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Being called "skilled": a multi-scalar approach of migrant doctors' recognition

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Abstract

This article highlights the way the specific configuration of migrants' skills relies on the relation between admission and inclusion policies, which involves several actors, time-frames and a multi-scalar integrative approach. It builds on a qualitative study which reports different scales of analysis for enhancing different actors participating in the recognition process of being called "skilled". The study investigates how the "skilled migration" category is socio-institutionally constructed and how it corresponds to a recognition process that interplays with different scales (macro, meso and micro scales) and the corresponding actors (regulatory actors, civil society organisations and migrants). The main argument of this article is that the regulatory framework (e.g. admission policies, academic institutions' procedures, professional bodies' rules), organised civil society interventions and networks of power are key factors for the development of an "ascribed qualified migrant" into a *de facto* "achieved skilled professional", and therefore the recognition of migrants as visible – and valued – "skilled professionals".

Keywords: Migration; doctors; multi-scalar approach; process of recognition; labelling.

Introduction

The international competition for skilled professionals is a central question in terms of what has been announced in the public discourse as the "knowledge-based societies".

Alongside "reception", admission policies mostly assume special relevance in the process of skills transferability. Depending on the definition used, the extension of migrants that could be named "highly skilled" varies accordingly (Parsons *et al.* 2014). Some authors, such as Irina Isaakyan and Anna Triandafylldou (2013: 2), underline the fact that besides who can be considered "highly skilled", the focus should be on how this status can be proven and what to do with this status after it is proven. Indeed, as pointed out by Metka Hercog (2017, 12), "skills are not valued in and of themselves". For instance, the evaluation of "skill" reveals gender inequalities (Kofman and Raghuram, 2005) and the female skilled migrants are often neglected (Kofman, 2000).[1]

Therefore, it is relevant to consider the process of recognition, essential for the social and political legitimisation of being named 'skilled'.

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[1] Please see Ribeiro (2008a) for the visibility of migrant women in medicine and nursing areas.

To be considered a "higher skilled" or "lower skilled" migrant depends on admission policies based on labour market forces which differentiate between who can be included or excluded in the primary labour market of the "receiving society". The launching of selective policies, based on either an employer-driven strategy or a points-based system, contributes to the recognition of the "highly skilled migrant" as the one who accomplishes at least one of the following requirements: finding an "adequate" job, and thus having an employer's selection of skills before entrance (the employer-driven approach); or being assessed by the level of human capital, for example professional experience plus educational credentials (the points system approach).

Taking for granted that doctors have been certified as qualified professionals by a foreign institution, the aim of this article is to analyse the mechanisms of regulation and non-state initiatives that intervene in the process of the recognition of migrants as *de facto* skilled professionals, using a multi-scalar approach. The main concern of this article is the process of skill achievement, that is, the recognition as a "skilled professional" by the "host society" institutions and organisations.

The intertwined relations between regulatory actors (macro scale approach), civil society organisations (meso scale approach) and individual strategies (micro scale approach) assume special relevance as they allow to conceive the process of recognition as a social and systemic process where several actors, coalition interests, countervailling forces, networks of power and internal (and external) mechanisms of in/exclusion intervene.

Therefore, the extension of the professional jurisdictional domain beyond nation-state borders is a question to be discussed, considering that "occupational licensure rules function as implicit, non-visa policy barriers to skilled migration" (Brenton *et al.*, 2014: 46). Bearing this in mind, it seems very much to the point to analyse the medical profession within the framework of the international skilled migration debate. In this vein, it is also important to remark that the brain drain phenomenon was first discussed in the mid-1950s by the British Royal Society to address precisely the international movement of Scottish medical graduates towards North America (US and Canada), and, from there, to Australia and New Zealand (Mackay, 1969). More recently, several cross-national case studies have covered the migrant's "host country reception" (Bernstein and Shuval, 1997; Bourgeault *et al.*, 2008; Wismar *et al.,* 2011), namely the "skills portability", considering the neo-economists and human capital scholars' language (Chiswick *et al.*, 2005).

This article contributes to analysing skills transfer as a process of skill achievement rather than of qualification ascription (Csedő, 2008) as it comprehends the socio-institutional recognition process of the human capital, placing the focus on the institutional-political frame instead of the individual.

This paper is based on longitudinal qualitative research into the mobility of healthcare professionals in Portugal.[2] In this article, the focus is on the medical profession and only on the non-EU doctors. Indeed, medicine is evaluated as "an occupation which has assumed the dominant position in a division of labour" (Freidson, 1989: xv). Regarding the non-EU citizens, there is no automatic recognition of diplomas. Moreover, the Eastern European migrants in Portugal were studied by some academics (Baganha *et al.,* 2004), who proved the skilled scope of the flows and the underemployment that they experience.

Despite being medical graduates, the interviewed doctors presented a differential inclusion (Espirítu, 2003), translating a migratory path usually performed by the migrants labelled as "lower skilled migrants", entering Portugal with a tourist visa and overstaying without leave to remain. Only when they manage to get a labour contract is there the possibility of reaching a regular migratory status (a "permit of stay"[3]). Therefore, they could be considered "overstayed and overqualified migrants" because, despite being formally highly qualified in an in-demand area (medicine), they have overstayed and are overqualified, working in jobs below their education level and work experience.

In addition to the doctors´ biographical interviews, semi-structured interviews were carried out with institutional actors (the World Health Organisation, an EU Commissioner, the former Health Minister, the Borders and Frontiers Service (SEF), the High Commissioner for Migration, the National Recognition Information Centre (NARIC), the Portuguese General Medical Council (Ordem dos Médicos), medical faculties, trade unions, student associations, an international Catholic organisation and a foundation), along with a document analysis of national and international regulatory frameworks.

The following sections focus on a multi-scalar analysis of the social and institutional construction of "who is a skilled migrant". Firstly, I seek to understand the process of skills re-distribution in the institutional ladder (macro scale) using institutional semi-structured interviews and the analysis of national and international legal and institutional documents; secondly, based on participant observation and interviews with an international Catholic

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[2] This longitudinal research includes fifty-eight EU and non-EU doctors and nurses. For the purpose of this article, eighteen biographical interviews were conducted with non-EU migrant doctors (ten males and eight females), trained in the Republic of Moldova, the Russian Federation, and Ukraine. Most of the non-EU interviewees were enrolled in a Project (Project of Support to the Professionalisation of Immigrant Doctors, PAPMI)), implemented by an international Catholic organisation and supported financially by a foundation. Regardless of the age group in which they are located (half of them have less than 35 years old), the family structure with parental and marital responsibilities is already framed. The most frequent situation is that the children were in the countries of origin with their maternal grandparents.

[3] The "Permit of Stay" was the document provided to migrants that entered in Portugal before 30th November 2001 with a valid work contract and their Social Security situation regularized. This was a one-year permit that could be renewed four times.

organisation and a foundation, I identify networks of support in different social systems (meso scale); finally, I report migratory paths that underline "capabilities of resistance" in the face of systemic structure conditioning in order to translate the way mechanisms of inclusion and exclusion drive personal biographical stories (micro scale).

Institutions, health and migration governance

Migration and health studies lack a harmonious definition of "who can be considered a migrant healthcare professional": the "foreign-born", the "foreign-trained" or the "foreign registered" healthcare professional? In this regard, the Action Plan for the EU Health Workforce (SWD [2012] 93 final) was one of the first EU positions regarding "how to define and measure healthcare jobs". Therefore, two supranational entities are relevant for this debate: the World Health Organisation (WHO) and the European Commission, as they are responsible in leading and/or supporting initiatives for promoting a knowledge base on health forecasting and planning methodologies. Among these efforts, we can distinguish the Joint Action on Health Workforce Planning and Forecasting (2013–15), financially supported by the EU in the framework of the Public Health Programme. One of its aims was the improvement of the quality and comparability of healthcare workforce data (particularly international mobility data) that is collected and supplied by member states.

In accordance with an EU commissioner from DG SANCO, building indicators related with migration flows is "the most important area for us to get consensus at the EU level… to improve data on mobility… We would like to develop a mobility indicator at EU level". It is an area which involves an effort in the cooperation of international organisations, mainly the WHO, the Organisation for Economic Co-operation and Development (OECD) and the International Labour Organisation (ILO). Some of the issues that came up during the interviews with international actors concern the fact that most of the countries are collecting information based on stocks in the public sector and are not considering the employment conditions (a part-time/full-time job or a double employment situation).

Besides the institutional definition of "who can be considered a migrant healthcare professional", it is important to know "who is allowed to be a healthcare professional". Therefore, it is essential to consider the gatekeeping role played by national regulatory bodies such as the Portuguese General Medical Council (Ordem dos Médicos) as it rules on the re-acquisition of the occupation license, a previous condition for practicing medicine. In this vein, Frank Parkin (1979) precisely underlined that credentialism is the way that professions establish a legal monopoly of a licensure.

Indeed, as medicine is a self-regulated profession, before achieving a "skilled status" the non-EU migrants in Portugal interviewed for this study had to pass through a process of assessment, which involved a training period (of approximately six months) and a set of exams (testing communication and theoretical and patient clinical diagnosis).

After succeeding in this process, the non-EU graduates could be registered at Ordem dos Médicos as General Practitioners (GPs), and therefore obtain a professional license, which is compulsory for the proper exercise of the profession. However, in most of the cases a provisory professional license was granted (a "supervised license"), which implies that the doctor would work under the supervision of a licensed doctor.

In accordance with legal procedures, the regulatory body in Portugal officially has three months to issue the professional license, but it can take up to six months to do so due to administrative procedures. As the vacancies for internships are defined on a yearly basis, the delays on the delivery of the license by the Portuguese physicians' association can also cause some problems for the non-EU migrants applying for the supervised internship that authorises them to practice.

After the implementation of a Portuguese law (Act 341/2007) that guides the recognition of qualifications in terms of level of studies (graduate, master and PhD), some relevant changes have been introduced. For instance, the period for administrative procedures has become shorter, the expenses have decreased, and the process now involves less bureaucracy and more transparency. Previously, the re-accreditation process was entirely controlled by the medical faculties, which, besides giving information to applicants in an inconsistent manner and at a very slow pace, required several documents, some of them difficult to access in the countries of origin (such as the graduation course program), along with their translation and authentication. Thus, since 2007, it has become easier to register the level of higher education. However, to obtain the equivalence of the diplomas – that is the academic recognition of the field of specialisation, level, length and program content of studies (a requirement for post-graduation proceedings) – is a more difficult process.

The former president of the Ordem dos Médicos was very critical of the above law, pointing out the fact that "the law allows the Eastern European peers, namely from Russia, Moldavia and Ukraine, to be registered in the Ordem dos Médicos and have the same rights as the doctors that are trained in Europe, without an evaluation exam… That's why I said that Ordem dos Médicos doesn´t guarantee the quality of doctors as we are obliged to accept the registration of many doctors, or all of them! At this moment, we didn't do any evaluation of doctors who are going to be registered in Ordem dos Médicos…We just guarantee the quality of the Specialists!"

In contrast, the national agency for the recognition and comparison of international qualifications – the National Recognition Information Centre (NARIC) – has a completely different approach and insists on the importance to modernise higher education, launch reforms to implement the Bologna system and promote international mobility among researchers and students. To make it possible, they collaborated with thirty-three countries to find out if the higher education institution that grants the diploma is trustful and if the diploma is authentic. For the director of NARIC, "it is considered good practice in the EU… For the immigrant communities it represented a possibility and a hope…".

Meso level actors as the bridges and the brokers

Being aware of the high level of qualifications of the Eastern Europeans in Portugal, and having the financial support of a foundation, an international Catholic organisation launched a Project (Project of Support to the Professionalisation of Immigrant Doctors, PAPMI, 2002-5) to promote the inclusion in the medicine profession for those who were overqualified in Portugal. At that time, and despite the announcement of some measures (e.g. the fast-track diplomas recognition, special short-term visas), there was not a selective admission policy or a special international recruitment scheme for doctors from countries where there was no automatic recognition of diplomas.

Being registered in this Project corresponds to being entitled to a monthly scholarship (which allows a focus on medicine studies instead of work), financial support regarding the translation of documents and the payment of enrolment fees required by the Portuguese medical faculties. Additionally, the international Catholic organisation supported the newcomers with "inclusion policies", such as Portuguese and medical language courses. The organisation was also an information mediator between institutions with an active role in the recognition process, such as SEF (Borders and Frontiers Service), embassies or consulates, medical faculties, Ordem dos Médicos and employers. This intermediary organisation strategically orients the applicants towards education institutions that are not too restrictive in terms of the required documents and the legal certification.

To overcome some difficulties, agreements were made between the Portuguese Borders and Frontiers Service and education institutions whose main priority was the assessment of participants' documentation and the establishment of a traineeship for them. In this way, the "permit of stay" of the candidates could be renewed during the training period despite the fact that they did not hold a labour contract. For those succeeding in that process, a "residence permit" was launched without needing a visa. Moreover, a protocol was established with the

Ministry of Health ensuring internship vacancies in the Portuguese National Health Service (NHS) for the beneficiaries of the Programme.

To sum up, this case study on Eastern European doctors' inclusion in the Portuguese healthcare sector reveals the importance of non-state initiatives in the recognition process of being called "skilled". Indeed, they act as service providers (of language courses or training programmes), as bridge-builders of social capital, as promoters of internal bonds among the participants, as mentors for newcomers and as certifiers, contributing to the social legitimisation of internationally educated professionals among employers and health-services users. However, the meso level actors are often ignored in the recognition process of those who are internationally graduated.

Mostly perceived as important actors regarding the implementation of social inclusion policies, the Third Sector organisations (in this case the "organised civil society") also have an active role in the creation of structures of opportunities for skill achievement. Indeed, after this Project was launched, some important amendments were introduced. First, a legal framework that provides fast-track diploma recognition in terms of level of studies was developed in Portugal (Act 341/2007). This occurred before the development of similar initiatives at the EU level, such as the EU Blue Card Directive[4]. Second, the medical faculties' requirements became more harmonised. Third, a state institution (named the High Commissioner for Migration) launched an Office for the support of Academic and Skills Recognition in 2003 (effective in 2009). Additionally, a fellow Programme (Professional Integration of Immigrant Doctors, PIPMI, 2008–9) was established, which instituted rigorous criteria for applicant admission. This last Programme was provided by the same organisation, coordinated by the same Foundation but sponsored by the Ministry of Health. These initiatives give evidence to a bottom-up institutionalisation process of non-state actors' activities.

Migrants' paths: aspirations, experiences and resistance

The analysis of biographic data constitutes an opportunity to approach the structural conditionings and networks of support involving the capabilities of resistance of migrant doctors. Drawing on Amartya Sen's approach (2009), the concept of "capabilities" refers to the subjectivities of agency, being the ability to choose the life people value (and therefore represents the ability to be

[4] Council Directive 2009/50/EC of May 25 on the Conditions of Entry and Residence of Third-Country Nationals for the Purposes of Highly Qualified Employment. This Directive was transposed to the Portuguese legislation through Act 29/2012 of August 9, which extends the grant of the residence permit to subordinate employees and for investment business purposes. In June 2016, the above Council Directive was reviewed (*Proposal for a Directive of the European Parliament and the Council in the Conditions of Entry and Residence of Third Country Nationals for the Purposes of Highly Skilled Employment*, SWD(2016) 193 e 194 Final, 7th of June).

subjects of their own lives). Here, the societal level is also stressed (hence the reference to resistance), namely the societal constraints for doing things a person may value or for being valued, in this case as a skilled professional.

Among all the interviewees, over-qualification and gender segregation are common biographical experiences at the initial stage in Portugal. While most of the males are working in the building sector (as bricklayers, hod carriers or machine operators), women have more diversified working experiences as maids, employees in restaurants, bakeries, aviaries or coffee shops, employees in cleaning services or escort services in bars, or working as the caregivers of disabled people or fruit wrappers in warehouses.

Even after the process of re-accreditation, all the interviewed doctors have to pass through an experience of "downward internal occupational mobility" (Shuval, 1998). Indeed, having their credentials recognised as General Practitioners means that their previous work experiences as specialists were devalued, and they could only work in health centers or private outsourcing enterprises that recruited General Practitioners for emergency services.

If the non-EU doctors wanted to progress up the career ladder they could apply either to the Board of Specialists of Ordem dos Médicos, and once again begin a new process of specialty recognition (an academic recognition); or apply for a post-graduation training (a specialty internship), which involves communication and theoretical exams. Depending on their grades, the applicant could then choose a specialty to perform during the residence period that varies in length depending on the specialty. Overall, the most representative specialties – Intern Medicine and General and Family Medicine (GFM) – are a second choice for the Portuguese doctors. This is in line with other studies that prove the allocation of foreign-trained doctors to underserved areas, less prestigious institutions and specialties (Oikelome and Healy, 2013; Fink *et al.*, 2003; Mick *et al.*,2000).

By presenting the following biographic profiles of Anatoly and Valentina (the names are pseudonyms), both specialist doctors in their countries and with a second specialty in Portugal, this section sheds light on the dynamics and individual strategies under the process of recognition as a "skilled professional". Additionally, the two profiles also denote gender differences. In the female case, the need to balance between production and social reproduction responsibilities is evident.

Anatoly

Anatoly is a Moldavian doctor who migrated because of "necessity". Since 1999, Anatoly has held a Dermatology specialty, granted in Moldova, his country of origin. Despite this, he never worked as a dermatologist. At the time he finished his specialty, he understood that his country could not give him a

future as there were no vacancies in the Moldavian cities for a dermatologist. He could work as a General Practitioner but, as he stated, "I didn´t want to… because it is not well paid, because it is not my specialty". Anatoly is the only one of his family who migrated. In Portugal, he worked irregularly in the construction sector as a servant and in a petrol station washing cars, a "tiring job", as he stated. There, he obtained a labour contract which allowed him to receive a "permit of stay" in 2001, and he became a regular migrant. In the first years in Portugal he lived with Ukrainians, but now he lives alone in his own apartment in Lisbon. When he worked in the construction sector he met a Russian married to a Portuguese, who had been in Portugal since the beginning of the 1990s. She visited the construction site to give support, delivering clothes and information. Meanwhile, he knew another Russian immigrant women, graduated in medicine, who advised him in the re-accreditation procedures, a process that she had already passed through. Moreover, she even encouraged him to begin the process straight away, despite not being legalised. He followed her advice. At that time, as Anatoly explains, "equivalence isn't related to the passport". It was really complicated to gather all the required documents and translate them. His mother had to help with this, as when he migrated he brought with him only the diploma and the specialty certificate. He had to wait six months for a positive answer from the medical faculty to follow the internship in February 2002. At that time, he worked as a machine operator on an agricultural site. During the internship, which lasted for four months, he had the support of the Portuguese students. One week after he took the state exam, the PAPMI Project was launched. He became aware of it through a newspaper. Being endorsed on the above Project allowed him to get financial support for the acquisition of books. Since September 2002, Anatoly has been registered with Ordem dos Médicos. As a General Practitioner, he spontaneously applied for the Emergency Services of a public hospital with a private management where he had worked. After more than ten years in Portugal, he acquired the Portuguese nationality and granted another specialty, Intern Medicine.

Valentina

Valentina came to Portugal twice. First in 1999 because her husband, a construction worker in Portugal, was ill in the hospital. She stayed nine months. Then she returned to Ukraine to do her Specialty in General Family Medicine for two years. She worked there as a Cardiologist in a State polyclinic. As she pointed out, "there, it is not hard to find a job, but when in the end you earn 40 Euros per month… The doctors and the lawyers, the two occupations that have to be better paid, isn´t it?". After she got divorced, and with a little child to care for, she decided to go alone to Portugal with a tourist visa and leave her daughter with her parents. Portugal "is the only country where we could be without documents. At that time, the police were not following us and never

caught us". She found work as a cleaner for a company in Lisbon. After obtaining a labour contract she had to wait nine months until she got a "permit of stay". A Portuguese friend and an international Catholic organisation supported her in the regularisation process. Additionally, the wife of her boss also helped her to contact the foundation leading the PAPMI Project. From the beginning, the process of re-accreditation came with some difficulties. For instance, when she contacted the medicine faculty to find out what the required documents were, "I felt… I don't know… 'right now we are really busy' [Faculty staff statement]. For the foreigners it is very complicated…". Moreover, during the internship she states that, "some Portuguese students were looking at us with some indifference". After succeeding in obtaining her medicine diploma recognised, she tried to bring her daughter to Portugal. Valentina succeeded in this, despite doing it in an irregular way. After receiving her medical license, she thought she would be working in the Health Centre where there is a scarcity of doctors. However, in the end she did a specialisation in Intern Medicine and now works as a specialist in a private hospital. Nowadays, Valentina acquired the Portuguese nationality and plans to stay in the country.

The above biographical profiles highlight some of the ways in which internationally educated doctors resist social mechanisms of closure. It also shows that their participation in the labour market involves a process of re-ordering in other systems of the society, which includes cultural (e.g. the knowledge of Portuguese language), educational (e.g. the recognition of diplomas), political and juridical (e. g. the residence status) and symbolic aspects (e.g. the informal professional recognition by their peers). Finally, it shows that the re-accreditation is an important turning point – rather than an end – in the migratory life path of the involved individuals, since it is followed by the acquisition of a medicine specialty and the Portuguese nationality.

Considering the occupational status transition in its interrelation with other "status mobilities" (Schuster, 2005), this study reinstates the importance of the analysis of the fluidity of social positions under geographical mobility and migratory temporalities. Anatoly´s case is particularly interesting as he began the process of re-accreditation before having a regular residence status.

Final remarks: being an "achieved skilled professional"

This article highlights the specific configurations of the social and institutional construction of migrants' skills regarding the selectivity of admission policies, and governmental and non-state initiatives. Indeed, the regulatory framework (e.g. extraordinary regularisation programmes, requirements of supranational institutions, EU Directives, professional associations´ rules) and non-state

initiatives are key factors for the development of an "ascribed qualified migrant" into an "achieved skilled professional", as I name it drawing on other authors (Raghuram, 2004; Csedõ, 2008). This process is particularly important in healthcare professions, whose skill-specific nature leads not only to formal but also informal professional recognition (Ribeiro, 2008).

Therefore, this study contributes to highlighting the diversity of actors, regulations and procedures that interplay at different scales in the process of socio-institutional recognition, which is relevant for any migrant population (e.g. refugees, economic migrants, undocumented migrants). The process of naming someone "skilled" involves different scales, which include the definition of "who can be considered a migrant healthcare professional" by international institutions, the rules of professional bodies about "who is allowed to be a healthcare professional", the role of non-state organisations in the creation of structures of opportunity for skill achievement, as well as the individual strategies of the involved migrants.

In our view, to research how migrants, non-state organisations, regulatory actors and supranational level institutions intertwine and interrelate the "foggy social structures" (Bommes and Sciortino, 2011) implies a multi-scalar approach. This view is essential to highlight the (in)visible social mechanisms that act as barriers, or supports, in the recognition as a "skilled professional".

In the case of medical practice, studying the social and institutional multi-scalar mechanisms involved in the process of obtaining a license (namely, the role of state interventions, regulatory bodies and non-state organisations) is essential to understand the terms in which the medicine labour market is closed or open.

Understanding the recognition process along scales (macro, meso and micro scales), with special reference to the re-accreditation process, this study also contributes to shedding light on the inter-endowed nature of other dimensions, such as migrant juridical and employee status transitions.

Finally, as the process of recognition calls for participation in different spheres of society (economic, cultural, social and political), and considering the comprehensive systemic conditions of inclusion/exclusion (Luhmann, 1995), in the end what is revealed as essential is the recognition of the conditions for participation in society: having access and being entitled to cultural rights, economic rights, social rights and political rights. In this regard, the process that drives from "ascription" to "achievement" translates an important transformation – from the entitlement of requirements (to have or not have qualifications, and then to be or not be an "ascribed qualified migrant") to the entitlement of rights (to be or not be recognised as "skilled", and then to be or not be an "achieved skilled professional"). A civic stratification (Morris, 2003) is then (re)produced and the frame of the "deserving migrant" is reinforced.

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