilled labour migrants and thus occupationally advantaged, medicine is internally stratified. Beyond the distinction of IMGs practicing in rural communities and Canadian educated physicians practicing

in Census Metropolitan Areas (CMAs), medicine in Canada is also horizontally stratified within specialties (Jenkins, 2020). In the U.S. for instance, Jenkins (2020) found IMGs matched to less prestigious specialties like family medicine, referred to as “IMG friendly,” and less prestigious training programs, while physicians educated in the United States matched to more prestigious specialties and residency sites.

Looking at local data, more Canadian educated physicians are “specialists,” while proportionately more IMGs practice family medicine or as “non-specialists,” as would be the case for South African educated physicians who do not have Certification in the College of Family Physicians (CCFP) (CPSA, 2021). Although a limited number of specialists have rural practices, the majority of rural health services are provided by family physicians. Most rural opportunities available are for family physicians.

Historical data from the Canadian Residency Matching Services (CaRMS) shows that of the many medical specialties available, family medicine residencies are the most likely to go unfilled, despite being the first choice of most matching physicians (CaRMS, 2014-2022; CaRMS, 2023; Woloschuk et al., 2017). This was true in Alberta in 2023 when 22 family medicine residencies went unfilled (CaRMS (a and b), 2023). The media and Alberta Medical Association president have suggested this outcome is the result of family medicine’s lack of prestige, demands, workload, and poor government-physician relations caused by physicians’ perceived lack of support/attack throughout the Covid-19 pandemic and the illegal and unilateral termination of their collective agreement by the government in 2019 (French, 2023; AMA, 2023; Eastman and Horvey, 2023; Pauls, 2023).

Research has found that Canadian medical students are disinterested in pursuing family medicine because of its lack of prestige, alongside other factors like an unreasonable workload

(Scott et al., 2007; Vanasse et al., 2011). Academically strong students who expressed an interest in family medicine were viewed to be “limiting” themselves and were directed towards more prestigious and competitive specialties (Scott et al., 2007). For those Canadians who specialise in family medicine, trends suggest that rather than practicing broad scope family medicine, the majority pursue family practice subspecialisations and focused clinical practices (Collier (b), 2011; AlAteeq et al., 2020). These subspecialisations and focuses are thought to offer increased income, enhanced knowledge and expert status, and improved work-life balance without call responsibility, while allowing physicians to feel confident through enhanced skills and experience (AlAteeq et al., 2020; Collier (a), 2011).

The Rural Generalist: Place-Based Professional Identity

The pathway to rural is not only about practicing rural medicine but being a rural generalist; limitations to place are also limitations to professional mobility. A South African educated physician’s aspiration for life in Alberta meets, and sometimes comes up against, the professional choices physicians are free to make, beginning with the kind of medicine participants wanted to practice.

Work Preferences versus Realities

While general practice was some physicians’ first choice in South Africa and in Canada, many participants had diverse medical interests. When it came to participants who were not interested in doing generalist work, they had two options in Canada: pursuing a non-family medicine specialty or shifting into a family practice subspeciality or focused clinic.

Although highly desirable, these non-generalist options were almost always entirely out of reach. More broadly, pursuing any professional opportunities apart from general practice was almost always off limits until participants had “served” or finished their contracts, made it onto

the general register, and/or obtained CCFP. Once the policies and practices that limited South African educated physicians to general practice were overcome, they were free to pursue other opportunities. Sometimes opportunities were available locally, but other times they meant moving. A participant explained:

*I can completely understand that not a single Canadian grad goes into family practice and the only reason IMGs go into family practice is because we don't have **any other choice**...But in five years, people leave because...they've paid their dues. And in five years time...Quit family practice and go do whatever the hell you want to go do. 'Cause your obligation is done. (female, 30-39, white)*

Canadian family medicine is an incredibly broad field with numerous areas of subspecialisation and means to craft focused practices. However, in most cases South Africans were recruited to fill generalist positions. Instead of hiring and recruiting committees asking about participants' interests, committees presented the 'gaps' in coverage. Just like some physicians were willing to go anywhere, some were willing to accept any position available.

We had applied with a mind that I went into family practice and my wife did the [family practice specialty] work...but then when we ultimately got into it they [community recruitment committee] were like, 'hey, actually we want a female family doc that also does [family practice subspecialty]. And we want you to be a [family practice specialty].' So I was, at that point if you had told me I had to, I don't know, go to psychiatry, I would have been like, 'sure, yeah, whatever.' You want me to make patient meals part time? I'm there. Like, I just want a job, man. (male, 30-39, white)

Work Permits and Contracts

This limitation to generalist medicine came about through the same means that had limited physicians to rural practice, including work permits and contracts. Closed work permits, obtained via a Labour Market Impact Assessment (LMIA) that found no Canadian was available to do the job, meant South African educated physicians could only practice in their sponsored positions, which limited their work to the sponsoring clinic and AHS facility. Contracts functioned similarly to work permits by limiting physicians to their contracted work. Contract

length often exceeded the duration of work permits, which left participants with work permits professionally limited even after they had obtained permanent residence (Table 5). In more recent years, despite a shift away from work permits and towards permanent residency upon arrival, employment contracts persist in keeping physicians bound to broad scope family medicine, particularly as the length increased from two to five years.

Yet, contracts impacted more than the type of medicine physicians could practice. After arriving in Canada, several participants found they had signed contracts that offered below market remuneration, agreed to “exorbitant” overhead, had contracts broken or unsigned mere weeks before their arrival, or been prevented from practicing their special family practice skills.

The first blow was in that very first week when I met the administrator of that hospital and he said, ‘I know that we recruited you as a [family practice subspecialist] here, but in the nine months that went by we got another [family practice subspecialist] so we don’t really need you anymore.’ And I was like, that’s the whole purpose of why I came! (male, 50-59, white)

Not only could this physician no longer practice his subspecialist skill set, but the work he was offered instead, ER and general family practice, paid significantly less than he would have earned. Physicians were generally left powerless in these situations and had to carry out the terms they were contracted to.

Despite the ways contracts limited the type of work South African educated physicians could do, those with permanent residence had the option to end their contracts without returning to South Africa and several participants did. Dissolution terms and conditions typically meant paying a specified sum of money, which physicians often justified on the grounds that they had to reimburse the sponsoring clinic and/or AHS what had been spent on them.

Credential Recognition and Physician Sponsorship

The College of Physicians and Surgeons of Alberta (CPSA) received physicians' medical credentials once they had been verified and evaluated and approved physicians to become regulated members of the college (Figure 2). The CPSA has a number of eligibility criteria to practice as a general practitioner or family physician, including 24 or more months of continuous "postgraduate training" (CPSA (a), n.d.). The two years of internship and community service training completed following medical school met this requirement.

AHS physician position sponsorship not only limited South African educated physicians to rural practices, but also generalist medicine. To begin, family physicians provide the bulk of services in the rural communities most likely to meet sponsorship criteria as 'underserved' or 'in need' (AHS (b), n.d.). While non-family practice specialists may also be sponsored, family physicians are the only physicians in many rural communities. (Doctor Jobs Alberta, n.d.). Only sponsoring clinics (and organisations) could request a position be evaluated for sponsorship and subsequently participants were only offered positions in family clinics and rural emergency rooms. Sponsorship is one of the contributors to a series of policies and practices that restrict South African educated physicians to general practice.

In summary, being limited to rural practice also meant being limited generalist practice. Although rural generalist medicine could perhaps be agreeable to South African educated physicians on a temporary basis as it would allow physicians to fulfill short-term aspirations in the lead up to their return to South Africa, in the long term, not having access to the medicine and opportunities that made professional aspirations possible could shape a physician's decision to stay. I continue to explain how this was the case.

“See One, Do One, Teach One” South Africans versus “Book Smart” Canadians

The type of work a physician does has major implications for their position, or the prestige they are allotted, in what is a highly stratified medical profession. As family/general medicine is perceived to be a lower prestige specialty, it is worthwhile to explore this status hierarchy, how it takes shape and how South African physicians buy into the idea that this lower prestige work is best for them. Despite the discrepancy between generalist work and the work physicians would have preferred, participants described themselves as ideally suited for rural general practice due to the highly practical medical education they received in South Africa. South Africans contrasted their education and practice to Canadian medical education and practice, which they considered “book smart,” highly “theoretical” and largely in conflict with the needs of a rural practitioner. They considered Canadian physicians’ absence from rural practice to be the result of this stratification.

“See One, Do One, Teach One:” The Practical South African Generalist

Most participants described how their medical education was very practical due to the amount of hands-on clinical experience they gained. This hands-on experience began in the second year of study, included multiple deliveries by the end of year four, and prepared students to practice with minimal supervision by the start of their internship. The saying “see one, do one, teach one,” spoken by numerous participants, emerged from this training environment where participants were expected to begin performing procedures and treatments on patients soon after they learned it. The practical nature of this medical education generally led participants to feel extremely skilled, confident, and competent.

I think the experience that we acquired in a short period of time was probably significantly greater than you would have opportunity for in Canada...we read the same textbooks, right? We had an adage in South Africa...you see one, you do one, teach one. (male, 40-49, person of colour)

When it came to practicing medicine in Canada, several participants said something akin to how “*people are people all over the world,*” the idea being that the human body was a constant across continents. Accordingly, participants thought the medical education they received in South Africa was sufficient preparation to look after Canadians.

Not only did South African educated physicians’ very practical medical education and training prepare them to look after anybody, but participants also perceived it to be the perfect fit and preparation for practice in *rural* Canada.

And I know I’m South African so obviously I think we’re amazing, but for the purposes of what Canada needs, South Africans are perfect because, as I say, everything we do is train towards rural generalist medicine...and that’s why we do so well in these rural communities, because that’s our bread and butter. (female, 30-39, white)

‘Born to Be a Specialist’: The “Book Smart” Canadian Physician

South African educated physicians’ practicality stands in contrast to their descriptions of Canadian educated physicians, most often the medical students they supervised. Canadian educated physicians were described as “book smart,” “too smart,” “academic,” and “theoretical.” This idea that Canadian physicians were “too smart” often meant that it was considered in the student’s best interest to pursue a more competitive, non-family practice specialty.

We have an acronym called the SPOT diagnosis...if you can come up with one thing that explains everything with this patient, then you know you’re most probably right. Whereas in Canada, the approach is very academic in a sense. Where when we ask them [medical students] what they think it could be, they come up with a differential diagnosis with like 20 different things. Like things that I don’t even know what they’re talking about. [laughter] Like I have to look them up, cause they’re smart...I think they’re too smart sometimes. They all need to be specialists. At the end of the day you very seldom find someone that’s born to be a generalist...Cause a lot of them need to specialise cause they’re smart enough for it and they’re so smart they should specialise. (male, 50-59, white)

Canadian medical students' academic nature was not perceived to be an individual trait, but the outcome of a system that valued specialisation. Unlike South Africa, the question in Canada was not would you specialise, but what would your specialty be, as all medical students were required to specialise to practice. These findings suggest that the “book smart” Canadian physician was never meant to be a rural family physician, but born to be a specialist, or born to inherit a highly prestigious position in the medical hierarchy.

Participants' views of the impracticality of Canadian medical education contributed to perceptions that Canadian educated physicians were not adequately equipped for the demands of rural family practice. Rural practice meant the ‘buck stops with you’, or that a physician had to be prepared to treat whomever and whatever ailment presented. South African educated physicians felt the realities of their medical education gave them the skills and confidence to take on these challenges more comfortably than their Canadian peers.

Versus here it's have you seen it 10 times? [soft, gentler voice] Ok, now you can try it 20 times. And then in three years time you can maybe teach someone. It's a lot of hand holding here. [normal voice] And we try and beat that out of our students pretty fast here. Like nope, you need to do this fast because you can and the only reason, the only thing that's stopping you is you. (female, 30-39, white)

Relative to the academic and theoretical knowledge South African physicians believe drove Canadian physicians, there is a clear contrast between South Africans self-described practicality and “see one, do one, teach one” know-how. Participants' descriptions harken directly to the “knowledge elite” and “rank and file that follows them,” as argued by Freidson (1985) and revitalised by Jenkins (2020), describing clear status hierarchies in the medical profession.

“Dog Work:” The Daily Grind of Family Practice

Family medicine is dog work, so let's just make that clear. (female, 50-59, white)

No doubt about it, participants found rural family medicine to be hard work, even dog work as described by the participant above. The workload was the central reason why South African educated physicians did not blame Canadian educated physician's for not practicing rural family medicine. Accordingly, South Africans took note that they found themselves working harder than their Canadian colleagues. In this sense, "dog work" captured the essence of the demands of rural family practice and their stratified position in the medical hierarchy.

To begin, most South African educated physicians found themselves working far more than they wanted, planned, or felt comfortable with prior to migrating, even compared to the demands of work in South Africa's public healthcare system. Numerous participants described the demand and detriment of numerous days, nights, weeks, or a month on call, providing hospital coverage during the night and clinic hours during the day, that led them to run on empty. No matter how hard someone worked, there was always more work to do. There was no getting ahead.

The first three years I was there, the only holiday I had was the September long weekend. So I worked emerg, did obstetrics, and ran a clinic. So I did that seven days a week, almost 365 days a year. Maybe 360 days a year. (male, 40-49, person of colour)

The responsibility of being a family physician was one of the things that made the job tough and the workload feel so heavy. Participants described how unlike working in South Africa's public hospitals where they were only ever likely to encounter the same patient once, in Canada they were solely responsible for the well being of their panel of patients. This not only meant seeing patients for repeated clinic visits but following up (unpaid) with any diagnostic tests they had ordered and in many rural settings without hospitalist programs, providing in-patient care services for those same patients. The increasing paperwork and administrative demands on physicians' time certainly did not help either. Although patient care was a common

favourite part of the job, the responsibility of patient care contributed to South African educated physicians' burnout. Poor physician-patient relationships were exacerbated when patients seemed to own physicians and as the government's 'attack' on physicians during the Covid-19 pandemic was perceived to turn public opinion against them (French, 2023; AMA, 2023).

South African educated physicians' observation that they worked harder than their Canadian colleagues came from a willingness to work more hours per week than their Canadian educated colleagues and to do non-clinical tasks, such as committee work or research participation, on a voluntary basis when Canadian physicians demanded remuneration. This was not to say that Canadian physicians did not do their job, but that they were perceived to demand work-life balance.

This isn't like a knock on Canadians in general. Like...we're totally Canadian, but we found Canadian physicians...tend to wanna work one or two days a week and see 10 to 20 patients a day...They always talk about student fees and student this, but a lot of them have their education paid for by their parents beforehand...they're not married, usually. There's no kids, there's no mortgage. So they don't have the stress of needing to work very hard. (male, 40-49, person of colour)

One participant commented on how he thought South African physicians were driven to work outrageously hard in their initial years in Canada until sufficient financial stability and/or wealth had been achieved for the now middle-aged physician to slow down. The same participant thought middle-aged Canadian physicians tended to work more than new graduates due to the increased financial demands of lifestyle costs for a family and saving for university and retirement.

One motivation for this willingness to work hours and see patients in a capacity that exceeded full time was the "incentive to make money." Given increased income was a

motivation to emigrate from South Africa, this “incentive” meant that South African educated physicians arrived in Canada eager to work.

So as a result, you kind of come with this mindset that if you want to get ahead, you're gonna have to work hard, right? (male, 40-49, person of colour)

While the drive to increase income played a role, ultimately such hard work was more a response to the demands of rural healthcare systems where there was always more work to do than could reasonably be completed, the desire to help patients, and to be a team player who struggled alongside colleagues. However, long hours and unmet demand took a detrimental toll on participant mental health.

And so there's that stress on a family physician. You saw this patient. You see what they need, but they can't access it. So what do they do? They come back to you. They come back to you every week and what can you do but put your hands in the air. And it just becomes fatiguing. You're just done after a while. (male, 30-39, white)

I don't think it ever got to the point where it interfered with my work or my ability to do my work but getting home and not having any words left over. Like not talking to my husband. Like coming home and not wanting to do anything. Like literally just needing to veg out so that [laughs] whatever energy came out of me will somehow come back. (female, 30-39, white)

Participants were not alone in their system-induced burnout as at least half identified having been burned out. While physician participants were burned out prior to Covid-19, the pandemic raised the demands on the healthcare system, thereby raising the demands on physicians. The struggle was further exacerbated as friends and colleagues made the decision to leave medicine to tend to their own health and wellbeing.

I recognize that people are in crisis, but I don't think people realize what their healthcare workers are putting themselves through right now. Like I have never suffered from burnout, like even in South Africa when I was working like crazy. I reached a point about two months ago, I was like, I just want to quit. I just want to resign. I'm done. (male, 30-39, white)

Sacrifice was a sentiment that ran parallel to burnout. The demands of rural family practice often meant physicians were asked and required to sacrifice family time, relationships, and their marriages. A certain degree of sacrifice seemed tolerable, perhaps even enjoyable or meaningful. However, when physicians were asked to give too much and any hope of making a difference removed, the sacrifice became insurmountable. This was the essence of “dog work,” completely giving oneself without any return.

Participants found rural medicine highly professionally demanding. These demands led to burnout and sacrifice that negatively impacted the physicians and their family’s health and well-being. Stratification between South African and Canadian educated physicians began to become clear as Canadian physicians were able to make more choices about their work environments.

The Absence of Canadian Rural Family Physicians

South African physicians’ professional experiences in rural Alberta exist in parallel with a relative absence of rural Canadian physicians. Participants strongly believed that the absence of Canadian physicians they witnessed was a mismatch between the theoretical, impractical, and specialist oriented Canadian medical education and rural medicine.

We were all from South Africa and the docs who were there before were all from South Africa. And in the surrounding towns, I think maybe one or two Canadians if that, but out of like the 10 [surrounding] communities, most of the doctors were South African. (male, 40-49, person of colour)

Oh, you can’t find a Canadian [laughs] to save your life. (male, 30-39, white)

In many ways urban practice was set up to be everything rural practice was not. Urban practice meant access to tertiary care in academic hospitals, specialist care, and more supported working conditions and pay. While specialisation and prestige as related to work undoubtedly played a huge role in preventing Canadian educated physicians from going rural, not only was

not having access to specialists about prestige, but it was also about having support and the resources to manage complicated patients.

While specialisation held some explanatory power for Canadian physicians' absence in rural practice, stratification was more complex than an urban specialist/rural generalist divide. Just as Jenkins (2020) found internal medicine residencies at a more prestigious urban academic teaching hospital were reserved for American medical students, in Canada, urban family practice seemed to carry different levels of prestige and to be a more appealing alternative than its rural counterpart.

I couldn't understand why, like in my mind, it seems to me like first prize for a Canadian grad would be to stay in Edmonton or Calgary, or let me put it this way, they seem to favour other disciplines, you know, rather than family medicine. And if they do family medicine it seems like they want to stay in the city and last resort would be coming out to the rural areas. (male, 30-39, white)

It is simply not possible for all Canadian medical graduates to pursue non-family practice specialties and as described in the literature review, family medicine is some Canadian graduates' first choice. However, as the above participant commented, it is perceived to be rare for Canadian family physicians to choose rural practice. Furthermore, participants suggested that the Canadians who do go rural do so as family practice subspecialists or limit their clinical work to a focused area.

If they do go to rural...so they'll do family medicine, but plus one in emergency medicine; they'll only do ER. Or they'll do family medicine plus anaesthesia and only do anaesthesia. Or they'll do hospitalist medicine and only do that. Full scope family physicians, from a Canadian grad perspective, I don't know where they are. (female, 30-39, white)

Participants offered a few thoughts on why Canadian educated physicians were unwilling to practice as a rural generalist. First, "dog work," or the uncontrollable demands of rural medicine were too high, while the rewards and support were too low.

Subspecialising was a means by which Canadian educated physicians could achieve better work-life balance and have better working hours/flexibility without the many unpaid responsibilities that came with being responsible for a panel of patients at a clinic. Accordingly, participants went so far as to say they did not blame Canadian graduates for opting out of this particular profession and perhaps they might have even made the same choice if given the option.

South Africans come over and they see the challenges and they deal with them and I think Canadians see the challenges in rural Alberta and think, 'well I'm not gonna deal with this. I'm just gonna go to an urban setting - it's so much easier.' And I probably don't blame them, like I'd probably do the same thing. (male, 30-39, white)

Family practice subspecialties also offered Canadian graduates a pathway to hospital over clinic based medicine. Hospital medicine often meant higher incomes. Participants explained that family practitioners who provided care and services as a hospitalist earned significantly more than their colleagues who practiced in clinics, in large part due to the cost of clinic overhead. Yet, money wasn't everything. The majority of participants thought family physicians were adequately remunerated and that compensation was not the main problem in attracting physicians to rural practice, but a couple of participants highlighted that what was good money for a South African was different than what a Canadian would be willing to accept.

While subspecialised family practitioners are not specialists per say, the title and relative knowledge mastery offered a sort of 'expert' status that was otherwise off limits to broad scope family practitioners.

Because it's become so difficult to do family practice, a lot of people are choosing those kind of areas of...added competence and they are sticking to doing that entirely and dropping family practice, right? It's also easier to stay current in the focused area of medicine than it is to stay current in something as broad as like broad based general family medicine, right? (male, 40-49, person of colour)

A couple of participants proposed that the problem was not too much specialisation and that in fact more (sub)specialisation was the solution to more Canadian physicians practicing in rural communities. These participants claimed that more training would give medical students and residents the exposure and confidence needed to feel competent in rural practice.

Apart from good working conditions, which were generally considered a requirement to attract Canadian physicians, community factors like amenities were more so considered nice to have. Work could be flexible, but communities were less malleable, or as one participant said, *“You can’t fix the community.”* Community related factors like a lack of amenities were associated with leisure, lifestyle comforts, and ways of living that were simply ‘missing’ from rural communities.

Family life considerations also factored into Canadian physicians’ decisions around choosing a rural community. Even for Canadian graduates with intentions to go rural, life got in the way, such as when they met a highly skilled, professional partner who could not find work in a rural community. Age and life stage played a role as well. Participants claimed that single physicians or couples without kids would end up bored with the limited activities and options perceived to be available in rural communities.

In regard to carving a path forward and finding ways to attract Canadian educated physicians to rural practice, a participant in charge of hiring noted that creating a supportive workplace, reasonable working conditions, and flexibility that allowed individuals to have their needs accommodated, had been so successful that not only had they been able to attract IMGs, but that an influx of new Canadian physicians had also made the decision to join them.

We became the most successful community in Alberta as far as recruitment, at least foreign physicians. And then, because we were so good at recruitment and so well man powered, Canadians started coming to the community as well...you need to recruit them, but you also need to make it attractive to work there...and

then what happened is, the stream of flow from South Africa has gotten less, but...we've recruited like seven new Canadian grads in two years. Which is unheard of for rural communities in Alberta. (male, 30-39, white)

This example offers guidance on how to address the absence of Canadian physicians in rural communities, while also calling for re-envisioning of the terms and conditions South African educated physicians are sponsored into.

Participants perspectives suggest that Canadian educated physicians have choice over place and profession that South African educated physicians do not. While Canadian educated physicians can avoid or at least moderate the demands of rural practice, South African educated physicians cannot. There is clear stratification within family medicine.

Conclusion

These findings speak to why Canadian educated physicians may be disinterested and unwilling to practice in rural communities, as well as the magnitude of the stratification between South African and Canadian educated physicians. These conditions limit South African educated physicians to general practice and to rural communities. Highly practical South African educated physicians have been willing to work in conditions and live in communities that Canadian physicians have refused. Similarly, South African physicians do the work that Canadian physicians have refused in favour of more specialised, higher prestige, higher remunerated practices, leaving broad generalist work for South Africans. With an eye on place, profession, and the status hierarchy between these physicians, I begin to make connections between South African educated physicians' aspirations and reasons for coming to Canada and how their stratified position could contribute to whether or not they stay in a rural community, asking if perhaps the prestige and opportunity physicians receive makes up for what they give.

Chapter 5: Professional (Im)Mobility: Implications and Opportunities of Rural Practice

South African educated physicians might need to begin their practice in Alberta, Canada as a rural generalist, but things need not stay that way indefinitely. Although participants considered themselves to be ideally suited for lower prestige rural generalist medicine, their position stands in contrast to the work of more prestigious Canadian educated (family) physicians. Given this stratification, the question of why South African educated physicians might consider *staying* in a rural community, given circumscribed opportunities for professional practice, I consider two scenarios: what happens when a physician stays in a rural community and what happens when they leave a rural community, either migrating internally in Canada or returning to South Africa. I highlight the relationship between professional (im)mobility and place, drawing on literature on internal, return, and circular migration, along with literature on stratification in the medical profession (Constant, 2019; White and Lindstrom, 2005; Cassarino, 2004; Jenkins, 2020).

If I Stay Rural

Simply put, South African educated physicians made the decision to stay in a rural community when their migration aspirations were met. A number of participants had practiced in rural Alberta for years if not decades, surprising given that most participants had initially planned to return to South Africa following several years in Canada. Physicians stayed when they had created a life with the type of work they enjoyed doing, were well supported professionally, and were in a place where they and their partner were happy and could raise a family.

Simultaneously, physicians thought life and opportunities in South Africa had not improved.

Staying or retention, however, should not be limited to a physician staying in rural practice.

Rather, it is useful to consider and expand conversation around a migrant's decision to stay in the

province/country from the retention described in the physician attraction and retention literature (Miedema et al., 2009; Cameron et al., 2010; Cosgrave, 2020; Gorsche and Woloschuk, 2012), towards immobility as described by de Haas (2021) and to consider attachment or ties to a rural setting.

Retention in Alberta, Canada

As many participants expressed temporary plans to stay in Alberta, I commonly asked what had changed or happened along the way that led them to stay. Physicians' explanations all pointed towards their aspiration of a comfortable life relative to their peers, an improved socioeconomic status and stable political climate, and a life free from crime. Participants opted to stay for other varied reasons including meeting their partner, to continue saving and earning a stable income, or because they thought it was too late to specialise in South Africa.

Sometimes people stayed because the life that awaited in the sending state should they return, did not meet aspirations (Cassarino, 2004). This appears to have been the case for South African educated physicians as the racialized socio-political, socio-economic climate, and poor infrastructure they experienced was perceived to have remained largely unchanged or to have deteriorated. Relative to South Africa, Canada seemed safe and comfortable.

So at that point we were kind of thinking, 'ok, if we're gonna go, it's gotta happen in the next year or two.' And at that time, I think there was a significant escalation in lack of security, power instability...we have load shedding over there...just basic services were kind of deteriorating and we kind of stopped and started to question whether we really wanted to put ourselves back into that. And then eventually we decided to stay. (male, 40-49, person of colour)

Staying was not just for the physician, but also for their family. For some South African educated physicians, the decision to have children was concurrent with the decision to stay in Canada. Participants who knew they wanted to have children had to decide where to begin and raise their family. For physicians considering returning to specialise in South Africa who wanted

to have children, parenthood would often be delayed until training ended. Alternatively, the physician could stay in Canada, practice as a family physician, and begin a family sooner. Many participants in this study chose to have a family, which suggests they were disinterested in returning to South Africa as a general practitioner.

We came across on a three-year contract. So...we were like cool, we'll start once the contract is done and also once we decided where we wanted to go, like South Africa or Canada...once we decided that we wanted to stay here, then we were like, ok, well now we'll start having kids. (female, 30-39, white)

Once participants had children, family obligations made moving more challenging. Years or decades later when families and children were older, children and sometimes grandchildren became continued reasons to stay. Altogether, participants stayed in Alberta/Canada because it was a relatively better option, professionally and personally, than returning to South Africa or going elsewhere.

Retention in a Rural Community

Sixteen participants practiced in a rural community, 10 of whom practiced in the community where they had initially settled (Table 2, Table 3). Despite most participants outstaying contracts and practicing in a rural community, physicians involved in hiring spoke about their community's inability to attract and retain physicians willing and interested in staying after their contract ended. This response to a perceived lack of retention suggested that retention meant something other than fulfilling a contract and that leaving following contract fulfilment was considered a retention failure. While these perceptions of failed retention are aligned with the physician attraction and retention literature, it does not capture the more holistic understanding of retention, or immobility, as equal options as proposed by de Haas (2021).

While physicians found working in a rural community extremely taxing, they also enjoyed what they did, be it general practice or more subspecialised work. Enjoying work was

usually coupled with factors that made work more flexible, like limiting hours or molding a practice into the preferred type of work. A valued spirit of camaraderie amongst colleagues kept several physicians from leaving.

I really liked the work in [community]. It was demanding and it definitely gave me the chance to do a full scope of practice, or do generalist medicine...my wife and kids could tolerate it and I liked it, so we stayed. (male, 70-79, white)

While loving your work kept some people going, the business and demands of practice, or an “inertia” a number of participants described, meant the almost impossible task of disrupting daily demands in order to even consider leaving. Other times, the thought of leaving patients or a community that was relatively less isolated, had more amenities, and better working conditions than friends and colleagues elsewhere, was unfathomable.

Staying because of community life came second to the work and family related factors described. Physicians and their families often valued and enjoyed community living. In fact, all but one participant lived in the community where they practiced. Similar to how the decision to start a family had led several participants to stay in Canada, children also led families to opt to remain in rural communities.

Perhaps families were so content in rural communities because of their children's role in retention. While starting a family led some participants to opt to raise their families in Canada, children were similarly influential in a family's choice to remain in a rural community. This ‘child effect’ acted in several ways. First, participants spoke about children as agents of integration that led them to get out into the community and helped them to meet people through their children's activities. Second, many men physicians had understood the move to be more difficult for their wives than for themselves. While they had quickly built relationships with colleagues and the community at work, their wives had initially been stuck at home without a

vehicle and very little money to go out. Becoming a mom meant being busy and introduced new ways of connecting with the community, ultimately making it feasible for some families to stay.

...fortunately the kids, you know, they started participating in everything right away. Our son started playing hockey that same winter and that's how you then meet people and get in contact with people - so that meant a lot to her [participant's wife]. (male, 50-59, white)

For parents in a dual physician partnership, having children seemed to contribute positively to participants' decision to stay *if* suitable work and childcare arrangements could be made.

Alternate Forms of Retention

While retention has been discussed here to mean the decision to stay in Alberta or in a rural community longer than initially anticipated, there are two alternate forms of retention that came up that push current understandings of retention. Retention need not refer exclusively to physical presence in a rural community where a physician would practice but can also encompass a physician's continued ties or attachment to the community. First, physicians maintained contact and offered support via short-term locums or coverage. Participants returned to locum because they loved the community but were unable to live there due to their families needs, out of a sense of obligation to the community, or to help a colleague and relive old memories. In one case, a participant explained how a community had been staffed in large part by South African physicians there on repeated short-term locums from South Africa (circular migration). This physician appreciated that while not ideal, it worked, and the community was happy.

Second, there was the odd time when a participant commuted to a rural community while living in an urban centre. This included commuting on a temporary basis while transitioning out of a rural community and in the case of one physician unable to find an urban ER position,

commuting to surrounding facilities. Commuting was not a common option and seemed to present an unsustainable, but short-term form of retention.

In summary, physicians made the decision to stay when their professional and personal aspirations could be met. Meeting aspirations meant doing the work you enjoyed and working an acceptable amount, both of which indicate a level of prestige. Family lifestyle considerations also had to be met, like the occasion to have children and the ability to connect with the community. However, the bigger takeaway is that retention should be understood more broadly to refer to the different ways physicians maintain relationships with rural communities and how physicians ultimately opted to remain in Canada instead of returning to South Africa. Attachment offers insight into why physicians were so displeased when their colleagues left following contract fulfillment.

Rural Deskillling

Professional opportunities also impacted physicians' desire to remain in rural communities. Physicians were almost certainly deskilled as rural generalists when compared to their practice in South Africa. While being deskilled had the potential to negatively impact a physician's capability to fulfill their professional goals in rural Alberta, and subsequently their reasons to stay, participants found ways to advance their careers that brought their goals to life. I unpack each point in turn.

Deskilling refers to someone doing work they are overqualified for and/or the gradual loss of skill over time, which Gotehus (2021) referred to as "hierarchical deskilling," or alternatively being deskilled by working in a sector outside one's training. There is broad concern about deskilling across Canada given efforts to select highly skilled immigrants who are expected to use their knowledge and skills in Canada, but often find themselves unable to do so

(Creese and Wiebe, 2009; Liu, 2019). Yet, the experience of deskilling is not universal, but both racialized and gendered. Not only do “...white immigrants fare better than immigrants of colour...,” but women are often unable to initially secure employment and subsequently relegated to the domestic sphere while their male partners work blue collar, survival employment jobs (Creese and Wiebe, 2009; Siar, 2013).

South African educated physicians deskilling appears to fall into the category Gotehus (2021) referred to as “hierarchical deskilling.” Physicians, many of whom were white men in this study, were not blocked from practicing medicine, but found themselves performing work they were over skilled for and subsequently lost many of the skills they came with over time (Table 1). While South African educated physicians described themselves as highly skilled in the medicine they practiced in South Africa and their medical education as ideally suited for practice in rural Alberta, they simultaneously noted that they consistently treated lower acuity patients in Alberta than in South Africa.

A participant who worked in a semi-regional hospital pointed out how South African educated physicians in “true rural” communities, or communities without a regional or urban ER and specialists, lost their ability to treat acutely unwell patients due to the infrequency of severe illness that presented. This physician considered it their responsibility to help protect the skills of physicians in smaller surrounding communities by offering them shifts in a semi-regional ER.

*Other individuals would be true rural and all they, with all due respect, all they do is sit in a clinic the whole day. And then they have experience that is far superior to mine, but unfortunately are stuck in a facility that only offers a spectrum of services that’s very limited. And after a year or two, you know, you may lose your skills, you know which is not ideal, right?
(male, 40-49, person of colour)*

Another participant explained how he had anticipated being unable to perform all of the skills and procedures he considered routine in South Africa due to the inability to obtain certain

medical privileges. While contracts, work permits, credentialing, and sponsorship limited South African educated physicians to rural general practice, privileges directly limited the skills and procedures physicians could carry out at a specific facility (AHS (a), 2015; CPSA (c), 2023). The decision on whether to grant privileges was facility specific and determined by AHS and the CPSA (AHS (a), 2015). Years later, the same physician warned a colleague en route to Alberta that she would not be able to perform c-sections and instead only manage low risk deliveries.

I realised that when I came here and everybody told me you will lose some of your privileges...I had a Zoom meeting with her [new physician] ...and she was talking like she's gonna do c-sections. I said to her, 'girl, you're not gonna do c-sections'...she said, 'why not?' I said, [laughs] 'cause there's an OB that's gonna do that....you're gonna deliver easy babies and if there's a problem, you're gonna phone someone to do it for you'...I didn't realise that I'll be restricted. (male, 50-59, white)

South African educated physicians found themselves prevented from working to their full qualifications and experience in rural Alberta. This less acute work was a form of downward professional mobility and subsequently a reason someone might not be interested in staying.

Rural Opportunity

Undoubtedly, not being able to practice medicine the way they wanted to and the way they could, shaped aspiration and forced participants to re-evaluate how they were going to accomplish what they came to Alberta to achieve. Despite being deskilled, compared to South Africa, Canada offered a number of opportunities and appeared a land of opportunity.

The sky's the limit really. Which is not the same in South Africa and that's kind of the whole point of being here. (male, 30-39, white)

For many, rural generalist practice did not fulfil their aspirations. One option available to do so was crafting a new practice. Participants explained leaving general family practice due to the demands of rural medicine, personal interest, local need, how some options were more lucrative, along with a more appealing work-life balance. Some professional opportunities were

available locally and did not necessitate moving to a CA or CMA, such as spending more time doing the medicine you enjoyed in the ER using procedural skills instead of specialising in surgery. Other times opportunities were available because South African educated physicians were limited from practicing medicine to their full capability by privileging and the varied factors that limited South African educated physicians to rural generalist medicine. Higher income often came with benefits of professional mobility like prestige.

Given these goals, participants were not interested in positions they considered a “lateral move,” or a move between positions that were roughly equivalent. Participants were after a “vertical move” which they explained as:

I guess it would have been specialising...but I guess at this point I would just become much more skilled...or more specialised than my peers in certain areas... I could move into just concentrating on certain aspects of medicine, so kind of like moving out of the all-encompassing family role. (female, 50-59, white)

Vertical opportunities, or upward professional mobility meant pursuing focused family practices and subspecialties. As seen in Table 6, there were clinical and non-clinical opportunities available to South African educated physicians in rural communities.

While South African educated physicians could come to Canada with subspecialist skills like family practice anaesthesia, their opportunity to pursue subspecialist practices in Canada was generally limited (Table 6). Focused family practices were a more accessible route to upward mobility in rural Alberta.

I personally did a diploma at the U of A...So that's what I do now as part of my work; I'm not full time in family practice...I think I'm a good example of someone who could do something. It's not a specialty, but it's a diploma and I can do more specialised work and I absolutely love it. And that will make me work longer and be happier in my work for sure. (male, 50-59, white)

Table 6 Professional Opportunities

| Clinical Opportunities | |
|-------------------------------------|--|
| Family Practice Subspecialty | Anaesthesia, obstetrics, dermatology and aesthetic medicine, hospitalist Predominantly rural |
| Focused Clinic | Sports medicine, paediatrics, women's health, mental health, care of the elderly, physician extender, emergency department Rural or urban |
| Non-Clinical Opportunities | |
| Administrative and Leadership Roles | Site or Zone Level Predominantly rural |
| Clinic Ownership | General or subspecialty clinic Rural or urban |
| Medical Student Supervision | Rural or Urban |

Non-clinical advancement opportunities including administration and leadership positions, clinic ownership, and medical student supervision provided status by virtue of their title and connection to a medical faculty and postsecondary institution. Participants often fell into these positions due to a lack of competition and ended up with a considerable amount of responsibility without a clear-cut benefit (Table 6). Furthermore, remuneration did not always match the added responsibility. However, owning a clinic did sometimes come with the added benefit of job creation for the physician's partner and/or extended family.

Just because some focused family practices and subspecialties were an option that made staying in a rural community a possibility, physicians could not necessarily seamlessly transition from general practice to a new practice. Instead, participants often had to rely on extra training, which required planning ahead and making an investment in their career. Making professional goals happen was difficult when running a busy practice.

Certification in the College of Family Physicians (CCFP) was another route to professional mobility, perhaps better explained as a prerequisite. At the most basic level, CCFP

represented a designation change from generalist to family medicine specialist. While this change provided specialist status and legitimised their knowledge and position within the Canadian medical hierarchy, it also gave physicians the option of moving their practice elsewhere and acted on professional mobility in more subtle ways.

So I felt the CCFP was really important...in that first four years, I was thinking of...creating a [subspecialist] clinic or a practice. So I knew I needed credibility and with that came credentialing and the two go together. So I worked towards that CCFP with the future in mind. So it was almost like I used it as a stepping stone, so I could put it behind my name. (male, 50-59, white)

Many times, rural generalists, especially those interested in returning to South Africa to specialise, were interested in pursuing non-family medicine specialties. However, participants generally considered these opportunities off limits. As most specialist training opportunities are not available in rural communities, physicians would have to leave the community and their practice to obtain this training. One participant was in the process of completing subspecialist training. Their application had been driven by organizational and community support rather than the competitive residency matching stream in order that they could return to the rural community to provide services not otherwise available. The physician had been required to sign a return of service agreement. While bound to a rural community in the short term, the physician considered the associated prestige, position, and subsequent opportunity that came with the job to outweigh the limitations of place. Another participants' partner had applied to the same program through the competitive stream but had not matched.

The opportunities that were and were not available to South African educated physicians and the effort required to transition away from rural generalist medicine show that professional mobility and geographic mobility are not always two different things. In fact, a number of professional opportunities are available in rural communities and these opportunities enable

physicians to stay by virtue of fulfilling their migration aspirations. However, these opportunities also show South African physicians' stratification within the medical hierarchy by suggesting that even professional opportunities come with 'strings attached' that limit physicians to rural practice.

If I Go

Regardless of whether or not aspiration could come to life in rural practice, staying in the initial rural community was not always possible or desirable. Physicians and their families sometimes made the decision to move elsewhere to look for the life and opportunity that was not to be in rural Alberta. Relocating, or internally migrating, occurred when a physician moved between rural communities, or between a rural community and urban centre, within Alberta or to or from Alberta from another province. Many South African educated physicians moved from the sponsoring community at least once. The types of internal migrations made and the when and why of these migrations shed light on what a participant would lose if they stayed rural and what they would gain professionally from going elsewhere.

Reasons for Internal Migration

Given that many participants made at least one internal migration, it is imperative to understand the decision to relocate to understand the relationship to stratification and opportunities elsewhere. While the decision to leave was typically the culmination of a series of issues, participants spoke about work and other professional factors as the primary driver, followed by community and family matters.

The working conditions physicians faced in rural practice was the most prominent reason to internally migrate. The resulting burnout of "dog work" and absence of relief via locum coverage effectively trapped physicians in rural communities without time off. Leaving rural

practice altogether was often the only means to escape. Despite these working conditions, physicians did not always actively seek out new opportunities elsewhere. Instead of searching for a job, opportunities often arrived via friends and colleagues. When a physician was at the end of their rope and better working conditions presented, they took it.

I think the move to [community] was our saving grace. I think if the [community] opportunity never came up, we probably would have seriously looked at moving back [to South Africa] because we were burning out and just working way, way, way too hard. And like I said, there was no opportunity to have a family, or step back or do anything. (female, 40-49, white)

Conflict with physician colleagues led some participants to leave practices and/or communities. A couple of emigrating physicians cited several years of a bad relationship with the government and a torn-up contract as their primary reason for leaving, while others cited it as their primary desire to leave the province. Participants varied in their intent to leave or remain in Alberta for retirement.

A couple of community related reasons also received mentions. A lack of privacy and anonymity was one of the challenges. Rural communities were described as a “fishbowl” where every move was visible to community members and patients looking in. Although participants also expressed gratitude for their warm relationships with patients and the community, the lack of privacy and anonymity that came with being a rural doctor, for both the physician and their partner, also presented challenges like being unable to leave home without running into a line of patients or feeling like patients owned you. This experience wasn’t for everyone.

You gotta be a rural guy. You gotta be comfortable with the idea that the guy you see in the clinic is probably the guy you’re going to face at the local grocery store tomorrow. Not everybody can adapt to that. It takes a special type of person that can be a housewife of the physician in town. (male, 50-59, white)

When it came to the practicality of living in a rural community, some physicians did perceive rural communities as lacking the amenities needed for daily living and leisure. Some participants

spoke of the lack of amenities as something that could be managed in the short-term, but as an eventual cause for departure.

It was harder for some participants to live in a rural community than for others, namely South African physicians of colour. Race and racism were not always at the forefront of these South African physician's reasons for leaving, but their own comments and insights from white colleagues suggest that race undoubtedly factored into the rural experience. South African physicians of colour claimed to get on with their white compatriots without issue. However, when it came to patient relationships, some patients refused to see Black and racialized physicians, preferring care from a white physician.

And yes, I feel for the community that can't find family doctors. Some of them are just plain racist and won't go to the new docs that I've hired and they're vocal about it. I'm like, 'honey, there's not a white doctor coming your way in a very long time.' (male, 30-39, white)

When it came to leaving, one participant of colour explained that his wife had a much easier time making friends after they moved to a more "cosmopolitan" urban centre, while another participant explained his family had ultimately made the decision to move in order to raise their kids as part of their ethnic and religious community.

The kids were getting a bit bigger and my wife preferred them having some sort of better school environment and you know, more social environment. Cause our background is obviously, we're [ethnicity], but we're from South Africa, and we're [religion], so we wanted a bit of a community that would be more suitable for the kids growing up. (male, 40-49, person of colour)

As the participant above hinted, family matters were common reasons to internally migrate. Just as some participants made the decision to stay to raise their family, others made the decision to go elsewhere. Several participants, primarily those in a dual-physician partnership, mentioned they had left or considered leaving as their workload prevented them from having children or they required reproductive assistance not available locally.

After kids were born, parents were motivated to internally migrate to improve their children's lives and opportunities through access 'better' schools and extracurricular activities, and for parents of children with disabilities, to make sure their children could access the support and resources they needed.

Sometimes the decision to leave was for the physician's partner. Participants who internally migrated occasionally identified their unhappy spouse as a major factor in the decision, their friends and colleagues who stayed rural often described an unhappy spouse, usually an unhappy wife, as their primary understanding of why a friend or colleague left. Generally, wives were understood to be unhappy because of their lack of employment and subsequent lack of a social network and community integration, but husbands who became stay at home dads were not immune from the conversation.

It was his wife's idea to move to Canada and then she really didn't like it here...she thought being a doctor's wife in a rural community would be nice and living in Canada would be fun, but I don't think she realised how rural it was. She was just very desperately unhappy. So I always say make sure there's a plan for the partner. Because the partner, if they're not working, are often very, very unhappy... it's a long winter and...even if you do get involved, it's really hard to keep yourself busy if you're at home alone. (female, 30-39, white)

More broadly, marital status appeared to influence who internally migrated. For couples who got divorced in the years following their migration, the event was a moment to reevaluate. As a result, two out of three divorced participants internally migrated for a new start, while the third physician stayed while constantly considering returning to South Africa. Physicians who were single when they came to Canada had all met and married their partner in the years since. Prior to settling down, most single participants migrated at least once, which physicians attributed to the difficulty of finding a partner in a rural community.

In summary, internal migration, or making the decision to leave a rural community, occurred when there was not another solution to the demanding working conditions of rural generalist practice and when living in the community presented insurmountable barriers to family life. However, the focus of internal migration is not just why someone is leaving and their unfulfilled aspirations, but the potential of the place where they are going. For South African educated physicians this meant relocating to improve working conditions and opportunity, whether in another rural community or a city. Perhaps internal migration is best understood not only as the inability to find or create what you expected, but as a continuous pursuit and the potential of the life physicians are looking for somewhere else.

Urban Deskilling and Opportunity

To achieve the prestige, position, and opportunity they were looking for, South African educated physicians could stay in a rural community and create a subspecialist or focused practice or make the decision to move to an urban centre. Relocating to an urban centre was one of several options available to South African educated physicians that came with a unique series of implications to professional mobility and aspiration. Moving to the city was not a cure for the rural deskilling participants experienced, nor a cure for more prestigious work. Rather, physicians continued to be deskilled and relative to rural opportunities, urban opportunities were sparse. The trade off, however, was lifestyle comforts and work-life balance.

Urban practice did not provide a clear path to higher acuity patients, a broad scope of practice, or more medical privileges. In fact, most participants had to change from providing broad scope rural family medicine in the ER, inpatient services, obstetrics, and clinic work, to primarily family practice clinic work when they relocated from a rural community to a CMA. This narrowing of professional options was attributed to urban academic and community

hospitals depending on specialists and family physicians with subspecialist training to provide patient care, while family physicians provided all outpatient care. Given this new professional deskilling, urban deskilling appeared to deskill South African physicians via policies and practices that were separate from the policies and practices that had led physicians to be deskilled in rural communities. When participants made the decision to relocate to a city, they were aware they were giving up parts of their practice.

*It was kind of sad for me cause I knew once I came to [CMA] I wasn't gonna to do emergency medicine anymore. I've lost that skill forever.
(female, 50-59, white)*

An area of practice that made deskilling and status hierarchies particularly obvious was the ER. There are four pathways to practice emergency medicine in Canada, each of which a participant identified came with different amounts of prestige, the least prestigious being working in a rural emergency department without any specific emergency medicine certifications, as was the case for South African educated physicians across Alberta. In addition to treating higher acuity patients than in a clinic, rural emergency department shifts offered slightly higher remuneration than general family practice.

Despite working in rural emergency departments, participants were unable to continue their emergency medicine practice in an urban area as urban positions required emergency medicine specific training (CCFP-EM). Even the participant who completed an IMG stream family practice residency and had subsequently challenged the CCFP-EM exam was unable to find emergency work in a CMA in the middle of the Covid – 19 pandemic due to their self described 'third tier' qualifications. This participant was hired in the ER of a census agglomeration (CA) instead. This lack of urban opportunity suggests South African educated

physicians are not necessarily leaving rural practice to pursue more prestigious opportunities in a CMA.

While unable to practice urban family medicine outside of a clinic even when presented with an opportunity, physicians found a few other ways to help meet their aspirations. In addition to clinic ownership and various administrative positions as described in relation to rural opportunities, participants were able to treat sicker patients and do slightly more prestigious, lucrative work in an urgent care centre or by commuting from a CMA to a nearby suburban emergency room. Since leaving rural practice was about far more than simply obtaining more prestigious work, these findings highlight aspiration and prestige in other ways, namely lifestyle and moving away from rural working conditions.

Circular Migration

Although South African physicians could often fulfil their aspirations within Canada, either by being retained in a rural community or by moving between communities or to a CMA, other times it was in a physician's best interest to return to South Africa, either temporarily, as was the case for circular migrations, or permanently. Several participants made temporary circular migrations when they returned to South Africa between short-term locums or to transition from a short-term locum to permanent stay in Canada. Several others returned to South Africa temporarily in the transition period following a divorce, or for one participant, for a few months while he and his family considered returning permanently. While participants' circular migrations generally corroborate with the literature that people move as "...a form of corrective migration due to unmet expectations..." or as a benefit-maximising strategy in the context of short-term labour shortages, such as South African educated physicians making temporary labour migrations, their moves were also about more than purely unmet economic expectations

(Turcatti, 2022; Constant, 2019). Participants' return extended to the life course and the role of the family's unmet expectations and disruptions, such as divorce, to family life.

If I continue to conceptualise circular migration more flexibly, participants' pre-Canada international migrations, previously discussed as an emigration motivation that enhanced both aspiration and capability, could be considered. Participants' vacations and family visits in South Africa could also be considered circular migrations. Perhaps participants or their friends and colleagues who sent their children to medical school in South Africa could also be considered a form of circular migration.

Return Migration

When the goal of rural physician attraction and retention is for physicians to stay indefinitely, return migration is positioned as the greatest failure. While no participants in this study permanently returned to South Africa, several contemplated returning and/or commented on the return of friends and colleagues. As argued by de Haas and co-authors (de Haas et al., 2015; de Haas and Fokkema, 2011), the absence of return migration behaviour need not be a problem as "return migration intentions" can offer valuable insight into the conditions and circumstances of migrants lives in the receiving country and subsequently, the ability to materialise aspirations. Given the nature of South African physicians' aspirations and their inability to achieve the life they wanted in South Africa as generalist physicians, it is perhaps not surprising that physicians did not opt to return despite the intent of the majority to migrate temporarily. Accordingly, return migration can be considered as the migrant's inability to achieve their aspirations in the receiving state (Cassarino, 2004; de Haas and Fokkema, 2011; de Haas, 2021). I unpack participants' observations on colleague's returns and why they would personally consider returning.

Work was the number one reason participants thought they and their colleagues would be most likely to return to South Africa permanently. Participants' remarks were centred around the professional goals and aspirations they could not reach in Alberta, namely the inability to match to a non-family medicine specialty residency. This was no surprise given that many participants justified a few years spent in Canada doing generalist medicine because of the option and/or intent to return to South Africa to specialise.

There was a young guy, [name], he went to [community] and they were just not happy here...He went back to South Africa to do anaesthesia - he doesn't like the GP work, it was just not for him. He wanted to specialise and I think it's just too hard for a foreign doctor to get into a speciality here. (male, 50-59, white)

Being a generalist was not for everyone and more accessible subspecialist and focused family practice options were not always sufficiently appealing. For one physician, transitioning into a family practice subspecialty had ultimately allowed him to do what he was passionate about and stay in rural practice.

Burnout and participants' unwillingness to tolerate the demands of rural practice became clear when they spoke about money. While money was a large part of the decision to emigrate, it seemed to play a relatively small part in the decision to return. Physicians knew they would take a pay cut if they returned to South Africa but noted that money wasn't everything in life; they would be willing to return even knowing they would earn less. Some things in life, like balance and wellness, were more important.

I think eventually you realise, like money's not everything in life and you have to find a balance in life. So it depends. Like I had had a lot of doctors leave to go back to South Africa. (female, 30-39, white)

While in these ways return migration was a form of protest against working conditions, it is worth pointing out that in some circumstances the decision to leave was not always the

physicians. One participant astutely explained that colleagues had been forced to return to South Africa because of an expired work permit and lack of permanent residence.

Many of participants' reasons to return were situated mid-career or linked to retirement. A number of South African educated physicians noted that friends and colleagues had retired to South Africa and/or that they did not intend to retire in Canada.

As professional aspirations were at the forefront of the return decision making process, issues with the community received few mentions. However, participants did speak about returnees' failure to integrate, or an overall lack of social support and community involvement, as though it was a common understanding that friends and colleagues who did not settle in well were bound not to make it. Long, harsh winters that meant both physical and social isolation did not help the situation.

Family concerns, such as raising children away from family in South Africa, received a few mentions, but more often it was a partner's unhappiness that was identified as the true cause. In summary, return migration very clearly occurred when professional opportunities and working conditions did not meet South African educated physicians' expectations.

Conclusion

The aspirations-capabilities framework paints a different picture of physician attraction and retention than what is assumed in the physician attraction and retention literature. Physicians do not stay because the community has succeeded in retaining them, or making them happy, but because the work they could do in the community allowed them to find and create what they were looking for. Physicians stayed in Alberta for years or decades longer than they had intended because the life they wanted in South Africa, and the reasons they left, remained unchanged. Participants made the decision to stay in a rural community because their work offered a

semblance of what they were looking for and their families could enjoy a taste of the good life. Retention, however, need not be limited to staying in one place indefinitely, but also include someone's relationship, or ties, to a place. Physicians' decisions to leave, via internal, circular, or return migration, confirm and complement retention. South African physicians' leave when the life they expected, the professional prestige, position, and opportunity, and the comforts they wanted for their family, were outside of their reach in Canada and home was the best option. While there were benefits to moving, namely the freedom from rural practice and burnout, there were also costs. The costs were professional, especially when it came to relocating to the city where physicians were further deskilled and prevented from practicing the medicine that had been required of them in rural communities.

Chapter 6: Discussion and Conclusion

Physician shortages in rural communities have made essential healthcare provision difficult. The primary policy fix thus far, encouraging the migration of internationally educated physicians, has not fully addressed this rural labour shortage. These policies and practices that function to direct physicians to rural generalist medicine on the national, provincial, and community level, have placed South African educated physicians in the middle of the conversation. As I have found, these physicians' work in rural Alberta is not a matter of attraction and retention, but a question of migration and professional mobility and how the two work together to influence a physician's choice to stay.

The Pathway to Rural Alberta: The Aspiration Behind International Migration

I began by explaining why South African educated physicians had made the decision to leave South Africa, how they selected a destination, and the limitations of their agency when they ultimately had to settle in rural Alberta. South African physicians' decision to emigrate extends beyond what could be understood as push or pull factors, or a cost benefit analysis as has been theorised by Lee (1966) and described by Massey et al. (1993). Their interest in leaving was grounded in what was impossible to achieve in South Africa as a general practitioner, and what they had seen and heard was possible elsewhere: upward professional mobility. This intent emerged from physicians' descriptions of the opportunities that were available to them in South Africa, a desire to see the world made possible by working along the way, a racialized perceived lack of opportunity and status, and wanting a better financial position.

This desire for professional mobility is best understood through de Haas' (2021) aspirations-capabilities framework. South African educated physicians' aspirations were shaped by their position in South Africa, where they were privileged compared to many, but relatively

deprived within the local medical profession. Previous travel and relationships with those who had left South Africa gave physicians an awareness of what they could achieve if they left. Physicians' life course and financial position provided them with the capability, or the freedom, to migrate (de Haas, 2021).

While the aspirations-capabilities framework provides an excellent place to begin to understand South African educated physicians' aspirations, it does not fully capture it (de Haas, 2021). For these physicians, the core of their aspiration to migrate was to achieve professional status and opportunity that was inaccessible in South Africa. Although de Haas (2021) mentions that there is a place for social status at the convergence of instrumental (labour migration, means to an end) and intrinsic (personal value) aspiration, that is where the discussion ends. Higher social status is not simply achieved by migrating from a low(er) income to a higher income country, but particularly for people in regulated health professions, there are countless ways prestige is off limits to highly skilled labour migrants. The journey to status is treacherous, but considered worth the pursuit, nevertheless.

Through this lens, the decision of where to migrate - country, province, and community - is not only about benefit maximisation, but about selecting the place where aspirations have the greatest potential to flourish. South African educated physicians navigated highly skilled, international labour markets and selected Canada because the people they knew provided an example of the status and lifestyle that was possible. Given the provincial regulation of medicine, connections with South African physicians already in Alberta were particularly helpful. While traditionally used to describe how they lower costs and risks and how the social context changes, networks, or network theory and cumulative causation, also plays a role in shaping aspirations by increasing knowledge of opportunity (Massey et al., 1993; de Haas, 2021).

Participants' choice of community helped their migration aspiration to become even clearer. Completing site visits, or checking out practice options and the community, taught people what the good life here looked like while simultaneously making them aware of options that existed and were available to them. Given the intent to increase professional status, it makes sense that work and professional setup were at the forefront of physicians' considerations, why finding the right set up was particularly important for dual physician couples, and how if the primary goal was being met, the family could make the best of the community.

While physicians were largely free to make their own choice about the destination country and province, the same was not true when it came to ending up in a rural community. In fact, there were quite distinct means that delineated a clear pathway to practice in a rural community. While participants could often choose between rural communities, they could not necessarily choose between rural or urban places and some participants would have made a different choice if they could have. Instead, a lack of permanent residence, medical credential recognition, provisional registration, contracts, and position sponsorship all prevented South Africans from going elsewhere. Acting on the national level, closed work permits, and a lack of permanent residency acted reciprocally to ensure physicians could only work where Canadians were not interested. On the provincial level, credentials and provisional registration denied physicians the geographic mobility granted to those on the full, or general register, while simultaneously determining how long they must stay. Contracts and position sponsorship meant physicians could only work in "communities of need" (AHS (b), 2015).

This is a textbook example of the absence of capability, or the ability to exercise agency and freedom to choose where you lived. Not being free to make this important decision had an impact on the ability to materialise aspiration, or status. Furthermore, not only did limitations to

rural practice shape aspirations, but the reason IMGs are typically limited to rural practice, stratification between South African physicians and Canadian physicians who are free to practice wherever they wish, began to emerge.

Geographic and Professional Mobility: Place, Profession, and Status Hierarchies

Work permits, contracts, credential recognition, and position sponsorship did more than limit South African physicians' agency and send them to practice in rural Alberta. The reality of these policies, practices, and rural medicine also had the effect of restricting South African physicians to generalist medicine. Although at first glance this might not seem like a problem given that participants were generalist physicians in South Africa, most had planned to specialise when they returned after a few years in Canada and subsequently had this trajectory disrupted when they decided to remain in Canada. Furthermore, a large part of what physicians were looking for was getting away from the limitations of general practice in South Africa. This was particularly troublesome because when South African educated physicians wanted to do something other than generalist medicine, including specialising in a non-family medicine specialty, there were not any pathways to do so.

In addition to only being permitted to do the jobs Canadians did not want, work permits and contracts locked South African educated physicians into doing the work they were legally permitted to do, which was usually clinic and ER. Credential recognition and position sponsorship acted similarly to ensure physicians' scope of practice was limited to what the community needed, which was often not what the physician was capable of. As will be discussed shortly, physicians were often deskilled because of this very process and their aspiration impacted. As the literature on highly skilled labour migration indicates, migrants are considered one means to address temporary labour shortages; the literature on using IMGs to address the

rural physician shortage agrees (Czaika and Parsons, 2017; Groutis and Arnold, 2012). What is not typically considered is how these bodies of work intersect and the specific ways the policies and practices, like closed work permits and position sponsorship, directly impact professional opportunity, which in the case of South African educated physicians in rural Alberta is central to whether they stay.

The problem with generalist medicine was not only that it was medicine many South African physicians did not want to do in the long run, but that a significant status hierarchy emerged between South African and Canadian educated physicians. In particular, while South Africans considered their training and practice to be very practical and ideally suited for rural generalist medicine, they viewed Canadian physicians, including the medical students they supervised, as incredibly smart and ideally situated to become a prestigious specialist. Like Scott et al. (2007) who found that strong students were directed away from family medicine, South African physicians agreed that Canadian medical students were ‘better than’ lower prestige family medicine. This set up a simple status hierarchy between lower prestige, practical South African generalists, and high(er) prestige Canadian specialist physicians, just as Jenkins’ (2020) research found status separation between physicians depending on where they completed their medical education as well as stratification between the specialties.

However, South African physicians experienced how even if Canadian physicians specialised in family medicine, the two were not equal; South Africans still occupied a lower status position, or as Jenkins (2020) would explain, there was horizontal status separation between the groups. This experience came from the overwhelming absence of rural generalist Canadian physicians that South Africans witnessed and how when they worked with a Canadian colleague or were aware of Canadian educated physicians in a neighbouring community, how

they were more likely to practice a family practice subspecialty or to only do clinical work in a very focused area such as anaesthesia or women's health. Canadian educated family physicians were thought to prefer urban work. By and large, participants' explanations of the reasons so many Canadian physicians shunned rural general practice was that their academic and specialty driven training did not prepare them for the practical realities of rural medicine, and that Canadian physicians were unwilling to accept the all-consuming workload and impractical realities of living in rural setting with a highly educated partner. Subspecialty training was proposed to result in better working conditions, higher income, and more prestige due to the slightly more specialised nature of the medicine. Subsequently, as participants noted, the higher income and working conditions allowed Canadian physicians to choose to work less than their South African peers.

This stratification appears much like the status hierarchies Jenkins (2020) found between American and internationally educated physicians completing internal medicine residencies. Despite qualifications that were found to be equivalent, IMGs ended up in lower prestige positions, while more prestigious, academic positions were reserved, by virtue of a social contract that was the result of having "played the game" and met all of the status requirements for admission to medical school. Canadian family physicians were awarded positions of similar privilege. Thinking about the role of status and the maintenance of the medical profession's prestige more broadly, Jenkins' (2020) summary of Freidson's (1985) seminal work explained stratification in the medical profession via the emergence of "...a knowledge elite that creates guidelines, an administrative elite that enforces them, and a rank and file that follows them." South Africans' perceptions of Canadian physicians paint a picture of the "knowledge elite" and how they come to occupy their position, and how while South African physicians occasionally

infiltrate the “administrative elite” position in rural communities, the majority fall in “rank and file” behind the Canadian leaders.

To build on the above idea, while Canadian physicians built comfortable lives and practices around their professional status, South African physicians were often left to struggle in rural, general practice. Explaining that physicians worked hard did not begin to encompass how physicians gave so much of themselves to keep local healthcare afloat. The result was system induced burnout, notably exacerbated by the Covid-19 pandemic. The toll rural practice took on South African educated physicians represents a profound failure of physician attraction and retention policies and practices to recognize and support the physicians they required to work in rural, generalist medicine. While early literature from the Covid-19 pandemic has identified the pandemic had a different and harsher impact on rural physicians, any future research needs to consider differences in the experiences of IMGs and Canadian physicians given the pervasiveness of status in shaping the rural physician experience (Anaraki et al., 2022).

Professional (Im)Mobility: Implications and Opportunities of Rural Practice

In light of physicians’ aspirations and stratified positions within the Canadian medical hierarchy and amongst family physicians, the relationship between geographic and professional mobility is central to understanding physician attraction and retention. Furthermore, given how participants are burning out because of the many challenges they face in rural practice, why someone would consider staying initially makes no sense. However, many participants did make the decision to stay in a rural community.

The physician attraction and retention literature narrowly define retention as a physician's indefinite practice in a single rural community (Han and Humphreys (a and b), 2005; Cameron et al., 2010; RhPAP, 2019). My research found that retention means something else. More

specifically, I found that retention should be defined in relation to South African educated physicians' migration intentions on the provincial/national and community levels, while also considered more flexibly. First, the majority of South African educated physicians planned to be in Canada temporarily in order to return to specialise, but also because as highly skilled workers intended to address the rural physician shortage, they were only given temporary status in Canada (closed work permits, no permanent residency). However, physicians made the decision to stay in Canada and applied for permanent residency. Through this light, retention should be considered a highly successful project. Second, while roughly half of participants practiced in a rural community at the time of research, several physicians had moved between rural communities, suggesting that retention did not have to mean staying in the community of recruitment. Coupled with the alternate forms of retention found in this study, attachment and commuting, it was clear that retention did not mean a single, indefinite stay as proposed in the attraction and retention literature.

When it came to physicians' explanations for how a temporary stay became permanent, many of the same factors that limited opportunity in South Africa pre-migration were thought to have the same career, life, and prestige limiting prospects. Given physicians' aspirations, returning would not help meet them. While aspiration remained centred in professional status, life course factors around the family played a role as well. Having a family and raising your children in rural Alberta, Canada made staying a more appealing and realistic option for families, as non-physician wives could assume responsibility for childcare.

Migration theory offers some perspective on retention, or as de Haas (2021) would refer to it, immobility. For de Haas (2021), staying was as natural and reasonable a decision as leaving; those who could voluntarily migrate could also be voluntarily immobile or had the

freedom to make the decision to stay. The freedom to stay meant that physicians considered staying to be a realistic option, or that it was sufficient in meeting their aspirations for status and that subsequently the aspiration to migrate was low because physicians knew there was not a better deal elsewhere should they migrate; hence a participant's comments on choosing not to make a "lateral move" (de Haas, 2021).

Relative to many highly skilled migrants, South African educated physicians found what they were expecting (Siar, 2013; Salami et al., 2018). Participants could practice medicine in Canada as soon as they arrived, with a scope and in a rural area that took advantage of many of their skills and experience from South Africa. However, that is not to say deskilling did not occur. Instead, deskilling occurred more subtly in rural general practice through a lack of acutely unwell patients and by preventing physicians from working to the scope they were capable of. Deskilling is an important consideration and Canada and Alberta prepare to welcome more international health care workers, many of whom will practice in rural communities, and work to fortify economic migration streams to rural communities (Tasker, 2023; GOA (c), n.d.).

While South African educated physicians were deskilled in rural Alberta, rural medicine also presented more opportunities than were available to physicians elsewhere. Once free of their work permit, contract, and provisional registration, participants could leave generalist family medicine to pursue focused clinical work or other non-clinical forms of upward professional mobility that provided physicians with more prestige and a more comfortable lifestyle. Often, these same forms of mobility were not available to physicians who moved to a CMA, where physicians were further deskilled and blocked from practicing in the areas that were their bread and butter in rural Alberta, as was the case for emergency medicine. This finding aligns with de Haas (2021) on voluntary immobility, with the exception that it adds considerations around

status and applies the aspirations-capabilities framework to instances of onward/internal migration.

Physicians did not always stay. Physicians in this study internally migrated within Alberta, between rural communities and rural communities and urban centres, and relocated between provinces. While no one had returned to South Africa, people had thought about it and often had friends and colleagues who had made the decision to return. Physicians relocated once again because of burnout, the availability of opportunities elsewhere, and to meet family needs, all of which ultimately highlight the inability to fulfil aspirations in the rural community. Sometimes this could be addressed with internal migration, as internal migration theory would agree that professional mobility could be improved with corrective migration, other times moves were made reluctantly, exchanging status for lifestyle and family needs (White and Lindstrom, 2005; King and Skeldon, 2010). Sometimes return presented the only viable solution, as was the case for physicians who wanted to specialise and found no accessible routes to do so in Canada. Corroborated here, return migration theory has found that people return because they have succeeded in achieving their aspirations or had them go unmet (Cassarino, 2004; de Haas and Fokkema, 2011; de Haas, 2021).

Limitations and Areas of Further Research

This thesis has made a case for how professional mobility, upward and downward, is related to South African educated physicians' choice to stay in a rural community, but there is space for the conversation to continue. I was fortunate to speak with six South African educated physicians of colour, however, a number of racialized groups were absent or underrepresented. I cannot say with complexity and certainty how the choice to stay and professional mobility compare between South African physicians of colour and their white colleagues.

This research was situated in Alberta, Canada. As noted, Canada was only one of several countries physicians considered. Further investigation into the role of aspirations and capabilities in destination selection is required (i.e., do people choose Canada because the cost of going to Australia is too high without a social network?). Furthermore, the study's bias towards the receiving state has removed most considerations of the role of South Africa, the sending state.

While this study was limited to South African educated physicians in Alberta, South African physicians practice in provinces and territories across the country. As medicine is a provincially regulated profession where we have observed the impact of physicians limited agency in choosing place and the subsequent impact of being limited to rural generalist medicine, it would be interesting to open the participant inclusion criteria up to generate a deep qualitative understanding of the impact of provincial regulation on geographic and professional mobility in other provinces. Additionally, studying South African physicians across Canada would likely provide a fuller sense of geographic mobility and how and where physicians can access upward professional mobility.

Ethics approval, which prohibited participant recruitment in any AHS or Covenant Health facilities, may have contributed to an underrepresentation of hospital based family practice subspecialties.

Whereas scholars have found that an absence of return migrants need not be an issue when it comes to generating insights into aspirations, it would be interesting to do a study with return migrants in South Africa that inquired about physicians' lives in Canada and the outcome of their return.

Recommendations

Based on my findings, I offer a few recommendations to improve South African educated physicians' position in Alberta, Canada and to subsequently work towards appropriate physician attraction and retention strategies, including an approach that takes a different view on retention.

- The installation of policies and practices that limited South African educated physicians to rural generalist medicine necessitates not just one, but a series of changes in a united effort to improve and have a (more) national pathway to practice for IMGs.

At the national and provincial level, as the federal government has done, governments can create immigration streams that offer permanent residence. South African educated physicians work in Canada should not be limited by a closed work permit.

- At the provincial level, provisional registration is a policy that keeps IMGs in rural practice rather than primarily a means to support physicians or monitor their competence. The CPSA needs to decide if physicians who have passed assessments are in fact competent or not, in turn making provisional registration a more supportive program, or providing physicians with full registration immediately as appropriate.
- In the best interest of Albertans and rural service provision, the CPSA should work with AHS to enable and support IMGs to receive and use privileges for all of the skills and procedures they are capable of performing.
- At the community level, AHS has significant room for reform. In regard to position sponsorship, trust communities to know what staff they need. Either provide rural communities with greater hiring independence or assume full responsibility for staffing because participants stressed that the current model is not working, nor is it able to respond to staffing needs in a timely manner.

- AHS should provide physicians with more flexible contract options. Contracts should be tailored to individuals and communities. Give physicians choice over their terms and conditions and assume responsibility for any hiring costs.
- The pathway directing South African educated physicians to rural general practice and the stratification this creates are clear. Health workforce policies and strategists need to conceptualise and respond to the rural physician shortage with new tools that are mindful of this inequality. An appropriate solution to the rural physician shortage is one that lets IMGs and Canadian educated physicians choose rural practice and offers them similar opportunities in rural or urban practice. In the short term, while I noted rural deskilling could be addressed through privileging, urban deskilling could be addressed similarly by allowing South African educated physicians with CCFP to practice the same medicine in urban centres as they did in a rural community.
- South African educated physicians are interested in pursuing professional opportunities in Alberta and I have linked the achievement of opportunity to retention. The provincial and federal governments respectively should increase support for programs that offer training and education opportunities to rural physicians, such as RhPAPs rural physician enrichment programs, and additional competency training for family physicians.

Along those lines, we should normalize the return of independently practicing physicians to residency to pursue a specialty change and create positions for physicians to do so. Although perhaps expensive in the short term, this is likely to keep physicians in the profession and in the country in the long term. This is an important measure to include given how many South African educated physicians had their opportunity to specialise in South Africa disrupted by their migration to Canada. This would likely encourage the

migration of a number of physicians hesitant to leave South Africa. Alternatively, South African physicians who wish to specialise could be encouraged to delay their migration until specialist training was complete.

- The Alberta Medical Association (AMA) is charged with representing physicians' interests. IMGs make up over one third of the Alberta physician workforce, but the AMA's advocacy is rarely geared towards IMGs. The AMA does however focus much of their work on family physicians and primary care, which I have demonstrated significantly overlaps with (South African) IMGs. Given the stratification present, the AMA could become a strong voice for the interests of (South African) IMGs.
- The interlocking and multi-level policies and practices that have limited South African educated physicians to rural generalist medicine have harmed physicians, as demonstrated through descriptions of burnout or similar experiences the majority described. In the short term the Government of Alberta and AHS are responsible to ensure physicians have access to the support and resources to aid in their recovery and ensure physicians do not lose out professionally, as is the case for those leaving medicine or reducing their hours (Kiran et al. (a and b), 2022). In the long term, staffing levels must be improved. Improved working conditions will help ensure new IMGs do not suffer the same fate.
- I have attempted to change the conversation around the role of rural communities in rural physician attraction and retention. Repeatedly, South African educated physicians described the prominence of work, not community pitfalls, in the decision to remain in or leave a rural community. The responsibility for healthcare provision belongs to the Government of Alberta and AHS.

- There is a need for a national and provincial health human resources strategy. While Canada must compete with other countries for a finite number of highly skilled healthcare workers, we need not compete amongst ourselves. As medicine is provincially regulated, Alberta and the CPSA have room to improve its recruitment model even without federal support. Other provinces and countries offer examples of different recruitment strategies and ideas. As healthcare provision is a provincial responsibility, rural communities should not be in competition with each other.
- There is room to improve Canadian physicians' medical training. Rural medical experiences should be required. Historically, like South Africa, Canadian physicians have had to complete a year of general practice before specialising. Alternatively, increase the number of family practice subspecialty and focused clinic residency and training opportunities in areas such as anaesthesia and obstetrics for both Canadian medical students who may then have the skills to practice in a rural community and for IMGs who are more likely to stay in a rural community in positions of greater prestige.
- Lastly, many South African educated physicians do not go the journey to and through rural Alberta alone, but share it with their partner and children. Lack of employment for a physician's partner and subsequently depending on a single income or being unable to move elsewhere for opportunities for children when Canadian physicians are perceived to forgo rural practice for these very reasons, contributes to relative stratification between South African and Canadian physicians. While communities may support physicians' partners in securing employment to retain the family, it does not address the broader inequality that can only be addressed through employment equity and equal status in the medical profession.

Conclusion

Alberta has greatly benefited from South African physicians' hard work. South African physicians are the reason many rural Albertans have a family doctor and services available close to home. However, rural communities are still short physicians, and the government still considers attracting South African physicians to rural Alberta to be a viable solution. As I have shown, these national, provincial, and community level policies and practices have been crafted in a way that complicates South African educated physicians' relationship with rural communities and subsequently undermines their long-term settlement. South African physicians leave South Africa to come to Canada in order to access the status and prestige they were denied in South Africa, but found themselves in lower status generalist medicine, while the Canadian family physicians around them enjoyed higher status positions. Despite any downward professional mobility, physicians found creative ways to manage their aspiration and often stayed in rural communities. To move forward towards physician attraction and retention policies that are effective, physicians' best interests and well being must be at the centre of new policies. Physicians cannot simply be deployed to fill labour shortages, but have to be enabled to create the work and life they came for.

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Appendices

Appendix A: Interview Schedule

Interview Schedule

How are you? It's nice to meet you.

Thanks for agreeing to talk with me/participate in my research. I'm looking forward to chatting with you. and hearing about your experiences.

Did you have a chance to go over the consent form I emailed a few days ago? Any questions about it? As the form mentioned, your participation is completely voluntary. If you change your mind at any point just let me know and I'll stop recording. We can always skip a question - you control what you do and don't want to tell me.

Verbal Consent Script: The research study has been explained to me. I have been given the opportunity to ask questions and my questions have been answered. If I have additional questions, I have been told whom to contact. I (full name) agree to participate in the research study described.

Great. What do you prefer I call you?

Warm-Up

To get started, can you tell me about how you decided to study medicine?

- How did you decide where to study?
- Did you specialise in any area?

Core Questions

Migration

1. How did you make the decision to leave South Africa?
 - What was the role of money in the process?
2. Before you relocated, how did you envision life in Canada?
3. How did you decide where to move?
 - How did you decide on Alberta/Canada?
4. How did you come to (name of current community)?
 - What led you to relocate from community X to community Y?
5. What was the process of coming to town/Alberta/Canada like?
 - Did you use an agent - why or why not?
6. From your perspective, what was coming to town/Alberta/Canada like for your partner and or children?

7. Were other South Africans living abroad influential in your move?

Work

8. How did you go about finding a job and navigating professional requirements?
 o What was your employment contract like?

9. Before you relocated, how did you envision your work in Canada/rural Alberta Community?

10. How did the way you envisioned your Canadian practice compare to reality in rural Alberta?

11. Has being an IMG/internationally educated physician influenced your professional life?

12. How does government health policy (OR the rural physician shortage) influence what you do every day and how you think about/view rural medicine?

13. How long do you plan to stay in your current job?

Concluding Questions

14. What would you tell other South African educated doctors thinking of coming to Canada?

15. What do you think keeps Canadian trained doctors from rural practice?

16. Are there any questions you thought I would ask but didn't?

17. Could you introduce me to anyone you think might like to participate?

There are a few details to confirm - they'll help me get a general sense of who's participating. (Only ask what was not addressed in the interview)

- Age/Age Range:
- Sex/Gender:
- Race/Ethnicity:
- Medical School:
- Contract Status:
- Route of entry/admission category:

Thanks again for talking to me and for sharing your time. If anything comes up, please feel free to reach out to me.

Appendix B: Information Letter

INFORMATION LETTER

Background

Thank you for your interest in participating in research on South African educated physicians' experiences of relocating to and practicing in rural Alberta.

Researcher: Ashley Hadley, Masters student, Department of Sociology, University of Alberta.
Email: ahadley@ualberta.ca

Supervisor: Dr. Nicole Denier, Department of Sociology, University of Alberta.
Email: nicole.denier@ualberta.ca

Purpose

This study will look at the experiences of South African trained physicians to better understand the experiences of international medical graduates in rural communities in Canada, as well as to better understand the implications of the rural physician shortage on an internationally educated physicians relocation and practice. Research on how the current pathways to Canadian medical practice work for South African educated physicians will help to improve the relocation process for other South African educated physicians.

Study Procedures

Participating in the research project will involve an approximately 45-60 minute interview held over Zoom. Interviews will be recorded and transcribed verbatim. You may choose to have Zoom call audio or audio and video recorded. Interviews will be held at your convenience. If requested, I will share a copy of the thesis, and any published research with you.

Potential Benefits & Risks

The perceived benefits and risks associated with this research are minimal. You may enjoy the opportunity to tell your story and reflect on your experience of moving to Canada. However, you may find it very difficult to share the reasons you left South Africa and the challenges of relocating and getting settled. Please share only what you wish to. If needed, we can take a break during the interview or stop it completely.

Confidentiality

Interview content and participant names will remain private between the participant and Ashley Hadley. Transcripts with pseudonyms may be provided to the research supervisor, Dr. Nicole Denier, in some circumstances. Any interview quotes will be used anonymously in published research. The names of the communities and hospitals/clinics where participants practice will not be published. Recorded interviews and transcripts will be stored on the researcher's password protected computer.

Voluntary Participation & Freedom to Withdraw

You are invited to participate in the research, not obligated. Please ask any questions to better understand the project. You are free to change your mind and withdraw your interview prior to

January 31, 2023, or during the interview. It is perfectly acceptable if you prefer not to answer any of the interview questions.

Ethics Approval

Research ethics approval has been obtained from the University of Alberta Research Ethics Review Board.

Research Ethics Office: reoffice@ualberta.ca

Ethics Approval: Pro00122607

Appendix C: Consent Form

CONSENT FORM

Consent

A letter of information and consent form will be provided to participants electronically over email. Please sign and return this consent form prior to the interview. Participants may keep a copy of the form. A paper copy of this letter and form are available upon request. Should this consent form not be returned prior to the interview, verbal consent may be provided.

Please indicate the option that indicates your choice. For all options, please check yes if you do consent and no if you do not consent.

Research Consent

- Yes, I consent to participate
- No, I do not consent to participate

Recording Consent

- Yes, I consent for my interview to be recorded
- No, I do not consent for my interview to be recorded

Participant Name (please print)

Signature

Date

Name and Signature of Researcher

Date

Appendix D: Required Assessments

| Assessment | Abbreviation | Purpose and Regulatory Authority |
|---|---------------|---|
| Evaluating Exam | N/A | <p>No longer in circulation.</p> <p>Used primarily in the 1990s and early 2000s. Administered following arrival in Canada. Required assessment. Unknown regulatory authority.</p> |
| Medical Council of Canada Qualifying Exam 1 and 2 | MCCQE 1 and 2 | <p>Administered by the Medical Council of Canada to graduating medical students and residents. IMGs must complete prior to commencing practice in Canada.</p> <p>The MCCQE 2 was discontinued in 2021.</p> <p>Intended to assess foundational medical knowledge.</p> |
| Licentiate of the Medical Council of Canada | LMCC | <p>Not an assessment, but a required status an IMG can apply for following a successful MCCQE 1 result. Administered by the Medical Council of Canada.</p> <p>The LMCC recommends physicians for independent practice to the provincial regulatory college.</p> |
| Therapeutics Decision Making | TDM | <p>Nationally administered by the Medical Council of Canada but made a provincial requirement by the CPSA in 2018.</p> <p>The assessment is specific to family and general physicians.</p> |
| Certification in the College of Family Physicians | CCFP | <p>An optional assessment that can be undertaken with 5 years of Canadian medical practice. CCFP denotes specialisation in family medicine.</p> |
| Preliminary Clinical Assessment | PCA | <p>A required 3-month assessment that is administered by the CPSA and an assessing physician. Like a medical student, the observed physician suggests patient assessment, treatments, and documentation to the observing physician who is ultimately responsible for patient care. The PCA is unpaid.</p> |
| Supervised Practice Assessment | SPA | <p>A required 3-month assessment that is administered by the CPSA and a supervising physician. The IMG</p> |

practices independently with supervision from a generally licensed physician. The SPA is paid.

The final assessment completed prior to provisional registration.
