South Asian Women Physicians' Working Experiences in Canada

by Nilima Mandal Giri

Cet article nous parle des femmes médecins installées à Montréal depuis le début des années 1990. Il met en évidence les expériences des immigrants et des femmes qui entrent sur le marché du travail au Canada.

The South Asian physicians that arrived to meet the increasing demand for doctors were obliged to deal with unpleasant racial biases and discriminatory attitudes as they struggled to prove their medical qualifications were equal to those of their Canadian counterparts.

For the first time in the 1960s, professional South Asians were able to immigrate to Canada and practice medicine. Three factors created the opening for South Asian physicians. First, there was a need for professionals in the field of medicine in Canada which could not be met by Canadians and the preferred immigrants from the United States, Britain, and France (Ghosh; Whitaker). Secondly, the Canadian government lifted the restriction based on ethnic origin and nationality from the immigration policy (Estable; Whitaker). Thirdly, Canadian universities and the Canadian International Development Agency (CIDA) created some financial assistance for foreign graduate students (Statistics Canada). As a result, a large number of South Asian professionals and graduate students, mostly men, came to Canada and joined the workforce. Yet, as as immigrants from Third World countries, the South Asian physicians that arrived in Canada to meet the increasing demand for doctors were obliged to deal with unpleasant racial biases and discriminatory attitudes as they struggled to prove their medical qualifications were equal to those of their Canadian counterparts.

My study focuses on the experiences of South Asian women physicians who availed themselves of the newly created opportunity. My conclusions are based on the quantitative and qualitative analysis of the data collected from questionnaires and in-depth interviews I conducted between December 1991 and November 1992 with 23 physicians whose names were collected from South Asian community centres and from other physicians. These women started to arrive in Canada in the late 1950s. Their number accelerated in the '60s and '70s and decreased in the '80s and '90s. They are a minority among minorities and, until now, scarcely visible in the literature of immigrant and South Asian women (Mandal Giri).

The majority of the South Asian women physicians arrived in Canada either accompanied or sponsored by their husbands who were professionally employed or graduate students. The women assumed entering Canada would be easier for them as dependents and wives than as independent women physicians. A few women did, however, enter independently, as physicians or students, and one as a refugee from the social unrest in her home country.

At the time of their arrival in Canada the majority of the women were in their twenties, and came from middle-class families. Most had fathers who were university educated professionals while their mothers had elementary or high school education and were housewives. All the women had graduate or post-graduate degrees and the majority had work experiences as interns, residents, family physicians, teachers, and researchers varying from one to seven years.

In spite of their professional degrees and work experience, however, the majority of the South Asian women physicians were not considered qualified to practice in Canada. Most were obliged to re-qualify. Although the few physicians who had graduated in England were at an advantage, their experiences differed depending upon their professional specialties. For example, one physician who earned her Bachelor of Medicine and Bachelor of Surgery (MBBS) degree in England and had two years working experience did not require a Canadian degree or any further experience to join the workforce. She did however, have to pass an examination to earn her Licentiate of Medical Council of Canada (LMCC) certificate which qualified her to practice in Canada. Another physician who received a Doctor of Optometry degree but did not have any practical experience, was obliged to complete another optometrist degree from a Canadian university before starting her practice.

Other women physicians with degrees and work experience had to successfully complete four stages before they were considered qualified to practice medice in Canada. They had to pass the Educational Council for Foreign Medical Graduates' (ECFMG) examination (prepared by the United States), complete three to four years of intern and residency programs in hospitals, and pass another examination to obtain their LMCC certificate which is required for private practice in Canada.

Some of the women physicians took the ECFMG examination while still in their home country. Others were unaware or unable to take that examination before coming to Canada. As the ECFMG examination in Canada is held only once a year, the majority of the women who had not taken the exam before immigrating later waited a long time to write it and prepared for the exam by joining a

special class designed for foreign students or studying by themselves. Married physicians with employed husbands did not face financial problems during this time, but the single physicians were compelled to accept odd jobs. One physician who arrived alone in the early '60s went to the medical director in a Vancouver hospital to find work and was sent to work in the hospital's laundry. Humiliated, she felt she had no choice but to work in that laundry until the time of the ECFMG examination. "I was so miserable that I cried every night and asked God why my parents sent me with my qualifications to work in a laundry in a hospital in a foreign country so far away from home?"

They were made to feel inferior for being women and specifically for coming from Third World countries which are not technologically advanced. The women felt obliged to prove that they were as smart, intelligent, and aggressive as their Canadian colleagues.

The ECFMG examination was easy for some but difficult for others, mostly because the form of the exam—multiple choice questions—was unfamiliar to them. Some of them had to rewrite the examination more than once. Physicians who had graduated from a medical college not on the approved list were not allowed to take the examination at all. For example, one physician graduated from a medical college's Faculty in Ayurvedic Medicine with a degree in combined medicine, allopathy, and ayurvedic medicine. She arrived in Canada in the early '60s after two years of working as an intern in a New York hospital. According to her, the ECFMG examination was not required at that time and she was hired in a Montreal hospital as a physician. After working there for seven years, however, the administration declined to renew her contract without the ECFMG. She was not allowed to appear for the ECFMG examination because the name of the medical college from which she graduated was not on the approved list. Her work experience in New York was not considered relevant. As a consequence, she had to give up her career as a physician.

After passing the ECFMG examination the physicians became eligible for the internship program. Many found that even after passing the ECFMG, entering the internship program was difficult, and some had to wait three to four years before being accepted. Even physicians with post-graduate degrees had difficulty entering the internship program. One physician with a post-graduate degree wanted to intern in a children's hospital and specialize in pediatrics. She was told she was too old to intern although she was only 26 years old. She applied for a research position and was again turned down. She was told "research work is available only for Canadian citizens not for immigrants." She was finally accepted as a pathology intern.

During their internship, the majority of the women felt overworked. The working hours were too long and they were unhappy with the on-call arrangements. One physician felt there was discrimination in her working conditions. In the hematology laboratory, she was assigned ten bottles of blood to draw in a day while another was given one or two bottles. Another physician, however, said that compared to her previous experiences in India she worked fewer hours and was never overworked.

Although the women physicians were paid while in the internship program, for most the salary was not adequate. Some of them felt, "it was not enough for rent, grocery, and other necessities." Fortunately, the majority of them did not suffer financially as they were married and had employed husbands. The single women physicians lived on a very tight budget.

As interns, the women physicians interacted with professors, supervisors, colleagues, and patients. In general, they were satisfied with their professors. However, one physician felt professors undermined her professional knowledge because she came from a Third World country. Another physician found that her working relationship with her professors varied from hospital to hospital, some being better than others.

Interns on duty are supposed to hand over patients' reports to the supervisor in-charge at the end of the day before leaving the hospital. Some physicians experienced unpleasant relationships with their supervisor in-charge. For example, one physician felt her supervisor made her long hours of hard work even harder. She said,

> *the in-charges are supposed to be around at 5:00–5:30p.m. but my in-charge never showed up before 8:00–8:30p.m. So after giving my report I used to leave the hospital at 10:00p.m. and had to come back at 7:00a.m. the next morning. It was hard.*

She felt she was treated respectfully only by supervisors who were not of Anglo-Saxon origin.

While working as interns the majority of the women physicians felt uncomfortable with their Canadian colleagues' behaviour. They were made to feel inferior for being women and specifically for coming from Third World countries which are not technologically advanced. Therefore, the women felt they were obliged to prove that they were as smart, intelligent, and aggressive as their Canadian counterparts. One woman physician faced derogatory remarks such as, "Oh, you have short legs," or "women should shave their legs," etc. Another physician, married and with small children, received cold and unsympathetic behaviour from both male and female colleagues.

> *I had a two-year-old boy. To start work at the hospital at 7:00a.m., I had to wake him in the early morning and leave him with the baby sitter at 6:30a.m. So I was always worried for the child. When occasionally I talked about my worries, nobody showed any sympathy.*

In general, South Asian women's interactions with patients were satisfactory except for a few incidents. Patients were satisfied with the physicians' behaviour and treatments, because the South Asian physicians were more inclined to listen attentively to what the patients said and tried to diagnose without depending solely on machines and laboratory tests. This was a skill they brought with them from their home countries, as technological apparatus is not as readily available in South Asian hospitals and physicians are therefore trained to diagnose by paying attention to a patient's perceptions and without technical supports. However, a few of them faced uncomfortable behaviour from patients. For example, one patient did not want to be treated by one of the South Asian women physicians because she was wearing a *bindi* (red dot) on her forehead (which indicated that she was married). Later, that physician never wore a *bindi* again while working in the hospital.

The women believed that the practical knowledge they had acquired working with patients with many different diseases made them more skilled than many western doctors. Some handled more patients a day with a wider range of diseases in South Asian hospitals.

After finishing the internship program the physicians could choose to enter the residency program and specialize in a particular field. The duration of the residency program is up to four years depending on the field of specialization. A few South Asian women physicians applied to the residency program, but found if very difficult to gain admission. The study revealed that after initial difficulties they were admitted to specialize only in fields where their countries had already achieved academic success. Some of the women did their residency rotating in the several hospitals in Montreal, while others went to different provinces in Canada. During the period of residency many of them changed their chosen field. For example, a few of them completed half or even all of the residency program in pathology and realized they were at a disadvantage to work as pathologists because a qualified pathologist must be attached to a university. They believed getting an academic position in Montreal would be hard for them as women and as a visible minority. As a result, these physicians re-qualified as gynecologists or started a private practice as general physicians.

At the end of each year of the residency program the physicians are evaluated by doctors they work with. Some of the women physicians were better treated by their colleagues and other doctors than when they were interns. Others, however, continued to face problems as women and as South Asians. One physician said that she experiencded a lot of discrimination in the department of gynecology because she was a woman, pregnant, and non-white. "I did not know whether my age [over 30] and/or pregnancy with second child played a role because I was slow compared to others." At the end of the first year, she was evaluated by four doctors. Three of them considered her very good and wanted to her to return for a second year. One doctor evaluated her as incompetent and said she should not continue her residency. She decided to drop the residency and opened her own clinic. Another physician felt she was under stress to prove her capability as a medical doctor from a Third World Country. She felt she had to become as aggressive as the others, in contrast to the culturally-valued moderate, humble behaviour taught to women in her country. Physically she also was under tremendous stress as she tried to combine her hospital work with care for her family and newborn baby.

All the physicians, whether they completed the residency program or not, appeared for another examination and without any difficulty received LMCC certificates which qualified them for private practice. Also, they passed the French language test to be eligible to practice in Quebec. Some physicians received graduate or post-graduate degrees from Canadian universities.

At the time of my research, the majority of the South Asian women physicians were working in private clinics which they owned solely or jointly. Some were working in hospitals and a few were working in both hospitals and clinics. The majority preferred to work in private clinics. Many had dreamed of having their own clinics while some realized it was the only way to combine family and career, because, they could schedule their working hours according to family needs. Finally, with determination and hard work the South Asian women physicians overcame all obstacles and established themselves as successful physicians.

As women and immigrants from Third World countries the South Asian physicians had faced a number of unpleasant situations during their internship and residency, dealing with racial biases and discriminatory attitudes as they struggled to prove that they were as qualified medically as their Canadian counterparts. Later they realized that there were reasons why their expertise was undermined by Canadian colleagues. The western doctors' knowledge about Third World diseases was mostly theoretical, based on literature, but they had the advantage of sophisticated technology. The women believed that the practical knowledge they had acquired in their own countries working with patients with many different diseases made them more skilled than many western doctors. Some of them had handled more patients a day with a wider range of diseases in South Asian hospitals than in Montreal hospitals. Furthermore, they often had to diagnose manually, not depending on machines and laboratory tests. However, they admitted that they were delighted to have an opportunity to use modern technological devices and to learn new things in Canadian hospitals.

Further studies are needed on the experiences of Cana-

dian born South Asian women physicians and also comparative studies on other ethnic women physicians in Montreal and elsewhere in Canada. Over the last four decades, the number of ethnic women physicians in Canadian hospitals has increased. It would be interesting to know whether the second generation of Canadian South Asian women physicians have experienced more respect and understanding from their colleagues and teachers. Have Canadian hospitals succeeded in creating a learning and working atmosphere free of gender and race bias?

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For the past 15 years, Wendy Lewington Coulter has been creating quilts which are firmly rooted in the traditional craft of quiltmaking in both design and construction. She uses the historical context of the quilt-form to explore issues of social, spiritual, and personal identity. While her work utilizes traditional techniques such as hand and machine appliqué, hand embroidery, hand quilting, and piecing, her work also incorporates contemporary techniques such as screen printing, painting, stamping, collage, laser imagery, and dying. Lewington Coulter lives in Mission, B.C. While designing, creating, and exhibiting her work is her primary focus, she also teaches, lectures, and has served as a juror and judge for a variety of art and quilt exhibitions.