

Push, Pull, and Plant: The Personal Side of Physician Immigration to Alberta, Canada

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Background and Objectives: *The global migration of physicians has led many international physicians to enter practice in Alberta, Canada. The study was designed to explore the personal side of migration and transition experiences of these international medical graduates (IMGs). Methods:* A qualitative study using telephone interviews and a semi-structured interview guide was used to interview 19 IMGs who are currently practicing and have held Part V, restricted or temporary practice licenses for less than 7 years. **Results:** Three major themes were identified. The first was the “push” from their own country of origin and their perception that moving to Alberta would be better for them. Professional opportunities in their home country had been affected by changing policies, lack of infrastructure, and personal/family safety issues culminating in highly stressful work environments. The second was “pull.” An improvement in the quality of personal life was associated with geographical, educational, recreational, and spiritual aspects of daily living for participants and their families in their new environment. The third theme was “plant”—ie, factors that encouraged them to stay in Alberta. **Conclusions:** This study demonstrates the continued relevance of push and pull theory in understanding IMG physician migration. Our findings in this study indicate that remaining in place, or “being planted” is conditional on political, social, and economic aspects.

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Almost one in four physicians practicing in Canada has graduated from medical school in a country other than Canada.¹ Along with the debate that global migration of physicians and patterns of migration from less developed to more developed countries has generated,¹⁻³ there is recognition that adjustment to practicing in a new environment entails adapting professional practice to suit new environmental demands.

The learning curve faced by international medical graduates (IMGs) who hold Part V licenses in Alberta⁴ and the phenomena of recertification as a doctor in Canada has been explored,⁵ and the skills and clinical performance of immigrant physician have been examined and compared to those of physicians who graduate from Canadian and American schools.^{6,7} Part

V “limited” or “restricted” licenses restrict the scope and nature of a physician’s practice until the physician passes the Medical Council of Canada (MCC) licensing examinations and the physician meets certification requirements of the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada. These physicians have 30 months in which to pass the MCC examinations, although this time interval can be extended at the discretion of the regulatory authority.

However, little work has been done to explore the personal side of the decision-making process associated with migration and the decision to stay in a new country. Kinship ties have been associated with the migration of doctors in the South Pacific Islands.⁸ Interviews conducted with IMGs in Australia to determine their integration into communities revealed that there were four types of IMGs.⁹ These were categorized as (1) satellite operators—those who lived in the city but worked in rural areas, (2) fence sitters—affiliated with city fringe areas, (3) the ambivalent—uncertain about their future settlement place, and (4) those who

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'integrated' into the community.⁹ A Canadian study focused on managing migration of health professionals from sub-Saharan Africa identified that professional, economic, social, and political factors were associated with migration decision making.¹⁰

The process and factors associated with migration have also been widely discussed and well established in demography, anthropology, economics, and sociology in terms of "push"-pull.¹¹ Postulates from the initial research on global migration were that the main reasons for migration were to improve professional and economic conditions.¹² It was believed that when market forces were allowed to operate freely, physicians trained in countries without economic capacity to employ them were subject to a migration "push" from that country and a corresponding "pull" from countries with an economic capacity to employ more than they can train.¹² Nonetheless, it is unclear what personal factors and conditions enable their transition and retention in a new country.

Our previous work using a dataset of interviews with IMGs had identified the learning and examinations that physicians had had to undertake as part of the professional transition to successful practice.⁴ The human or personal and family side was not clear from that analysis. The objective of the present study was to reanalyze the data from our prior research to examine the personal factors associated with the transition into life in Alberta, particularly considering the push and pull aspects of migration along with those phenomena that affect retention.

Methods

Qualitative methods of data collection and analysis were used. As noted in a previous publication, we invited IMG physicians who had been in practice in Alberta primarily in rural areas for less than 7 years and had not completed their Canadian licensing examinations to participate in one 20-minute telephone interview.^{13,14} We chose physicians who had been in Alberta for this short length of time because we conjectured that they would be actively transitioning through the processes of change and accommodation to their new environment. All interviews were conducted between June and November 20, 2006.

We first asked the physicians the following questions. "What helped you decide to come to Canada and Alberta?" and "What major differences are there between practicing here and practicing in your home country?" We then collected personal demographic information including gender, age, and country of origin, medical school location, and former education.

Each interview was audiorecorded and transcribed verbatim for analysis. We used a combination of paper and electronic (QSRN7[®]) data management systems to expedite the multi-levelled coding processes integral to

grounded theory.^{13,14} This system enabled our team to work with the data, compare coding categories, and examine the data for causes, contexts, contingencies, and conditions of learning.

We followed a constant comparative technique, which meant we analyzed our data as they were gathered, reflected on how our questions enabled us to meet our objectives, and made adjustments to our interview guide to improve the quality of data that was collected.¹⁵ We continued sampling until no new categories were identifiable and we reached categorical saturation.¹⁵

Data collection and analysis was carried out using the following strategy. Three interviews were conducted. Each team member read these transcripts, became familiar with the data, and identified the topics raised by the participants. We then met as a group to compare and discuss the data. We used this data to construct an initial open coding structure with numerous codes and sub-codes. More interviews were conducted, and this coding structure was used by one investigator to code the next seven interviews. As new topics emerged in the text, the coding structure was built on and revised. After 10 interviews had been conducted, a second investigator recoded each of these 10 transcripts to make sure that each of the topics was coded in each of the transcripts.

After 10 interviews had been fully coded, our team identified that although our text was sufficiently rich, most of the participants were male, and we were concerned that females were underrepresented in our sample. We amended our recruitment strategy by inviting more female physicians to take part. Five more interviews were conducted, transcribed, and coded following the same process as before until no new categories emerged. The complete list of codes was shared with the research team and discussed at two meetings to reach consensus about the themes.

Because the experiences of the physicians in our study were so diverse, at 15 interviews we decided that we needed yet more interviews to be fully convinced saturation had been reached. We conducted four more interviews and after 19, no new categories emerged.

After the open coding was complete, two individuals (different from those who performed the aforementioned coding) proceeded with axial coding focused on the central phenomenon of personal transition. To do this, they compared and contrasted data in and among the categories, and refined the categories, to determine the central themes. They discussed the categories and the emerging central theme related to the process of personal transition in this theoretic sample.

The entire group met on three more occasions to discuss the thematic categories, the relationships of the categories to each other, and the conditions related to transition into Canadian practice. This research project was approved by Calgary Health Research Ethics Board

and the University of Alberta Health Ethics Research Board.

Results

The participants included five female and 14 male physicians. Ages ranged from 27 to 60 years old. Thirteen were between 35 and 50 years, four were younger than 35, and two were older than 50. A majority of the physicians (n=15) had been in the province and country for 3 or fewer years at the time of data collection.

Of the total, 11 came from Africa, and the others were from South America, Europe, and Asia. Nine physicians had made multiple moves to other countries before coming to Alberta. Two physicians described internship and residency on two different continents before coming to Canada from their country of origin. Eight indicated that they came to Canada with the initial intention to stay, and 11 never stated their original intentions. Some physicians returned to their country of origin to take care of financial issues or to maintain ties with their original country before settling in Alberta.

Their clinical experience and skills were diverse. These physicians reported skills in obstetrics, emergency medicine, internal medicine, anesthesia, psychiatry, and surgery. Their clinical experience was gathered over 1 to 26 years, and the average was 11 years in prior practice.

Themes

We identified three themes in our data: “the push” from their previous country, “the pull” of Alberta, and a phenomenon we termed “plant,” which represented those phenomena that influenced their decision to stay in place.

Push Factors

These new Canadians came from a variety of home environments. Many had unfavorable experiences prior to their move to Alberta, and these provided an important push factor. Several came from an area of crime or violence where personal safety was cited as a reason for leaving. Negative comments regarding home environments were described by 12 participants. These are described in the following quotes. One physician said:

The push factor was violence in (country of origin) and also my relative was hijacked and [there was] a lot of trauma related to that and we were finding a place to settle down a little bit peacefully so we opted for Canadian immigration.

Another stated:

From the non-professional side the whole society—you can see there’s no future for your kids . . . The society is against the white people there. It’s black apartheid

in reverse and you see this huge AIDS problem, crime problem unsolved, the country getting unsafe so you can’t leave your kids there . . . We don’t see the things here that I refused to work in my former country—there’s no stabbing and all that stuff. It’s intelligent work.

Yet another stated that:

Crime actually increased so much in (country of origin) that we decided it didn’t seem safe to stay there.

And finally, a fourth stated that:

It’s actually general standard thing in (country of origin), especially that time . . . It changed a little bit since we have the multiple trainees ah, died with the sudden death. Um, I lose my colleagues, ah like five of colleagues throughout the four years training . . . Some of them committed suicide, ah some of died with the aneurysm, three actually died like that and ah, that’s how it was quite intense.

Pull Factors

With the home situation becoming more difficult, individuals were looking for opportunities in new locations for employment and new places to live for their spouse and family. The participants selected Canada and, in particular, Alberta, for specific reasons. Ten participants had a family or social connection to Canada, and four made connections through a recruitment agency. Several statements from the physicians indicate the pull factor. One physician stated that:

I had several children who were seriously considering moving to Canada and they, they were probably be the, the biggest prompters.

Another said that:

I was born in (Canadian city). I was raised in (other country). . . . we have family, you know, in different parts of Canada . . . I have family and friends in (Canadian city) as well . . . those made it easier for me to come here . . . soon after I finished medical school I had started writing my Canadian born exam . . . I kept my options open . . . the fact that I was a citizen made it easier too.

A third physician said:

I think the Canadian regard the family still as an important structure, contrary to the British or my experience of . . . my idea of the British. I think Canadian people sort of think family life is important. That’s one big reason.

Most of the participants described multiple pull factors when discussing Canada or Alberta. They viewed Canada as a good place to live in addition to being a good place to work. Twelve participants provided positive general comments about Canada and the Canadian people. As an example, one physician said that:

We've always wanted to move to Canada. We made up our minds a long time ago. That doesn't necessarily have to do with work but it was personal and other reasons.

Another said that:

The Canadian society is so much more tolerant, and multicultural and diverse . . .

Yet another stated that:

Obviously there's a difference between living in a third world country and a first world country, and there's obviously lots of benefits living in a first world country, including a lot more political stability and things like that.

The opportunities for spouse and family were also described. For example, one physicians reported that:

My (partner) wanted to come to Canada ever since we could remember.

Another stated that:

I'm a Muslim and there are very few who belong that particular type of Muslims who live in (home country) so we've always wanted our children to grow up where there are more of us—to keep our culture, religion, and traditions—and that has always been the main reason to want to go to Canada.

Still another said that:

We've got two cities within an hour of us and two hours from the mountains and you've got all the positive things about city life without the problems of city life . . . The schools are still stable and nice and my children are in public school and they enjoy it.

Plant Factors

In addition to being attractive locations to work and live, the participants described that Canada, and specifically Alberta, had important features that continued to support their choice of migration and support staying in place. Some of these features included good public services like schools and universal health care. For example, one physician said that:

After checking out the place and we found the school system was so good that we decided to stay.

Others included good opportunities for recreation and quality of life, stating:

That's why we decided to stick with Alberta. I think the sunshine. Just because of the . . . you got longer summers and you got lots of outdoor activities to do whether sleighing or, or in the summer with the lakes, that was just a big comfort.

Another example include the comment that:

I have a better personal life. I have much more free time to spend with my family. My wife hasn't had to work 12 hours as she had to work there. My income here is almost three times more than the income—our total income—there and I work many, many times less.

Discussion

This study focused on a group of IMG physicians who came to Alberta to provide medical services in rural locations at some distance from the two largest cities and five mid-size cities. We looked specifically at the personal side of their transition into Alberta practice when they were new to the country. Previous work had established that they faced a number of professional hurdles, including passing the examinations that would ultimately determine whether they could stay in Canada and those aspects of patient care that were different—including managing different patient expectations, new clinical presentations (chronic diseases, sports injuries, geriatrics), and new approaches to referral.⁶

The central themes identified in this study correspond with the categories of push and pull in established migration theory as well as one we termed plant.^{10,12} However, our work differs from earlier work^{10,12,16} in that we identified conditions that enabled individuals to resist a further migration pull and thus plant themselves within a community. Our participants' experiences suggest that personal factors including kinship networks influence choosing Alberta as a destination¹⁷ and that factors including safety and security enhance the transition into life in Alberta. Because nine of the 19 physicians had made at least one move from their country of origin to another country prior to arriving in Alberta, one could conjecture that the absence of specific factors and the presence of others stimulated their move to Canada.

Our study demonstrated that plant factors extend to the personal factors associated with family and personal life. Our findings support the incorporation of aspects of social network theory¹⁷ and push-pull¹² in attempting to explain why some IMG physicians who come to Canada migrate from province to province before

becoming planted in one place.¹⁸ They felt privileged to be in Alberta and were grateful for the opportunities they were given.

Limitations

Our findings are limited, however, by the fact that study participants were a select group of IMGs. Therefore, we do not know if their experiences are transferable to other IMG groups. Most of the participants in this study were males who came from one location, and all were practicing in one province in Canada, so we don't know how transferable these findings may be to other geographic locations and contexts.

The participants varied in age from 27 to 60 years, so the findings may not apply to physicians in other age groups. Further, this study was not designed to determine differences between individuals within the group. Further study may determine whether age is an important factor in physician transition. Finally, the credibility and dependability of our findings depends on our participants' abilities to speak freely and the research team's ability to understand what is said.

Conclusions

This study sheds some light on the personal side of settling into a new community as an important aspect of physician migration and transition. Individuals migrate to a new location for improvements in quality of personal life, professional opportunities, and security. Our study demonstrates the importance of a helpful and welcoming reception into Canadian life, the need for continued support, and recognition that there are many personal factors required for successful transition of IMG physicians into local life. We anticipate that our findings may be useful to those working with physicians who are transitioning into practice from another location. Clearly, the results of this study indicate that more qualitative research is needed to further explore the concept of "plant."

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