FedUni ResearchOnline

<https://researchonline.federation.edu.au>

Copyright Notice

This is the author's preprint version of the following publication:

R. Terry, D., & Lê, Q. (2014). Social capital among migrating doctors: the "Bridge" over troubled water. *Journal of Health Organization and Management*, 28(3), 315–326.

The version displayed here may differ from the final published manuscript.

The final published manuscript is available at Emerald Insight via:

<https://doi.org/10.1108/JHOM-09-2012-0178>

Copyright @ Emerald Group Publishing Limited

Social capital among migrating doctors

The 'Bridge' over troubled water

Quynh Le, Daniel Terry

University Department of Rural Health, University of Tasmania,
Locked Bag 1372, Launceston, Tasmania 7250, Australia

Abstract

Purpose: This paper will examine the concept of social capital amongst International Medical Graduates (IMGs). It will specifically examine bridging social capital and greater intercultural communication which provides IMGs access to the wider community and plays a key role in cross-cultural adaptation and acculturation.

Design/methodology/approach: A review of the literature

Findings: An Australian wide shortage of doctors has led to an increased reliance on the recruitment of IMGs. As IMGs migrate, they may encounter different meanings of illness, models of care and a number of social challenges. Nevertheless, greater cross-cultural adaptation and acculturation occurs through bridging social capital, where intercultural communication, new social networks and identity aids integration. This process produces more opportunities for economic capital growth and upward mobility than bonding social capital.

Practical implications: Concerns regarding immigration, appropriate support and on-going examination processes have been expressed by IMGs in a number of studies and policy papers. However, there is very little insight into what contributes cross-cultural adaptation of IMGs.

Originality/value: As IMGs migrate to not only a new country, but also a new health system and workplace they arrive with different cultural meanings of illness and models of care. These differences may be in contrast to the dominant western medical model, but often bring positive contributions to patient care in the new environment. In addition, improving bridging social capital provides IMGs access to the wider community and has been demonstrated to play a key role in cross-cultural adaptation and ultimately acculturation.

Keywords: Acculturation, bridging social capital, bonding social capital, culture, ethnomedicine, intercultural communication, medical pluralism, International Medical Graduate

Paper type: Conceptual paper

Background

The globalization of health is the flow of health knowledge, technology, people and human capital across the globe where a symbiotic relationship of the health workforce exists between government, employers and migrants (Knight, 2003). Migrant labour is historically viewed as a source of low-cost human capital for employers and governments. In addition, migrants with health qualifications remain a source of increased economic capital for migrants and the donor countries. However, the internationalization of health and the health workforce means more than simply globalization. Internationalization is also about developing relationships, memorandums of understanding and shared learning between health care systems of recipient and donor countries (Forcier et al., 2004). Internationalization of the health workforce also means embracing the diversity of cultures within hospitals, primary health care settings and the wider community (Knight, 2003).

The increased migration of health professionals to Australia has accelerated over in the past few decades, with the migration of doctors and other health professionals from developed countries being part of this globalization of health care (Brown and Connell, 2004, Oman et al., 2009). As such migrant labour has been observed as a means of meeting job shortages within developed countries, from low-skilled employment to professional occupations (MacKenzie and Forde, 2009). Migrant workers have also been observed to be a cheaper alternative to training within their country of origin and filling positions which many of the local population are reluctant to fill themselves. Migrants have the same economic output for much less human capital input (Fellini et al., 2007). Often migrant workers are under paid compared to local workers, are employed based on the stereotyping of a particular culturally and linguistically diverse (CALD) community, and are often overqualified for the positions they fill. There is also evidence, particularly, within the UK's National Health Service (NHS), the least prestigious and lower level medical practitioner positions are being given to those migrants of color (MacKenzie and Forde, 2009, Fellini et al., 2007).

It has been shown that the motivations for migration are based on a mixed number of complex 'push-pull' factors, including political instability, family welfare, frustrations with career progression, lack of further education opportunities, gaining competitive advantage to economic reasons (Oman et al., 2009, Brown and Connell, 2004). In addition, there are other factors which influence migration, such as family or community ties in the country of destination, and where greater social capital may consequently exist. Also in a number of countries, such as West Africa and Lebanon, health professionals and academic institutions maintain a well-developed culture of medical migration, where migration is promoted and expected to occur (Akl et al., 2007, Hagopian et al., 2005).

There are also instances in the South Pacific, Cuba, India and the Philippines where a premeditation of occupational choice and human capital investment by individuals and

governments occurs. This choice in profession and investment above the country's needs ensures international migration transpires. This guarantees a migrant's remittance is sent home, to support relatives. Remittances remain a major source of income and aid the long-term development of the country of origin (Brown and Connell, 2004, Forcier et al., 2004). At times the remittance is 'large enough to compensate for the economic losses associated with emigration' (Forcier et al., 2004).

In addition to the motivations for migrating, health care professionals, particularly International Medical Graduates (IMGs) are faced with a number of challenges upon migration. These challenges are associated with bonding and bridging social capital and developing different types of networks which aide the ability to acculturate both professionally and socially within a new country, health system and workplace. Bridging social capital is about bridging between gaps or the separation which exist between different networks that occur between individuals and across groups, for example a gap which may exist between CALD groups and a dominant population (Burt, 1992, Lancee, 2010). Conversely, bonding social capital is related to the trust and co-operation between members of a network who have similar social identity. This may include those who share the same ethnicity, are part of local groups, which include guilds, societies and sporting clubs (Kawachi et al., 2004, Szreter and Woolcock, 2004, Pretty, 2003, Baum and Ziersch, 2003). At times this acculturation can be further impacted by the different meanings of illness and models of care IMGs migrate with. A number of these challenges are highlighted below.

Social capital of migrants in a new environment

It has been well documented that migrants have the capacity to contribute a wealth of economic, social and cultural capital to their new country and environments. As such, the work of Lancee (2010) and Portes (2000), amongst others have focussed on the economic capital of migrants, whereas Kim's (2001) seminal work has focussed on cross cultural adaptation through intercultural communication. Regardless, each work has stated bridging social capital, such as intercultural networks and communication, produces greater opportunity for economic capital growth, upward mobility and greater cross cultural adaptation than bonding social capital (intracultural networks and communication).

CALD community ties thus remain a valuable social and economic resource for number of migrants or individuals more collectively (Lancee, 2010). For migrants with a tertiary education, obtaining professional employment in Australia often requires these intercultural networks with the host culture (Thompson et al., 2002, Rogler, 1994). These networks often contribute to a greater integration within the wider community, but more so in professional subcultures. This has also been observed within other professional migrant and IMG studies, thus acting as a 'bridge' of social capital (Han and Humphreys, 2005, Kilpatrick et al., 2011). Lancee (2010) maintains this bridging of social capital creates greater opportunities, whereas bonding social

capital can limit opportunities. Lancee (2010) describes this difference as quite powerful to the migrant experience arguing that ‘bonding social capital is to get by, bridging social capital is to get ahead’.

Nevertheless, Coleman (1990) argues the insular effect which can occur within bonding social capital networks can also be positive. These intracultural networks offer increased reliable communication and safeguards against exploitation. In addition, there are also opportunities within these close knit networks to gain employment and produce economic capital. However, ‘the relationship between social capital and labor market outcomes is stronger for bridging than for bonding social capital’ (Lancee, 2010). In addition, within large CALD concentration there is ‘a high level of community support, but also a high level of community control and pressure’ (Colic-Peisker and Walker, 2003). Both bonding and bridging social capital have positive and negative aspects, yet bridging social capital leads to greater cross cultural adaptation and acculturation.

Cultural and professional acculturation and identity

Acculturation occurs when an individual who migrates, is separated from a familiar social network and the development of new social networks and identity development within a host society (Thompson et al., 2002, Rogler, 1994). The ability to successfully re-establish social networks in a host society with heterogeneous networks as well as CALD community support is beneficial. However, a plethora of social factors are involved in the acculturation process and identity transformation.

Interestingly, Colic-Peisker & Walker (2003) who researched refugee migrants in Australia, argued there were three essential elements of human capital which aide acculturation and the formation of social identity. These include skills, language, and an individual’s sense of place within a given environment. As such, these three elements of human capital are determined by the nature of the interface within a new social context, where the process of acculturation and identity re-building occurs (Colic-Peisker and Walker, 2003, Kim, 2001).

In addition to the characteristics of the migrants, acculturation is also determined by the reception of the community in which they live (Salant and Lauderdale, 2003, Thompson et al., 2002). For example, Val Colic-Peisker and Walker state that this ‘reception’ can relate to the:

‘Visibility, cultural distance from the host society, human and social capital represented in the group—and the host society with its specific treatment of immigrants, through official policies and informal encounters... [This creates] a series of cumulative, compounded and mutually reinforcing actions and reactions that determine the shape and direction of the processes of acculturation and identity re-building’ (2003).

Lastly, for most migrants, employment or the formal recognition of their human capital can also improve social identity and successful acculturation within a community or nation (Colic-Peisker and Walker, 2003). However, if human capital is not recognised, a sense of a migrant's identity is also invalidated (Colic-Peisker and Walker, 2003). Interestingly, not only does acculturation of an IMG occur in the new society, but also workplace acculturation is required when an IMG enters the Australian medical system. For example, IMGs may need to acculturate and develop new medical practitioner identities. Particularly when an IMG is faced with a new 'colloquial' language, new or challenging types hierarchy and perplexing doctor-patient relationships. They may also be required to shed ethnomedical systems (Han and Humphreys, 2005, Pilotto et al., 2007). These changes in role behaviors or conforming to the requirement of social interaction can be achieved, however are not always accepted or well understood by migrants (Kim, 2001). For IMGs a lack of acknowledgment of professional identity, through their human capital may be remedied by undertaking the requisite examinations or further training, the human capital challenges which migrants, specifically IMGs face as they migrate with conflicting meaning of illness, are discussed below. Nevertheless, acculturation, although a complex process, is largely determined by social capital and a migrant's new country's capacity to recognise and appreciate individual human capital or the capacity to provide access to re-invest in congruent human capital, whether this is language proficiency, formal education and qualifications. It also requires an improved reception of the community to where the migrant is living (Colic-Peisker and Walker, 2003).

Migrating with conflicting meaning of health and illness

Migrant beliefs are influenced by their original culture, their cultural capital. This largely determines how they conceptualise their new environment. Concepts such as health, illness and health care are encompassed within their cultural worldview (Chen et al., 2009, Ma et al., 2008, Lê and Lê, 2005). These beliefs and meanings can cause confusion and distress when they conflict with the reality and experience of living in a new country. The severity of such conflicts are to a large extent dependent on the migrants' particular experience with health care in the new country, as well as the time spent in the new country, their gender, age, and education (Salant and Lauderdale, 2003, Biddle et al., 2007). In addition, language, religious beliefs and cultural practices may also be confounding barriers when working in or accessing health care, health services and health care information, especially if these are not culturally congruent (Dean and Wilson, 2010, Lê and Lê, 2005). As such meanings of illness and models of care which IMGs bring with them as they migrate and work in health care settings requires broader understanding.

The experience and cultural meaning of illness

Illness is defined as the subjective experience of disease, which is a complex socially constructed phenomenon within an objective and subjective social context (Anderson, 1986, Castro, 1995). As such, the illness experience is deeply entrenched in the cultural and social values of an

individual, family and society. Therefore the experience of illness occurs when an individual's own socially shaped subjective perceptions of impaired wellbeing are authenticated by the perceptions of those around them (Castro, 1995, Hunt et al., 1989). Therefore becoming ill is a social process and each individual is influenced by social expectations and the beliefs they possess which assist other individuals to learn how to experience, behave and 'have' an illness (Waxler, 1981).

This process is further constructed through interaction with socially determining natural and manmade environments. This includes the social, political, economic, spiritual, supernatural and cultural environments while being articulated through a constellation of social metaphors (Castro, 1995, Erikson, 2008). IMGs bring with them the social meanings of illness, how one must behave as an ill patient. They therefore can omit or ignore vital cues when diagnosing illness in western practice (Steinert, 2003). In addition, IMGs bring with them 'cultural differences in approaches to and beliefs about communication, authority, gender roles, interpersonal relationships, and the role or status of physicians' (Bates and Andrew, 2001). However, illness is not a static phenomenon; it actively changes over time. It continuously evolves with each individual in their ever-changing circumstances and within the cultural and societal environments, in which they live (Hunt et al., 1989). As such bridging social capital enables the acculturation process to occur, which allows individuals to be exposed to and adopt a number of the new culture's health beliefs and social practices (Biddle et al., 2007) including new or changing conceptualization and experiences of health, illness and the healthcare system itself.

Nevertheless, there are other challenges within the health care system, which a number of IMGs face as they migrate. In new health care systems, a medical professional's power may challenge when migrating to western societies where the doctor is on an equal footing to the patient. As such 'the concept of a patient questioning a doctor is quite alien to many IMGs because, in their home countries, the patient's role is one of compliance, trust and cooperation, and any other behavior is not tolerated' (Pilotto et al., 2007). In addition to this challenge of authority or differences in hierarchy, IMGs may also migrate with differing models or care.

Ethnomedicine

Ethnomedicine is a model of care which IMGs may understand and bring as they migrate. Ethnomedical systems are developed, embedded and submerged in a specific culture's morals, symbols and customs within a historical, political and environmental context (Erikson, 2008). Therefore it would be misleading to attempt to comprehend any medical systems without first understanding the underlying cultural context (Pedersen and Baruffati, 1989, Bhasin and Srivastava, 1991). For example, understanding the underlying cultural context of Buddhism or yin/yang assists to comprehend the mind-body is intrinsically linked to nature through the social, political, spiritual and supernatural (Erikson, 2008). Knowledge of the morals, symbols and cultural customs which shape ethnomedical systems enhances the ability to understand migrants

and the health belief systems which they unpack as they migrate (Chen et al., 2009, Ma et al., 2008, Lê and Lê, 2005).

Knowledge of personalistic and naturalistic medical systems within a culture is also vital to understand the models of care of which IMGs may be familiar. Cultures can use personalistic medical systems to explain disease being caused by the involvement of an agent such as relatives or friends, an ancestor, evil spirit or mystical deity. This is unlike other cultures which use naturalistic medical systems to explain illness being caused by natural forces such as cold, wind, dampness or an imbalance of an individual's life force (Erikson, 2008). For example, in various Ghanaian cultures malaria has been accepted to be the personalistic cause of angry gods. In contrast, until the nineteenth century, Europe accepted malaria was the naturalistic cause of marsh vapours or a 'miasma' its sufferers had inhaled (Agyepong, 1992, Winkelstein, 1996).

Medical pluralism

In addition to personalistic and naturalistic ethnomedical systems, knowledge of medical pluralism within a culture is also vital. IMGs may bring an understanding of a pluralistic medical paradigm as they migrate (Lindström, 2008). Medical pluralism is the concurrent use of biomedical and ethnomedical systems to heal or cure illness; however these pluralistic paradigms are always shifting (Bhasin and Srivastava, 1991, Pedersen and Baruffati, 1989). Knowledge of ethnomedical systems and issues surrounding biomedicine and medical pluralism is crucial to IMG recruitment. However this knowledge is complex as it is constructed through a quagmire of social, cultural, political, economic, and spiritual conditions entrenched within a culture's morals, symbols and customs. For example,

Australian Aboriginal ethnomedical and western biomedical systems are vastly different in philosophy and practices, yet the healing methods are used concurrently within many Australian indigenous cultures (Saethre, 2007). Medical pluralism also exists in many other countries, such as Mexico where, physicians merge biomedicine's view of the body machine with ethnomedical understandings such as anger, nerves and fright to explain illness (Finkler, 1994). In addition, traditional healers and their medicines are frequently used in Tanzania in partnership with biomedicine. The healer attempts to alter the person's experience of their illness and by so doing; the person experiences their body in a new way, which increases the healing process and furthers health-seeking behaviors (McMillen, 2004, Finkler, 1994).

The challenge and contribution of IMGs

International Medical Graduates may face challenges as they enter the Australian health care system as biomedicine has a propensity to alter and objectify the cultural experience of symptoms and obscure the structure and function of other ethnomedical systems (Bierlich, 2000, Finkler, 1994, Waldram, 2000). Biomedicine projects its own cultural presence onto other cultures. It has great difficulty in understanding and appreciating complex cultural beliefs, while focusing on efficiency and cost effectiveness to motivate treatment choice rather than a healing

systems philosophy (Bierlich, 2000, Finkler, 1994, Waldram, 2000). In addition, within Australia biomedicine may be vastly different to the models of care and training received in the country of origin where disadvantaged educational situations, with marginal access to western technology may occur (Han and Humphreys, 2005, Hawthorne et al., 2007)

Conversely, the use of complementary and alternative medicine (CAM) in western countries is increasing. Therefore IMGs with a knowledge and understanding of ethnomedical systems and issues surrounding medical pluralism may be better suited to assist Australian patients who wish to use alternative medicines (McMillen, 2004). For example, an IMG may educate and assists patients and their families through a language, values, and belief systems, which the biomedical system remains unable to achieve on its own (McMillen, 2004). Nevertheless, treatment choice is not always based on culture and beliefs. People utilise different medical systems to find and employ appropriate treatments, which they feel are most effective.

Contemporary IMGs may be a dynamic force in the era of greater globalization and population movement. They bring knowledge which embodies a range of tropical health, medical pluralism and the concurrent use of biomedical and ethnomedical systems. The skills and knowledge contemporary IMGs bring as they migrate can be used to accommodate the ever increasing cultural diversity in many countries (Phillips and Travaglia, 2011, Rural Health Workforce Australia, 2011).

Intercultural communication – bridging meaning and models

In addition to migrating with conflicting meanings of illness and different models of care, migrants, particularly IMGs, are faced with issues regarding intercultural communication. Intercultural communication challenges may occur within the doctor-doctor and the doctor-patient relationship. This is where, cultural capital, such as nuances, vernacular and colloquial speech are needed to communicate effectively, yet these forms of social interaction compliance can be achieved, but less accepted or understood (Steinert, 2003, Pilotto et al., 2007, Lindström, 2008, Kim, 2001). The intercultural communication phenomenon of cultural adaptation, where migrants increase their ability to adapt within a new cultural environment (Kim, 2005) will be discussed in greater detail at this juncture.

There are obscured demands and pressures through ‘symbolic violence’ or the unconscious social power or influence by the dominant society for others to conform (Bourdieu, 1986). For example, new migrants are unconsciously compelled to meet these demands, to learn and change, which leads to growth (Kim, 2001, Bourdieu, 1986). However, this is often dependent upon three key processes. Firstly, the preparedness a migrant is for an anticipated change. Secondly, the ethnic proximity or ethnic similarities between the IMGs and the dominant culture, the greater the similarities, the less the demands place upon the individual. Thirdly, it is dependent upon the adaptive personality of both the migrant and those within migrant’s bridging social capital network (Kim, 2001, Lancee, 2010, Kim, 2005).

Intercultural communication through bridging social capital networks plays a key role in cross-cultural adaptation. For example, the dominant language of the host community is often imposed on migrants, who then are required to instinctively conform (Kim, 2001). Through dialectic process individuals adapt and grow from the experiences they encounter. Kim's (2005) theory states this is the 'stress-adaptation-growth' dynamic which leads to adaptation, health and wellbeing in the new environment.

It is through this mode of interaction with others where a migrant, such as an IMG, is able to secure information, cultural learning and further bridging social capital (intercultural networks) (Kim, 2001, Lancee, 2010). It is the development of greater bridging social capital networks which govern and reinforce the language migrants are required to use. It is this language which conveys the implicit or explicit messages of dominant cultural values and social sanctioned norms (Kim, 2001). When wanting to understand the bridging social capital networks of IMGs, we must first look at their immediate opportunities and platform for these networks to occur, the workplace.

Blumenfield (1983), when speaking of the care of the elderly, has stated the hospital environment is a microcosm of the larger society, where attitudes and influences are carried into the hospital setting. Similarly, various medical facilities, which mirror the hospital setting, may also be viewed as microcosm of the larger society. They are platforms where the medical fraternity are dominant members of both the 'micro' and 'macro' societies (Durey et al., 2011). However, the demands and pressures through symbolic violence of dominant hospital culture, implicit rules and the unwritten expectations are not always positive (Kitto et al., 2011). There are elements of institutional racism, by imposing oppressive conditions against those of different race. This is well understood in terms of patient care, however between staff it is less well articulated (Durey et al., 2011, Henry et al., 2004).

As IMGs enter the hospital and medical 'societies' of a new country, they have been initially uprooted from supportive ties. These migrants, much like other migrants are 'keenly aware of the vital role that interpersonal relationships play by offering a personal community through which they can receive informational, technical, material and emotional support for their functioning in the new environment' (Kim, 2001). In many circumstances support is available for IMGs through official rural workforce agencies to meet the informational, technical and at times material support (Organisation for Economic Co-operation and Development, 2007). However it is the interpersonal networks and relationships, developed through intercultural communication in the workplace, which plays a central role in migrant acculturation (Kim, 2001).

Future research directions

Portes (1998) and others observed as bridging social capital from networks and connections with the wider community are reduced, a greater development of bonding social capital within family and culture occurs. (Portes, 1998, Gold, 1995). What remains less well articulated in the

literature, requiring investigation, is what occurs to individuals or small family units when social capital from both community networks and greater familial support are reduced or absent? What forms of social capital are developed or used in these circumstances? If both bridging and bonding social capital is underdeveloped or absent for individuals, such as IMGs or members of their family who are living in new communities, are these vital factors which impact acculturation and long term retention in these communities? (Colic-Peisker, 2009, Alexander, 1998)

Conclusion

The migrant workforce is viewed as a source of low-cost human capital for employers and governments. However as IMGs migrate, they arrive with different meanings of illness and models of care, to a new country, health system and workplace. These meanings of illness and models of care may be in contrast to the western medical model, however may act as positive contribution and can be viewed as a competing discourse, rather than a conflicting one. As discussed, there are two main forms of social capital, bridging and bonding social capital. Bonding social capital, intracultural communication and networks allow an IMG to access their respective CALD, which is vital for IMGs and migrants alike. However, increasing bridging social capital, intercultural communication and networks provide access to the wider community and have been demonstrated to play a key role in cross-cultural adaptation and ultimately acculturation. In terms of workplace relationships, improved intercultural communication and networks creates opportunities to have social interaction with a greater number of others within the hospital or medical facility and ultimately the wider community. Nevertheless this is dependent upon each individual's ability or personality to make a large number of acquaintances, but also the quality of these relationships is just as important. Those who do have the ability or personality adapt quickly and more easily, whereas those who do not possess this ability, may struggle. It is anticipated those with greater bridging social capital may exhibit great propensity to remain in place. However, what remains unclear is what occurs with individuals or family units when both bridging and bonding social capital remains underdeveloped or absent.

References

- Agyepong, I. A. 1992. Malaria: Ethnomedical perceptions and practice in an Adangbe farming community and implications for control. *Social Science & Medicine*, 35, 131-137.
- Akl, E. A., Maroun, N., Major, S., Afif, C., Chahoud, B., Choucair, J., Sakr, M. & Schunemann, H. J. 2007. Why are you draining your brain? Factors underlying decisions of graduating Lebanese medical students to migrate. *Social Science & Medicine*, 64, 1278-1284.
- Alexander, C. 1998. Why doctors would stay in rural practice in the New England health area of New South Wales. *Australian Journal of Rural Health*, 6, 136-139.

- Anderson, J. M. 1986. Ethnicity and illness experience: Ideological structures and the health care delivery system. *Social Science & Medicine*, 22, 1277-1283.
- Bates, J. & Andrew, R. 2001. Untangling the Roots of Some IMGs' Poor Academic Performance. *Academic Medicine*, 76, 43-46.
- Baum, F. & Ziersch, A. 2003. Social capital. *Journal of Epidemiology and Community Health*, 57, 320-3.
- Bhasin, V. & Srivastava, V. 1991. Medical anthropology: A review. *Journal of Human Ecology*, 2, 1-19.
- Biddle, N., Kennedy, S. & McDonald, J. 2007. Health Assimilation Patterns Amongst Australian Immigrants*. *Economic Record*, 83, 16-30.
- Bierlich, B. 2000. Injections and the fear of death: an essay on the limits of biomedicine among the Dagomba of northern Ghana. *Social Science & Medicine*, 50, 703-713.
- Blumenfield, S. 1983. The hospital center and aging: a challenge for the social worker. In: Getzel, G. S. & Mellor, M. J. (eds.) *Gerontological social work practice in long-term care*. Binghamton, NY: The Haworth Press, Inc.
- Bourdieu, P. 1986. The Forms of Capital In: Richardson, J. G. (ed.) *Handbook of Theory and Research for the Sociology of Education*. New York: Greenwood Press.
- Brown, R. P. C. & Connell, J. 2004. The migration of doctors and nurses from South Pacific Island Nations. *Social Science & Medicine*, 58, 2193-2210.
- Burt, R. S. 1992. *Structural holes: the social structure of competition*, Cambridge, Mass, Harvard University Press.
- Castro, R. 1995. The subjective experience of health and illness in Ocuituco: A case study. *Social Science & Medicine*, 41, 1005-1021.
- Chen, X. M. D. P., Stanton, B. M., Li, X. P., Fang, X. P., Lin, D. P. & Xiong, Q. M. 2009. A Comparison of Health-Risk Behaviors of Rural Migrants With Rural Residents and Urban Residents in China. *American Journal of Health Behavior*, 33, 15.
- Coleman, J. S. 1990. *Foundations of social theory*, Cambridge, Mass, Harvard University Press.
- Colic-Peisker, V. 2009. Visibility, settlement success and life satisfaction in three refugee communities in Australia. *Ethnicities*, 9, 175.
- Colic-Peisker, V. & Walker, I. 2003. Human capital, acculturation and social identity: Bosnian refugees in Australia. *Journal of Community & Applied Social Psychology*, 13, 337-360.
- Dean, J. & Wilson, K. 2010. "My health has improved because I always have everything I need here...": A qualitative exploration of health improvement and decline among immigrants. *Social Science & Medicine*, 70, 1219-1228.
- Durey, A., Thompson, S. C. & Wood, M. 2011. Time to bring down the twin towers in poor Aboriginal hospital care: Addressing institutional racism and misunderstandings in communication. *Internal Medicine Journal*, "Accepted Article".
- Erikson, P. 2008. *Ethnomedicine*, Illinois, Waveland Printing.
- Fellini, I., Ferro, A. & Fullin, G. 2007. Recruitment processes and labour mobility: the construction industry in Europe. *Work, Employment & Society*, 21, 277-298.
- Finkler, K. 1994. Sacred Healing and Biomedicine Compared. *Medical Anthropology Quarterly*, 8, 178-197.
- Forcier, M. B., Simoens, S. & Giuffrida, A. 2004. Impact, regulation and health policy implications of physician migration in OECD countries. *Human Resources for health*, 2, 12.

- Gold, S. J. 1995. Gender and social capital among Israeli immigrants in Los Angeles. *Diaspora: A Journal of Transnational Studies*, 4, 267-301.
- Hagopian, A., Ofosu, A., Fatusi, A., Biritwum, R., Essel, A., Gary Hart, L. & Watts, C. 2005. The flight of physicians from West Africa: Views of African physicians and implications for policy. *Social Science & Medicine*, 61, 1750-1760.
- Han, G. S. & Humphreys, J. S. 2005. Overseas trained doctors in Australia: Community integration and their intention to stay in a rural community. *Australian Journal of Rural Health*, 13, 236-241.
- Hawthorne, L., Hawthorne, G. & Crotty, B. 2007. The Registration and Training Status of Overseas Trained Doctors in Australia: Final Report. Melbourne: Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne.
- Henry, B. R., Houston, S. & Mooney, G. H. 2004. Institutional racism in Australian healthcare: a plea for decency. *Medical Journal of Australia*, 180, 517-520.
- Hunt, L. M., Jordan, B. & Irwin, S. 1989. Views of what's wrong: Diagnosis and patients' concepts of illness. *Social Science & Medicine*, 28, 945-956.
- Kawachi, I., Kim, D., Coutts, A. & Subramanian, S. V. 2004. Commentary: Reconciling the three accounts of social capital. *International Journal of Epidemiology*, 33, 682-690.
- Kilpatrick, S., Johns, S., Vitartas, P. & Homisan, M. 2011. Mobile skilled workers: Making the most of an untapped rural community resource. *Journal of Rural Studies*, 27, 181-190.
- Kim, Y. Y. 2001. *Becoming intercultural: An integrative theory of communication and cross-cultural adaptation*, Thousand Oaks, Sage Publications, Inc.
- Kim, Y. Y. 2005. Inquiry in Intercultural and Development Communication. *Journal of Communication*, 55, 554-577.
- Kitto, S., Petrovic, A., Gruen, R. L. & Smith, J. A. 2011. Evidence-based medicine training and implementation in surgery: the role of surgical cultures. *Journal of Evaluation in Clinical Practice*, 17, 819-826.
- Knight, J. 2003. Updating the definition of internationalization. *International Higher Education*, 33, 2-3.
- Lancee, B. 2010. The Economic Returns of Immigrants' Bonding and Bridging Social Capital: The Case of the Netherlands. *The International Migration Review*, 44, 202.
- Lê, Q. & Lê, T. 2005. Cultural Attitudes of Vietnamese Migrants on Health Issues. *Australian Association for Research in Education*.
- Lindström, N. B. 2008. *Intercultural communication in health care—Non-Swedish physicians in Sweden*. Doctor of Philosophy in Linguistics PhD, University of Gothenburg.
- Ma, S., Hoang, M., Samet, J., Wang, J., Mei, C., Xu, X. & Stillman, F. 2008. Myths and attitudes that sustain smoking in China. *Journal of health communication*, 13, 654-666.
- Mackenzie, R. & Forde, C. 2009. The rhetoric of the good worker 'versus the realities of employers' use and the experiences of migrant workers. *Work, Employment & Society*, 23, 142-159.
- McMillen, H. H. 2004. The adapting healer: pioneering through shifting epidemiological and sociocultural landscapes. *Social Science & Medicine*, 59, 889-902.
- Oman, K., Moulds, R. & Usher, K. 2009. Specialist training in Fiji: Why do graduates migrate, and why do they remain? A qualitative study. *Human Resources for health*, 7, 9.
- Organisation for Economic Co-Operation and Development 2007. International Migration Outlook 2007. Danvers, MA: Organisation for Economic Co-operation and Development,.

- Pedersen, D. & Baruffati, V. 1989. Healers, deities, saints and doctors: elements for the analysis of medical systems. *Social Science & Medicine*, 29, 487-496.
- Phillips, C. B. & Travaglia, J. 2011. Low levels of uptake of free interpreters by Australian doctors in private practice: secondary analysis of national data *Australian Health Review*, 35, 475-479.
- Pilotto, L. S., Duncan, G. F. & Anderson-Wurf, J. 2007. Issues for clinicians training international medical graduates: a systematic review: 1. *The Medical journal of Australia*, 187, 225-228.
- Portes, A. 1998. Social capital: Its origins and applications in modern sociology. *Annual Review of Sociology*, 24, 1-24.
- Portes, A. 2000. Social capital: Its origins and applications in modern sociology. In: Lesser, E. L. (ed.) *Knowledge and Social Capital: Foundations and Applications*. Boston: Butterworth-Heinemann.
- Pretty, J. 2003. Social capital and the collective management of resources. *Science* 302, 1912-1914.
- Rogler, L. H. 1994. International migrations: A framework for directing research. *The American psychologist*, 49, 701-708.
- Rural Health Workforce Australia 2011. Parliamentary Inquiry into Overseas Trained Doctors. In: Webber (ed.) *Submission to the Health Standing Committee*. Melbourne: Rural Health Workforce Australia.
- Saethre, E. 2007. Conflicting Traditions, Concurrent Treatment: Medical Pluralism in Remote Aboriginal Australia. *Oceania*, 77, 95-110.
- Salant, T. & Lauderdale, D. 2003. Measuring culture: a critical review of acculturation and health in Asian immigrant populations. *Social Science & Medicine*, 57, 71-90.
- Steinert, Y. 2003. Building on diversity: A faculty development program for teachers of international medical graduates. In: Graduates, T. C. T. F. O. L. O. I. M. (ed.) *Unpublished report commissioned by the Canadian Task Force on Licensure of International Medical Graduates, Ottawa, Ontario, Canada*. Ontario: McGill University.
- Szreter, S. & Woolcock, M. 2004. Health by association? Social capital, social theory, and the political economy of public health. *International Journal of Epidemiology*, 33, 650-667.
- Thompson, S., Manderson, L., Woelz-Stirling, N., Cahill, A. & Kelaher, M. 2002. The social and cultural context of the mental health of Filipinas in Queensland. *Australian & New Zealand Journal of Psychiatry*, 36, 681-687.
- Waldram, J. B. 2000. The Efficacy of Traditional Medicine: Current Theoretical and Methodological Issues. *Medical Anthropology Quarterly*, 14, 603-625.
- Waxler, N. E. 1981. Learning to be a leper: a case study in the social construction of illness. In: Mishler, E. (ed.) *Social Contexts of Health, Illness and Patient Care*. Cambridge: Cambridge University Press.
- Winkelstein, W. 1996. Eras, paradigms, and the future of epidemiology. *American journal of public health*, 86, 621.