Education and Employment: A Post-Intentional Phenomenological Exploration of the Lived Experiences of Foreign-Trained Black Immigrant Medical Doctors Finding Work and Working in the United States of America

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Dedication

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Abstract

This study explores the lived experiences of Foreign-Trained Black Immigrant Medical Doctors (FTBIMDs) who are International Medical Graduates (IMGs), finding work and working in the United States of America. Their identity construction as Blacks in America renders them racialized and undervalued. In bringing to the forefront the problem of "doctors becoming doctors," this dissertation uncovers the difficulties and challenges for FTBIMDs who go through the long and winding process of finding work and working in the USA.

This research is informed by Racial Formation Theory (Omi & Winant, 2015), Post-Colonial Theory (Fanon, 1967), Borderlands Theory (Anzaldua, 1987) and Forms of Capital Theory (Bourdieu, 1986). As a pioneering study, post-intentional phenomenology (Vagle, 2014) is utilized as a methodology for data analysis. Data sources included in-depth interviews and participant observations with13 Foreign-Trained Black Immigrant Medical Doctors. Six major findings or "tentative manifestations" (Vagle, 2014) emerged from the study. These include: 1) finding work is a challenging endeavor; 2) medical residency and licensing is complex; 3) there is the occurrence of brain waste; 4) difference is a hindrance; 5) the immediate and extended family well-being is affected by the process of FTBIMD finding work and working in the U.S.A. and 6) the FTBIMDs utilize coping mechanisms. These tentative manifestations have important implications for the theory, practice, and policy. There is a need for policies geared at removing obstacles to the medical residency and licensing system without lowering standards. Given the health care needs of the diverse population utilizing FTBIMDs and IMGs

would be a way of attempting to provide health security as well as attending to the Doctor Shortage in the U.S.A. Licensing FTBIMDs/IMGs would also foster family literacy including, parental involvement in the successful education of children in school and bridge the intergenerational gap for the future workforce.

Keywords: Medical Doctors; immigrant employment; brain waste; intellectual Borderland; Black and race.

Cette étude explore les expériences vécues par les Médecins Noirs Immigrés Formés à l'Etranger (MNIFE) / Diplômés Internationaux en Médecine (DIM), dans la recherche de l’emploie et en travaillant aux États-Unis d'Amérique. La construction de leur identité en tant que Noirs en Amérique les rend racialisés et sous-évalués. En soulignant de manière pointue le problème des « médecins devenant médecins », cette thèse révèle les difficultés et les défis des (MNIFE) qui traversent le long et sinueux processus de la recherche d’un emploi et dans leur emploie aux États-Unis.

Cette recherche est éclairée par la Théorie de la Formation Raciale (Omi & Winant, 2015), la Théorie Postcoloniale (Fanon, 1967), la Théorie Borderlands (Anzaldua, 1987) et la theorie des Formes du Capital (Bourdieu, 1986). Du fait que cette étude est pionnière, la phénoménologie post-intentionnelle (Vagle, 2014) a été utilisée comme méthodologie pour l'analyse des données. La source des données incluait des entrevues approfondies et des observations des participants auprès de 13 médecins formés à l'étranger. Six conclusions majeures ou "manifestations provisoires" (Vagle, 2014) ont

émergé de l'étude. Il s'agit notamment des suivantes : 1) Trouver du travail est une entreprise difficile ; 2) la résidence médicale et la délivrance du permis sont complexes ; 3) le phénomène de gaspillage des cerveaux est observé ; 4) la différence est un obstacle ; 5) le bien-être familial immédiat et élargi est affecté par le processus de recherche et de travail des MNIFE / DIM aux États-Unis et 6) Les MNIFE utilisent des mécanismes d'adaptation. Ces manifestations provisoires pourraient avoir des implications importantes sur la théorie, la pratique et les politiques. Il est nécessaire de mettre en place des politiques visant à éliminer les obstacles au système de résidence médicale et de délivrance du permis sans baisser les standards.

Compte tenu de la diversité de la population et leur besoin de santé, accroitre des opportunités pour les MNIFE (DIM) de devenir médecins autorisés aux États-Unis, serait une façon de faire face aux disparités de santé. Tout comme L'utilisation des MNIFE et des DIM serait un moyen de tenter de combler le besoin de la sécurité sanitaire, ainsi que de répondre au problème de la pénurie des Médecins aux Etats-Unis. Donner aux MNIFE / IMGs la possibilité d’exercer favoriserait l'alphabétisation familiale, y compris, la participation des parents dans la réussite de l'éducation des enfants et briserait l'écart intergénérationnel pour la main-d'œuvre future.

Mots clés : Médecins, emploi des immigrants, gaspillage des cerveaux, frontière intellectuelle, noir et race.

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List of Acronyms

ATMG	American Trained Medical Graduate
CBO	Community-Based Organization
CNA	Certified Nursing Assistant
ERAS	Electronic Residency Application Submission
ECFMG	Education Commission on Foreign-Trained Medical Graduates
FTIMD	Foreign-Trained Immigrant Medical Doctor
FTBIMD	Foreign-Trained Black Medical Doctor
FTBIMG	Foreign-Trained immigrant Black Immigrant Medical Graduate
IMG	International Medical Graduate
N.P.N	No Page Number
USMLE	United States Medical Licensing Examination

Chapter One: Introduction

> I urge each one of U.S. here to reach down into that deep place of knowledge and inside herself and touch that terror and loathing of any difference that lives there. See whose face it wears. Then the personal as the political can begin to illuminate all our choices (Lorde, 1970, p. 28).

> They are seen as black. Therefore they are black: they are seen as women. Therefore, they are women. Before being seen that way they had been made to be that way (Wittig, 2003, p.159).

This research work, in brief, unveils how racism is engraved in institutional structures in the USA leading to the exclusion of a skilled immigrant labor force because of its non-white identity construction. Black identity construction is complex because of the heterogeneity within Blacks which adds a layer of complexity that has resulted in on-going tension between the various black sub-groups. These tensions are a normal occurrence in life. However, the tension among Blacks is related to their identity constructions. Black immigrants are styled as hardworking (Waters, 1994) and are often seen as model minorities as a way of criticizing U.S. born Blacks (Pierre, 2004). Such criticism needs to be disrupted because it helps divide Blacks and propagates the dominant culture agenda of the divide, rule, and marginalize minority populations.

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Disrupting the model minority model used to describe African born Blacks would foster the African Philosophy of Ubuntu, "togetherness" and communal good.

African immigrants and American born blacks are all of African descent. Various Scholars have referred to Black subgroups differently. For this dissertation, the focus is on Blacks from the continent of Africa and those from the Caribbean Islands. Black immigrants from the African continent are sometimes classified in empirical studies as African immigrants (Hurashimana & Owukoya, 2011, Allen et al., 2012) and at other times continental Blacks (Ibrahim, 2014). Blacks from the West Indian Islands are known as Caribbean Blacks (Waters 1999), American-born Black, and African Americans (Nazir, 2011).

Specifically, this dissertation explores how foreign-trained black immigrant medical doctors experience the process of finding work and working in the U.S.A. Deleuze and Guattari (1987) write that knowledge could be *cyclical and rhizomatic.* This dissertation argues that Black as a racial category is being racialized in education and the workforce. This racialization produces a rhizomatic assemblage of temporality in finding work and working in the U.S.A. Deleuze and Guattari (1987), assert that "assemblages are defined simultaneously *by matters of expression* that take on consistency, independent of the substance from relations……Assemblages swing between a territory closure that tends to re-stratify them and a reterritorializing movement that on the contrary connects them with a cosmos" (pp. 336-337). This temporality in finding work and working in the United States depicts Black identity construction. That is self or other identified.

Hegemonic powers are continuously constructing a Black identity which is subsequently deconstructed through resistance by Blacks. As well, Black identity is reconstructed within heterogeneous Black ethnic groupings that include the difference in immigration and, social class.

To this end, this introductory chapter walks through: first, the meaning of work to Black Immigrants; second, the rationale of the study; third, the background; fourth, research purpose; fifth, my positionality; and finally, the progression of chapters.

Work and the meaning of work to Black Immigrants

Work and the meaning of work to Black African immigrants have been defined as paid and unpaid (Stebleton, 2010). Unpaid work refers to volunteer work in the community. Women's work as a stay at home moms is also unpaid work. Black immigrants are hard working. Hard work is a cultural value that enjoins Black immigrants to invest in their human development and that of the community. For example, taking care of the family, both immediate and extended is a moral obligation. The emphasis on "togetherness" or "Ubuntu" as an African philosophy of education (Nabudere, 2005) propels Black immigrants to invest in the education of their families in preparation for future employment and development. Black immigrants work to take care of themselves and their families (Kent, 2007, Stebleton, 2010, Nyamwege, 2014). This approach to work derives from Ubuntu.

Skilled Black immigrants who are legal residents of the United States would resort to low income jobs to take care of their families when they cannot find paid work

with their qualifications. Stebleton, (2010) observed in his research with African immigrant students in a university in the Midwest that, “many individuals, including African immigrant students, are excluded by an emphasis on traditional career beliefs, primarily a Western perspective with its corresponding assumptions of privilege and self-determination” (2010, p.70). The systematic exclusion of Black African immigrants by customary Western positionality of dominance continues to follow International Medical Graduates (IMGS) who are Foreign-Trained Black Immigrant Medical Doctors (FTBIMDs).

Given the growing population of immigrants in the U.S. including Black immigrants, education and employment policy makers, and employers need to review certain education and workforce policies to ensure a smooth transition of Black immigrants into the workforce. The United States Medical Licensing process needs to be reviewed with the exponential growth of the immigrant population and slots for physician residency increased for culturally responsive doctors to meet the doctor shortage in the United States. Also, Black immigrants are among the fastest growing immigrant groups in the United States

Capps et all], 2011) This increase in the population of Black immigrants requires that policymakers pay close attention to the population growth and initiate policies to assist new immigrants to adjust to the American life-style and also their new place and home in the U.S. (Gruenewald, 2003).

Being Black in the U.S.A is an uphill task that has led to frustration and survivalist life styles because of the stereotyping of Blacks as “lazy” and “Useless” (Watkins, 2001). Survival approaches to finding work occur because of the uncertainties in the workforce system. Some skilled immigrants are unemployed or underemployed. There is no certainty that skilled immigrants would transition smoothly to the jobs for which they have training.

This uncertainty has left most skilled immigrants frustrated because they have to go through several hoops that serve as exclusionary policies, especially traditional careers like medicine. A majority of immigrants pursue temporary low income jobs to cope with their uncertainty in finding work and working in the U.S.A. Stebleton (2010) suggests that “New perspectives on work including innovative tools and helping strategies that are culturally sensitive are necessary for practitioners to develop and hone” (2010, p.70). It is these innovative tools that I seek to unveil as I am specifically investigating how skilled black immigrant medical doctors are navigating the workforce system to find work with their qualifications and how they negotiate their new identity as black doctors seeking to become doctors in the U.S. workforce.

I have been intrigued by these phenomena of finding work and working by immigrants in general and Black immigrants in particular. I am curious to investigate what it is like to live through this process of finding work and working in the U.S.A. The phenomena I am studying, therefore, manifests itself in multiple, partial and varied ways (Vagle, 2014) as job search, seeking employment or finding work and working.

Rationale for the study

My dissertation explores the experiences of Foreign-Trained Black Immigrant Medical Doctors (FTBIMDs) finding work and working in the United States. Understanding how FTBIMDs go through this process of finding work sheds light on education and workforce policies that affect Black immigrant medical doctors and their families. Investigating how finding work might take shape for Black immigrant doctors will illuminate the effect of this process on the family. For example, the underemployment of parents who are black medical doctors can affect the success of their children. The parents are bound to work more than one temporary job to make ends meet for the family.

This trend means that parents spend less time with their children and participate less in their struggle toward upward educational mobility. This lack of parental involvement in monitoring the education of children where parents work multiple menial jobs to survive affects the success of the children (Prins, 2008). Lack of parental involvement may lead to children's failure and consequent drop out from school. There is a likelihood that children would have a promising future, if they have a home that is financially stable, with parents working one stable job that can sustain the family. Parents would be involved in the education of their children as partners with the schools. In contrast, where parents are working two or more temporary jobs children's education and upward mobility would be negatively affected. The absence of parents in children's educational life could compromise the future Black immigrant workforce.

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My interest in investigating the trajectory of health professionals has been ongoing since I set foot on U.S. soil. I noted that there is a socialization process in community spaces through which new immigrants are schooled to begin their journey in the workforce in the U.S.A. There is a multiplicity of options presented to newcomers, for example; babysitting, cleaning, housekeeping, interpreting and the Nursing Assistant Course. These jobs are survival or side jobs some immigrants do because they are desperate.

Furthermore, immigrants are often oriented to take the English Language test and register for the Certified Nursing Assistant (CNA) training. The CNA is pitched as the springboard for achieving the American dream. Becoming a Certified Nursing Assistant has therefore become the norm, an entry point into the workforce system in the U.S.A for most immigrants. This entry point is a *plateau* (Deleuze & Guattari, 1987); a plateau could be read as a staging post. A good number of new immigrants including International Medical Graduates seem to get into the health profession, specifically, the (CNA) because it is the "beginning point, that is where everyone starts." (Personal Communication, Ms. Bony, August 2014). The staging post offers a multiplicity of opportunities to newcomers in the U.S.A. Some new immigrants see it as a temporary position, while others see it as a permanent position. It all depends on the context.

Nursing is a noble profession because it concerns care of human life. Though it is a profession of choice for some, there are others who get into the Nursing Assistant Program out of desperation. These people including International Medical Graduates are

often underemployed because they are trained to be practicing physicians, not nursing assistants. That is why Dr. Lesley, a participant in my study, elected not to do the CNA training; “I don’t want to do the CNA training because I am a physician.” She preferred to maintain her professional identity as a medical doctor even though not licensed to practice medicine in the U.S.A. In contrast, some immigrants who are passionate about nursing see the CNA as a springboard for financial security.

For some, it is a foot into the American workforce system as new Americans. For example, Dr. Marvin, (another participant in this study) who is now a licensed physician, began his journey in the workforce by enrolling in the CNA program. His enrollment helped him to learn English, gained working experience before preparing for his United States Licensing Examination (USMLE). The certified nursing assistant course can be read as a survival strategy that most immigrants have been oriented by community networks to adopt. It is not uncommon that the CNA is the beginning point for some highly educated/qualified immigrants to get into the workforce.

Some resettlement agencies, including some community based organizations (CBOs) that “serve immigrants” and refugees, encourage new immigrants to register to test for spoken and written English immediately they arrive the U.S.A. The next step is to get a scholarship that would pay for the Certified Nursing Assistant (CNA) training. The training is often said to be free. Thus newcomers, therefore, see it as an exciting opportunity to get into the workforce veil on the job description. The Minnesota African Women’s Association (MAWA) offers *“Free Certified Nursing Assistant Training for*

Low-Income African Refugee and Immigrant Women resident in Minnesota."(Minnesota African Women's Association [MAWA], 2016). Another organization also serving immigrants in this arena is Education Connect (Education Connect, 2016). This training ranges from three to seven weeks depending on the institution and the urgency with which the immigrant wants to graduate and get into the workforce. A board examination confers this certification on the graduates. Typically the first place these nursing assistants apply for a job is the nursing homes or group homes, where some seniors reside. This nursing assistant job is an example of a tentative manifestation (Vagle, 2014) of the phenomenon on finding work and working. Tentative manifestations in post-intentional phenomenology the methodology of my study refers to the various themes that make and remake up the findings. These tentative manifestations are multiple, partial and unstable (Vagle, 2014).

Some jobs like the CNA seem to be temporary for some immigrants, but become permanent because they may pay higher than other minimum wage jobs. The need for CNAs is high because there are many seniors who need personal care. In contrast, some Black African immigrants do the CNA program out of a passion for the nursing profession and others do it just to make ends meet because they cannot find work in their preferred profession. Some International Medical Graduates (IMGs) get into the CNA program to learn English and acquaint themselves with the health care system as was the case with Dr. Marvin:

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> I went to school to become a nursing assistant at St. Francis College. Becoming a nursing assistant was an opportunity for me to learn some medical terminology. There was a class specifically reserved for medical terminology, and I took advantage of it to better my medical English. Between when I graduated from CNA school and when I found my first job as a CNA I worked as an on-call French-English interpreter going to different hospitals (Dr. Marvin 5/17/2016).

Other IMGs got into the CNA program to make money for the family to survive and not perish; this is what one immigrant medical doctor said during my interview with her:

> I began by doing the CNA course when I arrived the U.S. to make some cash for my family. I had to take care of a senior as a personal caregiver. I clean his pie, and his poop. I give him a bath and feed him. It has been a trying moment in my life I remember how our building was shot at once. Broken window glass fell over me while I was sleeping on the floor in the home where I was taking care of seniors. It is horrible. I cannot forget that experience. If God were not on my side, I would have been hurt even more. {Crying}. I don't want to think about that night because it was very frightful. (Dr. Nina pseudonym, an IMG) 08/08/2015)

A majority of Black immigrants send money "back home" to their countries of origin to take care of their extended family members as a moral obligation. Stebleton (2010, Bangura, 2005). Some immigrants work two or three menial jobs and a lot of overtime to meet up with their responsibilities as breadwinners for the family. Though they work hard, they hardly find time to relax, spend time with their children, check homework or

monitor their children's academic progress. Thus some parents miss out being part of the education of their children because they have to work and make enough money to keep the family afloat.

It could be a very humbling experience, especially for those who do the CNA out of desperation. Some would not even discuss where they work in the company of friends. The reason is that it has to do with cleaning patients' bodies, having to deal with stool or excrement as well as all the other things that go with the profession. However, others appreciate their work and respect their patients because they are paid to work. An investigation into how it feels like to live through this process of finding the right job for the right skill while holding onto a temporal and reachable or side job is therefore of interest to my study.

Background

Immigration law in the United States of America is complex. Its complexity has contributed to the influx of immigrants to the United States of America. There is a variation in the reason for immigrating to the U.S.A. Immigration is fostered by globalization which has encouraged the movement of people all over the world. These twin openings have led to the unprecedented movement of people to new spaces (Massey, 2001) and places (Gruenewald, 2003) in the U.S. The sense people make as they connect and relate meaningfully to the world in which they live in new spaces (Massey, 2001) and places (Gruenewald, 2003) is relevant their adjustment.

This relevance has triggered my interest to explore the lived experiences of immigrants finding work and working in the US. Gruenewald writes that places are: "profoundly pedagogical. That is, as centers of experience, places ***teach*** U.S. about how the world works and how our lives fit into the spaces we occupy. Further, places ***make*** U.S. as occupants of particular places with particular attributes, our identity, and our possibilities are shaped…… It is also clear that people make places and that places make people" (2003, p. 621). It is from this perspective that our lives fit into the places we occupy that Africans were granted specific visas to gain entrance into the U.S. The Refugee Act of 1980 gave the opportunity for refugees from African countries to come to the United States. The United States Naturalization and Immigration Act in 1990 created the diversity lottery that enabled approximately 50,000 African immigrants to come with their families to the United States (Hume, 2002).

Immigration from our understanding refers to the process by which people leave the countries where they were born to go to other countries and settle as permanent residents or citizens. However, some people who move to other countries without the legal documents to settle are considered to be illegal immigrants. Legal migration confers an immigration status including refugees, asylees, permanent residents, who may become citizens eventually.

Many skilled workers have immigrated to the U.S.A as a result of the Hart Cellar Law enacted in 1965 facilitating the entry of skilled workers. The 1965 Law made provision for families separated as a result of the work visa to reunite by granting visas to

relatives to enter the U.S.A. It made the stipulation for family reunification. Therefore, American doors were opened to a large number of Black African immigrants leading to an exponential growth of the population (Capps, et al., 2011). The Diversity Lottery Program is another United States Department of Citizenship and Immigration System (U.S.CIS) Law that makes available visas to countries with low immigration. Some immigrants come to the U.S. through this Diversity Visa Lottery.

These legislations facilitated Black immigrants being among the fastest growing immigrant groups in the United States (Capps et al., 2011). This increase in the population of Black immigrants requires that policymakers pay close attention to the population growth and initiate policies to assist these new immigrants to adjust to the American life-style and their new home (Gruenewald, 2003). Since 1980, there has been a 200% increase in the number of Black immigrants in the United States (Capps, et al., 2011). Black Africans migrate for a variety of reasons. Some immigrants flee from their nations of origins because of political persecution (United Nations 2006).

Furthermore, there is empirical evidence that immigration policies towards Africa propel the exponential growth of Black African immigrants in the United States, specifically the reunification of families (Nyamwange, 2014, Sandy & Kennelly, 2006). Some Black African immigrants come to the United States seeking economically lucrative jobs because Africa is a “poverty-stricken” continent (Nyang, 1998, Ogbu, 1978). Other Black African immigrants seek education and a better life for themselves and their families through employment (Nyamwange, 2014).

Foreign-Trained Black Immigrant Medical Doctors (FTBIMD are among the skilled labor force that is in the United States (Milkman, 2011; Nyamwange, 2014). However, a majority of them are underemployed (Traverse & McMahon, 2012). Some of these immigrants work at the level of a high school diploma to earn some income to survive (Milkman, 2011).

Research Purpose

This research focuses on the lived experiences of Foreign-Trained Black Immigrant Medical Doctors (FTBIMDs) finding work and working in the United States. I am interested in exploring the lived experiences of Black African Immigrant Medical doctors because Black as a racial category has historically has been marginalized, discriminated against, and are the bottom of the Labor queue (Djamba & Kimuna, 2011) in the United States. Immigrants of African descent are categorized as Black when they come to the United States (Ibrahim, 2014). This categorization is a pointer to how the U.S. system has classified the black as inferior (Fanon, 1967, 1980) in a hierarchized society like the U.S.A. For example, Blackness is a discursive discourse that veils the potentials, talents, and skills of Black and brown people or people of African descent. Awad Ibrahim asserts that “When Blackness encounters the syntactic structure of identity, it seems that new becoming spills over, a rhizome is given birth to” (2014, p.1). This rhizome leads to a rhizomatic third space where Black immigrants could be located. Though Blackness is unspoken, the Black body is speaking loudly. (Ibrahim, 2014) And

can be read differently in various contexts. This contextual racialization of Blacks is apparent in the language used in Black identity construction.

Furthermore, race possesses a language said to be "symbolic capital" with differential values. While "whiteness is an unmarked, transcendent, and a universal signifier, Blackness is a subaltern" (Ibrahim, 2014 p.31). Black identity is constructed as the "Other." Such Othering as described by Kumashiro (2001), leads to marginalization, discrimination, and dehumanization of Blacks as seen in the underemployment of Black immigrant medical doctors as CNAs, scribes and interpreters.

Black immigrant medical doctors are more vulnerable as International Medical Graduates because of their blackness. In contrast, Medical Doctors are a special category of skilled workers whose human capital and cultural competence resources for physician patient centered (communication) are highly needed in the health care system in the U.S. plural society. The American society is an amalgam of different ethnic groups that makes health security an important issue.

Black distinctiveness renders FTBIMDs to be Othered, rejected, under looked and implicitly excluded from a caring and life-saving profession like health, for which they have a passion. These FTBIMDs are continuously seeking "to proof themselves" even as licensed physicians as revealed in the data with participants in this dissertation.

The speaking Black bodies of FTBIMDs are racialized in education and employment in the U.S.A. Additionally, the foreign accent and foreignness (Inniss, 1999; Milkman, 2011) also stand in the way of the foreign-trained Black African immigrant

doctors FTBIMDs transitioning into the medical profession in America. Understanding how FTBIMDs are finding work and working in the United States will lead to recommendations that could facilitate the formulation of policy decisions concerning medical education and employment.

The study seeks to understand how (FTBIMDs) learn to navigate education and the workforce systems to train and seek employment simultaneoU.S.ly. The need to investigate the lived experiences of FTBIMDS derives from the fact that a majority of these FTBIMDs are underemployed. They do low income jobs, for example, driving taxis, delivering pizza or janitorial service as temporary work while waiting to get into the licensing program.

Furthermore, medical expertise is highly needed to provide care for the growing population and also take care of the aging baby boomers including medical practitioners (Peterson et al., 2015). In contrast, FTIBMDs are “Othered” and discriminated against because of their nations of origin by the medical education and employment systems and the workforce.

Foreign-trained immigrant medical doctors are presumed to have sub-standards training (Ibrahim, 2014) because of the technological divide between the developed and under developing world. The digitized society like the United States has an up-to-date medical arsenal to take care of all health care needs. In contrast, “digiprived” societies from which these Immigrant Medical doctors emigrate do not have the up-to-date medical equipment. Thus, the presence of these International Medical graduates in the

United States, a cultural mosaic, is an opportunity for continuous education and retraining in digital literacy. Such training of IMG in the U.S.A is intended to increase their medical performance. Here lies the need to expand the residency program to accommodate foreign-trained medical doctors likely to serve in the U.S. health care system.

Skilled Black African immigrants face enormous problems finding work commensurate with their academic qualifications in the United States. The FTBIMDs in a majority of cases work low income menial jobs, including security guards, personal care givers, and interpreters. Their underemployment affects the society negatively because it is leading to brain waste (Batolava, et al., 2008, Sumption, 2013). The need for immigrants to have a pathway to employment when they come into the United States cannot be over-emphasized. When immigrants train to enter the workforce the probability that they will no longer be dependent on state subsidies, such as food stamps, transportation, and temporary housing, is very high.

The situation of skilled immigrants, including International Medical Graduates (IMGs), has been very complex. Medical education in the United States requires that Medical Doctors get into a residency program no later than five years after graduation from medical school. Residency is a three year program (Traverso & McMahon, 2012). The residency program is a vetting process for medical doctors to be licensed to practice as physicians in the United States (Traverso & McMahon, 2012). However, these provisions do not take into account the years of practice by IMG or experience as physicians. The year of graduation is more preeminent than years of practice as a medical

doctor in the country of origin. A review of the Match Program to increase the number of slots and expand the program taking into account years of experience as a physician would be a welcome dream for Foreign-trained Immigrant Medical Doctors in general and Black immigrant foreign-trained doctors in particular.

Statement of the Phenomenon (Research Question)

The statement of the phenomenon (research question) in post-intentional phenomenology begins with an intentionality statement describing the phenomenon (Vagle, 2014). The intentionality statement in my study is that Black African immigrants engage in finding work and working for the well-being of their families. However, Black immigrants and specifically Foreign-trained immigrant Black doctors are racialized in education and the workforce system because of their identity construction as Blacks. Systemic racism excludes FTBIMD from the workforce despite their skills.

Furthermore, it is documented in the literature that foreignness denies immigrants economic justice (Milkman, 2011). Hence**,** investigating the work-related lived experiences of Foreign-Trained Black immigrant medical doctors is essential. African immigrant doctors in America will fill a knowledge gap related to immigrant work. Primarily, the precarious situation of Black African immigrants finding work and working will have policy implications, disrupt the exclusionary workforce system and lead to possible solutions for economic justice. It will also cater to the shortage of medical doctors and meet U.S.A health care needs. Understanding the process of finding work and working in the United States as Black African immigrants will create avenues

for dialogue with the powers-that-be to seek economic opportunities for these immigrants in general and Black immigrant medical doctors in particular. The research questions guiding this research are:

- How might finding work and working take shape for Foreign-trained Black immigrant Medical Doctors in the U.S.A?
- How does finding work and working affect the individual, the family, and community?

These research questions led me to reflect on my experience with the phenomena, finding work and working in the U.S.A. a graduate with two advanced degrees in a land-grant University in the Mid-West.

Researcher Positionality

My positionality in this research is intertwined with my experience engaging with the phenomena of finding work and working in the Minnesota as an educated Black African immigrant woman. My experience propelled me to become open and reach out to other professionals to understand how their experiences seeking employment in the U.S. have been. As I was serving the community as a member of a community based organization (CBO) the medical profession was unveiled as a site of racialized underemployment. I was attracted to engage in this research project to understand how Foreign-trained Black immigrant medical doctors experience finding work and working in their lived worlds (Dahlberg, Drew & Nystrom, 2008) in the U.S.

EDUCATION AND EMPLOYMENT

My subjectivities are shaped by my Black identity and my history of underemployment in the U.S. As an emerging scholar and educator, I position myself to be able to capture tentative manifestations of the phenomena as *they appear and burst out (*Sartre, 2001) in the process of data gathering. I am passionate about a rights perspective to finding work by all humans. My intention in this work is to engage participants and reflect on their intentional relationships finding work and working as skilled labor in a lifesaving profession like medicine.

I immersed in this work as a graduate from a renowned university in the U.S. When I finished my Masters in Comparative International Development Education; I started looking for a paid job. I visited the career counselors at my institution, who helped me rework my resume and curriculum vitae. I was advised to open an account in the state system to apply for jobs for which I was qualified. I followed the advice. I then applied for a couple of jobs and was called for interviews. These interviews were in person, phone interview and even follow up interviews with the top management of some organizations. Unfortunately, I was not successful in getting any paid work.

My efforts at finding work did not bear fruits. I did not find paid work, as an immigrant with two Masters degrees, from the University of Minnesota, a top public research university and my background in English Private Law as an undergraduate degree level; Philosophy of Law and Legal Perspectives, a Graduate Degree and a Diploma in International Human Rights Law.

EDUCATION AND EMPLOYMENT

Some friends in my community advised me to go and do a certified nursing assistant course for three weeks and get a job that would take care of my immediate needs. I listened to my kinfolks and went to the Minnesota International Institute. The majority of the people I saw there were immigrants from diverse nations. Most of us were helpless and stood in long lines to get help from the attendant. I finally realized that there was a pre-selection written English examination to qualify to do the CNA course. I felt uncomfortable because those with whom I took the examination spoke very little English. I felt like I was in the wrong space given that I have earned two Masters Degrees from the University of Minnesota.

It was a very humbling experience sitting in the same room with those struggling to understand Basic English and how to communicate in English. I took the pre-selection examination that was so simple that I felt insulted. I made all my points on the English Language examination as I expected. It was at this moment that I decided to abandon the CNA project. I knew that this was the wrong place for me. The reason is that I was over qualified to do the nursing assistant job. Though I knew I needed some funds to provide for my family's basic needs, I abandoned the Certified Nursing Assistant (CNA) project after I got the results of my admission into the program. The moment was ripe for me to pursue my dreams as an academic. I decided to apply for a doctoral degree program.

However, a man in my community told me that his family was doing just fine because his wife was "a registered nurse" (personal communication, 01/03/07). After our conversation, I regretted my decision to withdraw from the CNA program early in 2007

because of its lucrativeness. My family's financial situation was not stable. I resorted to self- employment as my "plan b' while pursuing my Ph.D. I chose to follow my passion instead of going with the masses for a survival job as a nursing assistant. I am convinced that my passion as an educator and an agent of change gives me more satisfaction than a nursing profession that I would have done for the sake of the survival remuneration it offered. I can now relate with the FTBIMDs who choose not to do the CNA. In contrast, I applaud Dr. Marvin who used the CNA program to learn medical terminology that improves his English language communication. It paid off for him, and today he is licensed to practice medicine in the U.S.A.

Self-employment for me was a *line of flight* (Deleuxe and Guattari, 1987); doing unpaid work (volunteer) in the community another *line of flight*. These were alternative moves that needed to take place in my lived world at that time and space. As an entrepreneur, I decided to use my talents in the non-profit sector in serving the community for the past ten years. I founded a non-profit organization Africa Network for Development Inc. (ANDI) to serve immigrants in Greater Minnesota. The mission of this organization was to facilitate access to resources for immigrants. Access to resources to flourish in the U.S.A seemed to be a problem with immigrants. Even though I could not find work that I qualified for, I could assist others to the best of my capability to navigate various systems, for example, the college preparation for children, and education pursuits, health, and the legal systems, among others. In post-Intentional phenomenology, lines of Flight are explored to see what the phenomenon shall become. These lines of

flight gave me temporary respite about finding work and working while pursuing my doctoral degree. For example, self-employment afforded me flexible time to go to school, pursue my doctoral degree, and take care of my family. I was my boss and doing what I am not ashamed to do and serving my customers and building relationships with them. Being an entrepreneur has been fulfilling to me because I am very passionate about building communities and promoting communal good. Reflecting on my lived experience searching fruitlessly for paid work in the Midwest empowered me to undertake this research project.

Furthermore, an incident at the state level led me to investigate the education and employment of Black Immigrants. I attended a statewide policy reformulation conference both as a doctoral student and an executive director of a community based organization (CBO). The head of the Department of Human Services did his presentation about the need to employ new workers in the state because baby boomers were retiring.

I seized the opportunity, as researcher and immigrant, to raise the question about the employment of immigrants. I raised my hand and said “I am an immigrant and I speak with an accent. I wondered how I could secure employment at the state level. I was told on the spot that there are translation services available to help me with translation. In fact, that was not what I meant. I reformulated my question by saying that I represent people who look like me but who speak with an accent and have difficulties finding work. Now that the state is reformulating its policies could there be an opportunity for immigrants who are qualified to be employed? At this point I imagined myself wearing the same

shoes like the subjects in my study finding work. After the session, the director of human services gave me his card and asked me to call his office. When I called his office, I was told how to find translation services. The next day I called his office a second time, but no one seems to understand neither my call nor my message. However, I was finally invited to a meeting at higher education to examine my concern.

I met a director in the Department of Higher Education, Ms. Carol. Ms. Carol seemed to understand my predicament and took an interest in my desire to find a "voice" for immigrants at the level of the state to enable the state benefit from the assets that immigrants bring to the United States of America. She investigated at the state level and found out that there were some programs for immigrants. There were many agencies working with immigrants that had not paid attention to the fact that when "baby boomers" start retiring there will be a need for skilled workers to fill the gap. She later asked me what I wanted to do with the information. I told her that immigrants bring assets. These assets are not harnessed. The state could benefit from these unharnessed assets if it gives immigrants the opportunity.

I invited Ms. Carol to be a member of the Board of Directors of the organization I founded with a mission to facilitate access to resources for immigrants. She accepted my proposal and attended one meeting of the Board of Directors. She indicated that this issue of immigrant education and employment was very pertinent and that the Board of Directors should come to the meeting that she had organized since I raised the issue. She said other state stakeholders would also attend this meeting so that together we could

brain storm on how to handle the issue of immigrant education and employment. In the spirit of togetherness from our Ubuntu roots, I thought it was the beginning of seeking solutions to unemployment and underemployment of immigrants as a whole.

This meeting became known as “Barriers to Education and Employment for immigrants.” Ms. Carol partnered with Ms. Deb from the Department of Employment and Economic Development (DEED) and invited other non-profits working with immigrants to come to this conversation. Ms. Carol and Ms. Deb became chair and co-chair of this group, respectively. When private foundations starting taking an interest in the project, Ms. Carol resigned from the Board of Directors of the non-profit organization I was running. I was shocked by her behavior because I thought she positioned herself as a white privileged female to help build inroads into the state system for my non-profit organization. How she could breach her commitment to our Board of Directors and still look at me in the face when I attended the roundtable conversations facilitated by her was bizarre.

I kept participating in the roundtable meeting. Ms. Carol later lost her job at the state level, and so she could no longer host the meetings at her office. Ms. Deb asked for a volunteer to co-chair the meeting with her. I quickly volunteered to be co-chair because it was our project and I had a stake in it.

When we (“the project participants”) developed a proposal to take to the Secretary of State Ms. Deb said she would go with another person and not me. I asked her why I could not go with her as co-chair. Her reaction was that she had a personal relationship

with the Secretary of State. Thus as with my subjects, it is "who you know" that matters for you to have access to certain people and resources in the state. A majority of FTBIMDs also lack this personal relationship to usher them into residency.

I kept the faith and continued contributing to this conversation. Another opportunity arose to take our proposal to the Council of Mayors. I was told that the Council of Mayors would rather not see "people who look like me." I was amazed at the open and frank racist slur. In the interest of the success of the project, I said this project was meant for the common good and those whose complexion would not offend the Mayors could go and present it. The proposal, a culmination of monthly conversations for two years ended in someone's drawer. It is my hope that this issue of immigrant education and employment is discussed in policy spaces where solutions could develop. Seeking solutions to the plight of skilled immigrants would help the society as a whole. Investigating the experiences of FTBIMDs finding work working, and bringing the results to the public arena is hopefully one step in the right direction.

These controversies should instead not stifle the "voice" because stifling "voices" of FTBIMDs could lead to organizing and resisting the ongoing racism and marginalization of skilled Blacks. For example, the Black Lives Matter movement is a racial project against police or officers gunning down blacks and others as if they were a game in a park. Omi & Winant would classify this movement as an example of resisting or disrupting the marginalization and killings of Blacks in the U.S.A by police officers. My trajectory seeking employment buttresses the assertion that blackness is a

normalizing discourse that perpetuates discrimination and flaunting inalienable human rights.

Progression of Chapters

This dissertation comprises six chapters. Chapter one lays out the rationale for the study; it includes some background to this work, my research purpose, research questions, and my positionality. Chapter two covers a partial literature review and the conceptual framework to help explain the existential situation of participants in my study as they seek a place in the U.S. employment system. The conceptual framework is thus a combination of theories: Racial formation theory with Omi & Winant (1994/2015), Postcolonial Theory by Frantz Fanon (1967/2008), Borderlands theory by Gloria Anzaldua (1987) and finally the Forms of Capital by Pierre Bourdieu (1986/2011). Finally, this partial literature review derives from the research methodology for this study, post-intentional phenomenology (Vagle, 2014). In the partial literature review, I explored an integrative literature review approach. An integrative literature review is a form of research that reviews, critiques and synthesizes, the representative literature on a topic in an integrated way such that new frameworks and perspectives on the topic is generated (Torracco, 2005). First I examined empirical works on immigrant employment in general, second, I reviewed the literature on Black immigrant employment in particular, lastly, and I review the literature on medical education in the U.S.

In chapter three, I describe the study's methodology. I employ post–intentional phenomenology, a qualitative research methodology. I begin with the philosophical

underpinnings of post-intentional methodology. Next, I explain the methodology and methods. I outline how the participants for the study were selected, participants' profile are reported, data sources, data gathering methods, and data analysis plugging in various theories and concepts. Further, I outline how participants Used voice as critical pedagogy, to explore *voice as project*, *voice as participation* voice *as social struggle* and voice *as becoming* (Lensmire, 2000) in finding work in the U.S. Finally, I demonstrate the trustworthiness of the research, and also validity and reliability. Chapter four comprises the results of my study. The results are findings in tentative manifestations. The chapter outlines various themes that emerged from my research. These themes explained and analyzed. Chapter five distills the research. It summarizes, discusses the research findings and the implications for future research and conclusion.

Chapter Two: Partial Review and Conceptual Framework

The plague of mankind is the fear and rejection of diversity: monotheism, monarchy, monogamy and, in our age, nanomedicine. The belief that there is only one right way to live, only one right way to regulate religious., political, sexual, medical affairs is the root cause of the greatest threat to man: members of his own species bent on ensuring his salvation, security, and sanity (Szasz, 1960).

Part 1: Partial Literature Review

A partial review of literature is required in post-intentional phenomenology as stated in Vagle (2014). Since, in simple terms, phenomenology is the interpretive study of human experience, the aim of this partial literature review is to examine and clarify human situations, events, meanings, and experiences "as they spontaneously occur in the course of daily life" (Von Eckartsberg, 1998, p. 3). The goal is, therefore, a rigorous. Investigation of human life as lived and reflected upon in all interrelationships, for example, first-person concreteness, urgency, and ambiguity.

I elect to use an integrative approach to this review as stated in Torraco (2005) to help bring together literature from various spheres related to the topic of education, employment and Foreign-Trained Black Immigrant Medical Doctors (FTBIMDs) finding work and working in the U.S.A. Torraco (2005) states that "an integrative literature review is a form of research that reviews, critiques, and synthesizes the representative literature on a topic in an integrative way such that new frameworks and perspectives on the topic are generated"(p. 356). To this end, this review seeks to answer the following

question: How have researchers examined the issue of education and underemployment of FTBIMDs finding work in the U.S.A?

Given the areas that the review question covers, this review is divided into three sections, where finding work might take shape. The first section examines empirical studies defining the macro immigrant work situation in the U.S.A. Section two highlights studies in medical education and International Medical Graduates (IMGs) transitioning into the workforce. Section three discusses empirical studies are dealing particularly with African immigrants and work.

Immigrant work situation in the U.S.A

Iris Chang (2004) writes that "America in the twenty-first century gleams for many hopeful immigrants …broadcast to the world a raw new culture not necessarily locked into old ways"(p. 20). Immigrants dream to embrace this new culture as they transition into educational and workforce systems in the U.S.A. This trajectory is short for some but very long and very tiresome and frustrating for others despite the "infinite resources" that America has. Furthermore, Chang asserts that "To thousands worldwide who found themselves desperately trapped without money, property jobs, or a future. This land of wide open spaces, seemingly infinite resources, and unsettled territories…..held out the promise that here (America, emphasis added) was a place where a person could walk away from his or her past and begin again, reinvent himself or herself. And give that new self a better life" (Chang, 2004, p. 20). It is for this reason that many immigrants seek to reinvent themselves and have a new life in America.

International Medical Graduates for example build on their training as medical doctors, hope to reinvent themselves in this "open wide space with seeming *infinite resources".* Chang (2004) has proven that this reinvention has been a utopia for some IMGs. The reality is that most IMGs who are seeking residency in the U.S. find themselves trapped by the requirements of residency and the Match program.

Immigrant Struggles in their new land, America. Iris Chang (2004) in her book *Chinese in America* also writes about the immigrant struggles in a new land or new home America. Chang asserts that immigrants are faced with racism and xenophobia as well as prejudice and discrimination. Immigrants migrate to America to make a better life for themselves and their families. Adjusting to a new environment takes time.

However, a perpetual transition period fraught with uncertainties is cause for concern. Chang asserts that Chinese were regarded as model minorities, working hard, being paid less, but enduring and persevering. The label of model minorities is seen in the literature as unacceptable. The dominant privilege of white culture uses this label model minority as a cover up for systemic racism (Lee & Ngo, 2007; Chhuon. 2012; and Waters, 1999). Immigrants have no choice than to work hard because the system is set to exclude them from some high paying jobs. To remain afloat, immigrants continue to work hard despite the little remuneration they receive. This poor remuneration of immigrants explains why wage disparities in the U.S.A are no news (Djamba & Kimuna, 2011; Nyamwange, 2012). The wage disparities have become a concern, especially with skilled labor.

***Medical Migration, a global concern*.** Healy & Oikelome (2007) write that the issue of "medical migration is a global concern" (p.1917). It is because of this concern that the World Health Organization (WHO) noted that the migration of health professionals brings an imbalance in the health workforce globally. WHO, resolved during its 57th General Assembly session in 2004 to, "urge members to develop strategies to mitigate the adverse effects of migration of health workers to remain in their countries……. to help countries set up information systems to monitor the movement of health resources, and to include human resources for health development as a priority programme of WHO from 2006-2015" (p.1918).

Despite the resolution of the WHO, in 2016 we still find an avalanche of health professionals, including black medical doctors from the developing countries in the U.S.A, who are finding work. What happened to the WHO good faith resolution adopted in 2004 for developing the human resources for health development? How accountable are WHO and members of WHO? How can nation states take responsibility for the unfortunate imbalance in the number of health professionals in developing countries and that of the UK and U.S.A? Our concern in this study is the plight of physicians who have migrated because of some push and pull factors and now find themselves doing what they call by a variety of names: GED Jobs, high school graduate level jobs, side jobs, low income jobs and temporary jobs for survival.

Furthermore, in Healy & Oikelome (2007) the WHO also suggested that developing countries should offer incentives for health professionals to remain in their home countries and attend to the health needs of their people. What kind of incentives is offered to physicians working in a war tore environment or physicians persecuted because of their political affiliations, for example? Incentives may be good. We must also question, how sustainable are the incentives? If incentives are not far reaching, the tendency would still be for physicians to follow the push and pull factors and immigrate to the U.S.A where the system is designed to exclude IMGs.

*Country of qualification***.** Healy & Oikelome (2007) write that, "In the UK .and the U.S.A. It seems that not only are race and ethnicity important but also country of qualification is a major determining factor where doctors will work what will be their specialties and their relative disadvantage and degree of periferization" (p. 1928). Entry requirements for residency are rigorous and hierarchical. Though the Match program has few slots (Traverso & McMahon, 2012), the number has been maintained instead of expanded about the population growth**.** The wave of physicians migrating to the UK and the U.S.A is on the increase. This increase demonstrates that the WHO resolution is not implemented in most developing countries. Now the question is how are these physicians transitioning into the workforce in the U.S.A?

Overall, the immigrant work situation is precarious as seen in empirical literature (Milkman, 2011). The precariousness of immigrant employment is compounded by

various factors including; the age of arrival, English language proficiency, and foreignness.

Reasons for immigrating. Immigrants have a variety of reasons for immigrating. Work or economic considerations are some of the several reasons why people emigrate. Transitioning into the workforce is complex. Contemporary research on immigrants and work indicate that race is a determinant of immigrant employment and wages (Djamba & Kimuna, 2011; Nyamwange, 2014; Waters, 1990. Djamba & Kimuna (2011) assert that the increasing population in the U.S.A notwithstanding, race directs the labor market in contemporary America. The whites are at the top of the labor queue while Blacks are at the bottom. Their study demonstrates that white African immigrant men earn higher wages than Black African immigrant men. Black African immigrant men thus suffer from the stigma around Black as an inferior status that carries with it lower economic remuneration and standards.

Medical Education in the U.S.A

Medical education in the United States requires that international medical graduates (IMGs) or foreign-trained medical doctors (FTBIMDs) take the United States Medical Licensing Examination (USMLE) to get into a licensure program called residency (Traverso & McMahon, 2012). The residency program is governed by, a Match program. The Match program makes available a certain number of slots for medical graduates to get into residency every year. These residency slots are few and competitive (Traverso & McMahon, 2012). This competition has unfortunately led to discriminatory practices. For

example, the procedure for selection in the Match program could be termed a systemic allocation of jobs to the privileged few through a shifting strategy (Dore, 1975) that excludes many foreign-trained physicians, especially immigrant medical graduates. This approach to employment of IMGs disregards the benefits derived from investment in human capital and resources.

Some scholars have argued that "expenditure on education….is to be thought of as an investment ---in mankind. The returns on education, both individually and socially are at least as high as those in physical capital (Vaizey and Debeauvais, 1961, p.38). Underemployment of IMGs is, therefore, brain waste (Batolavo & Fix, 2008).

Women's participation in residency. Women's participation in residency programs has been low. The medical profession in the U.S.A has been the preserve of men. There has been consistent discrimination against women. More men are placed through the match than women (Iserman, 1980). Nonetheless, in 1988 there were women in residency programs being trained in several accredited areas of medicine. In 1988, 36% of women were in Internal Medicine and Podiatry. Additionally, 28% were in Obstetrics and Gynecology, Psychiatry and Family Practice (Iserman, 1980).

The Equal Employment Opportunity Act (EEOC) stipulates that once a medical graduate is in residency, he/she is an employee and a resident. The resident is protected under Title V11 of the Civil Rights Act, 1964, from discrimination because of race, color, sex, religious beliefs or national origin. Discrimination has become complex and covert. Some employers fear to "work with women as equals" and "women are still under-

represented in residency as faculty especially at associate professor and professorial rank" (Iserman, 1980, p. 221). Women applying for residency programs experience specific difficulties because of their femaleness.

Possible Expansion of Residency Slots. The need to expand these slots in the Match program is urgent because the health care needs in America have increased following an expanding population (Traverso & McMahon, 2012).The health care needs of the population cannot be post-poned. The need for more physicians, be they foreign-trained or American-trained to attend to the current health care, needs is imperative. Peterson *et al*. (2015)) found that forty thousand additional primary care physicians will be needed to meet the health care needs of the growing population in the United States in 2035. The physician shortage was based on the estimates that compared supply and demand of doctors (Fein, 1967). Drs. Rogers, L. Lee & Lewis W Jones undertook the significant study on the subject matter. The projection or estimate of physician need was gathered from expert opinions on the amount of care. Lee & Jones (1933) had on the number of physician hours required to prevent, diagnose and treat specific diseases and health conditions.

The study translated the number of hours needed for a physician requirement of 134 hours (Lee & Jones, 1933). The authors' analysis proved that there was a shortage of doctors (Fein, 1967; Traverso & McMahon, 2012). This analysis was done through their observation that there were 165 physicians per 100,000 physicians for the nation (Lee & Jones, 1933). American medicine cannot easily justify dual standards for licensing

physicians, one standard for American Trained Medical Graduates (ATMDs) and the other for IMGs but dual standards exist in spite of the urgent healthcare need for physicians, physician shortage, and an aging population of physicians.

Accommodating the talents and skills of International Medical Graduates in the U.S.A. Incorporating the skills and talents of IMGs into the physician workforce system would likely be a great investment in the healthcare system. Whenever policy makers undertake steps to review the licensing process for IMGs it would be an excellent opportunity to utilize globally skilled health professionals. Maintaining a good health care system for the United States may demand that foreign-trained immigrant medical doctors get into residency programs and become licensed physicians.

Besides being medical graduates, FTBIMDS are experienced in working with culturally plural populations. In a cultural mosaic like the United States, foreign-trained Black immigrant medical doctors (FTBIMD) could be an added resource whose usefulness is not in doubt. They also have an additional advantage of being culturally competent and sensitive because they understand the beliefs and value systems of the immigrant population.

The influx of immigrants into the U.S. necessitates the provision of culturally sensitive health care. In an informal conversation with one FTBIMD, he confirmed why this was necessary. “I was volunteering in a hospital doing an observership. I met someone from my country, who had a health issue but could not communicate properly in English. The translators did not communicate her health condition accurately. She told

me in our mother tongue what was going on. I told the medical doctor in charge, and her treatment plan was revised. She responded positively to the treatment." She told me that she would direct some of her friends to call me to assist them so that they could have proper treatment**"** 20/10/15, Dr. Tyler (participant). This example explains the urgency to revisit the employment of the FTBIMDs by paying attention to culturally competent doctors pursuing a residency in the U.S.

Black immigrants working in the United States

Black immigrant work in the U.S.A is divided into four sections. First, we shall examine the definition of work for and by Black African immigrants. Second, we shall explore human capital. The third section will discuss the impact of foreignness, and English Language proficiency.

Defining Work for, and by Black African Immigrants. Scholars have categorized work as paid or unpaid (Stebleton, 2010; Milkman, 2011). Participants in the Stebleton (2010) study were adult Black African immigrant students. The methodology used to collect data was narratives, following a Gardamerian hermeneutics approach. Three themes emerged from the study. First, the context was crucial in orienting the meaning of work; second, a connection between family, work, community, and the identity of students as it relates to work is unveiled (Stebleton, 2010). Stebleton did a good job at highlighting the African philosophy of work (Ubuntu), which means togetherness or service to the community and the meaning of work and family. Stebleton (2010) discussed the meaning of work to the family, but nothing is discussed, about the

participants' lived experiences finding work or working. However, his discussion did not differentiate related work experiences from career development which was his research focus.

Finding work and working is very important to most African immigrants because they work to take care of both their immediate and extended families (Kent, 2007; Nyang, 1998). Current conversations about African immigrants have focused on professional career development for African students and labor market differentials of immigrants (Kent, 2007; Stebleton, 2012). There is a gap in the literature about FTBIMDs. This study would contribute to knowledge relating to harnessing the human capital of foreign-trained Black African immigrant through training and employment as a viable option for the capitalist economy like that of the United States.

Human capital. Human capital refers to the investment in human beings, for example, knowledge that accrues from education, training, and apprenticeship (Sweetland, 1996). The economy of the United States has shifted from manufacturing to a service led economy. This shift necessitates investment in human capital to meet global competitiveness (Zula & Chermack, 2007). Scholars have indicated that "Black African immigrants are among the best-educated U.S. immigrants" (Capps et al., 2011, p.12). The authors further assert that "Black African immigrants have relatively high employment rates (exceeding 70% for most countries of origins" (2011, p.1). Despite this impressive data about Black African immigrant employment, a great majority of them are underemployed. They do not find themselves in professions they trained for because of

their foreignness, racial discrimination, accent, or age of arrival into the United States of America (Bleakley, 2000). Accommodating foreign credentials is also a problem (Bleakley, 2000; Capps et al., 2011; Piske, et al. 2000; Milkman, 2011). The U.S. economy does not benefit much from the skills and talents of those who are obliged to work menial jobs to survive. Such misuse of skills is a marker of brain waste. In brief, the returns on investment in human capital cannot be accounted for because "human capital theory suggests that individuals and society derive benefits from investment in people" (Sweetland, 1996, p. 341).

Foreignness. Foreignness is another challenge faced by Black African immigrants. Foreignness is a stereotype that stands in the way of immigrant employment. In a study titled *"Immigrant Precarious. Work and U.S. Labor Movement*", Ruth Milkman, (2001), asserts that "immigrants are faced with a lot of challenges, in the workplace where these immigrants are exploited because of their foreignness" (p.1). Foreignness denies immigrants economic justice (Byoum, 2013; Milkman 2011). Cheng writes that "it is the foreigner within me that most eagerly needs to understand the web of American racial dynamics and their particular articulation of aspirations and rejection and expulsion" (Cheng, 2001, p. xii*).* The racial dynamic in America is complex. Most foreigners cannot comprehend it.

The English language seems to be an indispensable medium of communication for a majority of employers in the public sector. The American system requires English language proficiency, in both oral and print, to ease communication in the workplace.

EDUCATION AND EMPLOYMENT

Scholars have found that most immigrants and refugees enrolled in English as a second language (ESL) programs learn to speak English despite the influence of a foreign accent (Piske et al 2000). Speaking English with a foreign accent poses problems to some employers who are not accustomed to hearing a foreign accent.

Several variables have been found to have an effect on the accent of immigrants: age of arrival into the United States, second language acquisition, and the degree of the influence of foreign accent (Bleakley, 2000; Piske et al. 2000). Immigrants who are self-employed also need English language proficiency to communicate better with their customers (Constant, Shachnurove, and Zimmermann, 2003). However, some low skill jobs may not need proficiency in the English language (Sanders, Nee, & Sernau, 2002). That is why most low skill jobs attract immigrants without English language proficiency.

The scholarly works reviewed indicate that there is a gap in knowledge relating to the work- related lived experiences of African immigrants finding work and working.in the U.S. Specifically, there is no empirical literature on FTBIMDs finding work and working in the U.S.A. Therefore, there is the need to investigate and highlight the meaningfulness of work, benefits, challenges, and effect of finding work and working on their holistic lives, and the lives of their families. Understanding how Black African immigrants learn to navigate the American system finding work and working will help policy makers revisit their options in formulating new policies to accommodate immigrants. The goals here are to ensure that the talents that Black immigrants bring into the U.S.A are not wasted as well as bring attention to the “talent pool of immigrants”

(Papademetriou & Sumption, 2012, p.4). This policy option will enable the American workforce to utilize the skills and talents Black African immigrants bring into the United States as established through empirical, theoretical, personal, and practical problems.

Conclusion

This partial literature review set out to examine empirical research about immigrants' education and employment in the U.S.A. The review was divided into three sections. The first section examined Iris Chang's work on the Chinese in America. Her work depicts the experiences of all immigrants. Section two examined the literature on medical education in the United States. It discussed the hurdles for International Medical Graduates concerning the residency program in the United States licensing program. Furthermore, the section also examined literature on the racist and ethnic discrimination of International Medical Graduates from developing countries. The third section looked at literature on Black immigrant work in the U.S.A.

The partial literature reviewed demonstrates a few trends. The first is that throughout the entirety of its history as a country, America has been the home of hundreds of millions of immigrants. Lately, many waves of people from Africa have sought peace or a place to rebuild their lives in this "land of the free." The question that immediately springs to my mind is: What are the various catalysts for these African immigrants' journeys to America? The factors affecting African immigration can be grouped into two categories- "push" factors, and "pull" factors. The main push factors are poverty, conflict and political repression in Africa and the main pull factor is the

opportunity to "start over" and build a new life in affluent America. Obstacles encountered by African immigrants in America such as racism, underemployment and uncaring capitalist drive for profit frustrate the efforts of many of these Black African immigrants. Hence, it is compelling to find out how these African immigrants find work and work in a capitalist America whose individualistic values are quite different from their communitarian African countries. There is a gap in the empirical literature concerning the plight of FTBIMD finding work in the U.S.A. This gap in the literature is the impetus to my research.

Part 2: Conceptual Framework

Constructing Black identities in Education in the United States

The prophetic utterance of a scholar and civil rights activist, W.E.B. Du Bois, who stated that the problem of the 20th century was the color line (1903), remains the reality in education in the United States. The racial tension, oppression and marginalization of Blacks in the United States in general and educational institutions, in particular, have been increasing recently. The killing of Black youths and men, including more recently, the murder of Trayvon Martin, is raising Black consciousness (Freire, 1970) and has culminated in the rise of the "Black Lives Matter" movement. This movement is an anti-racist representation of Blacks (Rodriguez, Geronimus, Bound & Dorling, 2015). Black Lives Matter is a way of resisting oppressive police brutality and killings, and defending the rights to life and education for the Black (Rodriguez, Geronimus, Bound & Dorling (2015). As stated in the Universal Declaration of Human Rights – UDHR (1948), these

rights are inalienable human rights. Objectively, all lives matter and the rights to life and education are fundamental human rights.

Blacks are marginalized, discriminated against, oppressed, marginalized, and interiorized in education because of their pigmentation (Fanon, 1967). Consequently, they struggle with the construction of identity. From the civil rights movement in 1960 till recently, white privilege stands in the way of the construction of Black identities in education from the perspective of equality with whites. Some Blacks learned to act white, to escape the stigma of inferiority and survive in the United States. Similarly, some whites *learn to be white* (Thandeka, 1999) to claim their superiority.

The construction of Black identities in education is rooted in the history of slavery and immigration (Ibrahim, 2014; Waters, 1999**).** An exploration of the construction of Black identities begins with the search for answers to the question: "how are blacks being represented and how does that bear on how we represent ourselves" (Hall & Du Gay, 1996, p.4) as a race? An attempt at an answer would be that "Black" is a label attributed to people with dark skin, intended to denigrate them. As a result, Black people have to work hard to proof their human worth and reconstruct their identity. Following such interrogation, Ibrahim (2014) writes that "racialization is the process of becoming Black …and race is a complex semantic system…… that is forever dual: conscious and unconscious forming and performing, constructing and representing" (p.34). Race has a performative (Butler, 1990) nature. It is unstable and fluid as a result of intermarriages,

the mixing of races leading to hybrids, *mullatos* and *mestizas.* For example, Black students perform whiteness by acting white to have their way in the academy.

Blackness in education and employment is complex because of Black heterogeneity in a dominant white privilege and hierarchical system. Blacks are perceived from a variety of perspectives that include self-identification or other identified. Blacks identify themselves from the national origin as African-American, meaning American-born Blacks (Nasir, 2011), Continental Blacks - African immigrants from the continent of Africa (Ibrahim, 2014) and West Indian immigrants from the Caribbean Islands (Waters, 1999). This heterogeneity of Blacks complicates the construction of a universal Black identity and renders it amputated (Fanon, 1967). It is difficult to lay claim to a single approach to classifying Blacks because of the variation in black identification. Having the same roots called African descent does not make Blacks homogenous. They are separated or given different names where they settle. This seeeppparation and naming is amputation.

Some scholars are suggesting that Black identity construction should be contextual. An exploration of identity construction should start with how Blacks are being represented and how they represent themselves (Hall & Du Gay, 1996) in various contexts. Black as a category is adapted internationally as a cue of identification of people of Black African descent (Ibrahim, 2 014). Africans who were identified as *Ibo, Yoruba,* and *Tikari*, in their home country became, “Black” upon arrival in the United States, based on a racial logic of “maintenance of a color line” (Ibrahim, 2014, p. 35).

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The Black skin is distinct because Black bodies speak loudly in the United States (Ibrahim, 2014; Toldson, 2014; Sullivan, 2000) and are read in various ways. The binary of them versus us fosters the racial divide between whites and Blacks (Fanon, 1967). Therefore, identity, nonetheless, is a production always in progress, never complete, and represented within various contexts (Hall, 1999). It is relational and birthed at the boundaries of "self" and the "Other" (Bakhtin, 2000). It is in these in-between spaces that dialogue occurs. Hall (1991) posits that:

> The critical thing about identity is that it is partly the relationship between you and the other. Only when there is another can you know who you are……..And there is no identity without a dialogic relationship to the other. The other is not outside but also inside the Self, the identity, so identity is a process. Identity is split; it is not a fixed point, but an ambivalent point. Identity is also the relationship of the other to oneself (p.11).

Identity is being situated in context as the self, and the other co-exist. Blacks are therefore Africans because Africa is born in them. The African identity is a common denominator. Identity here is a sense of connectedness and belonging (Gosine, 2002, Chhuon & Wallace, 2012). This sense of belonging can be fostered in education when educators or teachers intentionally engage students with culturally sensitive care (Ladson-Billings, 1995).

This review explores the construction of Black identities in education and employment. It is informed by theories, such as Racial Formation by Omi & Winant,

(1994, 2015), Postcolonial and violence theories by Frantz Fanon (1967), Borderland theory by Gloria Anzaldua (1987) and Forms of capital by Pierre Bourdieu, 1986/2011). These theories include lived experiences of some authors. Several scholars have also used the framework of these theories to address identity construction in education. Many scholars (e.g., Stets & Burke, 2000) have studied self-identity using social and identity theories.

Understanding how Black identities are being constructed in education and employment sheds light on the various racial identity issues in education and employment in the United States. This study argues that the construction of Black identities in education and employment in the U.S.A is radicalized. Inequities and discrimination in schools and workplace abound "as a result of standardization, corporatization, and privatization" (Roberts, 2010, p. 449). Blacks are treated in formal and informal education as inhuman, violent, and disruptive, and the white supremacists refer to Black youths as an expendable population and seek to incarcerate them (Giroux, 2008; Quinn, & Meiners, 2009).

To this end, the review seeks to address the following question: How do major theories help us understand the construction of Black identities in education and employment in the United States? Answers to this question shall be elicited through an exploration of the afore-mentioned four theories.

The review is divided into four sections. The first section discusses racial formation theory (Omi & Winant 1994, 2015) and the second section discusses Post-

colonial theory (Frantz Fanon, 1967). The third and fourth sections discuss borderland theory (Gloria Anzaldua, 1987) and Forms of capital (Bourdieu, 1986) respectively, and conclusion.

Racial Formation Theory

Race is "a way of making up people" (Omi & Winant, 2015, p. 105) by the dominant white privilege and hegemonic culture. It is *a master category* that is complicated and imbued with shifting meanings (Cheng, 2000; Nazir, 2011; Omi & Winant, 2015). Racial formation can be defined as the contextual construction of race and identity enacted within social and historical space and time (Omi & Winant, 1994). Furthermore, Omi and Winant (2015) assert that racial formation theory is to explicate race as a construct. Therefore racial formation is geared towards developing "a theory of race and racism, adequate to their complexity, historical depth, and ongoing political importance" (p.107). The theory, therefore, explains how concepts of race developed historically, dissipated and is permeating sociological, cultural, political, and educational spaces in the United States of America. Omi and Winant (2015) argue that "throughout U.S. history race has provided a "template" for patterns of inequality, marginalization, and difference" (n.p.n).

Racial formation theory is grounded in racial projects. And, "race making can also be understood as a process of Othering" (Omi & Winant, 2015, p. 105). The consequent othering of people because of their race sexuality, nation of origin, age, nationality just to name a few is imbedded in *implicit bias.*

These racial projects are either macro or micro. Macro projects are racialized policies with covert inequities while micro-projects take place in everyday interactions in institutions of learning and the society. Racial projects connect the project and the subject of the practice in everyday life. (Omi & Winant, 1994). According to Omi and Winant (1994), a racial project is "simultaneously an interpretation, representation and, or explanation of racial identities and meanings of an effort to organize and distribute resources (economic, political) along racial lines" (p.125). It is in this light that the Black Lives Matter movement is a racial project. This racial project is an anti -racist racial project aimed at disrupting the wanton killing of Blacks by police officers expected to protect and serve communities.

Racial formation discusses how concepts of race are being created and transformed, how race directs U.S. society and how it involves both identities and institutions in education. Omi and Winant argue that throughout U.S. history, race has provided a template for patterns of inequality, marginalization and difference. Race is perpetually in formation in everyday interactions in education in the U.S. (micro projects). Also, race is not a biological but a "socially constructed way of differentiating human beings…race is now a predominantly political phenomenon" (Omi & Winant, 1994, p. 65). As a political phenomenon, race has driven ethnicity-based approaches to racial discussions to focus on colorblindness and promoted whiteness in recent years. Omi and Winant indicate that "the default to whiteness has gradually revealed the true message of the ethnicity paradigm of racial theory in that being "ethnic" turns to be about

whether and how much an individual can assimilate or hybridize with whiteness…... Being racial is about how much difference there is between an individual or a group and their white counterparts" (Omi & Winant, 2015, p.46). This assertion reveals the complexity and politics in ethnicity and racial discussion. The categorization of racial groups about white and privileged, and the superior category is geared towards assimilation of the marginalized inferior groups. An example of categorization of racial groups and identification is the Sussie Gilroy Phipps case where racial identity was legislated and validated by a court of law.

Omi and Winant (1994) begin their racial formation theory with a significant case in the Sussie Gilroy Phipps case in 1982-83. The plaintiff Phipps sued the Louisiana Bureau of Vital Records to change her racial classification from Black to white. Phipps grew up knowing that she was white because of the color of her skin. To her dismay, a state court ruled that she was Black because she had 1/32 of Negro blood. This court ruling upheld the state's right in classifying and quantifying racial identity. She is legally categorized as Black on her birth certificate (Omi & Winant, 1994; 2015). Phipps's case is an indication that the American society has a racial problem that is rooted in its history of slavery. Even in the 21st-century, race remains an issue in America as observed in the several racial slurs and killings of Blacks in recent years. The 2012 presidential elections indicated that the number of Blacks who voted had reduced because of the increased number of Black killings. (Rodriguez, Geronimus, Bound & Dorling, 2015). It can be

assumed that the killings of blacks is a micro racial project that is being gradually executed.

Phipps's circle of influence is predominantly white because of her skin color, a mulato. Her social networks will not change because of her identity as Black, constructed by legislation. Phipps "would have to wrestle with her newly acquired 'hybridized' condition. She will now confront the other in her" (p.54). Who is the "Other" in Phipps? Is it blackness or whiteness? Phipps, requesting a change of her racial classification from Black to white is evidence that the other in Phipps is Blackness. This case helps us discuss how the "Othering" (Kumashiro, 2002; Asher, 2005) of non- whites or people of color is being examined in some areas of scholarship. As Asher states, "it is the colonizer who creates the otherness" (2005, p.1085). Phipps' case in Omi and Winant (1994) demonstrates the racial complexities in the U.S.A.

Reconstruction Black identities in formal and informal education could be from an anti –oppressive education perspective (Kumashiro, 2001) and also decolonization (Fanon, 1967; Smith, 2012).

Furthermore, the construction of Black identities is complex and evident in power relationships in education. The dominant culture imposes identity categories and classifies Blacks as *subalterns* (Omi & Winant, 2015; Ibrahim, 2014).

Macro projects are state and national policies, for example, the "No Child Left Behind" law of 2001 and standardization of tests. These standards eliminate the new and struggling Black immigrant and refugee children who are in transition and adjusting

(Njue, 2010). Immigrant students would benefit from more attention to flourish in education as they adjust to their new home, America (Hurashimana & Awukoya, 2011; Allen et al., 2012).

In contrast, Black immigrant students are stereotyped like African American students (Nasir, 2001) as disruptive, lazy, and non-achieving, when they perform badly in standardized tests with little or no time to prepare for the examination. The school system classifies immigrant children as, "Black" because *they all look black.* The No Child Left Behind (NCLB, 2002) policy enacted in 2002 was a racial project on face value. The NCLB seemed to be inclusive of all children, including immigrants, but its implementation had fine lines that excluded them. It was a one-size-fits-all legislation. Free and reduced lunch for example, required a lot of paper work that is overwhelming to new immigrant parents. Some of these parents give up filling the paper work. The children may not take lunch at school. Starving at school may affect their academic productivity because a healthy mind is a productive mind. Thankfully, the NCLB, Act of 2002 has recently been replaced by Every Student Succeed Act (ESSA) of 2015. The ESSA empowers States to redeploy their resources when necessary for school improvement. This gives states the opportunity to be more accountable, yet flexible with the goal of meeting the specific needs of students.

Micro projects refer to everyday interactions with people, for example, a classroom teacher who stigmatizes an immigrant child as disruptive in class just because of her/his blackness (Ibrahim, 2014, Abdi, 2013). This approach to classroom

management by teachers is oppressive and compels some students to condone the stereotype that Blackness is disruptive (Abdi, 2012). One of the students interviewed in (Abdi, 2012) performed Blackness as was expected of him by his teacher by being disruptive. Furthermore, racial profiling of Blacks by police officers is a racial project. Restriction to voting, for example, is a racial project. Omi and Winant (2015) assert that, "The imposition of restrictive state voting rights laws, organizing work for immigrants, prisoners, and community health rights laws, organizing work for immigrants in the ghetto ….are all examples of racial projects" (p.125).

Omi and Winant (1994) argue that race has no fixed meaning. Race is being constructed and transformed sociologically through the cumulative convergence and conflict of racial projects that structure and signify race. These racial projects are built into educational institutions and policies imposed on the marginalized by the dominant culture.

Black immigrant medical doctors in the U.S. are thus situated in a "*social imaginary- a discursive space where they* are already imagined constructed and thus treated as "Black" by the hegemonic discourses and groups, hence asked to fit racially into a subordinate group. This racial construction is done through complex, and mostly "subconscious processes of racialization" (Ibrahim, 2014, p. 59). Becoming Black is the first step in finding work and working for FTBIMDs in the U.S.A. In the United States immigrant doctors of African descent whose skin color is Black are classified as Blacks. Being Black has a historical connotation that is rooted in slavery, dehumanization, and

racism. A complimentary theory for this study is a postcolonial theory by Frantz Fanon (1967, 2008).

Postcolonial and Violence Theory with Frantz Fanon

Frantz Fanon writes about the impact of colonialism and violence in a post-colonial era on the colonized. Fanon addresses racism and its psychological impact on Blacks. He also writes about overcoming the wrong that racism has done on the colonized. Fanon (1963, 1967) was passionate about disrupting violence against humanity in his brief time on earth as depicted in his two books: *Black Skin, White Masks* and *The Wretched of the Earth.* In this dissertation, I will focus on *Black Skin, White Masks*.

Fanon addresses the emotional well-being of the colonized people. He also speaks about his lived experience as a Black man and as a psycho-analyst. In so doing he highlights the psychological impact of racism on Blacks from his experience with some French Caribbean. Such psychological impact derives from internalized hurt or injury from violence and oppression. He asserts that the dominant culture "identifies the Black skin of the negro with impurity "(p. ix). Fanon is disgusted with the fact that Blacks have condoned such identification.

For example, colonized women choose to cohabit with white men. Fanon posits that this scenario is "pacification" or lightening of the skin. In other words, the colonized women were attempting to be white by drifting towards white men to attain the superior status of whiteness. He frowns at the extra sensitivity, "self-contempt" and "anxiety" of

some black colonial women who appear to disown their blackness. The writer asserts that Black children adhering to such self-contempt for blackness and dark skin would appropriate whiteness. In this case, they will be wearing a white mask. That is why the title of the book is *Black Skin, White Masks*.

Fanon (2008) focuses "on the problems of identity created for the colonial subject by colonial racism and on the (attendant) need to escape from this neurosis which colonialism has produced"(p. ix). As a psycho-analyst Fanon was concerned with the "psychological burdens, colonial racism imposed on its victims" (Fanon, 1967, p. ix). His desire as a revolutionary writer is to see human beings co-exist in love and peace. He writes that; "The Blackman is no more than the white man. Both have to move away from the inhuman voices of their respective ancestors so that a genuine communication can be born. Before embarking on a positive voice, freedom needs to make an effort at disalienation" (Fanon, 2008, p. 206).

The inclusion of the voice of an individual is assurance of participation as an equal subject thereby fostering communal good. Fanon's goal is to see people live in harmony forgetting past racial injury. This wish values human beings cherishing one another as people of one race, the human race, thereby dismantling racism.

Borderland or Border Theory by Gloria Anzaldua

The Borderland, La Frontera: The New Mestiza, by Gloria Anzaldua (1987) is a ground breaking contribution to knowledge by a Chicano feminist immigrant scholar. Anzaldua's multiple identities help us understand the construction of Black immigrant

identities. As a scholar, Anzaldua developed a border theory based on her lived experience as an immigrant and border woman growing up in South West Texas. Anzaldua writes that "borders are set up to define the places that are safe and unsafe, to distinguish *us* from *them.* A border is a dividing line, a narrow steep edge. A borderland is a vague and undetermined place created by emotional residue of an unnatural boundary. It is a constant state of transition" (1987, p.5). The conceptualization of borderlands theory appear to connote a constant state of being, reflecting safe and on safe spaces, inspires me to explore how skilled immigrants including FTBIMDS transition into the workforce in the U.S.A.

She distinguishes four borderlands in her book: *physical borderlands, spiritual borderlands, psychological borderlands and sexual borderlands*. She writes that: "the Borderlands are physically present wherever two or more cultures edge each other, where people of different races occupy the same territory, where under lower, and upper classes touch, where the space between two individuals shrinks with intimacy" (1987, preface, n.p.n). Thus when people from different cultural backgrounds co-exist, the cultures tend to edge each other out, and a hybrid culture emerges, called the Third Country by (Anzaldua, 1987), and the Third Space by (Bhabha, 1994). Identities of various groups and individuals are therefore constantly being constructed where people of diverse cultures coexist. There is a "translation" leading to a Third Space where there is a cultural difference (Bhabha, 1994).

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I draw on Anzaldua's framework of the border theory and intermixing of race as a result of hybridity, leading to hybrids, on the one hand, and a new consciousness on the other. The various borders immigrants encounter in various contexts raise new consciousness that results in resistance to oppression by the dominant white privilege culture. Our task here is to understand how Black immigrants experience oppression and develop resistance in formal and informal education. For example, immigrants are presumed to speak English with a foreign accent (Anzaldua, 1987; Corea, & Lovegrove, 2012). This foreign accent has generated conflicts in education. Anzaldua and her friends spoke "Spanglish" as a way of resisting English only in school and incorporating their cultural identity in language.

In the context of my study, I build on the spiritual, psychological. physical and sexual borderlands enunciated by Anzaldua (1987). I explore academic, intellectual, professional, geographical borders and workplace borders. The identities of individuals and groups are constantly being constructed within the borders and hybrid spaces where people of diverse cultures coexist. This border culture leads to a "translation" into a space of cultural difference, a Third Space (Bhabha, 1994) and a Third Country (Anzaldua, 1987).

Black immigrant medical doctors, participants in my study come with their cultural capital in addition to education, their human capital (Bourdieu, 1986) as trained medical doctors. As they interact in the society in their trajectory of finding work and working, they are confronted with the dominant white privilege hegemony.

FTBIMDs have to resist the temptation of giving up living. The tidum of the licensing process has led some FTBIMDs to seek out allies and find their voice through Community-Based Organizations (CBOs) that are helping them, organizing and reaching out to legislators with their underemployment issue. Thankfully the Minnesota Legislators have responded positively by enacting a bill authorizing funding to sponsor three International Medical Graduates to get into residency. However, the number of slots authorized was insignificant compared to about 100 IMGs who are waiting to be licensed someday.

The forms of Capital theory by Pierre Bourdieu (1986/2011)

Pierre Bourdieu theorizes capital as an embodiment of labor that are forms of capital. He emphasizes the tangibility of capital. This tangibility makes sense for my dissertation as I explore the returns on the investment in the education of the underemployed FTBIMDs in the U.S.

Pierre Bourdieu (1986) writes that "Capital is accumulated labor in its materialized or incorporated or embodied forms of capital that are living labor" (p. 241). Education and training cost money. When skilled laborers, for example, FTBIMDs, accumulates knowledge that is not made use of or is wasted in underemployment, there is no return on the investment. It is for this reason that I agree with Pierre Bourdieu's opinion that it is, in fact, impossible to account for the structure and functioning of the social world unless one reintroduces capital in all its forms and not solely in the one form recognized by economic theory (Bourdieu, 1986)**.**

Capital has three forms. Cultural, the social and economic capital. Social capital refers to social networks that connect people to resources that have economic value. Cultural capital includes property rights, and education qualifications, and distinctive cultural ways of knowing. Economic capital seems to be an amalgam of social and cultural capital (Bourdieu, 1986).

These four theories, racial formation theory, borderlands theory, post-colonial theory, and forms of Capital by Pierre Bourdieu, help my investigation of the experiences of Black immigrant medical doctors finding work and working in the United States.

Black is an imposed identity that invokes the history of slavery, dehumanization and racial discrimination against Blacks. Labeling immigrants of African descent Black not only renders them subalterns but leaves them at the bottom of the labor queue in the United States (Djamba & Kimuna, 2011). Skilled Black immigrant doctors are not absolved of this stigmatization of Blackness since the speaking Black body is offensive to some privileged white persons whose goal is not to deal with the Black race at all because of the superior institutionalized status and privilege of whiteness.

The situation of Black immigrant medical doctors in the U.S.A is thus tenuous. Black foreignness leaves them perpetually on the borders where there is unequal competition. This state of affairs leads Blacks to become conscious and develop resistance to oppression. Blackness is an additional challenge to finding work. Blackness in North America is a normalizing discourse, in education and employment. The colonial mentality of seeing the colonized as inferior still looms in the air in the 21st century.

Hence, W.E.B Du Bois, by prophetically stating that the problem of the 20th century is that of the color line, remains important today.

Chapter Three: Phenomenology as Philosophy and Methodology

"The American Immigration Council believes that the dignity of the individual knows no boundary. Our nation's moral and ethical values must be reflected in the way we welcome immigrants" (American Immigration Council, 2015).

"I did nursing specifically, the Certified Nursing Assistant (CNA) course, to put food on the table for my family. That is where everybody starts; that is not my calling. I am a teacher" (Personal communication, Ms. Bony, 8/8/14).

Introduction

The first epigraph above by the American Immigration Council enjoins Americans to assume moral responsibility for immigrants. This role suggests the need to uphold the assertion that *the dignity of the individual has no* boundaries and is inclusive of immigrants. This dignity of the individual could involve creating avenues for finding work that is consonant with the education and experience of immigrants. Thus welcoming immigrants could enhance human relations in the community. This suggestion by the American Immigration Council fosters its mission of strengthening America by respecting the historical background of immigrants and influencing how Americans perceive and relate to immigrants currently and in the years to come.

The goal of the organization is therefore to encourage harmonious relationships in the community. This goal is meaningful to me as a Black African immigrant whose cultural values encourage togetherness and respect for humanness (Ubuntu). Extending

America's moral values to welcoming immigrants coupled with the contrasting experience by Ms. Bony described in the second epigraph, compels me to see "what the phenomena (finding work and working) might become (Vagle, 2014) in my study as I engage participants through post-intentional phenomenology. Phenomenology is a methodology rooted in philosophy. I will begin with the definition of phenomenology.

Defining Phenomenology

There are several definitions of phenomenology, but I will limit myself to a few. Phenomenology is a qualitative research methodology that examines the "living of lived experiences, and the meaningfulness of our lives" (Van Manen, 2014, p. 13). Furthermore, phenomenology leads researchers to engage in reflective moments. These reflective moments are openings that enable the researchers to see deeper into themselves and others (Van Manen, 2014). These openings are unveiled as people interact with others in their life worlds. The words people utilize as they experience life can be interpreted differently by different people leading to various "phenomenality" as stated by Van Manen (2014). Words are therefore very significant in the "life world or lived world" (Dahlberg, Dahlberg, & Nystrom, 2008) of people in the society. The life world or *Lebenswelt* foregrounds, the world of lived experiences (Husserl, 1970). Inspired by Brentano, to engage in Phenomenology, Husserl is known as the father of phenomenology for his devotion to intentionality, a fundamental concept in phenomenology.

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Vagle writes that *phenomenology is an encounter, a way of life and a craft* (2014). This definition demonstrates that phenomenological inquiry is embedded in moments of livelihood, meaningful moments in the living of life, and through crafting. Lastly, Sokolowski (2000) writes that "phenomenology …signifies the activity of giving an account, of various phenomena of the various ways in which things can appear" (p. 13). These definitions situate the researcher's role to be that of being attentive and taking the time to observe new manifestations of the phenomenon.

Phenomenology can be better understood if we define the meaning of phenomena. Moon and Mooney assert that:

> The phenomena of phenomenology are to be understood in a deliberative broad sense as including all forms of appearing, showing, manifesting, making "evidencing" witness, truth, checking and verifying including all forms of seeming, dissembling, including obscuring, denying and falsifying (2002, p. 5).

As noted above a phenomenon must "appear" or "manifest" itself in a way that makes sense and is meaningful about the world in which the participants (subjects) live. Examples are; the intentional relationship between pastor and church members, doctor and patient, teacher and student. It also features relationships with objects such as children and toys, receiving guests, and playing soccer in old age. Such interrelationships are avenues for *tentative* manifestations of phenomena. Also, Heidegger (1998), described a phenomenon as that which manifests as lived.

It is noteworthy that phenomenology is both a philosophy and a methodology of gathering and analyzing data. This duality of philosophy and methodology offers me as a scholar the opportunity to engage with my subjects more profoundly to perceive the lived meanings in the interrelationships in their lifeworld.

Phenomenology as philosophy

Phenomenology is primarily a philosophy (Husserl, 1970, Sokowloski, 2000). As a philosophy, phenomenology is well situated in human sciences, leading researchers to deep thinking, reflexivity and continuous exploration of options (Dahlberg, Dahlberg & Nystrom, 2008; Vagle, 2010; Van Manen, 2014). It is in this light that, Van Manen, posits that "the phenomenologist is driven by a pathos to discern the primordial secrets of the meanings of the human world" (2014, p.17). Discerning the meaningfulness of the human world of foreign-trained Black immigrant medical doctors (FTBIMDs) in the United States in their work-related lived experiences necessitates in-depth investigations. This inquiry opens up new areas in the lived world of Black African immigrants in the U.S.A finding work and working. Furthermore, phenomenology leads researchers to engage in reflective moments. These reflective moments are openings that enable the researchers to see deeper into "self" and "others" (Van Manen, 2014). These openings unveil as people interact with others in their life worlds. The life world or *Lebenswelt* denotes the a priori world of lived experiences (Husserl, 1970). Husserl was foresighted to encourage researchers to go "to the things themselves" to understand the lived

meanings in their relationships (Husserl, 1970). It is what these lived meanings produce that I explore with (FTBIMDs) in this dissertation.

Phenomenology as a methodology

Phenomenology is a disruptive methodology (Husserl, 1970) with an ontological leaning (Heidegger, 1998, Vagle, 2014). A phenomenological study typically focuses on experiences, events, and occurrences with minimum regard for the external and physical reality. In other words, in phenomenology studies, ideas are generated from a rich amount of data using induction and human interests. Advantages associated with phenomenology, therefore, include a better understanding of intentional meanings and what these meanings produce for people and its contribution to the development of new theories. Intentional meanings differ from purpose or rationale for undertaking a project. Intentional meanings in intentionality is a fundamental concept in phenomenology.

Intentionality. Intentionality refers to the intentional relationships that occur between subject and object. It denotes how we are "meaningfully connected to the world" (Vagle, 2014, p. 27). Intentionality is the interconnectedness in relationships. That is the way meaning comes into existence in relationships. Intentionality thus refers to circulating meanings (Vagle, 2014). Intentionality is directedness.

Furthermore, sense making is of the essence in phenomenology. The sense people make as they connect meaningfully to the world in which they live in spaces (Marcey, 2001) and places (Gruenewald, 2003) is relevant. Gruenewald asserts that "places are profoundly pedagogical. That is, as centers of experience places teach us about how the

world works and how our lives fit into the spaces we occupy." Further, as foregrounded, "places make us as occupants of particular places with particular attributes, our identity, and our possibilities are shaped…… It is also clear that people make places and that places make people." (Gruenewald 2003, p. 612). The connectedness and intentional relationships that move around in these centers of experience are dynamic and endless.

The researcher remains observant and reflexive to notice how phenomena manifest themselves. Intentionality is pivotal in phenomenology. Initiated by Husserl, intentionality is part of old phenomenology that is very relevant to the phenomenology of practice. Vagle emphasizes intentionality in his ground breaking phenomenological approach: post-intentional phenomenology (2014). Husserl (1970) posits that intentionality is *directedness of subject to object*. Thus it is concerned with identifying the structures of intentionality in two dimensions. One is the "directedness of the objective reality, and the other is the directedness to the self as a temporarily extended and unified flow of experience" (Drummond, 2014, p.125). It is this flow of experience from the subjects of this study that is the core of this work. Intentionality requires going to the things themselves to explore the relationship between subject and object in the life world to find meaning in the living of life.

This dissertation employs Post-Intentional Phenomenology, and I will proceed by defining it.

Post-Intentional Phenomenology. Post-intentional phenomenology is "a post-structural commitment, such as seeing knowledge as partial, situated, endlessly deferred, and circulating through relations" (Vagle, 2014, p.111-112). Post-intentional phenomenology is a groundbreaking methodology in Western thought developed by Mark Vagle in his on-going work that began in 2010. The author is reformulating the desire of Donald Schon for a *phenomenology of practice.* Mark Vagle distinguishes his work by emphasizing what the phenomenon might become in the various contexts of life. The dynamic nature of life necessitates a methodology that is not static but always moving with the changing times, opening up spaces for deeper comprehension and meaningfulness. Furthermore, *through-ness* is highlighted in this methodology to demonstrate *how it is like to be in the world* (*Vagle, 2014).* The newness of post-intentional phenomenology has attracted a question that needs clarification. For example the use of the hyphen in "post-intentional phenomenology."

Vagle insists on the use of the hyphen between "post" and "intentional" not to get away from intentionality. Instead, post-intentional phenomenology continues on this line of thinking by experimenting with Deleuzo-Guattarian ideas. It is a continuance, not a departure. Vagle has been "purposefully using a hyphen between post and intentionality experimenting between some Deleuzo-Guattarian and phenomenological ideas" (2015, p. 596). It is for the same reason that I am standing on Mark Vagle's wings to see what finding work and working in the United States might become for foreign-trained Black Immigrant Doctors.

Knowledge is therefore perceived as spontaneous. multiple, partial, unending, varied, interrelated, meaningful and always in circulation (Vagle, 2014). In brief, Deleuze and Guattari (1987) assert that knowledge could be *cyclical and rhizomatic*. From this perspective, post-intentional phenomenology enables one to pause, take a moment to observe the interconnectedness between *subject* and *object* in the life world (Vagle, 2014). Vagle writes that "Western philosophy has needed and continues to need to get out of its own head-and out into the inter-connectedness of human relations among human beings and with the things of the world" (2014, p. 28). Opening up to the inter-connectedness of the world is a great contribution to knowledge that should be recognized in research as it offers opportunities for further reflection.

I am carrying out my inquiry bearing in mind that post-intentional phenomenology is *dialogic* and can offer the occasion to be used to negotiate political issues, such as employment of immigrants. Such attentiveness will unveil various realities in the lives of participants in my study. Examples of such dialogic approaches are discusssed in Grumet (1988), Ahmed (2006) and Vagle (2014). It is from this dialogic and interconnectedness of life that post-intentional phenomenology is situated. The underemployment of qualified FTBIMDs is examined in this study.

In post-intentional phenomenology, intentionality is the dynamic intentional relations that the researcher and participants and their positionality put together. This positionality happens in the in-between spaces, on the edges of things and in the

intersections. Further intentionality is the way meanings "come to be" or are becoming in relations (p.112).

The main purpose of post-intentional phenomenological research is to investigate, how it is like to "*find- ourselves- being- in- relation with others.* Some examples include preacher with congregation mentor and mentee, pilot and passengers and also objects leisure and music, skin and skin care products and the list continues. Vagle asserts that phenomenologists affirm that human beings create a phenomenological experience, human beings "find themselves in the experience in the world" (2014, p. 21). These are moments of reflexivity and contemplation on the meaning of living and relating to one another in various spaces and places opening up the meaningfulness of such lived experiences.

Post-Intentional Phenomenology suggests a five-step process (Vagle, 2014) in carrying out research such as:

1) Identify a phenomenon in its multiple, partial and varied context;

2) Devise a clear yet flexible process for gathering data appropriate for the phenomenon under investigation;

3) Make a post reflection plan;

4) Read and write your way through your data in a systematic responsive manner;

5) Craft a text that captures tentative manifestations of the phenomenon in its multiple, partial and varied context" (Vagle, 2014, p. 121).

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These five steps stated above are not linear. Some parts may be skipped or utilized as deemed fit. This methodology section walks through the following sections

1) The philosophical underpinnings of post-intentional phenomenology, 2) Identify a phenomenon in its multiple, partial and varied context, 3) Participant selection,

4) Philosophical conversation

Philosophical Underpinnings of Post-Intentional Phenomenology

In the continuum of the phenomenological movement, Post-Intentional Phenomenology recasts meaning from old phenomenology by utilizing other theories for

In this section I explore some of the methodological underpinnings of post-intentional phenomenology by addressing five of the "sub-components" of component number one: Identify a Phenomenon in its *Multiple, Partial, and Varied Contexts of a Post-Intentional phenomenological study* (Vagle, 2014, p.11).

Given the flexibility of Post-Intentional Phenomenology the research statement, research question and the partial literature review have been moved to chapter one and two respectively.

This section, therefore, walks through the five steps of component one (Vagle, 2014) to identify a phenomenon in its multiple, partial and varied contexts. Firstly, in an examination of sub component one, stating the research problem is necessary: the large and overarching concern empirically, theoretically, personally, and practically. Secondly, a partial review of the literature situates my research problem in existing scholarly

conversations. Thirdly, establishing my philosophical claim, by making an entry into at least one philosophical conversation (within, on the edges, or outside of phenomenology) is the next logical step. Fourthly, examining the statement of the phenomenon, the research question helps in situating my paper. Finally, situating the phenomenon in the multiple and varied contexts in which I believe it resides makes sense.

In post-intentional phenomenology, the goal is to see what the phenomenon (finding work) might become (Vagle, 2014). I will proceed to identify the phenomenon.

***Identifying the phenomenon in its partial and multiple states*.** My attempts at identifying the phenomenon in my study led me to have conversations with scholars to clarify what the phenomenon for this study would likely be, as suggested by Vagle (2014). Our conclusion was that the phenomenon I am studying is finding work. In my reflexivity, I realized that finding work is good enough, but the end goal is working. These FTBIMDs work low income jobs including; serving as security officers in some companies, delivering pizza, driving taxis, and giving personal care to patients. Their dream of being licensed to practice as physicians in the United States is on-going. Thus, the phenomena became finding work and working. In post-intentional phenomenology, the goal is to see what the phenomenon (of finding work) might become (Vagle, 2014).

***Statement of the Problem*.** The problem of this study is that Foreign-trained Black African immigrants' medical doctors have several challenges finding work and working job commensurate with their academic qualifications in the United States.

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Briefly, FTBIMDs are racialized in their process of finding work and working in the U.S.A. Understanding how Black African immigrants learn to navigate the American education and workforce systems through finding work and working, will help policymakers pay close attention to the return on investments made by the government in the education and employment of immigrants in general and Black African immigrants in particular. The goal here is to ensure that skills and talents Black African immigrants bring and acquire in the United States are effectively utilized to contribute to the economy. I will state this overarching problem empirically, theoretically, personally and practically.

Empirical problem. This empirical exploration of the problem will begin with the sub theme of globalization. Globalization has facilitated the movement of people all over the world and the shifting of the labor force from developing countries to the United States (Jagannathan, Kapoor & Shaunburg, 2013). The United States has attracted more immigrants because of the Diversity Lottery and U.S. Immigration and Nationality Act 1965 (the Hart-Keller Act). The U.S. seeks to attract skilled immigrants who can contribute to the economy in this era of global competitiveness (Fix, Papadimitriou, and Sumption, 2013). In contrast, globalization has led to underemployment of older skilled immigrants because of their age of arrival into the U.S. (Friedberg, 1992). Such underemployment of immigrants in areas not commensurate with their qualifications is critical and needs a remedy.

Black African immigrants are historically diverse. A great majority of them come from English speaking West African countries including Ghana, Nigeria, and Sierra Leone (Capps, et al., 2012). There are also Black African immigrants who are not well documented but who come from French-speaking countries as Senegal, Congo, Togo, Cameroon and Ivory Coast (Takougang, 2003). The World Bank global skilled migration database documented that African immigrants are a great addition to U.S. economic development (Walker, 2008). That is why an inquiry of their work-related lived experiences is important because it will unveil the lived realities of commitment to being good additions to the economy.

However, the great depression in the U.S. economy in 2008 compounded the situation of immigrant employment because the U.S. government was focussed on recovery measures (Walker, 2008, Migration Policy Institute, 2010). Also, the terrorist attacks on September 11, 2001, had an impact both on the number of immigrants entering the United States and their employment. Jobs became scarce for both U.S.-born citizens and immigrants (Garnett, 2006 and Palmie, 2013) due to mistrust of immigrants. The consequences of this tragedy have been distrust and unemployment of immigrants (Palmie, 2003). The Patriot Act, enacted in 2004, was very stringent since racial profiling and discrimination increased. Distrust is also visible in the workplace (Garnett, 2006; Palmie, 2003). In contrast, there has been an exponential growth in the number of Black immigrants coming to the U.S.A.

*The exponential growth of Black African immigrants in the U.S.A.*The growth is propelled by U.S. immigration policy towards Africa, especially reunification of families (Nyamwange, 2014, Sandy & Fennelly, 2006). Black African immigrants are documented in the empirical literature as being among the fastest growing immigrant groups in the United States (Capps et al., Seyan, 2012). According to the Migration Policy Institute, there has been a 200% increase in the number of Black African immigrants in the United States since 1980 (Capps, et al., 2011). Some Black African immigrants come to the U.S.A to seek economically lucrative jobs because Africa is *poverty- stricken* (Nyang, 1998; Ogbu, 1978).

Other Black African immigrants seek education and a better life for themselves and their families and are becoming employed as permanent residents (Nyamwange, 2014). Others

come to the United States because of political turmoil and unrest. These are refugees and asylees who are escaping from political persecution in their home country. The U.S. offers them asylum through its humanitarian protection program. Eventually, they become permanent residents and U.S. citizens. The next issue is Employability.

Employability. Employability refers to those skills that people need to get a job and work efficiently. These skills are: teamwork, friendly attributes, decision-making skills, time management, and others. These skills differ from special or technical skills needed for specific jobs (Robinson, 2000). Employability as a discourse seems to be taking center stage because "finding workers who have employability or job readiness skills, that help them fit into and remain in their job is a problem" (Robinson, 2000, p. 1). Employers in the twenty-first century seek workers who can compete in the global work market. These workers should be good team players and great additions and possess the human capital that brings added value to the company (Robinson, 2000).

Age of arrival. Age of arrival in the U.S.A, academic qualifications, and employability are all connected. The age of arrival is a challenge because it affects the employability of immigrants. Older immigrants have more difficulties finding work. Children of immigrants who study in the United States stand a better chance of getting into the workforce easily (Friedberg, 1992; Nyanwange, 2014). Most employers would prefer young people who are employable because they learn the English language faster in American schools (Friedberg 1992, Robinson, 2000). Such children have the possibility of staying longer on the job before retiring. Older immigrants have a hard time

finding work despite their qualifications because the American Workforce Department does not tolerate old immigrants even if they are highly educated (Byoun, 2013; Milkman, 2011). The immigrant foreign accent is another compounding problem, especially for older immigrants.

*Foreign accent and English language acquisition**:*** Black African immigrants must learn to speak English to communicate in the United States. However, first generation immigrants speak English with a foreign accent. Employers expect them to refine their accent before work or during work (Cretico, Schultz, Beeler, & Ball, 2006). Failure to refine their accent is often viewed with disdain by employers. Some scholars have used performing arts to express the tension that exists in the community and to expose some subtle discrimination against immigrants because of their accents (Anzaldua, 1987, Correa & Lovegrove, 2012). For example in Correa & Lovegrove (2012), graduate students used performing arts to demonstrate "the usual question why don't they speak English?" (p. 355). This question is not new to most immigrants. And "at the university, I and all my Chicano students were required to take two speech classes. Their purpose, to get rid of our accent" (Anzaldua, 1987, p. 54**).** Anzaldua's mother once mocked at accent issue by saying Gloria speaks English with a Mexican accent.

Accent is closely linked to the native language and one's identity. Therefore foreign accents tend to affect immigrants adversely in finding work. Although accents cannot affect credentials and certificates that offer access to employment in the United

States, they are often used as opportunities for the exclusion of African immigrants from work.

Credentialing and evaluation of foreign certificates. The credentialing and evaluation process is a complex and gruesome. This process frustrates many immigrants because their certificates are sometimes undervalued (Yildiz, 2010). Many families become tired of the long process and, out of desperation; they are forced to look for menial and available jobs to "put food on the table" and survive instead of perishing. There is consequently a pattern of brain waste among immigrants in America. This pattern is very concerning and raises the question whether immigration is brain gain or brain waste. (Batalova, et al. 2008). These polar-opposites of qualifications and unemployment lead us to the theoretical problem.

Theoretical Problem. In this section, I explore labor queue and assimilation theories.

The labor queue theory: The labor queue theory states, that "employers follow a preference of ordering in selecting their workforce" (Model, 1997 as cited in Djamba & Kimuna, 2011, p.1). Race- consciousness in the United States has led employers to use the ranking of applicants according to their race or ethnic backgrounds (Waldinger, 1996). At the top of the rank in the labor queue model are whites, the second position is occupied by Asians, the third position features the Hispanics and at the bottom are Blacks (U.S. Census, 2010). This ranking confirms that race is at the center of employment in the United States. Such race-based ranking raises the issue of assimilation.

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Assimilation theory. Assimilation theory refers to the process of immigrants adapting into the mainstream. Assimilation as a process has both economic and sociocultural dimensions that, begin with the first immigrant generation and continues through the second generation and beyond. Assimilation is said to occur between three to four years after immigrants enter the United States. However, this process is often incomplete because individuals and ethnic groups assimilate differently, due to their variation in human capital and social context (Alba, & Nee, 2003, Brown & Bean, 2006).There is some resistance to the assimilation theory. Some scholars are using the performing to vocalize this resistance (Correa & Lovegrove, 2012). In their article, *the making of rice*, Corea and Lovegrove (2012) used performing arts to voice their resistance against assimilation.

I draw on economic assimilation based on segmentation. Segmented assimilation refers to the hierachization of immigrant labor according to educational attainment. Less educated immigrants are assimilated at the bottom of the labor market, in low paying jobs while highly educated immigrants who have invested in their human capital are assimilated in the higher rungs of the assimilation ladder (Portes and Zhou, 1993). These labor queue and assimilation theories have exemplified the plight of immigrants in adjusting and finding work in America. The preference in employee selection invites the sharing of my personal experience finding work in America.

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Personal problem. My personal experience finding work and working is the genesis of my study as foregrounded in chapter one of the work-related lived experiences of Black African immigrants finding work and working in the United States. As an educated Black African immigrant woman, I did not find paid work with a graduate degree. I resorted to self-employment and also doing unpaid community work by managing a non-profit organization for the past nine years.

I arrived at this decision to be self- employed after being turned down in several places that I applied to work with my graduate degree. I have some friends in my community with whom I interact; that is my social capital (Bourdieu, 1977)**.** These friends advised me to do the Certified Nursing Assistant Course (CNA) for three weeks. This advice was aimed at enabling me to find a job that would take care of my immediate needs, such as, pay my bills, rents, and feed my family. I welcomed their advice and went to a renowned agency serving immigrants and refugees in the Twin Cities.

A written English language examination was required to qualify to do the CNA course. It was a humbling experience writing an examination for a position I was over qualified. This encounter was the moment I knew I was in the wrong place. The experience became my *line of flight* (a window of opportunity to explore other work options).

My goal is, therefore, to study how other Black African immigrants' experience finding work and working in the U.S. I seek to unveil the lived experiences of Black African immigrants to demonstrate how they contribute to the national economy of the

United States and also highlight the underemployment (United Nations, 2006) of highly qualified Black African immigrants. I base my inquiry on the work of some scholars who have found that even though Black African immigrants may be highly educated, they earn lower wages than some U.S. citizens (Nyamwange, 2014). This analysis could identify some social justice issues in immigrant employment, unemployment, and underemployment.

Practical problem. Most Black African immigrants enter the United States legally but without a road map to follow to get into the workforce (Hume 2002). As they live through this process, instead of becoming schizophrenic as portrayed by Deleuze and Guattari (1987), they look for *lines of flight* in their circles of influence (Byoun, 2013). They would rather welcome any menial job to stay afloat and take care of their families (Milkman, 2011) since family survival and well-being is very meaningful to Black African immigrants.

In sum, the empirical, theoretical, personal, and practical problems indicate that several Black African immigrant families are impacted negatively in their trajectory of finding work and working in the U.S. Underemployment, discrimination, and brain waste, among other issues, foreground understanding of the lived experiences of Black African immigrants finding work and working in America. The next section is my philosophical conversation.

Philosophical Conversation

I am entering this philosophical conversation by giving a synopsis of old phenomenology and luminal philosophers who inspire my study. Edmond Husserl, a German philosopher, and father of phenomenology, established phenomenology as a disruptive philosophy of egocentric western thought. Husserl, as explained in Van Mane (2014), emphasizes "the primacy of practice" (p. 15), thus actually encouraging researchers to *go to the things themselves* as stated in Satre 1943. These things themselves could be read as the intentional relationships that involve consciousness, appearance or manifestations of the phenomenon bursting out as lived experiences. Martin Heidegger, a former student of Husserl, states that "being" is the ontological manifestation of the life world. Husserl's life world had a great impact on Heidegger, who in his hermeneutic philosophy came up with *being -in -the world*. Thus a phenomenon is a state of being that transcends time and space (Heidegger, 1998). Humans, therefore, live in the world and their everyday activities are determined by their experiences.

Another philosopher of interest is Merleau-Ponty, in his Phenomenology of Perception (1945/1962) asserts, that "bodies are our access to the world." This assertion conveys the message that bodies constitute the vehicle through which life is lived. However, Merleau-Ponty did not pursue how these bodies are "cultured" as mentioned by Vagle (2014). Thus as I pursued my inquiry with Foreign-trained Black immigrant medical doctors from Africa, I sought to understand the meaning of giving immigrant

bodies access to the world. Frantz Fanon in his *Black Skin, White Masks* offers an opportunity to question if Black immigrants in the U.S. need to mask the color of their skins to Use their "bodies" as access to the world of work. Should a Black man or Black woman pretend to be white to find work? The answer lies in this assertion, "we believe that the juxtaposition of black and white races has resulted in a massive psycho-existential complex" (2008, p. xvii). This text could be read as presenting the reality of the American society. For example racial capitalism, "the process of deriving economic and social value from the racial identity of another" (Leong, 2013, p.152). It is complex. Some black women are compelled by circumstances beyond their control to seek white partners for survival. Fanon refers to this state of affairs as *pacification* (Fanon, 2008). Since Blacks are stereotyped as *lawless, lazy, and inferior* (Watkins, 2001), there is a tendency to mask embodiment.

Idhe embraces embodiment instead of subjectivity, applauding Merleau- Ponty's view that bodies are the medium through which people have access to the world and bodies are existential not transcendental (Idhe, 2003). However, bodies in this sense are not blended into the social context but that "an embodied intentionality exists in which the body is lived through and is permeated into the social" (Vagle, 2014, p. 113).

Intentionality is a key concept in phenomenology. And, the relevance of intentionality in old phenomenology motivated Vagle (2014) to expand Merleau-Ponty's idea of the the thread. Mark Vagle proposes an alternative view by stating that threads are frequently being cultivated and destroyed and destabilized. Intentionality is running all

over all in the business of life. Tracing intentionality may appear to be a vain effort because of the interconnectedness of life (Vagle, 2014). It is the "intending" of the *subject* that matters. In my study, the focus is on the manifestations of the social that is enabled by the participants' *intending* to find work and working.

Mark Vagle builds his post-intentional phenomenology on three pillars: Heidegger's manifestation, intentionality, and post-structural commitment to knowledge as dynamic, unending, being, situated and in circulation (Vagle, 2010b, 2014). In post-intentional phenomenology, researcher and participant's positionality and, the intentional relationship with the text as a whole are important. Thus intentionality is constantly moving and therefore can be read post-structurally because it is unstable (Vagle, 2010b).

In my study, the shifting nature of the phenomena, finding work and working, may manifest themselves as job search and temporary work experiences as participants move through their life world to work and earn a living. With time, the old phenomenology is put in conversation with theories for example post structural theory. Phenomenology, therefore, became a political tool as forwarded. For example, the taken –for- granted presence of Black African immigrants, as the labor force for menial jobs, brings a new dimension into the phenomenological conversation. This conversation continues with Deleuze and Guattari, 1987.

In the light of this philosophical conversation, Deleuze and Guattari (1987) offer my study concepts like *plateaU.S., lines of flight, multiplicity, territoriality and deterritoriality* as a good picture of the life of an immigrant in the United States.

Plateaus. According to Deleuze and Guattari (1987), plateaus may be "any multiplicity connected to other multiplicities by superficial underground stems in such a way as to form an external rhizome" (p. 22). Plateau here can be read as a staging post or branching post that represents the multiple options that open up for immigrants as *lines of flights* in finding work. A plateau could be temporary work that is available to immigrants, for example, baby-sitting, packaging, and house-keeping, just to name a few survival jobs. At time access to some of these options to work is gotten through ethnic organizations, resettlement agencies, friends, and families. This pattern shows how Black African immigrants live through various possible or temporal plateau as they seek an adjustment in the United States. Temporary work intended to meet an immediate need in the family can be said to be a plateau.

However, the long term goal is always to find work that is commensurate with one's skills and qualification. Thus, the temporality of the plateau may lead to lines of flight, an opening (Holland, 1991) that may burst forth and continue moving to a different plateau that appears to be more rewarding. Such nomadic way of living is what I desire to unveil in my study that could have implications for policy and future research.

The multiple options in finding work and working are always unending, moving and not stable (Vagle, 2014). That is why experiencing a multiplicity of options in finding work and working is rhizomatic. The rhizome portrays a picture of the shifting and cyclical nature of the adjustments. Black immigrants experience in finding work and working in America. Phenomenologists are therefore concerned with how people live

through this experience of making decisions about the various options in the life world. As Black African immigrants situate themselves within the nomadic horizon in the community, they go through several plateaus that give them temporary solace within the multiplicity of options for adjustment. Nevertheless, Black African immigrants have difficulties in adjusting in the U.S. because of *foreignness (*Milkman, 2011) and vulnerability. They are constantly seeking greener pastures and waiting to seize the moment through *lines of flight (*Deleuze & Guattari, 1987), my next concept of interest.

Lines of Flight. Deleuze and Guattari (1987) Use *lines of flight* in conjunction with plateau to demonstrate the rhizomatic nature of life. I read the lines of flight as the many opportunities in spaces and places where Black African immigrants *are being, and becoming,* in their daily lives that are changing continually. For example, community-based organizations and friends that suggest a nursing assistant course that would lead to a job after three weeks of training to survive are opportunities of working. The CNA certificate gives one a *plateau* to start working in the United States while continuing to pursue passions in one's professions of preference for acquired skills. Despite this temporal respite in a plateau Black African immigrants remain reflexive as they continue to explore new opportunities for finding work in the temporal world of daily activities expecting a better opportunity to present itself as a line of flight. The example of Ms. Bony foregrounded is very illustrative. Ms. Bony did the CNA training to put food on the table for her family. Her desire is to have a teaching job because that is where she has training and experience. If she had a teaching job, she would have territorialized.

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Deterritoriality and territoriality. Deterritoriality and territoriality exemplify the unstable nature of the status of Black African immigrants, who reterritorialize (Deleuze and Guattari, 1987) by leaving their home countries for economic and political reasons. The expectation is that when they come to the United States and become legal residents, they would *reterritorialize* (Deleuze & Guattari, 1987) and find work to sustain their families as they adjust to new situations in their new home America. This dream of reterritorialization varies with individuals. The dream would be meaningful if employment were their reason for fleeing from poverty (Ogbu, 1978). In such cases, there is an urgent need to work and earn some money. The reality is that Black African immigrants are presented with a rhizomatic "assemblage" "the social context of transition, of plateaus by the multiple networks of friends and family (Byoum, 2013) in their new home (America). Award Ibrahim posits that "this rhizomatic assemblage thus finds itself in a constant state of flow, deteritorialization and multiplicity" (Ibrahim, 2014, p.3). These networks are considered social capital (Bourdieu, 1986). I continue the conversation with an African philosophy *Ubuntu*, a philosophy of togetherness.

Ubuntu philosophy in phenomenology. Ubuntu is both discourse and philosophy in African education. My concern here is with Ubuntu as an African philosophy of education in dialogic relations with post-intentional phenomenology. Various definitions have been given to Ubuntu for example, “togetherness”, “I am because we are,” was Nelson Mandela’s definition used in the Truth and Reconciliation Commission in South Africa to avoid revenge against white South Africans for their apartheid atrocities (Nabudere, 2005). One definition makes sense to me in the context of post-intentional phenomenology. This definition states that “Ubuntu is a philosophy that promotes the common good of society and includes humanness as an essential element of human growth” (Wagid, 2004, p.1). This definition can be read as seeing Ubuntu on the margins of the life worlds of Black African immigrants in America, an embodiment of communal good that can be incorporated into the American society to foster development.

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The need for incorporation of diverse values that immigrants bring into the United States is imperative for an inclusive community as a human family or "one American family, President Obama, July 11, 2016, in Texas funeral. This philosophy of communal inclusiveness contrasts sharply with the individualistic philosophy of capitalist society. Policy makers need to pay close attention to this philosophical thrust immigrants bring into the American culture. For example, Bishop Desmond Tutu writes that "*you might have much of the world's riches, and you might hold a portion of authority, but if you have no Ubuntu, you do not amount to much*" (Archbishop Desmond Tutu, 2012). The Bishop's stress on Ubuntu as being the crux of the matter in life is very significant. Ubuntu as an African philosophy can, therefore, be adopted on the margins and interstitial spaces to promote the communal wellbeing of the human family. Professor Nabudere states:

> The rejuvenation of the philosophy of Ubuntu is, therefore, important because it provides Africans a sense of self-identity, self-respect, and achievement. It enables Africans to deal with their problems in a positive manner by drawing on the humanistic values they have inherited and perpetuated throughout their history Africans can thus make a contribution of these values to the rest of humankind through their conscious application (Nabudere, 2005, p.10).

My positionality in this inquiry is to engage Western philosophers in conversations about the relevance of Ubuntu to the life world of the Black African immigrant. Raised in a humane society but currently facing racial discrimination and dehumanizing treatment in

finding work is a tragedy for Black African immigrants. They have a moral responsibility to take care of both their immediate and the extended families (Bangura, 2005). Being unemployed or underemployed affects the community negatively because they become dependent on social welfare service. An example is food stamps which are contrary to the Ubuntu philosophy of independence and self-reliance. Furthermore embracing difference in the margins (Vagle, 2015) and shifting towards the equitable treatment of all residents U.S.-born or foreign born will foster social justice. The next section highlights the context in which participants live.

Context

The context, in my study, is political, economic, spiritual and cultural.

Political Context: I will situate the phenomenon in the multiple and varied contexts in which I believe it resides. The context has political, economic, spiritual, and cultural dimensions. Politics is implicitly embedded in finding work by black African immigrants. That is why post-intentional phenomenology is chosen as the methodology for my research. It offers me the opportunity to see the phenomenon of finding work in its varied and multiple contexts. Giroux argues that "under the bio-politics of neoliberalism conditions have been created in which moral responsibility disappears, and politics no longer advocates for compassion, social justice, or fundamental provisions necessary for a dissent life"(2009, p. 11). It is crystal clear that those marginalized because of class or race, the *expendable population are in a precarious situation* (Giroux,

2009). Black African immigrants fall into this category. That is why their employment situation is, therefore, tenuous.

Economic context. The economic context in which Black immigrants live in the U.S.A is tenuous. Given the history of slavery in America, Blacks are often stigmatized as inferior and available to be commodified, (Fanon, 2008, Giroux, 2009, Quinn & Meiners, 2012). This inferiority complex is always contrasted with a superiority complex for whites. This binary, *they versus us* persists and affects the national economy negatively. Fanon in his *Black Skin, White Masks,* highlights the fact that colonial racism persists claiming that "there is only one destiny for the Black man. And it is white" (2008, p, xiv). Colonial racism is at variance with the Ubuntu philosophy that encourages the spirit of humanness preserving human dignity together in the human family.

Spiritual Context. The churches and spiritual teachings from the motherland have formed a firm foundation of resisting frustration. Most Black immigrants have relied on their faith in God to remain hopeful. My spiritual inclinations have helped me to remain hopeful and perseverant in finding work, walking by faith and not by sight. Cynthia Dillard's scholarship is instructive in the spiritual context. She writes that students "want to talk about how the spirit weaves into our lives in Divine ways that guide U.S.A, nourisheses us and sustains us as human beings who have chosen the important work of teaching and research" (2006, p. 67). Her response is very inspiring, and many immigrants can identify with her. Divine guidance is what sustains most immigrants

through adjustment in the United States. A community leader consultant and evangelist stated that "If I had a good job when I just came to America I would not have grown spiritually" (personal communication by a Foreign-Trained Black African Medical Doctor Dr. Lesley December 14th, 2014). Dillard states in conclusion, "what we have too often attributed to luck or coincidence or our ability belongs to the workings of the spirit" (p. 68). In fact, most immigrants find solace in their spiritual safety nets and ethnic CBOs.

Cultural context. Black African immigrants converge in cultural and ethnic community based organizations that provide social and cultural capital (Bourdieu, 1986, Byoun, 2013). These organizations serve as a support system for adjusting into the United States because they reflect the cultural heritage of these immigrants. However, these networks affect some immigrants negatively because they propagate the survival policy of temporary and menial jobs as a starting point. That is why the Nursing Assistance Course (CNA) is branded as the place where everybody begins. Meanwhile, Black African immigrants are an embodiment of funds of knowledge (Moll & Gonzales, 2005) that are great assets in the United States. Ethnic African ways of knowing and values merit the attention of local and national governments. Thus Black African immigrants' adjustment in finding work in the margins where blended cultures emerge requires attention by policy makers and researchers.

Paying attention and exploring what cultural values Black African immigrants embody could enhance meaningful coexistence in community life world. The family, for

an African, is considered broadly to include the community. That is why the African proverb states that it "takes a village to raise a child." Ubuntu highlights togetherness and caters for the well-being of all.

Participant Selection.

I employed a purposeful sampling method to select participants for this study. Purposeful sampling method "is based on the assumption that the investigator wants to discover, understand, and gain some insight and must select a sample from which the most can be learned" (Merriam,1998 p. 61). The intention is to select purposefully participants who are Black immigrant, foreign-trained medical doctors. The subjects must have experienced finding work and working in the United States. Some of these participants had intentional relations with agencies assisting them in finding work and working. These study participants were selected through a purposeful sample as presented in chapter three. The participants were all Black foreign-trained Medical doctors, legal immigrants in the U.S. from the continent of Africa. Some participants were members of a collective of foreign-trained medical doctors organizing and supporting each other within a community-based organization in the Midwest. A few participants were located in my social networks in the U.S. However, the collective of Foreign Trained Immigrant Medical Doctors (FTIMD) or peer support group is based at a non-profit organization in the US. Participants' profiles and work history include; sex, age, specialization, and current employment produce the phenomena. Participants who are aspiring to become licensed are those who are younger. Others who were not being

served by any agency had intentional relations with their places of work. The participants were Black African immigrants who have experienced the phenomena of finding work and working. These participants must have gone through the trajectory of finding work, and the effect of this process on the family. This "thoroughness" is emphasized by Vagle (2014) to distinguish post-intentional phenomenology from other qualitative research approaches. It illuminates the feeling and the meaningfulness of the process to the participant. The participants in the project were capable of offering a detailed description of experiencing the phenomenon finding work and working. Furthermore, concerning genre participants for this project are categorized as follows:

1). Black Immigrant Medical Doctors who are not doing any temporary job: 2

2). Black medical doctors who are doing temporary jobs: 8

3). Black medical doctors who are working as Medical Doctors: 2

4). Black medical doctor who is working in an alternative profession: 1

Similarly, some FTBIMDs have given up pursuing their dream of practicing medicine in the U.S. These FTBIMDs are categorized as working in an alternative profession. In contrast, some FTBIMDs who have been served by community-based organizations (CBOs) in the U.S and are still actively pursuing their dream of becoming licensed in the U.S. Others were those who had no direct services from any agency that affected their experience finding work in the U.S. They have made it without any assistance from the

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CBO. Those being served by a CBO shall be those who participated in a pilot study with foreign-trained immigrant doctors from Europe, Africa, South America, and Asia.

Participants' description: pseudonymes, profiles, and demographics

	Participant	Sex	age	Marital status.	Specialization	Current Employment
1	Dr. Lesley	Female	56	Single	General Practitioner	Works in a hospital setting as community resource person
2	Dr. Karla	Male	49	Married	Emergency Medicine	Has an International Job
3	Dr. Leah	Female	55	Married	Family Medicine	Licensed and practicing physician
4	Dr. Bob	Male	34	Single	General Practitioner	Customer Service, Pharmacy
5	Dr. Pet	Male	35	Married	General Practitioner	Research Assistant in a hospital
6	Dr. Tyler	Male	41	Married	General Practitioner	Interpreter in a hospital
7	Dr. James	Male	50	Married	General Practitioner	Mental health Counsellor

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8	Dr. Rita	female	32	Married	General Practitioner	Scribe in the hospital
9	Dr. Fred	Male	46	Divorced	General Practitioner	Interpreter/security guard
10	Dr. Ann	Female	35	Divorced	General Practitioner	Manager of a community health center
11	Dr. Lisa	Female	30	Married	General Practitioner	Works at home as a housewife while preparing for USMLE
12	Dr. Brown	Male	48	Married	General Practitioner	Working in a research facility
13	Dr. Marvin	Male	39	Married	Infectious. diseases	Licensed physician,

Table 1: Participants' pseudonymes, profile demographics.

This table indicates the pseudonyms, profiles and demographics of the Foreign-Trained Medical Doctors who participated in my study. I purposefully used the suffix *Dr.* because of my observations of my interactions with FTIMDs in the peer support group and also in a one-on-one interview. I noticed that calling them Dr. was embarrassing since they were not licensed to practice medicines as physicians in the U.S.A.

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I had written in my post reflexive journal about my observation concerning the difference the prefix (Dr.) made to some participants. During my analysis, I thought it was appropriate to explain why the pseudonyms and prefix have "Dr." to validate the representation of the professional identities and voices of the participants.

I intentionally ascribed the pseudonym with the prefix "Dr." signifying Doctor of Medicine. I was very touched during my participation at a peer support group (07/6/2015) when I addressed a participant as a doctor, and it sounded strange to a majority of participants. I wondered why they deemed it strange. I then reflected on this question, do they consider themselves not to be doctors because they are not licensed to practice in the U.S.? Have they become habituated to not being practicing physicians? Has their professional identity been deconstructed and have they assumed a non-professional identity by being underemployed? I then went into my post–reflexion journal and noted their reaction.

Another example where I got a similar reaction was during my interview with Dr. Pet. I addressed him as Dr., and, this is what he said, "I don't remember when I last heard someone call me doctor," and "that's nice of you to call me doctor even though I am not a doctor here in America." "Hmm, when I heard doctor I thought you were talking to someone else until when you called my name." As a participant observer in their peer support group, I also noted that when I addressed them as a doctor they smiled. Their professional identity as a doctor has a deep meaning to them. It is for this reason that a

majority of them continue tirelessly to explore the possibilities of practicing as licensed physicians in the U.S.A.

The participants are all Foreign-Trained Black Immigrant Medical Doctor (FTBIMDs), legal immigrants in the U.S. from the continent of Africa. Some participants were members of a collective of FTBIMDs. A few participants are located in my social networks in the U.S. Two participants are licensed, physician. Participant's profiles and work history, include sex, age, specialization, and current employment produce the phenomena. Participants who are aspiring to become licensed are those who are younger. This is spelled out in Table 1 above.

Six participants have written and passed the USMLE; Dr. Fred, Dr. James, Dr. Ann, Dr. Bob, Dr. Leah and Dr. Marvin. Four participants are studying for the USMLE, Dr. Amy, Dr. Rita, Dr. Pet, and Dr. Brown. One participant, Dr. Amy, is, however, pursuing an alternative pathway and preparing for USMLE concurrently. Another participant, Dr. Lesley, has given up her medical career in preference to cater for the education of her children. Dr. Tyler is still trying to take care of his family before relaunching his struggle to find work as a medical doctor. The last participant, Dr. Karla, is currently working as a medical doctor in an international organization. Dr. Leah is an established physician running her clinic in the U.S. Dr. Marvin is currently working as an internist.

Step 2. Device a clear, yet flexible process for gathering data appropriate for the phenomenon.

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The guiding principle in post-intentional phenomenology is to "study participants' intentional relationship with the phenomenon under investigation" (Vagle, 2014, p.129). A combination of methods was used including unstructured interviews, observations and email communications. These were the data sources.

Observation: I observed the participants during my visit with the family when convenient for them to conduct one- on -one interview. I noted how participants relate to the children, spouse, and their profession. I emailed semi-structured questions to the participants before the interview. My goal was to gather as many data as possible to help me dig deeper into the phenomena of finding work and working. In sum, their intentional work–related lived experiences finding work and working were examined.

I observed participants demeanor during the interview to determine her embodied expression of the phenomena. Dr. Liza, for example, made sure her partner was not anywhere near in sight before telling me how she is verbally abused for not working as physicians. I that her identity would be protected. This moment of interaction with Dr. Lisa is memorable. It left me with the impression that fear, spousal abuse, and subjugation of the female foreign-trained immigrant medical doctors were common occurrence and noticeable

However, the commitment to pursuing residency opportunities was fraught with uncertainty because of their relationships with their spouses. As I listened to some participants experiences, I noted in my post reflexive journal (11/17/2015) that some female participants lived in fear because they were verbally and physically abused by

their spouses. One participant told me that her husband mocks at her because she cannot get into residency though she is raising their first born currently. Another participant could not get high scores in her USMLE because she was emotionally distressed as noted post-reflexive journal 3/15/2016.

As participant observer during my interviews with women who had young children, I would stop recording and make a joke with the baby or comment on her/his activity and make her be part of the conversation. I carried Dr. Lisa's baby who was restless while we were conversing. By helping with the baby, Dr. Lisa was able to set up a computer program for her baby to watch. This activity preoccupied the baby and gave U.S. time to complete the interview. In my post-reflexive journal, I wondered how she is preparing for her USMLE while raising a baby who needs a lot of attention simultaneously.

Raising children is, therefore, a big challenge to the female participants. They had to look for baby sitting or stay home and care for their child or children. This states of affairs led to perpetual verbal abuse and subjugation of the females. Details of participant's flow of lived experience are outlined in the data presentation and on-going analysis.

The peer support group*:* The peer support group housed in the CBO assisting some of the participants is a safe space for the immigrant medical doctors. It is a point of contact, networking space that gives the IMGs a voice. Some testified that coming to the group helps them cope with the frustration of the gruesome process of becoming a

licensed physician in the U.S. They meet their colleagues with the same issues, and they become comforted. They console themselves that they are not in this alone.

I also noted how they related to each other. I observed how IMGs built community, shared information about interviewing, writing a personal statement, and seeking recommendation letters and learning how to cultivate new relationships with each other. Sharing strategies that would help them be more competitive in the licensing process.

I conducted semi-structured audio-taped interviews and sustained field work at the organization in the U.S. hosting immigrant medical doctors as they participate in the peer support group towards achieving residency positions for all foreign-trained medical doctors. Sustained field work at this organization as recommended by Vagle (2014) enabled me to observe the progress the medical doctors are making in finding work.

The meaningfulness of this peer support group to the medical doctors and their peers was a big part of my analysis. I was able to observe how the participants are finding their voice as they participate in their peer support group deliberations and their interactions with their colleagues. I noted how the doctors developed friendships across cultural borders (Anzaldua, 1987) and saw everyone as a stakeholder in the process of finding work.

I also examined documentary evidence to validate how the medical doctors were being served by the CBO, for instance, reimbursing part of the expenditure for the United States Medical Licensing Examination. I held informal conversations with participants to find out how relationship building with their peers have helped them emotionally as the

participants are finding work together. I was creative and worked around participants' availability in ways that lead to eliciting enough data for the project. In the case of an eventuality, I would have gathered enough data to analyze. I have access to Black African immigrants who have lived experiences of finding work and working in the United States through community networks the social and cultural capital (Bourdieu, 1980).

In sum as suggested by Vagle (2014), I conducted a pilot study with foreign-trained medical doctors in the summer of 2015. This pilot study has helped me to practice data gathering methods using various techniques, consisting of interviewing and observation. My next step was how to select data sources.

Select data sources. Data sources were observations, informal conversations, unstructured interviews audio-taped interviews, sustained field work, and document analysis. I used data from my observation of participants both at the host organization and at home where applicable. I observed their participation at the Community-based organization hosting the immigrant medical doctors. I paid attention to subject's participation in peer group discussions. I made sure I followed up with subjects after the session to find out how they think their voice was part of the discussion
If not, I inquired why they are not having their voice heard by active participation. There was variation in the responses. Some were not confident enough to find their voice. Others were afraid to make mistakes, and yet others were being respectful as it is cultural for them.

Unstructured interviews with participants. These semi-structured interviews were audio recorded and transcribed. First I emailed participants questions about their lived experiences of finding work in the U.S.A. I requested that the participants write the first efforts they invested in looking for work. I also asked them to indicate who assisted them in this process. I sought to know the community networks helping in compiling papers or job applications. Furthermore, I asked participants to write about their lived experiences during this period. How might finding work take shape for a Black immigrant Medical Doctor in the U.S.A? How might finding work affect their families? Some responded in detail answering every question; others preferred to summarize their response in one paragraph. Still, others declined to respond. They preferred a follow up conversation. Dr. James told me that he did not want to sit and write his story because it depresses him as he thinks of what he is going through and how it affects his children. However, he later consented to a one-on-one interview Dr. Tyler who was initially skeptical to be audio-taped during the one on one interview, had an informal conversation with me but was more skeptical of a follow up interview because he was scared about exposing himself. I assured him that his name would not appear in the data, but he opted not to continue discussing his lived experience with me. After one month I got back to him, and he now consented to an audio-tape unstructured interview because he had time to build a trusting relationship.

Sustained field work allowed me to gather as much data as possible to enrich my dissertation write up. During this time, I was able to observe the involvement of

participants in their peer support group, how they are giving back to the community organization assisting them. For example, some volunteered to be in the office and just answer the phone. They were humble enough just to play the role of a receptionist. Others did research about the legislators who could help them they are using their voices as participation, voices as social struggle and voices as becoming in finding work. Document analysis was a great source of data for this dissertation. Various documents were analyzed from the mission of the organization to articles published about the plight of foreign-trained physicians to the intervention of the legislature, passing a bill creating residency slots for physicians and providing funding. An examination of the effects of the bill and the expectations of the foreign-trained medical doctors was also carried out. I also did an analysis of efforts by some states at getting foreign-trained medical graduates into residency, for example, Florida, Minnesota, and California. My next step will be aligning the data with the research question.

Align data with a research question. Aligning data with research questions requires that for a specific research question, either primary or secondary, both must be retrieved from the data transcribed. I used the transcripts from interviews that I had audio- recorded with each participant. I also include a description of written lived experiences of participants from emails as well as observations. In this process, I made sure that the data response to the following research questions. How might finding work take shape for Black African immigrant medical doctors in the United States?

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What is the effect of finding work on the family? Data from various sources are aligned to these research questions. I developed a post reflection plan to help me capture tentative manifestations of the phenomena finding work and working in the U.S.A.

Table 2. Research Questions, Data Sources and Data Collection

Research Questions	**Data Sources and Data Collection**
Primary Research Question How Might Finding work and working take shape for a Black African immigrant medical doctor in the U.S.?	Audio-tape-recorded interview transcripts of face to face interviews with participants. Participants telling of their experiences appropriation of environmental opportunities. ● Please tell me your experiences of finding work and working in the U.S. ● Who assisted you? Human and material assistance. ● How did you begin, finding work? I will follow up with probing questions like: ● Tell me more about the challenges you faced? ● How do you feel during this trajectory of finding work and working? ● What are the community networks that assist you? ● How are you voicing your concerns? Who is assisting you? Where are you voicing your struggle in finding work and working? How are

	you participating in finding solutions to your underemployment? ● What is your hope for your professional identity as a Physician? ● My continuous. post reflexive journal
Secondary Research Question. What is the effect of finding work on the family?	**Participants telling of their experiences of becoming** ● Please tell me about the effect of your trajectory in finding work has on the family? ● The immediate family? ● The extended family ● The community family **My post reflexive journal**

Step 3. Making a post reflection plan

Given the importance of a post reflection plan in post-intentional research, I initiated a reflection journal in the early stages of my research (Vagle, 2014). This post reflection journal was on-going and in a continuous document. This document was dated as I make entries of my on-going post reflection. I set aside enough time to reflect and dig deeper into the data. This approach helped me to examine the data diligently as oppose to looking through without much attention. I was "looking at what we usually look through" (Vagle, 2014, p.132). This time, the commitment led me to see new insights in the data

and doing further analysis. It is also an opportunity for me to stretch my reflection in a humble manner to perceive new spaces (Vagle, 2014) by remaining open. Furthermore, as I continued in my post reflection, I was able to capture some moments that I could relate to participants as the themes emerged from the data. I paid attention to the nuances and complexity as I continued to wonder how the phenomenon of finding work by Foreign-Trained Black Immigrant Medical Doctors might become.

I committed to a post-structural philosophy in my reflexivity. I stayed reflective as the varied and multiple contexts of the phenomenon presented itself manifestly. I used visuals and graphics to illustrate some manifestations of the phenomenon. I was attentive to moments where my experiences connect with those of the participant's moments as well as when my experiences disconnect from their experiences (Vagle, 2014). Furthermore, I looked at my assumptions and what I consider to be normal. I verified for normality and bridle to get the most out of the data. In my bridling journal, I continued to wonder what this experience has been like for each participant.

In my craft, I was attentive to the following;

1. where I am surprised about what is happening,
2. moments, where I either connect or disconnect with the participants,
3. my assumptions about normality,
4. my bottom lines, perspectives and perceptions,
5. moments where the participants and I are shocked at what, they/we notice.

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Finally, it was important for me to be very attentive in the process and explore deeper into the data to see the shifting manifestations of the phenomena (Vagle, 2014). In fact, I wrote my post reflection journal each time I gathered data. By cultivating this habit of post reflection helped me to see the tentative appearance of the phenomena. My next step in post-intentional phenomenology is to read and write my way through.

Step 4. Reading and Writing through in Data Analysis.

I read and wrote simultanuoesly as I analyzed the data. I drew on "*Thinking with Theory*" by Jackson & Massei (2012) as I analyzed data. These authors encourage qualitative researchers to plug in various theories into their data analysis. Their proposition derives from the fact that all data is partial and incomplete. By plugging in various theories as I analyze data, I would be able to amass more knowledge from the way various theorists look at the current data in my research. Plugging in data as well as thinking about theory leads to the creation of something novel.

That is, I categorized the data, and think of the theory that fits the situation simultaneously. These are "moments of plugging" and "making new connections" (Jackson & Massei, 2015, p.4). Plugging in theory and data creates a new thing, for example using Anzaldua's borderland, opens up avenues to use Bhabha and Fanon in the same light. The intersection of these theories leads to a synergy between data and theory that makes sense in combining theories. A continuous reading of text may lead to another theory opening up. That is why Jackson and Massei (2012) proposition of Using data as

"brief stopping points' is continually being transformed into a new thing. "We Use theory to turn the data to something different and to push data to its limits" (p. 6).

I started by reading all my journals diligently to unearth every detail. I read to understand how the notes transcribed from audio-taped interviews, observations and my post reflection journal make sense. I made sure that there was a balance between quotations paraphrasing as I craft the text (Vagle, 2014). I read each line of the text carefully for understanding and also followed up with the participants about questions to clarify their lived experiences finding work. This process was challenging because some participants were not reachable. It was a privilege for me to have the opportunity to interview some participants one- on- one. The frustration finding work is such that make some participants hibernate.

I come in with my analysis. Meanwhile, I noted the tentative manifestation of finding work and working as what stands for African immigrants. Finally, I created a text which demonstrates the tentative manifestations of the phenomena of finding work and working by FTBIMDs. In my data analysis, voice is an indispensable concept in the lived experiences of participants.

Voice as a project. Voice by Lensmire (2000) is relevant in my dissertation. I Used participants' voices as individual participation, voice as participation, voice as a social struggle, voice as appropriation, and voice as becoming to unveil how the Foreign-Trained Black Immigrant Medical Doctors (FTBIMDs) navigate the education and workforce systems. Lensmire (2000) is concerned about "those who find no easy place

within the dominant meanings of our racist sexist and classist society" (p. 58). FTBIMDs fall into this category of people who go through this trajectory of finding work and working. Some encounter walls of resistance in the form of racial discrimination. Others face outright rejection because of their accents, blackness, and foreignness.

Lensmire Uses voice as a project to make a great contribution to knowledge. By highlighting how voice is initiated within time and space as an *active presence*. Such active presence refers to individual participation. Voice as the project is, therefore, a "liberatory" utterance that Lensmire developed to promote democracy. Democracy here is not meant to foster any neoliberal agenda. Rather, Lensmire writes that "when I say democracy, I mean what John Dewey (1951) called a "way of life"- a way of life that is "controlled by working faith in the possibilities of human nature" (p. 391) as cited in Lensmire (2000, p.5).

In a pilot study with IMGs, I observed that they all had a working faith to become licensed as physicians in the U.S. This working faith is what has propelled these foreign-trained medical doctors to be committed to their pursuit of possible licensure opportunities for them as they gather information through the peer support group within a community-based organization. This organization serves as a safe space (Leonardo & Porter, 2010) for education and advocacy. This peer support group is a safe space where participants can interact freely.

Medical doctors have found a voice. Membership of a peer support group gives them a voice as a project and as participation. Voice as a project gives these immigrant

medical doctors direction. They are purposeful in finding work by pursuing their career as medical doctors. Through organizing, they bring their problems of unemployment as medical doctors and underemployment as high school graduates for survival to the public arena.

As individuals and as a group they have one common goal to get into residency and become licensed medical doctors in the United States of America. Together they are exploring the possibilities of getting into residency and reclaiming their professional identities as medical doctors. The community-based organizations served as the vehicle through which this hope of a professional identity is being birthed in Minnesota. Finding one's voice is seeking an opportunity to express one's feelings about what is meaningful to one within a specific space and time.

***Personal voice*.** The use of personal voice is paying attention to what is meaningful to individuals. Secondly, individual voice is inspirational. It involves expectations and a commitment to self (Lensmire, 2000). In our daily lives communicating in a human voice adds a sense of personal and sociable human contact to the interaction with the public. This sociable human contact in conversational human voice may thus promote trust, satisfaction, and commitment in relationships between and among human beings. From a spiritual perspective as a Christian, I refer to Psalm 119 verse 130 states: 'The unfolding of {one's} words gives light; it gives understanding to the simple." In other words, the emphasis is on the clarity of the scriptures to believers. This is the perspective of the theologian.

Voice as participation: A radical theory of voice, it is critical and derives from critical pedagogy. The participants make their voice heard as they participate in the peer support group and also in the public arena where they encounter policy makers.

Appropriation. Lensmire explains it succinctly that, "the notion of appropriation emphasizes the activity of the self in the face of cultural resources. The concrete individual does not stand passively before the experiences, languages, histories, and stories that confront her/him, but assimilates and does work on these resources in crafting a self and a voice" (Lensmire, 2000, p.77). In this study, I examined how Black African Immigrant Medical Doctors appropriate resources such as workforce centers, community based organizations, legislature, university institutions, etc. to make their voices heard as people finding work in the U.S.A. In this vein, I examined voice as an explanation of the experiential encounter within the American environment by the Black African medical doctors. It also helped explain their experience with the material context in which they are finding work.

Social struggle. Lensmire acknowledges that "the project of voice involves work….it suppresses the emotional turmoil and moral complexity that can accompany speaking and writing" (p.79). For the purpose of this analysis, emotional feelings encountered by the Black African Medical doctors finding work were analyzed. Also, I examined the participant's emotional feelings in relationship to the American material context and the challenges faced. I shall delineate their commonplace experiences in contrasting backgrounds such as finding work in an American capitalist, an

individualistic society with that of the African Ubuntu philosophical foundations of "togetherness" in an individualistic American capitalist society.

Becoming. Furthermore, I used *becoming* (Lensmire, 2000) to reveal what the aspirations of the FTBIMDs may become. In my probing during the one on one interviews, I sought to understand the experiences of the medical doctors in situations where they recognize "that there are no guarantees" (p. 83) of finding work. Second I wanted to know how they reconstruct their experiences in finding work to benefit from "old words, old relations with audiences, old choices in the service of the ongoing renewal of {their} perspectives on the world and {their} places within" (p. 84) as they are finding work. Finally, I sought to understand how the FTBIMDs internalize the fact that they cannot find work "without the risk of rejection" (p. 84). I investigated how they seek to collaborate with others in their communities their social and cultural capital (Bourdieu, 1980) to find work.

In sum, the goal of voice-centered listening and analyzing is to interpret the interplay of dissonant (or harmonious.) and inconsistent "voices" dealing with the subject/ phenomena of finding work and working by FTBIMDs in the United States.

5. Crafting a text that captures tentative manifestations

I presented the tentative manifestation of the phenomenon: finding work and working in the U.S. by Black immigrant foreign-trained medical doctors in its multiple, partial and varied forms. The Phenomena "manifest" or "appear" as finding work, job search, working, challenges at work, work-life balance, and career development.

Further, I identified the various themes as they appear. This approach is suggested by Van Mane (2014). I am incorporating this approach into my post-intentional phenomenological research data analysis.

I weaved in various theories, elaborated in the conceptual framework including; racial formation theory by Omi & Winant (2015), Post- colonial theory by Frantz Fanon, Borderlands theory by Gloria Anzaldua and forms of capital by Pierre Bourdieu (1980). Furthermore, I used voice as participation, voice as social struggle, and voice as becoming (Lensmire, 2000) as well as my post-reflection journal about the various lived experiences of participants. I explored concepts from Deleuze and Guattari (1987) such as deteritorialization and territorialization, assemblage, plateau and lines of flight to see what the phenomenon of finding work might become for Black immigrants foreign-trained medical doctors. Do their experiences convince them that they are protected as human beings in the United States? (Advocates for Human Rights, 2014). If not, why not? I asked how long they would continue to pursue their goal of finding work. What changes are they expecting from policy makers? What efforts are they making to reach their goals? The coherence of my craft is where I seek to demonstrate my understanding of post- intentional phenomenological research as an emerging phenomenologist.

Validity and Reliability. I committed to validity and reliability of data gathering and analysis for this research. My continuous presence at the Community-based organization (CBO), engaging with "the phenomenon and with the participants who have experienced the phenomenon" (Vagle, 2014, p. 66), and attending their peer bi-weekly

support group meeting. As a phenomenological craft woman, I remained “open and sensitive” (Vagle, 2014) to the phenomena finding work and working. Furthermore, my “sustained engagement with the phenomena and the participants” have helped me to validate the one –one interview. The participant’s constant pursuit of work by organizing and advocating for themselves with the legislators gives this study validity and reliability. I am conscious of Freeman et al. (2007) suggest that the heterogeneity in validity be preserved. However,I bridle my previous knowledge as Dahlberg and Nystrom (2008) requires so that my earlier knowledge about the phenomenon do not dilute the data. The participants would have access to my research findings and recommendations as stakeholders in this research.

Credibility and trustworthiness. My proposed study is credible and trustworthy. In the summer of 2015, I had a research internship Award from the university that enabled me to carry out a pilot study of foreign-trained health professionals at a community-based organization serving immigrants in the (Mid-West). At the onset of my internship, I realized that the foreign-trained health professionals were all medical doctors. I decided to work with those who were attending their peer support group regularly. I approached a few of them from the onset. They were all skeptical about my research project. They hesitated to consent to the study. I decided to build trust with them by participating actively in their peer support group meeting, serving as a resource person, advocating on their behalf when presenters solicit their help from the community. After one month of participating in the peer support group, I was seen as an ally. I had

gained their trust After that, when I approached them individually to interview for my project, there was no hesitation. I did six interviews with three female IMGs and three male IMGSs

The pilot study found that all the participants but one, would like to pursue their career as medical doctors in the United States. However, they were all concerned about several challenges they faced in the *flow of their experience* (Drummond, 2014) including, accent, discrimination, and the number of slots available in the Match program for foreign-trained medical doctors to get into residency. The subjects all stated that "it is hard to get into residency" and "nobody cares." As most said, "I work at GED level to earn some income that could help me provide financially for my family." These results encouraged me to study the lived experiences of Black Immigrant Medical Doctors finding work in the U.S.A, to understand how their identity as "Blacks" further compounds their underemployment as an immigrant medical doctor in the U.S.

This chapter has outlined phenomenology as philosophy and methodology. The first part discussed the philosophical underpinnings of phenomenology as stated in step 1 of the five process approach established in post-intentional phenomenology. The second part detailed the process of participant selection, data sources, data analysis.

Black Medical doctors face a special problem because of their Blackness. Post-intentional phenomenology has been used as the methodology for this research. A combination of theories were utilised in data analysis. Voice as a concept is highlighted to ground the lived experiences of the FTIBMDs' aspirational and exceptional

expressions. An investigation of the lived experiences of these foreign-trained Black Immigrant Medical Doctors informs policy makers of this desperate need to expand the number of slots for residency in the Match program for IMGs.

Chapter Four: Analysis of Findings

"Accent is a difficulty, but we are educated, and that makes a difference because our accents do not affect our educational knowledge, we are trained physicians. We are trained to help take care of the health of the population." (Dr. Tyler, 2015, participant).

"Americans have been taught that their nation is civilized and humane. But too often, U.S. actions have been uncivilized and in humane" (Zinn, 2016).

In this chapter, I present an analysis of results from my exploration of the Lived experiences of Foreign-Trained Black Immigrant Medical Doctors (FTBIMDs) finding work and working in the U.S. These findings are derived from various themes that emerged from the study. The themes are *tentative manifestations* (Vagle, 2014) of the phenomena "finding work and working" by FTBIMDs in the U.S. Tentative manifestations in post-intentional phenomenology refer to the themes noticed in the social context and the interconnectedness of the subjects' experiences with the lived world. These tentative manifestations are multiple, partial and unstable (Vagle, 2014). As a result, there is the need for a continuous or ongoing exploration of the phenomena within social contexts.

This explanation corroborates the argument of this study that Black immigrant identity construction in education and employment is continually being racialized. This argument is validated to analyze the data and plug in various theories. In their book

Thinking with Theory in Qualitative Research Jackson and Mazzei *(*2012), encourage researchers to use multiple theories to analyze the same data set to open up spaces for knowledge. In other words, researchers are encouraged to look deeper into the center of the data "to see what newness might be incited" (p. viii).

I engage a combination of theories that frame this study, including racial formation theory by Omi & Winant (1994/2015), post-colonial theory by Frantz Fanon (1967/2008), borderlands theory by Gloria Anzaldua (1987) and forms of capital by Pierre Bourdieu (1986) as I analyze the findings as tentative manifestations.

In this chapter, I analyze the findings as an assemblage of tentative manifestations of the phenomena finding work and working by FTBIMDs in the U.S. I analyze the data and weave in the theories simultaneously to make sense of the findings. Finally, I draw conclusions based on the conceptual framework.

Analysis of Findings as Tentative Manifestations

The analysis of findings begins with a table of the initial tentative manifestations.

Findings: Initial Tentative Manifestations

Initial Tentative Manifestation	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	13
It is hard	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	X

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The residency system is complex	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	X
Brain Waste Survival jobs	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	X
Cultural competence	**X**		**X**			**X**	**X**	**X**	**X**	**X**	**X**	**X**	
Difference, Blackness, skin color, and accent	**X**		**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	X
Resilience, /Persistence and the American Dream			**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	
Spousal support /Spousal abuse	**X**	**X**	**X**									**X**	**X**
Children's Education	**X**		**X**									**X**	X
Family and transnationalism	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**		**X**	X

Coping mechanisms: Peer support group, spirituality	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	X

Table 3: Initial Tentative Manifestations

In Table 3, I have listed the initial tentative manifestations on the vertical axis and attributed numbers one to thirteen to the participants horizontally. I have used X to denote which participant vocalized which tentative manifestation of the phenomena of finding work and working in the U.S. Blank spaces denote unexpressed manifestations by some participants.

The following themes emerged from the interviews with participants in my study as an assemblage of participants' voices in initial tentative manifestations of the phenomena finding work and working in the USA: 1). It is hard, it is difficult, it is challenging; 2).The residency system is complex, there is no guarantee, and it is who you know; 3). Brain waste and survival jobs; 4). Cultural Competence; Difference/ Blackness, skin color, and accent; 5). Spousal Support/ Spousal Abuse; 6). Resilience and persistence; 7). Children's education; 8). The American Dream 9). Family and Trans-nationalism 10). Coping strategies

These initial tentative manifestations represent an assemblage.

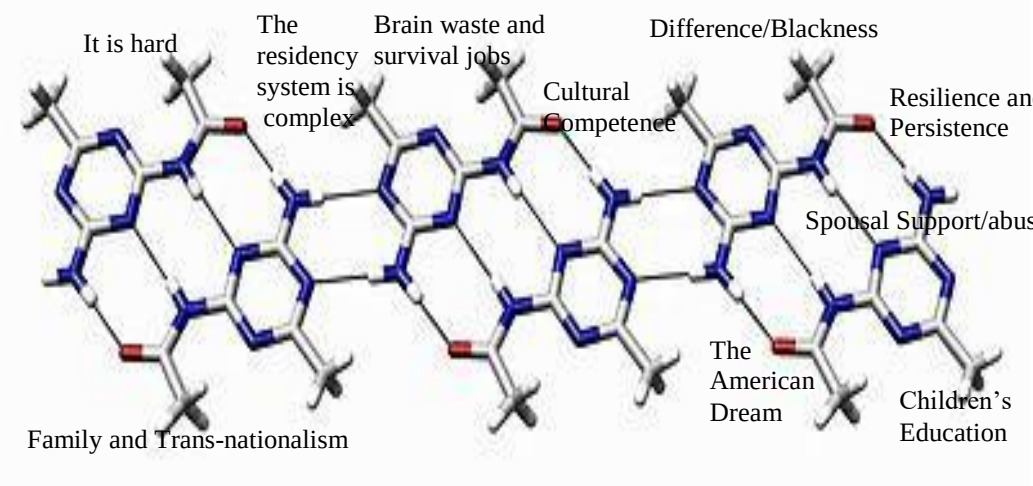

Figure 1: Assemblage of findings as initial tentative manifestations

Source; Google Images. Retrieved 04/12/2016

Figure 1 is the assemblage of findings as tentative manifestations of the phenomena, finding work and working by FTBIMDs in the U.S. The assemblage signifies the entangled nature of the initial tentative manifestations. It is one approach to organizing the initial tentative manifestation to indicate fluidity in the findings.

First, all participants said that it was hard or challenging to live through this trajectory of finding work and working as FTBIMDs in the U.S. Secondly, the participants all indicated that the licensing system is complex. In the words of Dr. Bob, "there is no guarantee, and you need to be known." Third, all participants said that being underemployed is brain waste because as physicians, they are trained to care for people. All participants are involved in making remittances to their countries of origin. This tendency to live in a foreign country but maintain one's relations with the country of origin could be trans-nationalism. They all made reference to working to take care of

family members “back home.” Nine participants highlighted cultural competence as a needed skill, which the FTBIMDs have to offer to the U.S. cultural mosaic.

Three female participants mentioned that their spouses were very supportive in this process of finding work and working survival jobs to pay daily bills. One male participant indicated that his spouse was very supportive. Two females voiced the disgusting concern that their spouses were very verbally abusive, especially because of their financial irrelevance to their families. Their spouses expected that they should be income earners rather than being dependent on their husbands.

In my post reflection journals, I wondered why some female medical doctors had to suffer from emotional distress just because they could not get into a residency program. It would appear that getting married to a female medical doctor means improving the status and financial well-being of the family. Failure to attain this goal seems to be the basis of abuse, physically and verbally (post- reflective journal, 15/3/2016**)**. It is noteworthy that though the similarities and differences in participants’ responses might be obvious, the bottom line is to handle every interview as possible occasions to learn something new about the phenomenon. The phenomenological attitude enables a researcher to be reflexive and open to newness. This newness is noticed in the assemblage of findings in tentative manifestations.

The assemblage of findings as tentative manifestation portrays the multiplicity in the identity construction of Foreign-Trained Black Immigrant Medical Doctors in the U.S. This identity construction appears to be a rhizomatic assemblage of the phenomena

of finding work and working. The rhizomatic assemblage was coined by Ibrahim Award (2014) who combined “rhizome” and “assemblage,” two concepts developed by Deleuze and Guattari (1987) to make sense of black identity construction.

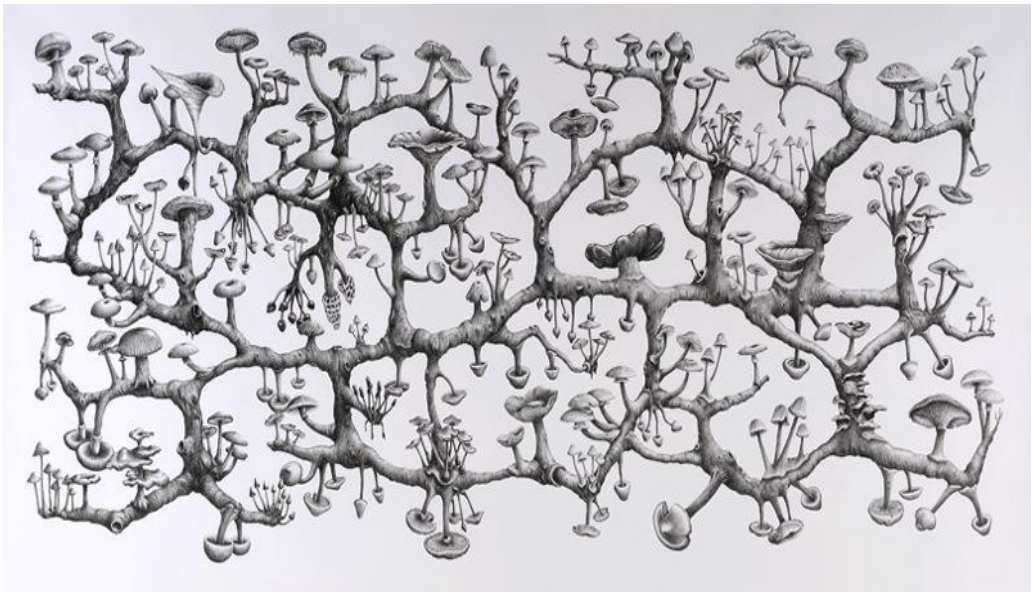

Figure 2: Rhizomatic Assemblage of Findings as tentative manifestations.

Figure 3: Rhizome, Retrieved online 01/04/2016

"The rhizome operates by variations, expansion, conquest, capture, offshoots. Unlike graphic arts drawing on or photography unlike tracings, the rhizome pertains to a map that must be produced a map that is always detachable, connectable, reversible, modifiable, and has multiple entryways and exits and its own lines of flight" (p. 21).

Assemblage is used here as both concept and process. It is a discursive concept that is used to illuminate the uncertainty in the trajectory of FTBIMDs finding work and working in the U.S. Assemblage is another concept developed by Deleuze and Guattari (1987). These two French Philosophers opined that "assemblages are defined simultaneously *by matters of expression* that take on consistency, independent of the substance from relations...Assemblages swing between a territory closure that tends to re-

stratify them and a reterritorializing movement that on the contrary connects them with a cosmos" (pp. 336-337). This definition of assemblage is complex. My reading of the definition is not conclusive. I am conversant with the fact that the origin of *Assemblage* is French, and this definition is a translation from French to English. Therefore, I draw its meaning from the French language that is my second and colonizing language. An assemblage as a concept is a collection or grouping that is in constant flow.

Deleuze and Guattari use assemblage metaphorically to bring to light the complexities of social life. The metaphoric exploration of assemblage has led some scholars to use 'assemblage' as an amalgam in identity construction. For example, Award Ibrahim (2014) states that "I am calling rhizomatic identity; a rhizomatic assemblage that is welcoming sociality, with everything that it brings (the good and the bad), but with no guarantees as to what it might finally look like" (p. 3). Deleuze and Guattari conceptualize social life as being unstable, partial and in continuous movement. In the same vein, post-intentional phenomenology sees knowledge as partial, unstable and circulating through relationships (Vagle, 2014). Such relationships could be that of a preacher and congregation and employer and employee. Assemblage could be read as an arena where people *experiment nomadism* (Deleuze & Guattari, 1987). Assemblage explores, what it is like to be in an unstable work situation like that of the FTBIMDs. For example, what it is like to experience being underemployed as a Black immigrant medical doctor? The assemblage is an encompassing concept. It has a mixture of good

and bad. It is a form of identification that is constantly moving or in motion; there seems to be no end in sight because it is flowing continually.

As I conducted the interviews attentively, I *looked at* what we *usually look through* to notice the tentative manifestations of the phenomena in my *persistent reflexivity* to ”realize a deeply layered and complex (post)reflexivity” (Vagle, 2014, p. 131).

This post reflectivity is seen in a majority of interviews I conducted with FTBIMDs finding work and working in the U.S. The themes are all connected to each other. That is why I draw on Deleuze and Guattari (1987) to call the themes an assemblage of disparate elements.

An assemblage as defined by Deleuze and Guattari (1987) in the context of this research refers to multiple and partial (Vagle, 2014) utterances expressing the lived experiences of participants and their relationships in daily life. To explain this further, Van Mane (1990) argues that “all phenomenological human science research efforts are really explorations into the structure of human lifeworld, the lived world as experienced in everyday situations and relations” (p.101). The way these lived experiences are shaped is what calls for deep reflection by phenomenologists.

In my research, tentative manifestations are noticed as I interview participants to understand how they are ‘being’ and ‘becoming’ as they reflect on their intentional relations with the phenomena in their lived world. Such reflexive moments result in tentative manifestations of the phenomena.

These tentative manifestations of the phenomena of finding work and working vary with each participant and context. However, there is a connecting thread among participants: their identity as black. Revisiting what denotes phenomena in phenomenology as opposed to quantitative and qualitative research will clarify how participants' voices as *active presence* are expressed during the interviews (Lensmire, 2001). Active presence refers to the personal engagement that produces meaning.

The assemblage of findings in tentative manifestations was a response to the following foregrounded research questions:

How does finding work take shape for a foreign-trained Black Immigrant Medical Doctor in the U.S.?

The secondary research question is:

How does finding work affect the family, immediate and extended?

The phenomenon of finding work and working manifests as: "it is hard." As a researcher, I could notice this phenomenon in my post-reflection when I began to bridle. Dalberg, Dahlberg, and Nystrom (2008) assert that bridling achieves two main things: First, removing foreknowledge of the phenomenon, and second, a continual expectation of the phenomenon manifesting. I was open to the various ways in which participants explained the hardness of experiencing finding work and working. The variation in what was hard made me more reflexive to dig deeper into the participants' interrelation with the phenomena, finding work and working. The difficulty finding work and working

propelled these FTBIMDs to appropriate available resources in the environment as they lived through finding work and working.

The FTBIMD as IMGs faced with the complexities of being licensed as physicians in the U.S. seek to use available resources in the process of finding work. Lensmire writes that these resources are "the experiences, languages, histories and stories obviously (that) constrain the possible selves you can become" (2001, p. 63). Such resources could be a *multiplicity, plateau and lines of flight (*Deleuze and Guattari, 1987) for the FTBIMDs as they adjust to their new U.S. home.

Deleuze and Guattari (1987) write that a *multiplicity* has neither subject nor object, only determinations, magnitudes, and dimensions that cannot increase in number without multiple changes in nature. The laws of combination increase in number as the multiplicity grows. The findings are analyzed as multiplicities that depict the continuous, becoming, in brief, various *formations.* I interpret *plateau* to be a staging post, and lines of flight as possibilities of movement in the context of finding work and working in the U.S. An analysis of the findings in tentative manifestations is what follows. All participants indicated that their trajectory finding work and working in the U.S. is summarily challenging because of the tentative manifestations. It is by this lived situation that the ten initial tentative manifestations of the phenomena are collapsed into six.

The six tentative manifestations are: Challenging endeavor, Complexity of Residency, Brain waste, Difference and Cultural Competence, Family Wellbeing, and Coping Mechanism.

Finding # 1). Tentative manifestation as Challenging Endeavour. Challenging endeavor is an overarching finding that is produced in multiple ways, including the initial tentative manifestations: It is hard, it is difficult, and it is challenging**.** Using differing lenses, participants' "challenging endeavor" is produced and lived through as hardness in finding work in the U.S. Hardness is seen from a perspective of multiplicity. As a result, there is the need for a continuous exploration of the phenomena within the social context.

This determination for continuous exploration would open up and lead to knowledge production to substantiate the argument of this study that black immigrant identity construction in education is continually being racialized. From this perspective foreign-trained Black immigrant medical doctors are racialized in education and workforce systems in the U.S. That is why finding work and working for FTBIMDs is a challenging endeavor.

Grounding the Analysis of Challenging Endeavors

The analysis begins with a restatement of the definition of the phenomena defined in chapter three. Amplitude phenomenologists Moon and Money (2000) write that "the phenomena of phenomenology are to be understood in a deliberately broad sense as including all forms of appearing, showing, manifesting, making evidence or evidencing" (p.5). Participants' embodied reactions or utterances could be tentative manifestations or evidence of the experiences they pass through in their inter-relationship with the life world of finding work. Heidegger (1998/1927), a German philosopher, asserts that phenomena manifest and are brought into being. The manifestation of phenomena occurs

as people live through their daily lives (Vagle, 2014). In post-intentional phenomenology, a researcher remains open to understanding tentative manifestations of the phenomena "in the dynamic intentional relationships that tie participants, the researcher, the produced text and their relationships together" (p. 30).

Initial tentative manifestation: It is hard, it is difficult, it is challenging.

It is hard, it is difficult, it is challenging are variations of expressing challenges in intentional relations in the life world (Dahlberg, and Dahlberg, & Nostrum, 2008) of finding work by International Medical Graduates (IMGs) who are Foreign Trained Black Immigrant Medical Doctors (FTBIMDs) in the U.S. As foregrounded, this dissertation argues that Black foreign-trained immigrant medical doctors are racialized in education and workforce systems in the U.S.

All thirteen participants in the study responded that it is hard; it is difficult, and it is challenging to the first research question. However, each participant's experience and intentional meanings of the phenomena finding work and working is contextual. Lensmire (2001) writes that "finding your voice involves looking to your own experiences" (p. 58). It is from this perspective that the excerpts from participants' voices as tentative manifestations responding to the research questions are presented and analyzed.

It is hard is noticed in multiple instances. Some participants experienced hardness as challenging because of their intentional relationships with the environment, their lived world. The black man always attracts a gaze that cast doubts on his capabilities. In fact,

the social context in which participants experience the phenomena influences how the phenomenon is produced.

> Dr. Tyler: Because of the things I feel here the environment, I have been to several countries, and I don't feel myself here.
> *Charity: Tell me more about, I don't feel myself here?*
> Dr. Tyler: It is something that I don't feel myself here.
> *Charity: Is it the snow, the people?*
> Dr. Tyler: It is not the snow, it is the environment

Dr. Tyler's experience finding work is unique and needs further exploration. He expresses what hardness has produced for him as "because of the things, I feel here, the environment……I do not feel myself here." My reading of this statement is that Dr. Tyler had embodied response to the question about how finding work takes shape for him as FTBIMD. What are the things he feels here? I draw on Fanon to help me understand the things Dr. Tyler is feeling. Fanon (2008) writes, "from time to time you feel like giving up. Expressing the real is an arduous job" (p.116). Feelings are truly inexpressible. Such inexpressible feelings may be disastrous. In my post-reflexion of the interview with Dr. Tyler, I wondered what the things he feels here (U.S.) are. Is it the people, the culture or his intentional relationships with the world of work? Is it the recertification process, it is the multilayer United States Medical Licensing Examination (USMLE)?

Furthermore, I wondered why he does not feel himself here. Is it his separation from family or is he regretting immigrating because he is not licensed to practice medicine in the U.S.? How does he feel about the things that produce hardness in finding work? Does he feel depressed, humiliated, unwelcomed to the U.S. as an International Medical Graduate? In addition to his not feeling himself "here," he said the

"environment." I wonder what is in the environment that produces hardness for Dr. Tyler. I wondered if the environment he made reference to was the social context in which he was living through as a Foreign-trained Black immigrant medical doctor. I wondered if it is the loss of status and loss of wages as a practicing physician in his home country. Dr. Tyler also states that "I have been to several countries, I do not feel myself here." I wondered further why he compared his being in several countries but does not feel himself here. I also wondered why he came to the U.S. I continued to wonder. What is the bottom line for him as a member of FTBIMDs in America? (Post-reflexion, 04/07/2016). I attempted getting Dr. Tyler to clarify what he meant in his interview by "I do not feel myself," but he could not be reached by telephone. I followed up with an email, but I did not receive any response. I met him at a social gathering and had an informal conversation with him. He seemed to summarize his lived experience finding work and working as, "I don't like the environment." In this case, he appears to be indicating that his environment is an issue, that is why he does not like it.

Vagle (2014) encourages researchers using post-intentional phenomenology to practice "post reflexivity as a dogged questioning of one's knowledge as opposed to a suspension of this knowledge" (p.75). Though there seems to be a theoretical contradiction here, these contradictions are an important part of the world. Similarly, knowledge is seen as unstable, in circulation and ongoing (Vagle, 2014). To this end, I draw on Omi and Winant (2015) who assert that "race is a way of making people up" (p.105) and therefore, "Othering," according to Dr. Tyler's utterances. Dr. Tyler as an

IMG does not seem to feel himself 'here" likely because he is being made up as Black instead of a physician. His identity is constructed for him as Black in America with all the stereotypes of inferiority, unintelligent, assumed to be good for slave labor. His black body is being politicized as noted by Omi and Winant (2015) who postulate that, "race and racism politicize the body, subjecting it to state control, surveillance and violence" (p.140). Furthermore, what does it therefore mean to become Black in America as an IMG?

Becoming Black in America strips Dr. Tyler of his respected professional identity of a medical doctor in his home country and the "several countries "he has been to around the world." Dr. Tyler, therefore, assumed a racialized identity in the U.S., which makes him not feel himself here. Also, because his black body is constantly under surveillance and violence through a perpetual gaze that makes him not feel himself in America as a FTBIMD.

Black is a label that identifies Dr. Tyler with a racialized and marginalized group of people who have been dehumanized since slavery. Such construction of Dr. Tyler's identity as "Black" renders him a subaltern (Fanon, 1967, Ibrahim, 2014). From this perspective, my reading of his statement about the environment is that it appears to be alienating.

It is difficult was another initial tentative manifestation that I noticed as I interviewed the participants. Some FTBIMDs indicated that going through the process of finding work as an IMG is difficult.

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"It is very difficult to find work in my field. The issue is if you want to find any side job, they will ask for an experience that makes it even harder. I'm very fortunate to be gifted in several languages" (Dr. Tyler).

This statement can be related to Dr. Tyler seeking "side jobs" because "it is difficult to find work" in his field. As an international medical graduate, his expectation is to become a licensed physician in the U.S. However, because *it is difficult* for him to be licensed, he resorts to temporary jobs. The meaning of a *side job* could be that Dr. Tyler is looking forward to the day the difficulty of finding work in his field can be resolved by those who have the power to do so.

This multiplicity in difficulty leads to an overarching discovery that finding work in the U.S. as FTBIMDs is a challenging endeavor. One may ask a question: why is seeking employment difficult for skilled professionals like IMGs especially FTBIMDs? An attempt at a response from the data gathered is that it is because FTBIMDs' identities are racialized. Omi & Winant (1994) define racialization as "the extension of racial meanings to a previously racially unclassified relationship, social practice, or group" (p. 111). Since black people were taken into slavery, categorized as inferior and racialized, their ability to escape the stigma in the 21st century is limited. Hence, international medical graduates, especially FTBIMDs are also racialized and marginalized in finding work.

Fanon (2008) in his *Black Skin, White Masks*, highlights the fact that colonial racism persists, claiming that "there is only one destiny for the Black man. And it is

white" (p. xiv). Colonialracism is in conflict with the Ubuntu philosophy, which encourages the spirit of humanness preserving human dignity together in the human family.

Ibrahim (2014) builds on Fanon's work in Martinique, France where Fanon lived and worked as a physician and psychoanalyst. Fanon wrote *Black Face White Mask* to deconstruct colonialism and to shame some Blacks who unfortunately accept their inferior identity and wear a white mask. Ibrahim (2014) expands Fanon's work in *The Rhizome of Blackness an Ethnography of Hip Hop Culture,* which expresses blackness as black bodies "speaking so loudly" (p. 1). The speaking black body attracts a gaze that casts doubts on the qualifications and competence of IMGs from Africa. This is what Dr. Marvin, a licensed physician, said about his experience in a medical facility:

> Some people will hate you for being a black doctor to the point of hurting patients, and the system protects them and threatens you to be fired. As attending working now for a couple of years, that assumption of you being inferior is still there until you prove the system wrong. I was shocked to surprise her nurse bad mouthing about how I'm just a Doctor from Africa and the only one who would let the patient be discharged. She eventually had surgery and was able to clear her bacteremia and was able to walk (she couldn't do that before surgery). I had a surgeon questioned my knowledge in a case where he has no knowledge of basic pathophysiology of post-op infections. I had to push him and the hospital where this happened to request a written apology, otherwise it was going to be put under the rug. The list goes on (Dr. Marvin, interviewed on 05/17/16).

From this quotation, I understand how Dr. Martin felt being "bad mouthed by a nurse" who said he was "just a doctor from Africa." Dr. Marvin is being discriminated against because of his nation of origin. Unfortunately, Dr. Marvin, a licensed physician, heard the conversation. Does his Africanness render him ineffective? How is he expected to be

related to the medical team where he is working? There seem to be no clear-cut answers to these questions. However, Omi and Winant offer some suggestions by stating that race is a *Master category* (2015) that is deeply rooted in the history of enslavement of people of African descent. Race is also continuously shaping the trajectories of skilled labor from the continent, especially FTBIMDs in education and employment. For example, IMGS who are black are vulnerable because of their black body distinctiveness. Also, Ibrahim (2014) writes that "racialization is the process of becoming Black" (p. 34). This process of becoming black blurs the possibility of FTBIMDs being verted as physicians in the U.S.

Furthermore, Dr. Marvin's education is questioned by a surgeon who "had no knowledge of the basic pathology of post operation infection." Dr. Marvin specialized in infectious diseases. He is confident of his treatment plan for the patient. That is why he asked for "a written apology" from the institution for undermining his credentials and professionalism. This experience with the nurse "bad mouthing" and the surgeon "questioning his knowledge" is a micro racial project (Omi & Winant, 1994/2015); it is situated with the purview of his everyday activities. This interaction with staff in the hospital could also be interpreted as a way of stigmatizing Dr. Marvin for his blackness (Ibrahim, 2014), that is regarded as not intelligent (Fanon, 2008). These racial projects are often designed in institutional structures and policies dictated to IMGs and FTBIMD who are marginalized by the dominant culture (Omi & Winant, 1994). Furthermore, Anzaldua (1987) would refer to the "questioning" of Dr. Marvin's knowledge as physical

borderland that is becoming an intellectual borderland. This intellectual borderland is producing continuous challenges for Dr. Marvin in his interrelationships at work as a licensed physician. This intellectual borderland is a good example of what Anzaldua meant when stating that immigrants are continually living on borders in the U.S. (1987). As a FTBIMD, Dr. Marvin can be experiencing racism at his work place.

In my post reflection, I wondered how Dr. Marvin felt at the moment of the encounter. I wondered why he was "under looked" Is it because he is a Black medical doctor "from Africa"? There is no doubt that his being from Africa distinguishes him from American-born blacks. This distinction between blacks as seen in the literature has led to tensions between African immigrants and American-born Blacks (Pierre, 2004). Pierre argues that the representation of Black African immigrants in the U.S., by social science scholars use the concept of ethnicity in a manner that seems to reinforce Black cultural inferiority in a "repackaged culture of poverty discourse" (p.141). From this lens, the ethnic distinctiveness of Black African immigrants is a rhizomatic package of poverty that occurs through the FTBIMDs' connectedness to the lived world of work. The FTBIMDs find themselves in a state of nomadism as they are becoming doctors a second time in the U.S.

It is this supposed *Black cultural inferiority* that Dr. Marvin is trying to disrupt by "proving" himself as knowledgeable and requesting "a written apology" when his knowledge was challenged. Anzaldua's Borderlands theory comes in readily. As an immigrant intellectual, the author was tokenized in education as stated in her writings.

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Anzaldua was "repeatedly tokenized" (Castillo, 2006, p. 260) as she agonized before passing on to eternal glory. In contrast, tokenizing Anzaldua led her to become a great writer and poet. And she encourages new immigrants to develop a consciousness that will help them to resist oppression (1987). Such resistance could lead to a pedagogy of disruption (Leonardo & Porter, 2010). It is this pedagogy of disruption that Dr. Marvin is exemplifying. For example, Dr. Marvin insisted on a written apology from the hospital when he was bad-mouthed and his knowledge was challenged. This is what he said, "I had to push him and the hospital where this happened to request a written apology, otherwise it was going to be put under the rug. The list goes on" (Dr. Marvin, 05/15).

For Dr. Marvin, hardness is ongoing, and he must continue to stand up for himself by focusing on "patient care" even though the "list of discouraging remarks goes on." Because of memories of deeply felt hard experiences, Dr. Marvin's professional identity could be read as becoming. He has to deconstruct continuously and decolonize (Smith, 2012) his identity as "the doctor from Africa" and self-identify as the licensed physician in America providing care to the population.

There is no guarantee that Dr. Marvin will be accepted as a licensed physician at the institution. His identity as a Black African medical doctor could be read as being racialized (Njuie & Letish, 2010) and rhizomatic (Ibrahim, 2014). Drawing on Deleuze and Guattari's *A Thousand Plateaux*, Ibrahim explains that "a rhizome is a constant flow of deteritorialization. It is not a point we reach, and finally, say, we are finally there. Rather, it is a way of becoming that we are forever struggling to attain" (2014, p. 3). In

contrast, he is reconstructing his identity as a qualified foreign-trained Black immigrant licensed physician who is a skilled professional. He focused, doggedly, on patient care in the ontological process of becoming a physician in the U.S.

This example helps us understand that Black identity construction in various spaces in education and the health care system is racialized and stereotyped as not intelligent, inferior (Fanon, 2008) and unprofessional. Knowledge is not inherited but gained through a learning process called education. Qualified and licensed physicians deserve to be respected. Mutual respect in the workplace is a prerequisite for achieving communal welfare, especially in the health care system. Lives have no duplicate. I learned this lesson growing up as a child whose dad was a medical professional. Physicians have a noble job that requires them to have a cool mind to be able to protect the patients as they give care.

Difficulty could be interpreted in various ways, such as finding work as an FTBIMD. The process of finding work is difficult because Dr. Marvin is a Black immigrant medical doctor whose Blackness renders him not likeable. He is stigmatized as inferior compared to whites who are superior (Fanon, 1967). Dr. Marvin may need to wear a white mask to become likeable. Fanon (2008), using his experience as a Black physician, writes that, "the dominant colonial culture…identifies the black skin of the negro with impurity... Fanon's approach in *Black Skin White Masks* focuses on the problems of identity created for colonial subjects by colonial racism; and on the consequent need to escape from this neurosis which colonialism produced" (p. ix). It is

from this colonial lens that colonialism is being produced in the 21st century by neoliberals who are monetizing the health care system by making the Licensing examination very difficult and expensive (Dore, 1967). IMGs, including FTBIMDs, are therefore implicitly excluded from being licensed as physicians in the U.S. because multilayered examinations have produced challenges that have complicated the trajectory of finding work.

International Medical Graduates have been, like their counterparts who were trained in America, "trained to care for people" as all participants in the study passionately stated during the in-depth interviews. FTBIMDs find it challenging to seek gainful employment because medical education and the practice of medicine has a dual standard - one for International Medical Graduates and the other for American trained medical graduates (Dore, 1967). FTBIMDs are more vulnerable than non-black IMGs because besides being foreign-trained, they are black and foreign. Foreignness (Milkman, 2011) stands in the way of IMGs finding work and working in the U.S.

FTBIMDs who participated in this research summarized how they negotiate their identity in the U.S. through finding work and working, highlighting hardness of the process. Though hardness may vary among participants, the bottom-line is that all participants experienced racism in their daily interactions when finding work and working as FTBIMDs in the U.S. The professional identity as medical doctors did not veil their ethnic identity as people of the black ethnic category.

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Specifically, FTBIMDs indicated that they were more vulnerable because of a multiplicity of reasons, such as their race, blackness, skin color, foreignness, and accents - all of which serve as great impediments as documented by scholars. Fanon (2008) writes that:

> "not only must the Blackman be black, but he must also be black in relation to the white man…although my emphasis…. Together we proclaimed loud and clear the equality of man in the world…..the real world robbed us of our share. In the white world, the man of color encounters difficulties in elaborating his body schema" (p. 90).

Article 1 of the United Nations' Universal Declaration of Human Rights, states that "all human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood." Unfortunately, the practice of equal treatment of all human beings still needs to be implemented in the U.S. in education and employment. In this study, for example, there is a clear disparity in the treatment of medical graduates.

FTBIMDs, as IMGs, are conferred certificates of completion from accredited medical schools, but their pigmentation and ethnicity are a challenge in seeking employment and also in being treated with equal respect as physicians in the U.S. The racialized stratification in the medical profession leaves IMGS in general and FTBIMDs in particular underemployed because of their blackness. When FTBIMDs are licensed

and employed like Dr. Marvin, the culture of inferiority still plagues them because they are racialized.

Black is an identity created by the dominant white privilege culture to perpetuate the unfortunate legacy of slavery, dehumanization and racial discrimination against people of African descent. Black is, therefore, a label that renders skilled immigrant doctors as subalterns (Ibrahim, 2012, Fanon, 2008) and also leaves them at the bottom of the Labor Queue in the United States (Djambe & Kimuna, 2011).

Dr. Fred expressed "hardness" differently:

Dr. Fred: It is hard to find a job. My credentials are not acceptable. I am being rejected.

Charity: why do you think you are being rejected?

Dr. Fred: The system is fragmented. The American medical board accepts our credentials, but the Nursing Medical Board does not accept our credentials.
I have to do a job to feed my kid. I have to be considered as a GED to have a job. A high school graduate. I have a sense of helplessness because the system works for me. Being educated seems to be a liability instead. The right hand does not know what the left hand is doing.

Dr. Fred: what I say to myself is, am I helping people?
Immigrant medical doctors even with the experience they cannot practice in the state.
If you get lucky to be accepted or there is no middle ground.

Charity: what about alternative pathways?

Dr. Fred: We are Medical doctors who have been trained, we have to fight. The program is underfunded. This is leading to limited spots.

Charity: What do you mean by limited spots?

Dr. Fred: There are least 60 FTMDs who have taken all the examinations. To get certified somebody needs to have passed the Step 1, Step 2 to be eligible. It does

> not guarantee acceptance into residency. We have certificates and experience, but we are not licensed so we cannot practice. The Bill passed by the legislators in Minnesota provides three positions. It is a sign of good things to come for which we are grateful (Dr. Fred, interviewed on, 07/15//15).

Dr. Fred's response to the research question is that "it is hard to find a job" because "my credentials are not being accepted." This response can be read as non-recognition of his credentials produced hardness in finding a job. Drawing from Borderland theory, I make sense of what Dr. Fred is expressing. Dr. Fred seems to be alluding to an apparent academic borderland that is producing hardness of the process of finding work in the U.S. for him. Hardness, in turn, is being transformed in Dr. Fred's lived realities as he connects and relates to the world of jobs. This interconnectedness with his lived world further produces rejection. Rejection could be read from various angles. His experience seems to be cyclical and rhizomatic.

What does "I am being rejected" mean to Dr. Fred? Why does he feel he is rejected? In *The Melancholy of Race*, Cheng (2001) refers to her identity as an immigrant and foreigner to say that "it is the foreigner within me that most eagerly needs to understand the web of American racial dynamics and their particular articulation of aspirations and rejection and expulsion" (p. xii*).* Racial dynamics produced rejection and expulsion for Cheng. And, in the same vein, racism is producing hardness leading to rejection and hopelessness for FTBIMDs.

Similarly, hardness as a result of racialization has produced a rejection of some form for Dr. Fred, a qualified IMG who "had to feed" his family and had to be

"considered as a high school graduate to have a job". His identity is being constructed as a subaltern as some researchers have documented (Fanon, 2008; Ibrahim, 2014). Fanon (2008) referring to his experience as a Black physician posits that "the Black man is a toy in the hands of the white man…. Yet with all my being I refused to accept this amputation" (p. 29). Despite being identified as toys, Fanon inspires his fellow IMGs to resist such stigmatization. The participants in my study understand that the process of licensing international medical graduates is difficult. The hardness of the licensing process has produced innovative ways of being part of a possible solution to the licensing process.

All thirteen participants in the study responded that it is challenging to the first research question.

It is challenging. This initial tentative manifestation led me to get into a further conversation with the various theories that frame this study. The goal here is to see what meanings will open up from the tentative manifestations. I begin with Gloria Anzaldua's Borderlands theory in her book, *The Borderlands. La Mestiza (1987).* Writing from her experiences as an immigrant and feminist scholar, Anzaldua posits that,

> Living on borders and on margins, keeping intact one's shifting and multiple identity and integrity is like trying to swim in a new element, an "alien" element…not comfortable but home' ((1987, preface).

Dr. Marvin's experience as a licensed physician working with a medical team in a hospital can be likened to trying to swim in a new element, an alien element. He engaged

the hospital by demanding an apology when his knowledge was questioned in a case where he actually provided appropriate care for a patient including a treatment plan that was effective.

Dr. Marvin's resistance to tokenism is very instructive here. Though racism may be on-going, developing a coping mechanism and resisting quitting is one way to decolonize (Smith, 2012) the workforce system.

Anzaldua's lived experience as a scholar is one that all scholars of color and especially Black immigrants can identify with. Anzaldua lamented before her death that she was "repeatedly tokenized" Castillo (2006, p. 260). Anzaldua uses the word "tokenized" to express how she was exploited and not acknowledged for her work as a scholar. In fact, Anzaldua "felt drained of the energy" as noted by Castillo (2006). She resisted this tokenist identity by embarking on her scholarship. Tokenizing Anzaldua was not a hindrance for her to pour her heart into the poetic writing of the Borderland. The new Mestizo highlighting the "Mestizo identity" or hybrid identity is one that most second-generation immigrants can be defined by in education. The impact of Anzaldua's work can be read from the eulogies about her. In Eulogy, "an open letter" about Anzaldua, it was stated that "your border theories have provided a model for Americanist scholarship of the twenty-first century and a foundation of thinking and writing about the multiple histories, languages, genders and racial realities that are converging in this great cornfield American life and culture" (Castillo, 2006, p. 261). Black immigrants using the lens of hybridity and border theory could use Anzaldua as a model to write and perform

their lived experiences and decolonize the imposed and amputated identities (Fanon, 1967) constructed for them.

Furthermore, each participant's experience and intentional meanings of the phenomena finding work and working is contextual. Lensmire (2001) writes that "finding your voice involves looking to your own experiences" (p. 58). It is from this perspective that the excerpts from participants' response to the research questions are presented and analyzed. The interview of Dr. Rita is instructive.

> *Charity: How might finding work take shape for you as a foreign-trained Black immigrant medical doctor in the U.S.?*
>
> Dr. Rita: It is challenging.
>
> *Charity: Tell me more.*
>
> Dr. Rita: The exams themselves are so detailed the competition is so much. Some come with the J1- visas have the positions. They come as exchange students- people who migrated to America like us for family reasons, I do not have the same opportunity as J1 visa holders. Most of us were trained back home, but it is not the same thing, but the teaching is different, conditions are different.
>
> *Charity: What conditions are different?*
>
> Rita: back home, you have diseases like malaria, a tropical disease which are treated with specific protocols. In the U.S. technology is sophisticated, we can learn to use this new technology once in residency. They consider taking people with J1 -Visa. They came as exchange students. It is harder for us who migrated into America to get slots for residency. It takes too long to study and pass the examination.
>
> *Charity: Any other challenge?*
>
> Rita: Time is a challenge. It takes too long to be incorporated into their system here. To get into USMLE exams, you get into the matching program which is also complex. When you are accepted, you still have to go through the residency

> program. Unlike the UK some friends of mine who are there told me you just do the exam, and you get into the program. (Dr. Rita, interviewed on, 11/17/15).

Dr. Rita asserts herself as a medical doctor and expresses the challenges related not only to writing the examination but also getting a residency slot. Dr. Rita says, "It is harder for us who migrated into America to get slots for residency." My post-reflection made me wonder whether it is easier for foreign-trained medical doctors to get into residency in other countries. And this is Dr. Rita's response: "Unlike the UK some friends of mine who are there told me you just do the exam and you get into the program." By bringing in her friend's experience in Britain, "where you get into the program after you pass the board examination," she faults the process of licensing physicians in the U.S. She immigrated under the Family Reunion Act of 1965, which allowed her to join her spouse. She is appropriating her right as a legal and skilled immigrant who should be given priority over any J1- Visa IMG, entitled to get into residency. I wonder why she brings in the medical doctors who come with a J1 Visa sponsored by employers. Is this part of her frustration? How can this frustration be alleviated? Who is in charge? Could the U.S. compare their licensing system with other countries? These are all questions I raised in my reflection journal (07/12/16).

My reading of Dr. Rita's utterance is that as a young mother, Dr. Rita sees "time" as a challenge because "the board examination is competitive" and needs a substantial time investment to expect to have high scores on the first attempt while nurturing children at the same time. Drawing on Anzaldua (1987), Dr. Rita could be said to

becoming conscious of her identity as an international medical graduate in the borderlands. Physical borders follow her everywhere as different racial groups intermix and compete for resources. That is where the examination becomes competitive. And, "the mestiza's dual or multiple personalities is plagued by psychic restlessness. In a constant state of nepantalism, an Aztec word meaning torn between ways, La mestiza is a product of the transfer of cultural and spiritual values of one group to another" (p. 79). Dr. Rita appears to be torn between two worlds, the United States of America and her home country.

In her nation of origin, Dr. Rita's professional identity was a practicing physician. She did not need to compete for resources with other practicing physicians. She would not be torn between ways. First, in her nation of origin and culture, time is elastic, and there is no competition. Second, her extended family would be available to help with babysitting in the spirit of togetherness because "it takes a community to raise a child" and the spirit of "I am because we are" Ubuntu, the African philosophy of education. I could relate to her frustration as an African woman who had her children in her nation of origin. I had adequate help from family members who were babysitting my children often with no salary while I pursued my professional career as a lawyer. At the time, I knew some of my family members were helping me babysit and I in turn, helped them by providing their basic needs and making sure they learned a trade, such as sewing. Now I feel guilty for doing that and I have confessed to God and asked for forgiveness for not putting these family members who served me as babysitters on a salary and not sending

them to school as full time students. Furthermore, I hope to contribute to the rectification of the babysitter culture and child labour by serving families in need of child care. The services I hope to render through a community based organization would be geared towards educating parents who need child-care to give babysitters the opportunity to go to school at some point in their living together, thereby promoting the right to education as stated in Article 21, of the United Nation Declaration of Human Rights (1948). The right thing would be to disrupt the culture of babysitting that hampers the education of family members, especially young girls, by establishing daycare centers. The reality is that the degree of poverty in most developing countries does not allow parents to afford daycare centers.

In contrast, living in the borderlands in the U.S. as an immigrant and professional woman, Dr. Rita must pay for babysitting because she has no family members in the U.S. to babysit her child. However, she does not make enough money from her temporary job as a scribe in the hospital to pay for the babysitting, which is provided by licensed daycare centers.

In my journal, I wrote my observation of Dr. Rita at a peer support meeting with her two-year-old daughter. Her daughter was restless, and Dr. Rita could not make the child stay quiet so that she could fully participate in the peer deliberations. At the end of the session, I observed Dr. Rita interacting with a resource person assisting IMGs by providing resources and also advocating in this process of licensing. This is what the resource person said, “You do not have to come to the meeting with the baby, and this is

distracting. Next time tell us ahead of time so that we can arrange for babysitting." I saw Dr. Rita's embodied reaction as being powerless. She appeared as a moving corpse; a *body without organs* (BwO) (Deleuze & Quattari, 1987).

As we walked out of the building, I patted her on the back, and she smiled in her agony. I said 'stay strong' and she smiled again. That was the last day I saw her at the peer support meeting. Reality had hit for her - no full-time job to pay for a daycare center to babysit her child so that she could focus on preparing for the licensing examination. Dr. Rita had brought her baby to the peer support group meeting because she could not miss the peer support meeting deliberations that serve as an inspiration for her to become licensed someday. Even the organization that advocates for IMGs did not seem to meet all her needs. She is frustrated because she must study for "the competitive board examination."

Also, Dr. Rita gives evidence of other nations assisting IMGs without making them go through a gruesome and frustrating process like in the U.S., where she resides. She appears to appropriate her right as one who came to meet her spouse as provided by the family reunion immigration law.

Nevertheless, the licensing process is difficult for participants depending on their positionality. Experienced and older IMGs who graduated from medical school more than 10 years ago face a lot of difficulties taking the USMLE. Here is an excerpt from my interview with Dr. Karla:

> *Dr. Karla*: It is quite difficult. Before you work here as a doctor. You need to be accredited to work in the U.S. You need to go through board exams and internships. Then you go for certification. There is no short course. It is not easy for you. You need to go through licensing process before you go to certification. You cannot get a salary as a doctor. It is not a short course.
>
> *Charity: What do you mean by it is quite difficult?*
>
> *Dr. Karla*: Writing the exams is difficult. It is difficult in the sense that you have to go through several stages. You pass one stage you go to another it takes… You have to go through different boards to qualify you for the exam. The exam involves basic sciences in the first and second year in the university. Things that you learned 20-30 years ago. You go back again. When you finish basic sciences, you have to go to physiology you have to work very hard.

Dr. Karla, who has been practicing for more than 20 years, expresses his frustration with the examination requirement based primarily on basic science subjects that he had been applying in his work. Taking the test, therefore, requires going back to the basic science subjects he studied decades back. He found it very hard. To his credit, 20 years of experience as a medical doctor is enough clout to warrant consideration. Taking work experiences of IMGs including FTBIMDs into consideration for matching IMGs in the licensing program would be a way of harnessing the skills and talents of FTBIMDs and expanding residency slots.

Though Dr. Karla finds the examination requirement to be hard, the need for some training for IMGs before being licensed to practice cannot be compromised. Nowhere on earth can non-natives adjust in a new place without an immersion program. Thus, non-natives in America - specifically IMGs - need an emersion program that would help them go through the licensing process with reasonable ease. The content of the

program is what matters. If an immersion program is developed to assist IMGs to transition into residency, this would help lessen the disparity in the treatment of all medical graduates; it would be a step in the right direction. Furthermore, a residency program that treats IMGs the same as American Trained Medical Graduates (ATMGs) with parity could diminish the difficulty of the licensing process.

Skilled immigrants joining their families in the U.S. aspire to transition into the workforce after training without a lot of challenges. However, the reality is that the challenges abound because these immigrants live in hybrid spaces which are bound to be conflictual because of the mixture of various cultures. In brief, there is culture clash (Anzaldua, 1987). These challenges produce varying effects in participants' lived worlds. This is what Dr. Amy said:

> Finding a job when I first moved here was frustrating. I came with my medical degree knowing that I could not work at the hospital as a physician. However, I thought I could find a good job with my background. Especially one that will leverage my skills. I realized after a couple of months of seeking for a job that it was not that easy. I quickly understood that I had to adjust. It will then be an emotional and psychological adjustment because I realized for the first time that I had to look for "non-skill" job despite my level of education. I would say that the only job I could do at that time was to be a personal care assistant. Just moving and dreaming, I had to get off my pedestal because I knew that I am a doctor who diagnose and treat disease.
>
> Going through that process was very frustrating and depressing. Even today, I still struggle with it but it is not as it used to be. I have to accept not practicing the job I wanted all my life to practice. Adjusting myself from once being a physician to having no label, no credentials or simply no profession was hard. I will say if you don't live the experience it will be hard to understand what immigrants like me go through emotionally and psychologically in such situations. What keeps me moving every single day is the support of my husband and the little voice in my head that said, there is still hope to have a better life?

> I do believe my background education is likely to be a challenge when I am looking for a job here, because American Education System and culture are quite different with that of my country. For instance, in my country, English is my second language. We use and treat English as an academic language and not our daily communication tool or language! The more advanced medical technology that the U.S has, is another example of challenge I am likely going to face!! Dr. Amy, interviewed on, 02/22/16).

Dr. Amy's interview could be summarized as challenges that produced hardness, and hardness, produced adjustment for her. That is why finding work is "frustrating" and "depressing." Dr. Amy said, "adjusting myself from once being a physician to having no label, no credentials or simply no pay." Race relationships seem to serve as a great barrier to FTBIMDs finding work and working in the U.S. These barriers are macro and micro racial projects (Omi & Winant, 2015). It can be read from participants' voices that their experiences finding work and working are a social struggle.

Voice as a social struggle is "the struggle to Use something old to do something new" (Lensmire, 2000, p.79). It is challenging and tedious for the FTBIMDs to find work with their medical degree. They have to take the United States Medical Licensing Examination, and pass and then apply for residency through the Match Program. Meanwhile, they have to do "side jobs" at "a high school level to survive." Though they are a skilled labor force, they do non-professional jobs to survice, including scribing and interpreting. In this regard, they are using their most basic skills to do side jobs, something new to them in the continuum of their professional lives with multiple identities.

Like in all countries in the world, adjustment takes time (Berry, 1989). There must be a period of retraining to ensure performance. The challenges mentioned by these participants indicate that this period of adjustment i, hard, complex and endless. These hardness hurdles could be read as the licensing system having dual standards, one for American-born citizens and American trained medical (ATMD) doctors, and another for IMGs or FTIMDs. Such dual standards render the FTBIMDs subalterns (Ibrahim, 2014). Such marginalization and racialization are what Omi & Winant (2015) refer to a way of "making people up" to fit the neoliberal purposes of the dominant culture. Also, race "is crossroads where social structure and cultural representation meet".

Omi and Winant (1994/2015), in their racial formation theory, refer to racialization as the process of categorizing bodies and skin color. Bodies are hierarchized and attributed a label and meaning (Omi & Winant, 2015) in a social context. Race, therefore, organizes bodies on a hierarchy with white as superior bodies at the top and Black bodies as inferior bodies at the bottom.

Furthermore, Omi and Winant (2015) argue that "race is seen as a social category that is either objective or illusory" (p.109). Objectively, race could be grounded in a *biological difference for example, skin color or hair texture. However, race is regarded* as "an illusion when it is an ideological construct" (Omi & Winant, 2015). *Three paradigms, ethnicity, race* and *nation* blur the difference between objectivity and illusion (Omi & Winant, 2015). It is through this lens that the reading of FTBIMDs' experiences in finding work and working in the U.S. is a "challenging endeavor." Omi and Winant

(1994/2015) argue in their racial formation theory that "throughout the U.S. history race has provided a 'template' for the patterns of inequality, marginalization and difference" (p.1). To this end, race as a template for inequality classifies people from different ethnicities in ways that render whites to be the superior ethnic group as opposed to Blacks, who are regarded as an inferior ethnic group. Adjusting to such inferior status is apparently a "challenging endeavor for FTBIMDs".

Furthermore, challenging endeavors could be a racial project. Racial projects are a fundamental principle in the racial formation theory. Such projects are either macro or micro (Omi & Winant, 1994/2015). Micro racial projects occur in everyday interactions However, a micro racial project could grow into a macro racial project. For example, to national and local policies, such as No Child Left Behind (NCLB) Act, 2001. Thankfully, the Every Child Succeed (ECS) Act, 2015, a new and more equitable policy, has been put in place to serve all children tangibly. Micro projects occur in daily interactions in a social context (Omi & Winant, 1994). All participants in this study made references to the phenomenon, finding work and working as being challenging.

Such challenging endeavor propagates racism, inequality, and marginalization because whites then appropriate privilege, at times, by learning to be white (Thandeka, 1990), while blacks are subjugated and oppressed in various ways except where they assimilate by wearing a white mask on their blackness (Fanon, 1967). Wearing a white mask is a survivalist strategy which some black immigrants adopt and which Fanon (1967) resents. Race relationships seem to produce challenges that are transformed into a

great barrier to FTBIMDs finding work and working the U.S. That is why finding work is difficult or challenging to the participants in my study.

Frantz Fanon, a post- colonial theorist and Black physician, helps my understanding of the continuum of racialization of Black immigrants in general and FTBIMDs in the U.S. in particular. Fanon (2008) writes, “the white world, the only decent one was preventing me from participating. It demanded of me that I behave like a black man or at least like a Negro. I hailed the world but the world amputated my enthusiasm” (p. 94). Fanon shares his experiences as a black physician who felt racialized and isolated in various spaces. In the same vein, FTBIMDs experience racism and exclusion as they live through seeking employment as physicians in the U.S. Finding work and working as a phenomenon manifests itself as a “challenging endeavor.”

Foreign-trained Black immigrant medical doctors experience several challenges in their trajectory of finding work and working as physicians in the U.S. The process of licensing seems to be too complicated and filters out FTBIMDs. The multilayered United States Medical Licensing Examination (USMLE) that is normally taken by second-year medical students in the U.S. proves to be difficult. The process of licensing requires a great investment of time, money and devotion to prepare and pass all the examinations. However, passing the examination does not guarantee entrance into any residency program. International Medical Graduates (IMGs) have to apply to several programs and get matched. There is still no guarantee that they will get into the residency program.

Hence, the FTBIMDs see their *enthusiasm amputated* in this continuum of the phenomena of finding work and working in the U.S.A.

Finding # 2: The residency system is complex. The residency/licensing process for International Medical Graduates (IMGs) is complex. This complex road map to licensing foreign-trained medical doctors as seen in the literature is frustrating to many skilled medical doctors who are legal permanent residents of the U.S. The complex licensing process exhibits a double standard (Dore, 1967) one for IMGs and another for American-Trained Medical Graduates (ATMG).

The complexity of the residency or licensing system (Dore, 1967) illustrates it as a racial project, a fundamental principle in the racial formation theory (Omi & Winant, 1994/2015). Racial projects refer to the structure and significance of racial ideology and practice. For example, a racial project categorizes people according to their racial identification and the hierachization of resources at the macro- or micro- level. Macro racial projects are ingrained in national and state policies while micro projects occur at the individual level in everyday life (Omi & Winant, 1994/2015). The multiplicity in the residency system where there is no guarantee could be racial project. International Medical Graduates not only have to prove that they attended accredited medical schools; they also must continually demonstrate their intellectual capability. Dr. Marvin for example has “to prove” himself in the continuous process of becoming a physician in the U.S. even though he is licensed. To say the least, the residency and licensing system appear to be systemic racism, which unfortunately Omi & Winant do not address as noted

by Feagin & Elias (2012). The authors offer a critique of racial formation theory (Omi & Winant, 1994). Feagin and Elias (2002), argue that the racial formation theory does not explain the depth of racial oppression in the U.S. In contrast, the authors propose systemic racism theory that is grounded in power relations unveiling "racial meanings" in lived realities of domination and oppression.

Omi and Winant (2015) address the issue of systemic racism by stating that "race is both a social/historical structure and a set of accumulated signifiers that suffuse individual and collective identities, inform social practices, shape institutions and communities, demarcate social boundaries, and organize the distribution of resources"(p. 125). These racial meanings are read from the voices of FTBIMDs as an assemblage of tentative manifestations. For example, IMGs also have to prove that the knowledge acquired in medical schools can be translated into practical use. That is why the first requirement for IMGs in the licensing system is to be certified by the Educational Commission for Foreign Medical Graduates (ECFMG). This apparent macro racial project that seems to be engineering the politics of exclusion, fostering inequality, and marginalization (Omi &Winant, 2015) of IMGs in general and FTBIMDs specifically.

The Educational Commission for Foreign Medical Graduates (ECFMGs) is charged with assessing the preparedness of IMGs to get into a residency program in the United States *that are accredited by the Accreditation Council for Graduates Medical Education(ACGME)*American Medical Association website (2016). The ECFMG administers the multifaceted examination; Step 1; clinical knowledge (CK) and Step 2;

clinical skills (CS). This examination requires IMGs to score above *75%.* Passing with a high score, like 90% does not guarantee a residency position.

All participants interviewed refer to the complexity connected with licensing, USMLE, and the Match Program. The ECFMG govern physician licensing process (Traverso & McMahon, 2012) in the U.S. The complexity of the residency process is reflected in the utterances of the participants. I begin with Dr. Fred expressing his disgust with the unending residency process.

> Dr. Fred: The main problem in any high stake exam, somebody has to work hard. The educational commission for foreign medical graduates (ECFMG) we have is not only passing, but after passing the exam, there is no guarantee to get into residency. It is discouraging. I have spent this much time, and there's no return on the investment. The help we get from people does not have any proceed on it. Because, we do not get into residency. The help we get from the Community-based organization assisting U.S., a presentation from elected officials and funding to help U.S. write the exam does not yield fruit. The exam itself is a hidden cost that is an uncalculated financial expense. I was not able to visit my mom. She passed away while I was studying for my examination.

Dr. Fred acknowledges that the USMLE are very important examinations. However, he is frustrated with the fact that, "there is no return on the investment" on the time and money invested in studying and paying for the examination. The help IMGs receive from CBOs, "financial assistance to pay for the expensive USMLE does not have any proceeds on it." The expected return of wages if admitted into residency is bashed. Why? Because passing the examinations does not give him a chance to get into the residency program. I draw on Anzaldua (1987), *Borderlands, la Frontera,* to read this barrier of getting into the residency program as an academic, intellectual and professional borderland. The

borderlands are perhaps one reason why Dr. Fred says "we have not only to pass the exam but also there is no guarantee to get into residency." The trajectory for FTBIMDs seems endless and fruitless because it is fraught with uncertainties. The multilayer USMLE produces complexities that are transformed into uncertainties.

Losing his mother when he was writing a multilayered examination remains an unforgettable experience. In Dr. Fred's words, "I was not able to visit my mom; she passed away while I was studying for my examination." The death of his mother produced frustration in addition to the uncertainty of getting into residency. Fanon (2008) would interpret this frustration by asserting that "the real world robbed us of our share in the white world the man of color encounters difficulties in elaborating his body schema. The image of one's body is solely negating. It is an image in the third person. All around the body reigns a certain uncertainty" (p. 90). My reading of Fanon's assertion is that Black bodies are not sure how to get into the licensing program, which appears to be a white space. It is for the same reason that Dr. Fred expresses his frustration with the licensing process as being "pro-American." That is why there is no guarantee to get into residency for FTBIMDs.

Initial tentative manifestation as no guarantee. Getting into residency is uncertain because there is still no a guarantee that one will be licensed. The reason is that IMGs face multiple barriers in residency including language, culture, discrimination, and isolation (Chen et al., 2012). Chen and colleagues found that "despite a long history of international medical graduates coming to the United States for residencies, minimal

research had been done to find systemic ways in which residency programs can support IMGs during this vulnerable transition". (2012, p. 1). Seeking answers to support IMGs in the U.S. is fundamental in this study. In my interactions with the participants during one of their peer support group sessions, I noticed hopelessness and helplessness on almost everyone's face in that space. An international medical graduate who was attending the meeting the first time and was narrating his story about residency. We all listened in disbelief as we heard and felt the intensity of the racism he experienced as a Black man while in residency. He was told that he was not fast enough to diagnose patients and some other things he could not say for fear of being tracked. I noticed a pedagogy of fear (Leonardo & Porter, 2010) that has been on-going with the IMGs. Leonardo & Porter argue that a *Fanonian theory of safety around race dialogue* is customary in education and employment (Leonardo & Porter, 2010). Safety in the public space continues to be a theme among participants. Dr. Joe's being fearful is understandable because he had been dismissed from a residency program. He has to be careful with whom he is mingling and what he is saying because his shouting Black body is vulnerable.

Dr. Joe concluded his story, "I was let go from my residency program after almost one year into the program. I have been a dead man since then; I am just resurrecting" (Personal communication, with Dr. Joe 04/07/16). His story in an informal conversation corroborated the stories of participants in the study, to indicate that there is no guarantee of licensure in the residency program, especially for FTBIMDs. The

licensing system could be read as being very racist, political, and complex (Dore, 1975). This complexity is seen from the requirements including: high scores in USMLE, strong recommendation letters from people who know you, to apply and be accepted into residency, and the categorization of the various specializations. By putting the specializations in a hierarchy, only the privileged few non-white doctors would get into highly graded specializations like surgery. The few non-white IMGs who may score very highly in the USMLE are placed in the least demanding areas like primary care. High scores in the USMLE could be read as a macro racial project (Omi & Winant, 2015) that exemplifies discrimination. Such injustice needs to be addressed by revamping the current system.

The humane bottom line may be that FTBIMDs should be treated justly. Rawls (1971) writes that "Justice is the first virtue of social institutions as truth is of systems of thought. Theory, however, elegant and economical must be rejected or revised, if it is a virtue: Likewise, laws and institutions no matter how efficient and well-arranged must be reformed or abolished if they are unjust" (p. 4). Given the unjust system of licensing International Medical graduates, the need for reforming the residency system cannot be overemphasized.

There is no guarantee that getting into residency implies an opportune use of resources. Pierre Bourdieu (1986) opines that cultural capital "explains the unequal scholastic achievement …… originating from different social classes relating to academic success" (p. 47). In the same light, the normalizing discourse of Black inferiority is also

seen in the fact that passing the USMLE does not give applicants entry into the residency program. IMGS, including FTBIMDs, experience discrimination in various social contexts. IMGs are prone to discrimination because of their nation of origin, and language and other biases (Desbiens & Vidaillet, 2010) during residency.

Licensed physicians are still being treated with skepticism. Dr. Leah, who is now a licensed physician, did not have it easy either. She said:

> It took me more than four years. More than four years. I had kids at that time I wanted to find a spot in the state (in the Midwest) because that is where my husband was, that is where my kids were I just couldn't, and then I started applying outside the state. Eventually, I was offered a spot in (out of state on the East Coast). And I had to leave my family here and went over there and then. I did my first year. I then I came back again, I came back again looking to reapplying to continue the second year at the University in the Midwest because I can do this. I looked into applying to get into the second the year at the at a local university in the Midwest)
> I was told to reapply, and they will be no guarantees. Reapplying to continue my second year at the (University in the Midwest) and they said no I had to re-apply as a first year applicant and there was no guarantee, so I went back to the East Coast and completed my residency. (Dr. Leah, interviewed on, 04/03/16).

It is disturbing to hear that an international medical graduate passes the USMLE and applies for a residency spot, but cannot be given an opportunity after four years of waiting to get into residency. Dr. Leah said "it took me more than four years." What did that mean? I wondered. Fanon affords some answers for us. Fanon (2008) writes, "color prejudice…. It was hatred; I was hated, detested and despised not by my next door neighbor or a close cousin but by an entire race" (pp. 97-98). Racial discrimination appears to be engraved in the physician workforce system.

One may also question why there is no guarantee to get into residency after passing the multilayer examination. A Land Grant University, which is internationalizing its campuses, should not give this image of discriminating against Black medical doctors to the world in an era of globalization. In contrast, data from one participant who got into residency in a Land-Grant University in the Midwest shed light on the issue of admission into a residency program. His example enabled me to understand that an IMG who scores highly in the USMLE on the first try and knows someone in a licensing program has a chance of getting into a residency program in a renowned university.

*Initial tentative manifestation as, you need to be known***.** The last aspect of the complexities of the residency program is that it is "who you know" or you have to be known. Being known refers to the relational system (Chhuon & Wallace, 2012). In the context of licensing International Medical graduates, being known could be termed a filtering system put into place to filter applicants in the match program for residency by their intentional relationships and connectedness in the society as verbalized by a majority of participants in my study, including licensed physicians. Dr. Marvin, who is currently practicing in a local hospital, is married to a white woman whose network has been very instrumental in helping him to access resources to get into the residency program.

> The process for me to get back into medicine had two starting points: 1) I was doing my self- study (like I did with English) and bought books on Amazon Biochemistry and physiology books. I would read these books on my spare time. 2) A relative of my wife found an article in the Sunday morning paper and brought it to my in-laws where I was still living. I emailed the addresses in the article (AAFCD and International Institute of Minnesota at the time). I heard

> back from the IIM within a couple of days. My wife and I went to meet with IIM. I happened to be the last person getting the state grant allocated for that course back then.The funds were not meant for Step 1&2 but enough for me to start Step 1. I later paid the rest of the needed money out of pocket. I should say my wife and I contracted a credit card debt of about $ 5,000, as I was not making much money at the time working as nursing assistant part time.
> I, fortunately, put all effort I had into being disciplined and determined to make most out of my opportunity to pass USMLE and become a Doctor again. I passed step 1, the first attempt with the 94th percentile of score back then, and about 7-8 months later I passed Step 2 CK (clinical knowledge) with 97th percentile and Step 2 CS (clinical skills) first attempt.
> Continued to work as part time nursing assistant while doing all this.
> When came the moment when I was in critical need for observership for a letter of recommendation, one of my wife's relatives has a friend who is a medical doctor. A dinner meeting was arranged with him and he took me in for twice a week full day observership starting at the hospital finishing in the clinic. I did that for about five months. He was very kind to introduce me to one of his colleagues that I followed. They both provided me two letters of recommendations. I had my previous mentor in medical school back home and my previous boss (the two years I worked after I graduated from school at home) each write me a letter of recommendation. My ERAS application package was ready.(Dr.Marvin),

Dr. Marvin was fortunate to have friends and family members of his wife who were very resourceful in helping him, “get back into medicine.” Getting back into medicine is a way of adjusting into his professional identity as a physician. His intentional relationships with his wife’s networks birthed the opportunity for him.

Dr. Marvin “being known” produced relevant information about assistance for International Medical Graduates that was published in a Sunday morning newspaper. Dr. Marvin was able to receive a scholarship from two community-based organizations to pay for the costly USMLE examination. After receiving funding for the examination, his status was transformed. He had access to those material resources because he was known. The need to be known produced the opportunity to get into residency. Dr. Marvin put in

his best effort and scored very highly in both required examinations. The second phase where his "being known" or who he knows played an important part when he needed letters of recommendation for observership. His network relations again stepped in to rescue him when he was in "critical need." He intimated that "one of my wife's relatives has a friend who is a Medical Doctor… who took me in" after a dinner party was arranged with the family. It is obvious that he got an observership with this physician, a family friend, because he was known and connected to the doctor through his wife, a white American woman. Furthermore, this physician also introduced Dr. Marvin to another physician who also gave him observership. After Dr. Marvin had completed the five month observership, he received a second recommendation letter to add to his residency application in the match program. Dr. Marvin said "my application package was ready" for residency. He was eventually given a residency slot at a University in the Midwest. If he had not been known by people, he might still be in the queue for the residency program.

Being known is very important in the practice of medicine in the U.S. Being known builds trust and dispels fears as stated vividly by Dr. Lesley:

> Because I don't know you, I do not know your country, what kind of medicine are you going to practice? Programs are looking and saying they are not good enough. The hospitals have to keep their reputation that they are not being sued by patients.
> You have to apply to a program when they admit you then they have to look for the hospitalist, so that is the mountain.
> Which hospital will take you, they will ask you did you really go to medical school? Say the president of a hospital you don't want any patient to die by mistake from a doctor you want to be sure that this student is safe, and you don't

> want to be sued, and you don't want anybody to be sued you don't want any person to die in your hospital
> I don't know you, I don't know your country, and it is like a business, Life is very important
> For instance, when you drink alcohol, and you get arrested first and foremost because you are in danger of killing somebody else, do you see that the police is taking you for killing people, you can choose, it is that kind of outlook on other people's lives.
> If you employ a doctor from Africa when they don't know
> What kind of training they went through, where they are trained, people will run away if they see five foreign-trained people when they are training around they will run away.
> I if I come to his hospital I would say I you hear the names of immigrants Chinese, African name. Patients choose their doctors
> Most Africans choose to go with the Chinese. These are patients they choose with whom to enroll. Those who qualified for residency they work. Unless you are a hospitalist, then you are paid a salary. For example, Meridian hospital (pseudonym) who employs doctors who are known as hospitalist then there are other' hospitalists who have faculty associates, who would like to employ other associates. They bring finances to the hospital based on the people they see the insurance is paid
> If you are a doctor; you are also paid by the insurance
> Your salary is not fixed it depends on how much money you bring in.
> If you are a foreign-trained, and your name is so complicated are only seeing two people a month, and with time they cannot sustain. When you do not bring enough money to sustain an association of people each month, they can't sustain you, the salary will be so little.(Dr. Lesley,interviewed on, 03/24/16)

Dr. Lesley used metaphors (Lakoff, 1980) to describe the complexities. In expressing her interpretation of the complexities of the licensing system, she seems to mock the categorization of IMGs into people who are not known; she referred to the complex licensing system as "mountains." She said this mountainous process was like going through two mountains. The first mountain is the USMLE, and the second mountain is the Match program (licensing program). She makes connections between the names of Black doctors and their skin color as a barrier to their getting into residency. This

figurative description of the licensing process as a “mountain” kept me wondering after the interview. In my post reflexion journal, I asked the following questions to make sense of her utterance:

Why did Dr. Lesley refer to the process as a mountain? What is a mountain? Is it because the licensing process is difficult or challenging? I wondered. Does it need many resources to climb? Will the process be tiresome? It is possible to get to the top? Can one easily give up? Are there alternative pathways? Is the mountain indicative of the double standards in the licensing process? Is there a remedy? These unanswered questions kept me wondering. How can the licensing process for IMGs be reviewed and revised to make finding work and working easier for skilled workers like IMGs? Answers to these questions are continually being elicited (Post-reflection, 03/24/16).

Dr. Lesley realized that this mountainous process of becoming a doctor a second time was not worth it. First, she had been working as a physician for over ten years before coming to the U.S. from a refugee camp. She decided to give up the pursuit of licensure and prioritize the education of children for the family wellbeing.

Visualizing the tedium associated with climbing a real mountain gives one a glimpse of what it is that IMGs are compelled to go through to become licensed physicians in the U.S. Other participants had different views regarding the trajectory of getting into residency. Some were convinced that their country of qualification is responsible for their not getting into residency.

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Country of qualification. Healy and Oikelome posit that, "In the UK and the U.S.A, ……country of qualification is a major determining factor where doctors will work, what will be their specialties, and their relative disadvantage and degree of mercerization" (2007, p. 1928). These authors noted that country of qualification was taken into consideration when matching applicants for residency. My reading of the country of qualification is an exclusionary factor in the licensing system in the U.S.

Specialization. Another important factor in residency is the type of specialization. The licensing institutions in the U.S. appear to have a ranking system for specialization, which seems to be discriminating against IMGs. Black immigrants from Africa, for example, are excluded from the matching process. These programs are not being inclusive of Black African immigrants as opposed to U.S. born-American citizens. I will present a few here.

> Dr. Bob: The application for residency is rightly pro- America year in year out, the rules keep changing for immigrants. There are hoops. They cannot get good letters of recommendation. The number of years from graduation and cost of just the application are a challenge. When you are thinking of immigration, you are thinking about the examination. I did an observership. The doctor liked my knowledge, but he was skeptical whether I could take the patient's history at first. I was stunned at his question. The hoops are made narrower and narrower. Sometimes it is a person to person it always comes with hard work. I have learned when to move forward and when to hold back. During my interview, the clinical director asked about the schools in Africa. Just talking to kids you will know more. Out of American borders is not just Europe. People are not well informed about the rest of the world; it is an attitude gap; we are different even where we come from.

Dr. Bob's perspective of the complex licensing system seems to be different because he had passed his USMLE and his focus was getting into residency. His focus is that

complexity has produced, transformed, and brought into his experiences the hard realities of "observations," "interviews" and how he was treated during an observership. An observership gives IMGs the opportunity to observe a medical doctor on duty. The IMG does not touch the patients. He/She just watches and learns the process. Dr. Bob seizes the opportunity to explain the impression about Africa and African trained medical doctors. He validates what Healy and Oikelome stated that country of origin was a very important aspect of the screening process in the match program. Africa still carries with it the stigma of being colonized. Even the decolonized like FTBIMDs continue to be recolonized as they seek employment in the U.S.

Dr. Bob indicated that "people are not well informed about the rest of the world; it is an attitude gap; we are different even where we come from." Taking a patient's history seems to be some basic skill that does not need to be an issue. However, during an observership "the doctor liked my knowledge, but he was skeptical whether I could take the patient's history." Fanon (2008) opines that "the black physician never knows how much he is being discredited. I repeat I was walled in: neither my refined manners nor my literacy knowledge nor my understanding of my quantum theory could find favor" (p. 97).

One can read from his interview the way he is frowning at the assumptions concerning recording patients' histories in the system by foreign-trained medical doctors in general and Black Immigrant Foreign-Trained Medical Doctors in particular.

Summary of findings as initial tentative manifestations

The findings as initial tentative manifestations are two: one, there is no guarantee to get into residency, and two, one needs to be known to get into the program. Participants demonstrated that this dual implicit requirement for residency is frustrating for those who know no one apart from their family members, because they are not trusted by others. In contrast, two licensed physicians have demonstrated that their relational resources afforded them the opportunity to get into residency. Recommendation letters were written by physicians who knew them before they applied for residency in the match program.

Given the degree of racialization and systemic racism (Feagin & Elias, 2012), getting into residency is no guarantee to graduate as a licensed physician. For example, an IMG can be let go at any time during residency. This double standard of the residency system as described by participants renders the situation of FTBIMDs tenuous as they are finding work and working in the U.S.

Finding # 3: Tentative Manifestation as brain waste. Brain waste is a critical manifestation that needs to be fixed (Batolava, et al, 2008. Sumption, 2013). Sumption (2013) writes that "foreign-trained professionals often encounter difficulties putting skills and experience to good use in the host country's labor market" (p. 1). FTBIMDs face several challenges in their trajectory of adjusting to the U.S. system as medical doctors. FTBIMDs waste their brains doing survival jobs. Examples of these survival jobs are interpreting, scribing, certified nursing assistants (CNA jobs), security attendants, and mental health counseling, among others. The difficulties they face range from

institutional racism (macro racial projects) to challenges in everyday life at the individual level, for example racial profiling, and racial slurs (micro racial project) described by Omi & Winant (2015).

The multiplicity of activities that amount to brain waste could be read from the underemployment of IMGs. Stebleton posits that by highlighting Western approaches to career development, several people, including African immigrants, are denied opportunities to utilize their talents in the U.S. (2010). There is consequently no return on the investment in human capital as outlined in the following two principles of human capital development:

"1. Labor inputs are not merely quantitative. They quantitatively include the acquired and useful abilities of all inhabitants or members of the society as well as the state of the skill dexterity and judgment with which labor is applied.

2. Ability acquired through education, study and apprenticeship always costs a real expense, which is a capital fixed and realized as if it were in person," (Sweetland, 1996, p. 343). For example, there is no return on the investment in the human capital of FTBIMDs finding and being underemployed in high school level jobs.

Though the FTBIMDs constitute a skilled labor force with medical degrees from recognized medical schools, they can only work with their medical degrees after passing the multi-layered examinations and getting into licensing through the Match program. In contrast, these IMGs work at the level for high school graduates judging from the types of work that the IMGs are currently doing. They are trained as medical doctors from

accredited universities in the continent of Africa. They cannot work as trained medical doctors because they are not licensed in the U.S. Given this dilemma, they seek low-income jobs to make ends meet. The jobs they do are not sustainable. They are temporal survival jobs.

Initial tentative manifestations in survival jobs. Most of these low and temporal income jobs are multiple and readily available to even unskilled immigrants. These survival jobs appear as some sort of cultural capital (Bourdieu, 1986) because of the socialization process in which they are situated. Survival jobs are floated to new immigrants as a temporal job to meet basic needs in the process of finding work for which one is trained and certified. These survival jobs, as cultural capital, have an economic effect on the body and minds of FTBIMDs in their process of finding work and working.

The multiple options in finding work and working are always unending, circulating, and unstable (Vagle, 2014). That is why experiencing the multiplicity of options in finding work and working is rhizomatic. The rhizome can be used as a metaphor that illuminates the temporality and cyclical nature of the immigrant adjustments in the United States. Here are a few excerpts from the unstructured interview with participants.

Dr. Amy**:**

At first, I started having a doctor in medicine on my CV, but nothing major happened except that recruiters were calling me about high school jobs

> requirements. I started hiding my real credential because it might scare or frighten people that ignore how the system works for the immigrants. This is a waste of my intellectual capability. (Dr. Amy , interviewed on 03/17/16.

By "hiding" her real credentials, Dr. Amy is intentionally adjusting to her new lifeworld of underemployment and survival. Her professional identity as a medical doctor may be a hindrance to her getting a temporal job. Her hope is to find an opportunity to be employed at any level for the sake of survival. This opportunity shows up as a line of flight (Deleuze & Guattari, 1987), a temporal job for survival. However, she is conscious that she is wasting her intellectual capital**.**

Another IMG expresses his disgust and his regrets about brain waste by focusing on health disparities and disparities in employment.

> Dr. Fred:
> People at the national and local level people know that there is health disparity. There need to mention about the human capital. No mention of the lack of return on the investment in training global medical doctors with funds of knowledge in addition to medical knowledge is a waste of our brains. The state should recognize that there is unrecognized manpower which could be absorbed. I am sorry to say this, but there is brain waste in the U.S. Those of us who have already passed the test should get into residency. The problem is that there are not enough slots to absorb Foreign-trained medical graduates FTIMG

Dr. Fred vocalizes his disgust with both the national and local governments for not paying attention to the health disparities and the availability of unrecognized skilled labor to meet the health care needs of a diverse society like the U.S. There is no return on the professional investment in human beings (Sweatland, 1996). This sentiment is also

expressed by Dr. Fred in the following words, “I have spent this much time, and there is no return on the investment. The help we get from people does not have any proceed on it.”

The investment in the education of the IMGs does not seem to yield any productive and commensurate returns because some of them are underemployed. The assistance IMGs may get from “people” as their cultural and social capital (Bourdieu, 2011) has “no returns” about what was invested in training them. As a result, Dr. Fred attempts to fault the licensing process by demanding an increase in the number of slots for FTBIMDs to help eliminate health disparities and bring about health equity. He sees a direct relationship among brain waste, health disparity, employment disparity, and the licensing system in the U.S.

Despite the employment disparity, there are also examples of FTBIMDs who have gone through the tedium of passing the multilayer examinations and training as certified nursing assistants. This tedious exercise is simply to work and earn some income while waiting to eventually get into residency. However, their racialized category as black and blackness continue to be exclusionary factors in obtaining residency spot in the U.S.

Dr. Leah, now an established physician currently running her clinic, did not have it easy either. After passing the USMLE, she humbled herself to train and work as a Certified Nursing Assistant (CNA) to support her family financially. There was no return on the human capital investment in her education. According to Sweetland (1996), human

capital refers to the additional value to labor as a result of education and training. Dr. Leah said:

> I felt that I was wasting my time, my spouse was in graduate school, and my family had meager finances. I had to find a job. I looked into working as a (Certified Nursing Assistant). I went and told them that I am a doctor, but I want to find something that is flexible, I have to stay home and probably work at night. Then I went to an agency serving immigrants. I was told that I had to go for training, (all laugh), and get training to be a Certified Nursing Assistant, which I really did, and I did that until I could find a residency spot (Dr. Leah, 04/03/16).

Finding a residency spot on the East Coast is a *line of flight*, an opportunity or movement that occurred and enabled Dr. Leah to escape from the frustration of trying to get into residency in the Midwest where her family resides to no avail. Her humility in working as a CNA, which brought her some income to provide financially for her family, was a survival job and a strategy she used during her transition into residency. Working as a certified nursing assistant despite the fact that she had passed the USMLE is brain waste. In contrast, her patience in pursuing residency paid off when she finally got admitted into a residency program on the East Coast. Dr. Leah is an outlier amongst foreign-trained medical doctors. She is one of the few FTBIMDs who went through residency successfully and now runs a clinic in the U.S.

Brain waste was perceived differently by Dr. Lesley with a unique approach to her finding work and working. An excerpt from the interview with Dr. Lesley:

Charity: How has this process affected your family?

Dr. Lesley: Loss of wages is coming from being able to afford everything for your family to not being able to afford. As a doctor in Africa, you can afford everything for your family and even the extended family. Raising kids as single parent like everybody else it is hard.

Charity: How is it hard?

Dr. Lesley: Income is not enough for children's schooling, wanting to help your aging parents, paying for food, and other bills. The big challenge is when you cannot treat your own family and you still have to go to a doctor.

Income instability and "loss of wages" as a medical doctor is very challenging. Additionally, Dr. Lesley's family members who received medical care from her in Africa cannot be seen by her when they fall ill because she is not a licensed physician in the U.S. In her words, "The big challenge is when you cannot treat your family." As a result, she is wasting her brain by not being able to serve as a physician who was "a doctor in Africa."

Besides, she has lost her status as a medical doctor, leading to a loss of wages. That is why Dr. Lesley regretted "loss of wages coming from being able to afford everything for your family to not being able to afford anything." This statement provides evidence of the hopelessness she feels of ever being able to serve as a physician again. She seems to be in a double jeopardy. For example, Dr. Lesley who had several years of experience as a physician in her nation of origin is no longer recognized as physician because she came to the U.S. from a "refugee camp." Also, she has lost both her professional identity as physician and the remuneration that goes with the status of physician because of a racialized system of licensing international medical graduates.

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Dr. Lesley came to the U.S. as a refugee. Employment counsellors in two resettlement agencies took the time to explain to her what it would take to become a physician in the U.S. After her first meeting with the resettlement agency that brought her from a refugee camp about the process of recertification in the U.S, she was worried about the uncertainty for her to become a licensed physician. She decided to seek a second opinion from another organization serving immigrants and refugees. Dr. Lesley was told the same story. She was advised to start with the CNA program as a stepping stone into medicine. She refused to get into the CNA because she was already a doctor diagnosing and treating patients. She did not want to do the job of a nursing assistant. She gave up her medical career, opting to volunteer for community based organizations and then found her niche as a resource person consulting for CBOs, trained as an instructor and gained a current position serving vulnerable groups in a hospital. Given the hardness of the process of "becoming a doctor a second time," she preferred to "put down her medical degree for her children's education."

The hardness of the licensing process produced a prioritization of the family well-being, and this is what Dr. Lesley said, "Ok I am going to put down my medical degree so that my family can succeed." I interpret "putting down my medical degree" to mean deconstructing her identity as a medical doctor and switching to a profession that would enable her to provide for her family. She became a resource person for the community as someone "who had done doctor work in Africa." Being a resource person working specifically with the African population as an FTBIMD is a survival job. Her medical

education is not being rewarded. Her income is lower; she is undervalued and underemployed as an IMG. This to me is a continuum of brain waste.

Furthermore, some FTBIMDs sought temporal jobs in hospitals to help them be in an environment to remind them of their oath as medical doctors, though they are underemployed and their brains are wasting. In my interview with Dr. Ann, this is what I wrote in my post- reflexion journal:

Dr. Ann is *a doctor at heart.* I wondered what this means. I imagined that what this means is that she is committed to caring for patients because that is the oath she took when she graduated from medical school. She is happy working in a hospital setting, serving patients even though she is not working as a physician. She says *it is better than nothing. Better than nothing* means settling for less because she is racialized as a Black immigrant medical doctor who is foreign-trained.

Why should skilled professionals settle for less when there is the need for physicians? Doctor shortage in the U.S. is not new news. Yes, IMGs and especially FTBIMDs are not being given the opportunity to be licensed. Opening doors to licensing of FTBIMDs would be more beneficial to the American society, a cultural mosaic. Getting into residency is the ultimate goal for all international medical graduates finding work in the U.S. In contrast, the uncertainty of the licensing process has rendered most IMGs not only undervalued but also underemployed since they tend to do menial survival jobs. Such underemployment has resulted in *racial capitalism (*Leong, 2013). The

underemployment of FTBIMDs is a way of making economic and social gains from the identity of qualified Black immigrant medical doctors.

Finding # 4. Tentative manifestation as Difference. Difference signals identity construction as seen in both empirical and theoretical works (Hall & Du Gay, 1996; Fanon, 1967/2008; Bhabha, 1994). Difference can be seen from various perspectives. Homi Bhabha, in his *Third Space* interview, argues that, "It is actually very difficult even impossible and counterproductive to fit together different forms of culture and to pretend that they can co-exist" (p. 209). Difference is continuously producing racial discrimination, marginalization, and inequality as people co-exist in the community. Such co-existence necessitates embracing cultural differences in the intentional relationships in daily living. These interrelationships produce a "cultural hybridity …. a new area of negotiation and representation" (Bhabha, 1994, p. 211). Such negotiation and representation may involve cultural values and languages. In contrast, racism and covert discrimination lie within cultural hybridity. .

Omi & Winant (1994/2015) write that "throughout the U.S. history race has provided a template for patterns of inequality, marginalization and difference" **(**2015, p. 1**).** This template of inequality is portrayed in the unequal treatment of IMGs. IMGs have several hurdles to scale through to be licensed as physicians in the U.S. Thus, racial relationships are at the base of the underemployment of FTBIMDs in the U.S. as seen from the findings in tentative manifestations. FTBIMDs are more marginalized because they look different; their black or brown bodies are unwelcomed in certain spaces

including physician workforce because of *implicit bias* (Omi & Winant, 2015). They are therefore marginalized and excluded because of their race and skin color.

Dr. Brown rightfully stated in his interview that "difference is not a deficiency." My reading of this statement is that in various encounters in the life world and relationships being different because of appearance, values and style for example do not render one deficient. What is germane is human worth, how the self relates to the other in ways that promote "we-go" instead of "ego" (Thandeka, 1999). Thandeka (1999) asserts that "this realm of difference is the self that is always more than itself alone because its sense of itself includes an awareness of the world of nature and the other human beings who are different from but participate in and alter its own core acts of relating" (p. 105).

Therefore, the fact that FTBIMDs are different does not make them deficient physicians in the U.S. FTBIMDs would benefit from an expansion of the residency program that provides more residency slots for IMGs through an emersion program. Such a program would offer IMGs technological, medical and language skills necessary to transition into the physician workforce in the U.S. It is during residency that their performance as medical school graduates can be verified. Though FTBIMDs are different because of their nation of origin and appearance, they are not necessarily ineffective as physicians. The FTBIMDs do not need to wear a white mask (Fanon, 2008) nor learn to be white (Thandeka, 1999) to be recognized as efficient medical school graduates.

*Initial tentative manifestation as Blackness***.** Blackness is a sub-theme that emerged from my study. Blackness is a way of identifying people with dark or brown

skin. Such identity construction of people with a dark skin implies a plethora of things. Fanon approaches blackness from a psychoanalytic perspective. Fanon (2008) asserts that "we believe in the fact that only a psychoanalytic interpretation of the black problem can reveal the affective disorders responsible for this network of complexes…. we believe that an individual must endeavor to assume the universalism inherent in the human condition" (p. xiv). The Black problem has a historical foundation in slavery, where blacks were seen as sub-humans with little or no capacity to reason because they are not intelligent. Such inferiorization of Blacks has rendered some Blacks to see their blackness as inferior. Internalizing such inferiority complex has led some Blacks to condone the ascription of sub-humanness.

It is in this instance that Fanon's approach in his book *Black Skin White Mask* is deemed psychoanalytical. Fanon (year) also opines that "the Blackman is his own Blackness" (p. xiv). Powerless, the Blackman has accepted his God given appearances Black because they are made in God's image. In contrast, at times some Blacks appear to self-identify, or other identify as an inferior category of humans. Unfortunately, blackness seems always to be in comparison to whiteness. This is in contradiction to the universalism in humans. Thus, individuals ought to appropriate their inalienable rights as humans. Blackness could also be interpreted as a socialization process that identifies people of African dissent in a uniform manner. Attributing such uniformity to black people seems to be a stigma. From this lens and expanding Fanon's work on Blackness, Ibrahim (2014) asserts that blackness is about "the unspoken…that which is speaking

loudly, the Black body" (p. 1). This speaking Black body has led to the labeling of blacks as inferior because of their blackness. Additionally, people of African descent are racialized in North America because of their blackness.

Furthermore, being black, a racialized category in the U.S., is a problem. Ibrahim (2104) in his *Rhizome of Blackness, a Critical Ethnography of hip-hop Culture, Language, Identity, and the Politics of becoming,* asserts that "when blackness encounters the syntactic structure of identity, it seems that a new becoming spills over, a rhizome is given birth" (p. 3). He uses the metaphor of the rhizome to describe blacks, blackness, and black identity construction. To this end, drawing on Deleuze and Guattari's (1987) *A Thousand Plateau*, Award Ibrahim explains that "a rhizome is a constant flow of deteritorialization. It is not a point we reach, and finally, say, we are finally there. Rather, it is a way of becoming that we are forever struggling to attain" (2014, p. 3). FTBIMDs are continuously seeking employment as IMGs in the U.S. This process is an uphill task, and FTBIMDs seem to be in a continuous mode of becoming physicians in the U.S. FTBIMDs' interrelationships with the life world of work are rhizomatic.

The cultural assets they bring in addition to being highly skilled are not being utilized. FTBIMDs possess cultural funds of knowledge. For example, African ways of knowing that can facilitate patient-doctor interaction by providing health care in a culturally appropriate manner. Thus, FTBIMDs are in a constant mode of deteritorialization in finding work and working in the U.S.

Merleau-Ponty, in his *Phenomenology of Perception* (1945/1962), posits that "bodies are our access to the world" (page #) Black bodies seem to be excluded from systemic structures that deny them access to the world of work as foreign-trained medical graduates in the U.S. However, bodies are not blended into the social context but "an embodied intentionality exists in which the body is lived through and is permeated into the social" (Vagle, 2014, p. 113) by persistence in the pursuit of residency in the U.S.

*Initial tentative manifestation in skin color***.** Skin color is mentioned by a few participants as a barrier to becoming licensed physicians in the U.S. The context in which each participant experienced skin color as a challenge also varies. Fanon (1967) writes:

> I am given no chance. I am a slave not of the idea that others have of me but of my appearance…I *make progress (my emphasis in italics) by crawling.* And I am being dissected under white eyes, the only real eyes….. Having adjusted their microtomes, they objectively cut away slices of my reality. I am laid bare…. when people like me, they tell me it is in spite of my color. When they dislike me, they point out that it is not of my color. Either way, I am locked into the informal circle" (p.116).

Skin color is perceived as a hindrance in the process of finding work and working by FTBIMDs in the U.S. This perception has led some FTBIMDs to be frustrated. Like Fanon, FTBIMDs appear to be frustrated in the trajectory of finding work and working in some cases because of their bodily appearance. An excerpt from this interview below elaborates what the participants said:

> Dr. Pet: I told you the last time, where I went to the hospital to get something from someone I was pushed by security authorities. I was still the one kicked out without bothering to hear my part of the story. I think it is just the society we find ourselves.
>
> *Charity: what is in the society?*
>
> Dr. Pet: In as much as we try to hide it. The color of your skin is an impediment. The color of your skin determines whether you would go into residency or not. The black/dark people have a hard time. We will try to work hard.
>
> *Charity: Could you just tell me the story and the incident?*
>
> Dr. Pet: I went to a medical facility; I went there not because of work but to give something to someone (my wife).
> I went there when the door was usually locked. There was a particular door behind where you can't get in without your pass. We waited outside. I was standing outside, it was very cold there.
> I had already called the person who was collecting the money from me.
> I met someone at the door who asked me if I wanted to get in
> I said yes I was waiting for someone. The door was opened for him. I followed the guy, but he told me I couldn't get in through this door. Then I said if you can get in why shouldn't I?
> If you can go in I too can go in if he said I don't have to go in. I said if you can go in I will go in. He pushed me so vehemently. As God would have it, I had my hand firmly on the door knob that was the only thing that saved me from falling. While we were raising our voices. He picked up the phone and called his wife to call the security men. The security men came and bundled I and my wife out of the hospital. They threatened my wife that they were going to fire my wife. I am sure they did this because we were blacks if were whites who are superior they would not have been treated this way (Dr. Pet interviewed on 02/11/2016).

Black skin color and blackness appear to be big hindrances to international medical graduates struggling to get into residency in the U.S. Dr. Pet asserts that "in as much as we try to hide it, the color of your skin is an impediment. The color of your skin determines whether you will get into residency or not." My reading of this assertion is that though there is a hierarchy in the categorization of races, people are not courageous

to confront it. Nevertheless, there is the consciousness that skin pigmentation is a barrier for FTBIMDs seeking residency in the U.S.

Dr. Pet's horror, though not directly related to his experience as a foreign-trained medical doctor, adds to his interrelationships and interconnectedness in his life world as a black man that produces emotional distress and frustration. Being Black and different in certain spaces is a nightmare. Skin color and difference undergird racialized societies, for example, Europe, Canada and the U.S. (Ibrahim, 2014). This could be referred to as the *color of fear*. Below is an excerpt from a practicing Black physician.

> Dr. Leah: At that time, I was married, I had children, and I was different. I noticed this when I went into my interview. I was being also interviewed by the residents. You could see that you are different. You could feel it; they were not rude; you could read more into the situation than what is said,
>
> *Charity: Could you tell me more?*
>
> Dr. Leah: I'm sure. I am not the only minority that has felt that. Pause, I was a minority there, most of the interaction was minimal and umm, you felt it. I don't know how well to explain it, you feel isolated, not included.
>
> *Charity: were they gazing at you or what?*
>
> Dr. Leah: They were not rude, they were nice, but you felt isolated.
>
> *Charity: when was this?*
>
> Dr. Leah: It was during the interviews. I ended up not getting into residency my state of residence. I experienced this difference even as a licensed physician. This is what she said about her relations with patients.
> My name sounds like a Japanese name. When they come in and it is this black lady with a strong accent, they come in and say I thought you were Japanese, with this accent. They come in and they spend ten minutes drilling me about my qualifications, where I trained, it is not happening now, but at that time they will ask to be reassigned to a different doctor. At that time because I had already experienced it in resident. I said it was their loss. After a while you develop a

> thick skin, when you are probably the only minority from the cleaner to the manager, you feel you are different. But how we are raised, you have to bolster up yourself and have the confidence that you are as qualified as any other physician (04/3/16).

These participants mentioned above saw the difference from the way they were treated. Dr. Pet said "I was bundled out because I was a black man." Does blackness give FTBIMD a different social class status? I wondered. For Dr. Leah, she was different because she was married and she was a minority. These variations in difference seem to produce barriers in their interrelationships in their life worlds. These participants have narrated their lived experiences about the effect of their skin color on their finding work. The accent is another marker of difference. It is a stigma for most immigrants in the U.S.

*Initial tentative manifestation in accent***:** The accent is a challenge for many immigrants (Inniss, 1999). The challenge of speaking English with a foreign accent has led to the exclusion of many immigrants from the workforce and discrimination in the hiring process. Speaking English with a foreign accent renders communication in everyday life very challenging.

Most immigrants are discriminated against in the workforce by employers because of their accent. The English language assessment test for spoken English is not objective. Some scholars have brought this accent discrimination to the public arena (Nguyen, 1994). Discrimination because of accent against immigrants, in general, is becoming commonplace in America. Some employers use telephone interviews to determine the accents of applicants (Nguyen, 1994). Thus, immigrants face accent discrimination when they apply for work in the U.S. (Nguyen, 1994). Such discrimination

flaunts their rights and promises to "equality of opportunity" as U.S. residents, enshrined in the Civil Rights Act (CRA, 1964). Title V11 of the CRA provides that no one shall be discriminated against because of his nation of origin.

The empirical literature has documented that accent is used as a cover up to discriminate against immigrants who have therefore become the subject of *prejudice* (Nguyen, 1994). When immigrants are skilled in the English language, some employers refer to their English as "incomprehensible" (Nguyen, 1994). Incomprehensibility is subjective and open to various interpretations. Thus, when some employers say that the English some immigrants speak is "incomprehensible," they could be accused of being biased and discriminatory of those immigrants applying for work. As a result, immigrants are sometimes excluded from the workforce *ab initio*.

Though English language is not their first language, a majority of FTBIMDs communicate in English that is influenced by their first language. English is not the first language they learned. This is what participants said about the issue of accent in the process of finding work.

> Dr. Fred:
> It is very strenuous in the family. When I came here, I took step 1 and step 2. I had a heavy accent, so I had to go for one on one English pronunciation training for three months to improve on my pronunciation in a global language institute. It was a very helpful training. I passed my English language skills examination. Fortunately, it was paid for by funding from funding agencies. I had to take off time from work. It is an examination of endurance, an examination of hope. Thanks to God I passed at one attempt. It was socially isolating. It is financially burdensome on my family. I applied for residency three times to no avail.

Dr. Fred was cognizant of his accent as an impediment to his communicating well in English. He took the necessary steps to get trained in American-English pronunciation. This was a worthwhile investment. He communicates in English better now. However, another participant did not find the issue of accent as one that should become a great barrier at the workplace. This is what he said:

> At my side job where I am managing, keeping afloat I am always being asked what accent is that, at times I ask myself if it is my fault that I have an African accent. Indeed, I think my African accent is just different from other accents. I know that difference is not a deficiency. My accent does not disturb my performance at work. I do not understand why the emphasis on the accent. Maybe employers need to train new employees on intercultural communication to help all employees accommodate others in a diverse workforce. (Dr. Brown interviewed on,6/16/2015).

Accents ought not to be a barrier because everyone has an accent. However, because accent is seen as a barrier to FTBIMDs in their process of finding work and working in the U.S., a possible solution could be that less emphasis be put on the accent and more emphasis on performance. It is from this lens that Dr. Brown stated that accent should be de-emphasized. In his words, “my accent does not disturb my performance at work.” Focusing on employee performance at work would be a way of accommodating immigrants who speak English with a heavy foreign accent. Foreign accents could be tolerated in the workplace because everyone has an accent. Dr. Brown encourages employers to ”train all employees in cross-cultural communication” to help build the workplace as a learning community **(**Senge, 1990). A learning community offers opportunities to all employees to learn as they work in teams. Such team learning offers opportunities for professional development and improves professional performance and

increases outcomes (Zhoa & Kuh, 2004). These learning communities combine the social and intellectual capabilities of cohorts (Zhoa & Kuh, 2004) for communal good.

Foreign accents as seen in the literature foster immigrant identity construction in education. Immigrants are stigmatized for speaking English with a foreign accent (Anzaldua, 1987, Corea, & Lovegrove, 2012). For example, Anzaldua and her friends spoke "Spanglish" as a way of resisting *English only* in school. Speaking Spanglish was also done to incorporate their cultural identity in language. Though FTBIMDs have accents, this accent has no bearing on their skills as medical doctors, to say the least. The availability of FTBIMDs to serve the community is an opportunity to explore and negotiate their integration into the healthcare workforce to help the population.

One participant asserts that, "accent is a difficulty. But, we are educated, and that makes a difference because our accents do not affect our educational knowledge, we are trained physicians. We are trained to help take care of the health of the population." (Dr. Tyler, participant).

Dr. Tyler acknowledges that accent is a barrier, but it could be accommodated for communal good because "accent do not affect our educational knowledge." Though accent may affect communication, it has no bearing on medical knowledge. Thus, given the health care needs of the diverse society, people ought to be intentionally patient when communicating with immigrant medical doctors. The doctor shortage Peterson et al (2014) and primary care doctor shortage (Fodeman & Factor, 2015) necessitates an expansion of the residency program to include IMGs.

Voice as becoming is well suited for this analysis because it is unstable, “always in motion” and “there is no guarantee” (Lensmire, 2000, p. 63). Voice is not unidirectional. It can flow in several directions. It is in the same light that Vagle & Hofsess (2016) assert that post–intentional phenomenology employs “innovative ways to conceptualize things as fluid, shape shifting assemblages, continually on the move interacting with the world, rather than perceiving them as stable essences” (p. 1).

However, the IMGs in their resolve to continue to struggle to become licensed physicians in the U.S, a majority become resilient and persistent as they pursue their American Dream. They, therefore, appropriate optimistic *lines of flights cracks that lead to movement if you would.*

Initial tentative manifestation in cultural competence. Cultural competence entails learning about *self and others* (Carter, 2001). Such learning may lead to the knowledge of “self” and “other” as vividly stated by Torres-Guzman and Carter (2000).

> “The goals of cultural education are not met solely to create tolerance of diversity but to change existing structures that perpetuate intolerance, oppression, and inequality. The broader message is that our society needs to change drastically, and that the paths towards those changes are multiple and must be taken in a concerted interactive way. By looking at self-one sees the other. We should each take on the task of understanding self. But we come to see self through the eyes of others. Thus, we must implicate ourselves in the development of the other if we wish to develop. This is a call to all” (p. 952).

Following the call to all to see *self through the eyes of others,* cultural competence should be gaining center stage as a possible strategy that could be used to eliminate employment disparities in the U.S. Efforts at acknowledging the importance of cultural competence are documented in literature. For example, some employers pay for their employees to be trained in cultural competence (Doorenbos et al, 2016).

When Medical providers receive training in cultural competence, they can become better equipped to serve diverse populations (Doorenbos et al, 2016). A quantitative study conducted at the University of the West Coast, U.S., is instructive. Employers of surgeons paid for these surgeons to be trained in cultural competence. The surgeons reported that they see diverse patients and that the cultural competence training helped improve how they treat patients in a culturally appropriate manner (Doorenbos et al, 2016). In contrast, FTBIMDs who are IMGs would not cost employers anything to train them in cultural competence. The IMGs are culturally competent, and they will not need cultural competence training. For example, culturally competent care is based on the beliefs and values of the patient. All participants in my study evoked their cultural competence as an asset the IMGs bring into the American health care system. Here is an excerpt from the interview with Dr. Leah:

> *Charity: what is changing in the U.S?*
>
> Dr. Leah; A lot of things are changing. The community is becoming more diverse The immigrant population is growing, so we need to be able to address that.
>
> *Charity; How?*

> Dr. Leah; I think we need to have more diverse providers to offer culturally competent health care. I have also to say that with the changing culture, I hope that this is also being incorporated into the medical school foreign cultures to be incorporated into the curriculum
>
> *Charity How?*
>
> Dr. Leah: If you are a health care provider you should be able to offer culturally competent care
>
> *Charity what is culturally competent care?*
>
> Dr. Leah: Cultural competence is based on beliefs of the patient his or her experiences. So you offer it in ways that are acceptable to her so that he or she can accept and understand.

The emphasis on having physicians who are culturally competent seems very relevant in the U.S. because of the diverse population. According to Dr. Leah, "things are changing. The community is becoming more diverse, so we need to take care of that."
My interpretation of "we need to take care of that" is that the growing immigrant population in the U.S. has led to a problem that needs urgent solutions, for example, the employment of culturally competent physicians. In the context of my study, it would mean more slots for residency for IMGs in general and FTBIMDs in particular.

The exponential growth in the number of immigrants as seen in the literature is cause for concern. The growth in "immigrant population" ought also to lead to an expansion of current services and policies, for example, the licensing system. Revising the regulations governing the licensing of IMGs would lead to a possible increase in the number of the culturally competent physician who would be available to provide care to the diverse immigrant population in a culturally appropriate manner.

Training FTBIMDs, who can help communicate with culturally diverse populations in a culturally appropriate manner, may meet the physician demand and the health needs of the society. This training can also provide a solution to the doctor shortage in the U.S.

Culturally competent physicians who 'understand the belief systems of the patients' would inspire more confidence in the patient and the treatment plan. IMGs, who are culturally competent physicians, are helpful and more effective than physicians who are trained in cultural competence because they speak the ethnic language and communicate freely with patients. Dr. Marvin explained in my interview with him that:

> "While on duty I came across a patient with tuberculosis, who is French-speaking, the patient had been diagnosed as having cancer. The patient was not responding to the treatment plan at the time. When I approached the caregiver I realized he was speaking French; the patient then explained to me what was going on in French. I reexamined the patient and diagnosed him as having tuberculosis that had spread in his body. I changed the patients' treatment plan. The patient responded positively to the new treatment plan." (Dr. Marvin, interviewed on, 05/17/2016).

The French language was used as a marker of cultural competence to produce an effective treatment for a patient who could have lost his life through a wrong diagnosis. Effective communication in such circumstances is crucial in medical diagnosis and saving lives.

Dr. Leah, also a licensed physician, indicated that the black skin presents some diseases differently. When she worked as a physician in a medical facility, she was called upon to determine what could be done if a black patient had cancer or some other skin disease. After examining the patient, she determined that it was not skin cancer. The patient had a skin disease called ringworm. This is what Dr. Leah said in her interview:

> "Things look different on U.S. even simple skin things. I know a number of times I was called upon to give my opinion about a diagnosis on a black immigrant patient. What do you think this is? Is it skin cancer? And I go oh no, it is ring warm; it just looks different on black skin. No, that is ring warm; it just looks different on our skin. The patients started gravitating towards me and urging me to start a clinic" (Dr. Leah interviewed on 03/04/2016).

Misdiagnosis could lead to a lawsuit. Facilitating entry into medical licensure for IMGs would be a proactive way of utilizing their cultural competence. The example of Dr. Leah above indicates that IMGs are culturally competent experts. Their expertise could be put to use in the current health care system because "sometimes I was called upon to give my opinion about a diagnosis on a black immigrant patient. What do you think this is? Is it cancer?" These are great questions that were asked of Dr. Leah because she was recognized as being culturally competent to make a better diagnosis or give an acceptable opinion as an IMG.

Furthermore, the relevance of cultural competence in a cultural mosaic like the U.S. derives from the fact that the health care system is very advanced and complex. The manpower/woman power needs to be equally diverse. A diverse workforce can help in

eliminating the cultural barriers. IMGs stand in a better position to educate the population about cultural barriers. Dr. Lesley said,

> "Sometimes there is a cultural barrier; the hospital system is different. So to explain when to go to urgent care and when to see a doctor, to African born patients' needs patients. Sometimes I address them in broken English where I cannot speak the native language to make sure they understand the importance of each aspect of their treatment plan because the system is complex.
> My big job is to advocate for the African born. I become like the cultural liaison person between the clients and myself. I have a teaching role which I take it personally. When it appears that somebody is not cooperating. I have teaching role that I take it personally even the type of communication they may not understand. I become like an advocate. The doctors and the nurses the other case workers how they can understand to work better with African people (Dr. Lesley, interviewed on 03/24/16).

The United States health care system is both different and complex and could be overwhelming to the immigrant. There seem to be cultural barriers to preventative health care, using urgent care services, for that population needs to learn to become comfortable with the system. Dr. Lesley seems to be content with her current job to "advocate for the African born." She takes the job "personally" for various reasons. For example, "when patients appear not to be cooperating," Dr. Lesley "plays a teaching role." Furthermore, messages must be clearly communicated to the patient. This wish explains why Dr. Lesley advocates that the target population being served, African people must be reached.

Communication in a culturally sensitive manner is key to a good diagnosis and treatment plan in health care. International Medical Graduates stand a chance of providing culturally competent care to the society. The licensing of IMGs would reduce the cost of training physicians in culturally relevant competence because IMGs are

culturally competent. In contrast, on the West Coast employers had to pay for physicians to be trained in cultural competence (Doorenbos et al, 2016).

Language and Multilingualism are great assets that IMGs possess in addition to their professional identity as medical doctors. This is what Dr. Tyler said about his talents. Languages as a marker of cultural competence:

> It is very difficult to find work in my field. The issue is if you want to find any side job, they will ask for an experience that makes it even harder. I'm very fortunate to be gifted in several languages. You have to do what you have to do. I speak Mandarin, Chinese, African languages, and French I am multilingual in when I try to discuss this. They are very amazed. Even sometimes when it comes to my field, I remember the doctor was examining a patient, and I was observing him. The doctor asked me how you handle this illness; the doctor asked me how you treated this. I told him you don't treat this you just have to tell the patient to drink a lot of water.

Communication is very crucial in the healthcare system. Having physicians who are multilingual would be helpful in communicating with a diverse patient population. Dr. Tyler humbly stated that "I'm very fortunate to be gifted in several languages. You have to do what you have to do." He was working as an interpreter in the hospital because he speaks, "Chinese, Mandarin, other African languages and French." Even in his "side job," he made an impact as an FTBIMD. This is what he said in the interview excerpt:

> I remember the doctor was examining a patient, and I was observing him. The doctor asked me how do you handle this illness; the doctor asked me how do you treat this? I told him you don't treat this you just have to tell the patient to Drink a lot of water (Dr. Tyler, interviewed on, 04/06/16).

I applaud the physician who reached out to Dr. Tyler when he was not sure of a treatment plan for a patient. The physician acknowledged the fact that though Dr. Tyler was an interpreter at the time, his medical training could still be useful. Dr. Tyler's simple

suggestion for a treatment plan is water. Having served internationally, Dr. Tyler is knowledgeable enough to give an opinion about patient care that could save a patient's life using ordinary everyday treatment strategies.

Finding # 5: Tentative Manifestation as Family Well-Being. Family well-being refers to a holistic worldview of the family as FTBIMDs go through this process of finding work and working. How is the family both immediate and external fairing, and how do FTBIMDs finding work and working affect the intentional connectedness among their family? Answers to these two questions shall be drawn from empirical literature and participants' interviews.

*Initial tentative manifestation as children's education***.** Children's education is an important part of the immigrant experience in the U.S. First and second generation immigrant children could be a great addition to the future workforce in the U.S. Paying attention to cultural ways of knowing, for example *Participatory Communal Citizenship engagement* as espoused in Knight & Watson (2014), would be an added resource. Participatory Communal Citizenship Engagement enables youth to internalize mutual respect, and foster social justice and good citizenship in various social contexts: home, church, school, community, and state. From this lens, Bourdieu in his text *Capital* writes that Cultural capital emanates from habitus, and can be passed on to children in time and space (Bourdieux, 1986). Thus, FTBIMDs have a moral and parental responsibility to

give their progeny educational resources to help them succeed in school, thereby preparing them for the workforce.

However, some public schools enact regulations that impinge on the rights of parents. When parents are too busy working multiple low income jobs merely to make ends meet, they might not stand up for their children promptly. For example, when community engagement states “that every family can help at home,” it presupposes that parents do not know their rights and responsibilities in grooming their children to attain academic excellence. Parents are vital in the education of their progeny. Parental involvement is insisted upon by the state institutions, therefore, doubting the fact that parents are aware of their roles as critical partners in growing up their progeny. This subtle accusation leaves parents in a position of weakness in the education of their children. Parental relationship with children is thus jeopardized. The social language enacted in this text and the distributions of social goods depict the school as trustworthy while families/parents are just partial helpers. Trust must be built between the education system and the family. Families adhere to certain socialization that affects children. For example, the language used in various cultural contexts, and ways of knowing that involve cultural beliefs and values, styles, dressing, and foods.

It is from this perspective that Dr. Leah advocated for her child in school to be taken out of a disability program. Her child was slow in learning and knew articles used at home differently from what the schools call them. Dr. Leah was able to make a case for her child even when she was in residency.

> That is what I tell a lot of immigrants when you come here you have to be your child's advocate. For example, we call sneakers, tennis shoes a jacket and coat. We call it differently. For this child they will show him is that this a jacket or is this a coat? We don't focus on those things at home; he tends to mix them. If he sees sandals, he calls it slippers because that is what it is called at home. (Dr. Leah, interviewed on, 04/03/16).

The relevance of education as a social process in human development cannot be overlooked. Children of immigrants have the blessing of benefiting from multiple cultural values, indigenous cultures and western cultures. However, the transitional period of their adjustment in the U.S. is crucial to their success.

Some scholars assert that immigrant children's success in school is a combination of home and school culture and the funds of knowledge of these new Americans. This combination is what makes them achieve their dream in the American academic system (Gonzalez & Moll, 2002). This dream can be realized in part when parents as partners in the development of their children pay attention to the upward mobility of their children in collaboration with teachers. Ladson-Billings 1994 writes that,

> Culturally relevant teaching uses students' culture in other to maintain it and to transcend the negative effects of the dominant culture. The negative effects of the dominant culture manifests by not seeing one's history, culture, or background represented in the textbook or curriculum or by seeing that history, culture or background distorted (p. 19).

Furthermore, when parents are underemployed, they will not pay attention to the academic achievements of their children. As a result, children's success will be in doubt, and the future workforce will be compromised.

The education of children is a central part of some participants' trajectory finding work and working. An examination of the narrative of some participants concerning their children's education would help clarify the choices they make as they seek to become licensed physicians in the U.S. Children's education is a preoccupation to some parents who have preferred to give up pursuing the complex residency option as FTBIMDs. Such preference is seen in participants' utterances:

> When I looked at the process what I would take, it became clearer, very quickly it was something I could not do? I was a single parent I had three children
> I had to look at priorities for my family. My son was in high school. My daughter was an undergraduate student and the youngest was in middle school. I had to look at my priority.
> My children's education was a priority.
> Ok I am going to put down my medical degree so that my family can succeed I am going to use my public health degree which I found out that public health here is different from
> What I had in Africa (Dr. Lesley, interviewed on 3/24/16).

Dr. Lesley had to make a tough choice between pursuing her medical career and educating her children. She preferred to send children to school and forfeit the pursuit of residency. Though married, she raised her three children single-handedly. Thus, she identifies as a single mom. She is satisfied that her children can now take care of themselves. She finds consolation in the fact that she still works in the hospital providing

care and counseling to a specific group of vulnerable people. Whenever she travels back to the continent of Africa, she still serves as a physician when the need arises.

She mentioned that the health care system in America is concerned with the health security of citizens. This may be the reason why the residency system is so complex and consequently strange to foreign-trained medical doctors, who are groomed mainly in curative medicine. Should the strategy for foreign-trained medical doctors to find hope in the U.S. as physicians be to form an organization that can be recognized to provide health care service and earn a decent salary and leave a comfortable life in the U.S. workforce? This question needs to be explored further.

Dr. Leah had a different experience with educating her children while she was away from home during residency on the East Coast.

Charity: How about the education of the children in the process of you pursuing licensing?

Dr. Leah: It affected them too I know one of the times I came back, my son who was very young then had just started school. He was not vocalizing a lot. And actually, they believed he was retarded; they thought he was retarded, I called the school and discussed with the administration. I assured them that he was not retarded. His vocabulary is changing from the home culture to the school culture where he was just with his siblings. They did not have the interaction they need with other kids, like in preschool those things at that time 30 years ago were not as common or well as rounded as it is now. The good news is that I called the school system and told them that my son is not retarded, the good news now is that, Mike is graduating from dental school, that would have been who would have been relegated to a lower class, special classes and those kinds of things. That is what I tell a lot of immigrants when you come here you have to be your child's advocate.
Early childhood education questions need to broaden up and need to be revamped to take into consideration kids that come from different backgrounds.
And there is no doubt in my mind that, if I did not fight for Michael he would not have been in dental school today. (Dr. Leah, interviewed on, 04/03/16).

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Being an advocate for your child appears to be a good way of using social and cultural capital (Bourdieu, 1986). The reason is that the home culture is different from the school culture. That is why Gloria Ladson-Billings (1995) in her theory of *Cultural Relevant Pedagogy* insists that children's home culture is an added value to the education success of students. Children's education pre-occupies the participants differently, and time seems to be a scarce commodity.

> *Charity: How do you find time to take care of your child?*
>
> Dr. Fred: when you go to residency you get paid so for my child I have to budget work time study time. I am actually stretched. To be honest with you I don't have enough time to attend to my child's educational needs as I would like. I barely check his homework on weekends that I am off. (Dr. Fred, interviewed on 07/15/2015).

Work-life balance appears to be an additional issue that makes finding work and working to be a gruesome process for FTBIMDs. Working, studying and being a good parent who engages in the child's education is challenging. Some participants find work through prioritizing children's education and family well-being. This is what Dr. Lesley said:

> Family needs will have to be prioritized. I am not emotionally depressed. What I cannot afford I pray and God helps me not to feel depressed. I prioritize utility, buy food and send my kid to school. I go on the bus; these are need because of income. The family needs will have to be prioritized not wants. And help others who are really suffering. We have to prioritize needs (Dr. Lesley, interviewed on 3/24/2016)

Dr. Lesley chose to forgo her medical career and professional identity for her children's education. This choice produced family well–being. That is why Dr. Lesley stated that "family needs will have to be prioritized, and I am emotionally depressed." As an IMG,

she may become emotionally distressed for various reasons, ranging from loss of status, to being a single mother even though she is married.

The public school system in the U.S. is set up to be predominantly of white middle class parenting and family–school interaction (Prins *et al.*, 2008). Immigrant parents need to be more involved in their children's education as partners in the development of their children to afford them a balance between school and home culture. Children's education is intrinsically connected to parents finding work and working in the U.S. Parental role cannot be suspended; it is a continuum in the life world. This role must be carried out as parents navigate family well-being.

*Initial tentative manifestation as spousal support/spousal abuse***.** Spousal support and spousal abuse are very deeply ingrained in participants' responses to the interview questions. Participants who had spousal support felt cared for.

Dr. Liza admits, "As I told you earlier during one of our one-on-one conversations that my fiancé is the one supporting me by hundreds." Dr. Liza is not doing any temporary work. She is fully dependent on her fiancé. My reading of "he is the one supporting me by hundreds" is that Dr. Liza has the full support from her fiancé. This implies many things. He provides all her needs and cares for her physical and emotional well-being, while she is preparing to write the USMLE.

In my post reflection journal, I noted that Dr. Liza, unlike her other female colleagues, had nothing to worry about except to study for the USMLE. I wondered how sustainable this state of affairs could be in the U.S. I concluded, however, that when a

family has a plan and executes it together, the outcome might be accepted by all with no regrets. I ended up praying that Dr. Liza would pass her USMLE and get into residency so that the family dream will come to fruition. However, studying is one thing, passing is another, and finally, being black is a hurdle that is insurmountable. She might still not get into residency, no matter how hard she studies. Dr. Amy also had spousal support:

> I would say, I am very happy to have a supportive husband that always brings me up when I am falling down. I have some good days where I am very optimistic, and some days I think I will never be socially integrated in the U.S.A. He always has the right word to comfort and help me gain back my confidence. My parents in Africa especially my father is disappointed because I am not doing what my passion is about. However, they are very supportive.

Participants who had spousal support like Dr. Liza felt loved and cared for. Another doctor, Dr. Amy also saw her spouse as always using the right word to comfort and help her gain her confidence. My reading of this statement is that words are powerful. Loving and caring words uplift someone and help build self-esteem, while unfriendly and wrong words could lead to self-pity and depression.

Dr. Pet, while acknowledging his spouse's support, blamed his spouse for insisting that he should leave his comfort zone as an established physician in Africa to join her in the U.S.

Below is an excerpt of his interview.

> *Charity. Please tell me about the challenges you are facing?*
>
> Dr. Pet: Financially it has not been draining, my wife works. I still have some business back home that brings in some little income.
>
> *Charity: I am happy for you because not every man has a wife who is supportive.*

What happened before you came to the U.S.?

Dr. Pet: We were dating for about five years. It was a difficult decision trying to come here, I already had a glimpse of what it would look like leaving your career When we were getting married, we made the decision that I come over to the U.S. women, they always have their way.'
(We both laugh).
Women always have their way but no regret

Charity: This makes me laugh because of Adam and eve in the bible.

Dr. Pet: It is not a blame game; it is just when two come to one everything has to be consulted there has to be consulting. If they want something they get it. No matter how hard you try, women they always have their way. It took two years for me to make the decision.

Dr. Pet is fortunate to have a supportive wife in his trajectory of finding work in the U.S. However, he seems to regret leaving his career as an established medical doctor in Africa to join his wife. That is why he says "it was a difficult decision." He also seems to think that he was under pressure by his wife to come to the U.S., when he said "women they always have their way." Even though Dr. Pet said "it is not a blame game," it could be inferred from his utterance that he misses his job as a medical practitioner in Africa. If not for his wife, he would have a comfortable job as a physician in Africa.

In contrast, the one participant who experienced spousal abuse felt isolated and unloved. Dr. Ann, who had studied and passed the USMLE, was being abused by her spouse, and the couple ended up divorcing. They are now in a custody battle. Spousal abuse and stress produced a separation of the couple in this case.

Dr. Ann: I got married. I networked with some organizations, serving young medical professionals. I was one of them a lot of them suggested I should move to Minnesota (Midwest) where I would have the likelihood to have support.

> My partner was not supportive of the move to Midwest. I worked with teen moms in another state.
>
> *Charity: Why?*
>
> Dr. Ann: I think it is cultural. He is a man. He wasn't happy with the idea of U.S. moving to the Midwest. What he wanted was a trophy wife. You look good as a physician, but you have to stay at home and take care of him (Dr. Ann, interviewed on 03/15/16)

While some IMGs had great marital support, one IMG had a bitter experience that ended in separation. Dr. Ann attributes her demise to culture when she intimates that "I think it is culture." This could be read as the culture of male dominance and wanting to be in charge that produced spousal abuse. Spousal abuse is often identified as a risk factor that can lead to depression (Dasgupta et al, 2013). Thus, the spousal abuse and verbal violence suffered by Dr. Ann could be read as producing depression, emotional discomfort, and divorce. She is experiencing distress raising their daughter currently as a single mom.

Family and Transnationalism. Transnationalism refers to the connection between an immigrants' nation of settlement with his or her nation of origin. After immigrating, a majority of immigrants maintain connections with their nation of origin, for example, sending money for community projects and for family upkeep like in the case of the participants in my study. FTBIMDs are engaged in transnationalism. This discourse of transnationalism is engineered by the fact that family refers to both immediate and extended family (Bangura, 2005). It is for this reason that participants preferred to do side or menial jobs to "send money back home" to assist their families

(Kent, 2007, Stebleton, 2010, Nyamwege, 2014). Stebleton (2010) found that African students who participated in his study with African immigrant college students assert that all alluded to the fact that they work to support their families in Africa.

Transnationalism here refers to the process of living in two nations, physically in one and emotionally in the other (Bigelow, 2010). These IMGs stay connected with their home countries for various reasons. First, it is a moral soother for them to talk with their loved ones. When they constantly communicate with their kinfolk, they have temporary relief from the hurt of the process of licensing in finding work. Dr. Rita stated in her interview that "no one cares about me here."

> Rita: I help buy groceries, I send money back home to my mom. If I were just sitting at home I would not have anything. My family has benefited. If I did not have a job I will not be able to assist them. My mom does not know that I am not a doctor here. She just knows that I am waiting to write the exams. She depends on me. She knows she has a daughter as a doctor.

The FTBIMDs have a moral responsibility of taking care of their parents and other relatives in their nations of origin. It is for this reason that Dr. Rita affirms "I will send money back home to my mother." Though working temporary, side or survival jobs is underemployment, it affords some finances to assist the families both in the U.S. and abroad. Working is a divine command. Christian's believe that "you shall eat from the sweat of your brow" (Genesis, 3, 17, New International Version). The pursuit of employment as skilled labor by FTBIMDs is in obedience to this divine regulation.

Findings #6. Tentative manifestation as Coping Mechanism. Coping mechanisms were appropriated by FTBIMDs in my study according to their situatedness.

Participants access resources to cope with their tenuous situation of underemployment and racialization in the process of finding work and working in the U.S. A coping mechanism appropriated by participants is the peer support group within a community based organization (CBO) that is assisting IMGs with residency process.

Initial tentative manifestation of peer support group within a community based organization.

There is a community-based organization in the Midwest that is assisting IMGs in this licensing process. A FTBIMD who lived this hardness of the licensing process decided to make a difference by developing a program that would assist IMGs transition into residency. Hardness has thus produced an innovative program. The organization helps connect IMGs with recertification agencies and also assists the IMGs in several ways, including providing reimbursement for the USMLE examination cost and facilitating a peer support group for education and advocacy. The organization has worked in a collaborative task force including various stakeholders in the state in the Midwest to present the licensing of IMGs to the legislature. This effort has yielded some success. The legislature passed a Bill funding the licensing of IMGs for one year at the time of this research in 2015.

The IMGs continue to organize as suggested by Quinn & Mainers (2009) to reach out to policymakers to look into the situation of IMGs. Quinn & Mainers (2009) assert that “concepts of identity and choice are intertwined and are integral to the particular erosion of public education in the United States. Framing issues as private is a political

act that ironically aims to remove certain identities, including women, people of color and the disabled from-and the bodies and labor attached to them from economic and political context" (p. 4). Such political acts are dialogic. This dialogism explains why post-intentional phenomenology is the appropriate methodology for this study. Post–intentional phenomenology is dialogic, and can be used as a political tool (Vagle, 2014). IMGs organized themselves in the Midwest and reached out to other state departments. A taskforce of stakeholders then took the case of IMGs to the legislators. The testimonies of the IMGs brought the demise of IMGs to the public arena. The legislators deliberated and agreed to support IMGs in the licensing process.

Legislators passed a bill in May 2015 authorizing the use of funds for the licensing of three IMGs. For the IMGs, it is a dream come true. It is a shift in the right direction. It is hoped that the legislators would continue to increase this funding and also increase the number of IMGs that could be funded to get into the licensing program.

Initial tentative manifestation in persistence, resilience, and the American Dream. Persistence, resilience and the American Dream are tentative manifestations of resources that most immigrants utilize to adjust to education and workforce systems in the U.S. Most immigrants are persistent and resilient in pursuing the American Dream despite the challenges they encounter finding work in the U.S. Gloria Anzaldua writes that the "third world grates against the first and bleeds, and before a scab forms it hemorrhages again, the life world of two worlds merging to form a third country- a border culture" (1987, p.

3). The hemorrhage between the Western world and the developing world stated figuratively depicts the challenges and conflictual life in the interstitial space. This space is called the third country (Anzaldua, 1987) and Third Space (Bhabha, 1994). I will add the communal space, where communal interest takes preeminence. Communal interest in my study is the good health of the diverse populations in the American society. FTBIMDs are good additions in the health care system, when given the opportunity to complete residency. They would prove their worthy services to mankind in the health care delivery system. This is what Dr. Marvin, a licensed physician, said in his interview:

> During residency, you have to prove yourself every day. The assumption from patients, co-residents, and attendings is that you are inferior. I had an attending telling that I shouldn't copy and forward my own assessment and plan but he was okay with my senior resident copying and forwarding my assessment and plan. I had an attending telling me that I did not know how to place Central Lines (this was the same day I placed 5 IJ and 4 radial arterial lines) and turned around to tell my intern (who missed all 4 of the arterial lines and 4/5 of the IJs that I placed) that she did great. I complained about it as discrimination to my program director but till this day I have not heard a single word back (System designed to protect the bigots). I had my chief residents tell me that I may have my right to go the VA take away for standing up labs not being drawn after 8 hours of numerous calls and face to face pleas to collect the labs, and after I was told by the nursing supervisor to draw the labs myself if they are important for me.
> I remember being the only Doctor saying a patient's knee is infected and needed washout to clear her bacteremia. I was shocked to hear the nurse bad-mouthing about how I'm just a Doctor from Africa and the only one who would let the patient be discharged. She eventually had surgery and was able to clear her bacteremia and was able to walk (she couldn't do before surgery). I had a surgeon questioned my knowledge in a case where he has no knowledge of basic pathophysiology of post-op infections. I had to push him and the hospital where this happened to request a written apology, otherwise it was going to be put under the rug. The list goes on (Dr. Marvin interviewed on, 04/17/16).

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FTBIMDs are persistent in pursuing a residency, completing the program and becoming licensed. Dr. Marvin had to prove himself every day as a black foreign trained medical doctor in order to complete residency and become a licensed medical practitioner in the U.S. The resilience of the FTBIMDs also derives from the fact that there has been an investment in their education. They are resilient in seeking various resources including social and cultural capital (Bourdieu, 2011) to assist them in their adjustment in the U.S. to achieve their American Dream. Persistence enabled Dr. Bob to go through the hoops and get into residency.

> Dr. Bob: It has been very difficult. If I were to recommend it to someone else, I would say stay in your country. I have learned to be resilient, I have learned to be patient, and now my day has come. I have been given a position on the East Coast.
>
> *Charity: Has your day come?*
>
> Dr. Bob: Yes, I have found myself a place, my day has come.
>
> *Charity: Why?*
>
> Dr. Bob: I know within residency, I expect that there will be knowledge gaps
>
> *Charity: Tell me about your struggle.*
>
> Dr. Bob: I needed accommodation I raised barely enough, I still need to save. I got a hostel where the observership was very good. I enjoyed my stay. I took five connecting buses to the observership site
> I got a very good letter of recommendation. Interviewed out of state and was pre-matched. I held my fort and now my time has come. I have found a place for residency. I was pre-matched in the East Coast. (Dr. Bob interviewed on, 02/01/2016).

Though things were "*difficult at home,"* Dr. Bob was tenacious. He stayed the course by enduring the challenges. He was finally admitted into residency on the East Coast. He used several metaphors and I could see that he had endured a lot in the interconnectedness of his social context.

The participants in my study were persistent and resilient. Knowing that in becoming, *there are no guarantees* (Lensmire, 2000, Ibrahim, 2014), they optimistically continued to explore other possibilities for residency out of state. This is what Dr. Leah said:

> I applied continuously for four years to get into residency in the Midwest but I couldn't. Eventually, I was offered a spot out of state on the East Coast. And I had to leave my family here and went over there and then. I did my first year. I then I came back again, I came back again looking at reapplying to continue the second year of residency at (a University in the Midwest because I can do this. I looked into applying to get into the second year at a local University in the Midwest). I was told to reapply and there will be no guarantee reapplying to continue my second year at the University in the Midwest, and they said no. I had to re-apply as a first-year student and there was no guarantee, so I went back the East Coast and completed my residency (Dr. Leah interviewed on, 04/03/16).

Dr. Leah persists in getting into residency; "applying consistently for four years" paid off. Even though she could not be with her family in her preferred state, she persisted and finished residency.

Some participants continue to pursue their American Dream to get into residency using a combination of resources, hard work and good scores in the USMLE, and building relationships that could facilitate their entry into residency. Good family support is vital in sustaining such an endeavor. Dr. Liza said, "I am going through my whole process of assimilating myself in American society and catching up with the

American Dream." Some IMGs had great spousal support in this journey of finding work. In contrast, others suffered from spousal abuse that depressed them, affecting the education of their children.

It is unfortunate that the categorization of people into racial groups has led International medical graduates who are medical professionals to become "Black" in their process of finding work in the U.S. as they pursue their American Dream. Becoming Black is therefore the initial step in finding work and working in the U.S. for FTBIMD.

Conclusion

In this chapter, an assemblage of participants' voices as tentative manifestations were individually outlined and explained. Summarily, the data produced multiple perspectives of the assemblage of participants' voices as tentative manifestations of the social struggle to find work and working such as hardness, difficulty, challenging, complexity, lack of guarantee, connectedness, brain waste, survival jobs, cultural competence, difference/blackness and skin color, accent, spousal support/spousal abuse, resilience and persistence, children's education, family and transnationalism, spirituality and peer support group.

Black immigrant medical doctors in the U.S. are thus situated in a "*social imaginary- a discursive space where they* are already imagined constructed and thus treated as 'Black' by the hegemonic discourses and groups, hence asked to fit racially somewhere. This is done through complex, and mostly subconscious processes of

racialization" (Ibrahim, 2014, p. 59). Becoming Black is the first step in the intentional relationships FTBIMDs live through in finding work and working in the U.S.

The foreign-trained Black immigrant medical doctors struggle/aspire to become licensed. In contrast, the licensing system is complex and uncertain. This uncertainty is what appears to produce academic and professional *borderlands,* resisting the inclusion of foreign-trained Black immigrant medical doctors from becoming licensed physicians. The multilayer examinations, USMLE, are financially draining, and there seems to be no light at the end of the tunnel for them. However, some states have started examining the plight of International Medical Graduates. For example, one state in the Midwest passed a Bill in May 2015 authorizing funding to train three International Medical Graduates. The legislators' move is seen by the participants in my study as laudable. The younger participants still have hopes of getting into residency while the older ones are looking at alternative pathways. Some older participants find it difficult pursuing an alternative pathway.

There is a crying need for a roadmap to residency for these legal immigrant medical doctors who are either reuniting with their families or fleeing political persecution. The lack of a roadmap to residency leads to unnecessary brain waste in that skilled labor is devoted to survival menial jobs. It was interesting to notice how the assemblage of the participants' voices in tentative manifestations was circulating among participants as a web of entanglements. Specific barriers like accent are also highlighted in ways that could be tolerated to enhance the use of skills by these medical doctors

needed in a cultural mosaic like the U.S. A further layer of analysis and interpretation of this assemblage of participants' voices in tentative manifestation as an ongoing synthesis, generated implications for theory, education policy, and practice will be discussed in the next chapter.

Chapter Five: Summary, Discussion, and implications

"Race works like a language and signifiers….gain their meaning not because of what they contain in their essence, but in the shifting relations of difference which they establish with other concepts and ideas in a signifying field. Their meaning, because it is relational and not essential, can never be finally or trans-historically fixed…That is there is always something about race left on- said" (Hall, 2002, n.a.p).

Chapter Five constitutes a summary of the study, discussions of implications of findings, and conclusion. The chapter further discusses implications of the findings for policy, practice and future research. The overall objective of the study has been to make sense of how Foreign-Trained Black Immigrant Medical Doctors (FTBIMDs) experience living through the process of finding work and working in the U.S. and how these experiences affect their families.

Summary of the study and discussion

The purpose of this qualitative, specifically post-intentional phenomenological study was to explore how foreign-trained Black immigrant medical doctors (FTBIMDs) as international medical graduates (IMGs) navigate the education and workforce systems to find work and work in the United States of America. To understand how FTBIMDs experience finding work and working in the U.S., one must examine how their identity formation affects their life world of work. Their changing identity formation from, for example their ethnic group, Luo in Kenya, Mfumte in Cameroon, or medical doctor in

Cameroon to Black in the U.S., presents challenges in interrelationships in their lived worlds and how they appropriate available resources to cope with their lived world.

This study is framed by a combination of four theories. These theories are Racial Formation theory by Omi & Winant (2015), Post-colonial theory by Frantz Fanon (1967/2008), Borderlands theory by Gloria Anzaldua (1987), and Forms of Capital by Pierre Bourdieu (1986/2011).

Omi & Winants' (2015) Racial Formation theory foregrounded race as a *way of making people up*. It is for this reason that IMGs from Africa are categorized as Black by the West and become Black when they come into the U.S. Being Black has implications for theory, policy and practice. All participants in this study indicated that their racial category as Black stands in their way of using their talents as International Medical Graduates (IMGs) becoming physicians in the U.S. The "reality is that though no one wants to mention it, race is an issue" (Dr. Pet, participant, 2016). Black IMGs applying to be licensed as physicians in the U.S. are racialized in the process of finding work and working.

Postcolonial theory by Frantz Fanon (1967) emphasizes that some Blacks strive to act "white" as a way of benefitting from "white superiority." Acting white and wearing a white Mask for some Blacks is a *line of flight* from the stereotype of inferiority imposed by colonialism and intercontinental slavery. Fanon (1967) frowns at the impact of colonialism on immigrants of African descent that has led some Black immigrants to condone their subjugated and inferior identity. In addition, Fanon emphasizes that

colonial racism pursues Black immigrants as they settle in new homes in the West (Fanon, 2008).

Colonialists subjugated Blacks and treated them as sub-human beings coupled with intercontinental slavery. Fanon (2008) highlights how colonialism pursues the colonized, for example, the FTBIMDs who are IMGs. The identification of these physicians as Black stigmatizes them as inferior and subalterns (Fanon, 2008, Ibrahim, 2014). Such categorization is a way of constructing the identity of FTBIMDs.

It can be inferred from the findings that the complexity in the residency and licensing systems appear to be a systemic organization to exclude FTBIMGs and other IMGs. The fact that there is no guarantee to be licensed even after getting into residency is a cause for concern. Despite this a priori exclusion from residency, some FTBIMDs persist to get into residency. The IMGs who succeed to get into residency are vulnerable because they are discriminated against by both the system and some patients who would not like to be seen by a "doctor from Africa," as stated during the interview by Dr. Leah and Dr. Marvin respectively.

Gloria Anzaldua's (1987) Borderlands theory stipulates that *there are physical borders everywhere*. These borders could be spiritual, sexual, physical and psychological. In this study, these borders have been expanded to the following: intellectual borderlands, academic borderland professional borderlands, academic borderlands, intellectual borderlands and cultural borderlands. A combination of these borderlands has led to the marginalization and discrimination of FTBIMDs finding work and working in the U.S.

Anzaldua (1987), as an immigrant who lived these experiences of marginalization, decided to document them to serve as an example not only for new immigrants but also for old immigrants in their daily living. It should be remembered that life is full of borders in the interstitial spaces (Asher, 2005), or grey areas and margins (Vagle, 2014) where there is intercultural intercourse. Crossing these borders demands a consciousness (Anzaldua, 1987) that leads to an awakening and resistance on the part of immigrants. That is why Anzaldua spent time writing and documenting her experiences as a way of coping with marginalization as an immigrant woman.

Bourdieu (1986) discusses cultural, social and human capital in the context of resources that are available for human beings in an interconnected world. In the context of my study, FTBIMDs appropriated their social networks to gather information about residency. Some used their cultural capital, for example community based organizations, to collect information and support to facilitate their job search. These efforts at finding work and working are geared towards earning income that is commensurate with their training as international medical graduates. Despite the "hardness" of the process, the FTBIMDs remain focused on seeking licensure that would enable them become physicians in the U.S. and earn salaries that reflect the investment in their education (Sumption et al, 2013).

The methodology for my study is post-intentional phenomenology. Post-intentional phenomenology is situated in post-structuralism where knowledge is seen as partial, and always circulating through relations (Vagle, 2014). From this perspective,

unstructured interviews were used to gather data. Thirteen participants were purposefully selected to gain insight and give depth to the inquiry. Two physicians were licensed, four participants had written and passed the USMLE, and six participants were either studying for USMLE or looking for alternative pathways for various reasons. One participant chose an alternative profession. The results of the study are explained in these six tentative manifestations: 1) Challenging endeavor, 2) Residency or licensing is complex system, 3) Brain Waste, 4) Difference, 5) Family well-being, and 6) Coping mechanisms.

These tentative manifestations are all interconnected in the lived world of FTBIMDs in the U.S. For example, "hardness" in finding work is due to a variety of reasons including the complexities around the residency system. This complexity renders the FTBIMDs powerless. They are a *body without organs* (Deleuze & Guattari, 1987). Their Blackness renders them unlikeable. FTBIMDs are left with the option of resorting to survival jobs and wasting their brains. These survival jobs are lines of flight (Deleuze & Guattari, 1987) while remaining hopeful that a better opportunity or a more lucrative job might open up. As FTBIMDs do survival jobs, their human capital in terms of skills acquired as physicians is underutilized, and their brains are wasted because physicians are a special category of skilled workers in a life-saving profession, medicine.

The professional identity of these FTBIMDs as physicians is lost in this process of becoming Black and finding work and working in the U.S. simultaneously. Becoming Black engenders inferiorization of Foreign-trained Black immigrant Medical doctors. This is because of the stigma associated with Blacks in the U.S. as being unintelligent,

lazy and inferior. Furthermore, their identity is being constructed as high school graduates because of the survival jobs they do. The findings reveal that FTBIMDs appear to be marginalized because they are Black, they look different, and they speak English with a foreign accent. Being different does not mean that FTBIMDs are deficient. Like Anzaldua, all the IMGs need is to *be met halfway* (Anzaldua, 1987). This implies that accent should not stand in the way of FTBIMDs finding work and working in the U.S. American-born citizens and others whose first language is English should also make an effort to understand immigrants who speak English with a foreign accent.

Also, the experiences of FTBIMDs affect both the immediate and extended family members. In fact, the struggles that FTBIMDs go through "*becoming doctors a second time in the U.S.*" affect the family negatively. For example, one participant referred to the process of residency and licensing as "two mountains." These "mountains" depict the uphill task involved in getting into residency and becoming licensed as an IMG. It is a way of referring to the tedium involved in attempting to scale through the examination "mountain number one and getting into residency Mountain number two" (Dr. Lesley, 24/3/2016).

To cope with this state of affairs, FTBIMDs appropriate certain resources spiritual, social and cultural capital (Bourdieu, 1986). For example, they connect with community based organizations (CBOs) that serve as spaces where dialogue and political organizing could occur (Milkman, 2011) to assist immigrants with adjustment in the U.S. An example is that of a CBO in the U.S. that succeeded in developing a program that

assists international medical doctors with certification. It also provides space and guidance for a peer support group that helps the IMGs, including FTBIMDs. This innovative model appears to be a derivative of Ubuntu philosophy, creating a safe space for community well-being.

This is a transformation of the Ubuntu philosophy of education (Nabudere, 2005) into practice. Starting a program to cater to the needs of international medical graduates is not only ingenious, but it is an innovative way of community building that has its roots in the African philosophy of *collective human interest and social justice* (Nabudere, 2005). Our collective good matters. The goal of the research was to examine how finding work and working might take shape for FTBIMDs in the U.S., a society that has no historical roots of the philosophy of Ubuntu.

Participants in my study relied on their spirituality. For example, churches and mosques were sought by a majority of these IMGs as respite from the "hardness" of pursuing licensing as physicians in the U.S. Relying on a Divine Being is what gives a majority of these IMGs hope. Yet others prefer to abdicate. For example, some have insinuated that it might be preferable to "go back home" and serve the population that needs them and that recognizes them as trained medical graduates because global health is being endangered with the migration of IMGs and wasting their brains in survival jobs in the West.

Implications and Conclusion

Implications of the study are seen from two angles: first, implications for policy and practice, and second, implications for future research.

Implications for Policy and practice

The implications for policy and practice have recommendations that derive from the six findings as tentative manifestation of the phenomena finding work and working in the U.S..; (1) Acknowledging, marginalization, racialization and exclusion; (2) Simplified Road map for residency and equitable treatment of IMGs; (3) Brain Gain, instead of brain waste; (4) Embracing difference; (5) Preparing future workforce through family literacy; 6) Appropriating Relevant Resources.

Implications for policy

This study has a few implications for policy.

1) **Acknowledging, marginalization, racialization and exclusion.** Acknowledging marginalization and racialization of FTBIMDs in the physician workforce in the U.S. as a result of obsolete regulations would be a vision for change that promotes social justice. This should be a first step in attempting to bring a solution to the plethora of frustrating concerns IMGs encounter in the U.S.

***It is frustrating*.** The process of finding work as an international medical graduate is frustrating for a variety of reasons. First, FTBIMDs become "**Black**" when they enter the United States.

In their country of origin, they were known by their professional identity of Medical Doctor or class as medical practitioners, not Black or Brown. In contrast, the dominant culture in the Western world has a category for people with Black or brown skins. Thus, using race as *a master category* (Omi & Winant, 2015) renders the process of finding work and working as FTBIMDs frustrating. Being given a label that attracts a gaze (Ibrahim, 2014), and a skin color Black or brown that frightens a child who sees a Black man and screams "Mama, look negro" (Fanon, 1967, page #) is disheartening. Such racial denigration seems to produce grief that becomes an injurious racial grievance (Cheng, 2001). Racial injury has enormous consequences. It may lead to depression and melancholy (Cheng, 2001).

Such emotional distress and depression was experienced by a majority of the FTBIMDs I interviewed. Most participants had been in and out of depression for lack of a better way of describing the multiplicity in emotional well-being involved in the immigrants' trajectory finding work in the U.S. Participants in my study voiced their experiences finding work and working in the U.S. as frustrating because of the complex nature of the process.

*Seeking alternative approaches to accommodating IMGs***.** This interpretation of the data gives policymakers the opportunity to seek a better understanding of the licensing process and make decisions for revision of the complex licensing process. The institution that oversees USMLE was established in the 1960s. There has been no

evidence of any revision of the provisions for residency since then to the best of my knowledge. This leads U.S. to the next implication for policy and practice.

2. **Simplified roadmap for residency and equitable treatment of IMGs.** The need for a simplified roadmap for residency and licensing of IMGs and equitable treatment of IMG is one of the major implications for policy and practice. It is possible to simplify the residency system by expediting the processing of recertification through the Educational Commission for foreign-trained Medical Graduates (ECFMGs). IMGs would have the requisite certification in a timely manner to proceed with their applications for residency. The justification for simplification of the certification process by EFCMGs can be seen in this excerpt from Dr. Marvin:

> ECFMG staff getting my school transcripts from back home and just discarding them, sending the standard "ECFMG requested your transcripts however your school has not responded" for so many times that I had to travel back home and ship the envelop from my school myself, tracked it until it got delivered and someone at ECFMG signed for it. Then I called and got the same message as above. I even had to talk to the supervisor who got the nerve to tell me that ECFMG received thousands of letters every day and that I should start the process over. I threatened a lawsuit after he told the above thing and the following morning the same guy who just told me to start the process of having my transcripts sent again after 18 months of back and forth, called me and left a voicemail stating that the letter from my school was found and that my ECFMG Certificate was signed and sent in the mail. This shows that some of the people working at ECFMG do all they can to block your progress. (Interviewed on 5/17/16)

Dr. Marvin's experience with the ECFMG appears to summarize the treatment of IMGs as subalterns. It took a threat of a lawsuit for his ECFMG Certificate to be signed and

sent in the mail. There is the need to revamp the certification process through the ECFMG. Revamping this process and removing the standard “ECFMG requested your transcripts however your school has not responded" would eliminate delays in the certification process. This change may be slow but it is an absolute necessity. Changing the way the educational commission for the certification of foreign-trained medical graduates treats IMGs would be a big step in the right direction.

The ECFMG was instituted in 1956. It has since certified over 320,000 international medical graduates. However, double standards (Dore, 1967) persist in the licensing system - one standard for ATMD and another for IMGs. This is what Dr. Leah pointed out in her interview about the examination:

“The ECFMG pass rate was 35.5%. Those were very unfair exams.” If you are setting an exam that the exam passing rate is 35.5% that means the people are set for failure. There is something wrong with that; probably those exams might have been made harder than what our counterparts were doing. For Foreign-trained medical graduates the examinations seem different. The USMLE seems different.”(Dr. Leah, 04/03/2016).

One of the strategies ECFMG use in screening IMG is geared towards “protecting the public.” There is no doubt that health security of the population is paramount, but “protecting the public” here can be read as IMGs are infectious or dangerous because of their foreignness, accent, or intellectual borders. Giving IMGs, especially FTBIMDs, the opportunity to contribute their educational and cultural wealth to the health care system

would be beneficial to all in a diverse society like the U.S. Thus, reviewing and revamping the residency system seem to be imperative.

3. Revamping the Physician licensing process for IMGs in the U.S. The need to revamp the physician residency and licensing process for IMGs in the U.S. is imperative. The current system seems to be redundant. The ECFMG was instituted in 1956. The American society has become more diverse with the growing population of immigrants. The health care needs have increased and there is doctor shortage. The need for revision of the regulations governing certification is urgent.

Revamping the residency and licensing system would promote equity by harnessing the available diverse skilled manpower from all over the world.

Doctor shortage. Alleviating the problem of Doctor Shortage overall and especially in primary care (Fodeman & Factor, 2015) would be one of the practical solutions to the underemployment of IMGs. There is doctor shortage and an influx of diverse population - these are polar opposites. Doctor shortage means the lack of physician/man or woman power to meet the health needs of the diverse population in the U.S. In contrast, there are several IMGs who are struggling to get into residency and licensing system to become licensed physicians in the U.S. The system is complex with multilayer examinations. Considering the work experiences of IMGs including FTBIMDs for matching IMGs in the licensing program would be a good approach utilizing the skills and talents of FTBIMDs and expanding residency slots.

Policy makers need to pay close attention to the results of this research especially the voices of participants as reported. FTBIMDs are a subset of IMGs in the U.S. The challenges they have indicated here are similar to challenges faced by other IMGs. However, identifying IMGs as Black denotes a stigma of inferiority. A review of the governing body for residency would lead to reflections about accommodating new international medical graduates who can be retrained through an immersion program. This recommended training program would be based on a specific curriculum designed to include all requirements for residency. This program would have implications for practice.

Implications for Practice

Implications for practice concern education and employment. This study has brought to light for the first time the plight of international medical graduates, who are Black, also known as foreign–trained immigrant medical doctors in the U.S. Their underemployment as a result of various hurdles does not cover any return on the investment in their human capital development.

Implications for Education

The challenge encountered by IMGs who are FTBIMDs necessitates the creation of an immersion program that would help prepare IMGs for the workforce when they arrive the U.S. An immersion program with an integrative curriculum is recommended for International Medical Graduates (IMGs) that includes both training for the USMLE

examination and English language communication skills (oral communication, presentations, interviewing, writing personal statements, and networking)intercultural communications skills, American academic writing in addition to English as a second Language (ESL). This immersion program would comprise adult basic education and literacies. For example, technological literacy that is greatly needed because FTBIMDs are coming from a deprived society to a society with advanced medical technology.

Some examples are English language communication, presentation, accent reduction, English language pronunciation, preparing for USMLE. How to write a personal statement, preparing for interview, networking and intercultural communication skills, that would help IMGs adjust into the medical workforce. This curriculum is different from an Adult Basic Education curriculum that focuses on English as a second language (ESL), basic math, reading and writing, up to General Education Diploma (GED). What the workforce centers offer is good enough, but IMGs need specific training that would be helpful in the residency process. An assemblage of resources including technological training, preparation for USMLE, and contextualized English as a second language, including medical terminologies would be needed. The immersion program described above is what the IMGs need.

The borderlands framework opened my eyes to academic borders, intellectual borders, and professional borders for FTBIMDs as IMGs. My engagement in conversations with the FTBIMDs showed that medical education is valued differently in different spaces. The IMGs have to go through a recertification process different from the

U.S.-trained medical graduates. While IMGs take the USMLE when they immigrate into the U.S. after graduation, U.S. medical graduates take the USMLE in their second year of medical school. Only exceptionally hardworking IMGs pass the USMLE. Yet passing the USMLE is not a guarantee to enter residency. This seems to be what some researchers have called a double standard (Traverso & McMahon, 2012). That is why all participants intimated that the process of finding work and working is a challenging endeavor. Furthermore, it is for the same reason that international medical education appears to be sub-standards or low quality. IMGs, especially those from Africa, are despised. FTBIMDs therefore experience an academic borderland. As an extension of Anzaldua's border theory, the academic borderland leads to an intellectual borderland. FTBIMDs are regarded as subalterns (Fanon, 2008, Ibrahim, 2014). As seen from the experience of Dr. Leah and Dr. Martin, both had to prove themselves to be knowledgeable licensed foreign-trained Black immigrant medical doctors now practicing as physicians.

For those who are in the process of pursuing residency, the intellectual borderlands are obvious in the USMLE where you must score very highly the first time you take the examination to apply for residency. And, after scoring above 90%, there is no guarantee because of the intellectual borderland. Even during interviews for residency, some participants were embarrassed about the type of questions they were asked. For example, Dr. Bob was asked if there were medical schools in Africa, despite the fact that he had passed his USMLE.

EDUCATION AND EMPLOYMENT

The study findings in tentative manifestation indicated that the residency process is complex. There is no guarantee and it is who you know or you need to be known by someone. The implications for residency are divided into two parts. The first part concerns those IMGs, especially the FTBIMDs who are preparing to get into residency, and the second part relates to those who are already in residency.

The complexity of the residency system for FTBIMDs is also seen in the fact that they have two learning contexts. First, as immigrants they learn the process of adjustment in the U.S. including communication, how to access resources for children's education, the health care system, housing and transportation. Second, they have to learn to become doctors "a second time" (Dr. Lesley, 03/24/2016).

Treating IMGs with humaneness would be an extension of the American ethic of caring for your neighbor expressed by the American Immigration Council, and mentioned in chapter three. As President Barack Obama stated on July 12, 2016, at the funeral of police officers killed in Texas after a protest march against the killing of a black man in Falcon Heights, MN, "One American family is the America I know." Former President George W. Bush asked the question, "How do our experiences shape us?" The experiences of these FTBIMDs shape their thinking in terms of their loss of wages, loss of identity, loss of status, loss of class and conjure up persistence in some FTBIMDs to succeed.

Implications for Employment

Facilitating the certification and USMLE process would be a way of helping IMGs get into residency and be licensed to practice medicine in the U.S. This step would lead to the employment of FTBIMDs or IMGs. Easing the process would be brain gain, thereby disrupting brain waste.

3) Brain Gain, instead of Brain waste. Expanding the physician labor force without lowering standards by harnessing the human capital of IMGs will lead to brain gain for the U.S. These IMGs are skilled professionals who have international experiences and also possess cultural ways of knowing. This cultural wealth is a great addition to the U.S. knowledge pool. Facilitating the certification process and USMLE would be a great way of utilizing skilled labor in the medical field. Such a move would alleviate the current underemployment of IMGs that leads to brain waste as they work at the level of high school graduates for survival. Some "hide" their credentials just to have some side job to provide for their family. Others feel that their credentials are no longer useful. Dr. Fred stated regrettably that "being educated seems to be a liability." On the contrary, education is an investment in humans because human capital should not become a liability. There are expected returns on the investment when the acquired training and education is put into use. However, Dr. Fred made this statement about education being a liability in the context of his frustration with the fact that his education as a medical doctor is not being utilized. He has passed the USMLE but has yet to get into the residency program. His rhizomatic identity as a Black immigrant medical doctor is

always becoming. His identity is always being shaped by the context. Given this tenuous situatedness of FTBIMD, one participant in the study, a licensed FTBIMD, recommended that specific slots be allotted for International Medical Graduates in the match program to allow them to leverage the possibility of getting into residency someday.

> *Allocation of specific slots for IMGs in the Match program.* One participant said: "Personally I feel that due to the discrepancies, specific spots need to be reserved for Foreign-Trained Medical Graduates (FTMG). I'm telling you if any of them have passed these exams and have done externships and have credible knowledge, they need to be given a chance to practice. There needs to be a pathway for them to offer their knowledge because I feel that there is still a great need in the U.S. for health care providers" (Dr. Leah, interviewed on 03/04/16).

There has to be a pathway through which they can use their immense knowledge.

As IMGs, they embody cultural values that render them different. Difference is seen from the way they speak the English language with an accent. Accent and foreignness are some of the obstacles faced by FTBIMDs finding work and working in the U.S. However when adequate information is provided to IMGs during visa interviews or at ports of entry, IMGs will be better informed on how their training and skills can be used in the U.S. It is recommended that adequate information is made available to IMGs on arrival by the worker's center about the process during their interview for a visa.

Giving adequate information to skilled professionals will establish a kind of a road map for them when they immigrate. Dr. Lesley was given adequate information as

seen in her interview. She sought information from CBOs serving immigrants and refugees about the licensing process. From this information, she realized that the process felt like becoming a doctor a second time, and this was something she could not do. She made a reasoned decision to put down her medical degree for the wellbeing of her family.

Developing welcome centers. Developing welcome centers will help alleviate the difficulty of the process of adjusting in the U.S. These welcome centers could be collaboration between the government and community based organizations serving immigrants. In a previous chapter I noted how these community based organizations are critical in assisting immigrants with resources as they adjust to their new home in America. In her work with immigrant employment, Ruth Milkman noted that these CBOs are called *workers' centers*. Working together with these workers' centers would be more productive because these CBOs do the grassroots' work of reaching out to the new immigrants and providing resources. For the FTBIMDs, reviewing the licensing system would be a welcome dream.

4) **Embracing Difference.** Embracing difference as a policy would be a great way of accommodating IMGs. IMGs are different in various ways. They come from different geographical locations, they speak English with an influence of other languages, and their appearance is also different. However, embracing difference would confirm the fact that "difference is not deficiency" as one participant stated. As IMGs, they embody cultural values that render them different. Difference is seen from the way they speak the English language with a foreign accent. Foreignness and accent are obstacles for

FTBIMDs in finding work and working in the U.S. As I reflected on the findings, I developed new questions for further discussion. Because IMGs have trained in accredited medical schools, they have a wealth of medical experience. Also, FTBIMDs who are IMGs have cultural knowledge that facilitates cultural competence needed in a plural society like the United States. More information could be provided to IMGs about the United States Medical licensing examination either during the visa application process or at a welcome center.

Cultural Competence. In a cultural mosaic like the U.S., building on the cultural competence of FTBIMDs would ensure that better care is provided for the diverse population they serve. Cultural competence plays a great role in the type of services that is provided by IMGs if given the opportunity. IMGs have additional talents in the form of cultural values and culturally specific experiences that could help meet the cultural needs of the diverse community. Based on the languages, cultural sensitivity, training and experiences, IMGs are equipped with the necessary cultural capital to provide culturally competent care.

As a strategy, cultural competence in the U.S. seeks to address issues of multilingualism; “I am fortunate that I am multilingual” (Dr. Tyler). He enacted his multiculturalism to demonstrate that multiracialism and complex cultural intersections are increasingly relevant in health care for diverse populations.

It is common sense that medical graduates from a global perspective have the same basic knowledge of physiology. However, there is a difference in clinical practice

for the following reasons: context, resources, epidemiology and technology. Thus, IMGs encounter special difficulties such as the culture of medicine in the U.S., workplace culture, and patients' expectations in addition to those of colleagues and supervisors.

Allowing FTBIMDS to have the opportunity to give back to use their skills in cultural competency that accompanied them will greatly impact patient health and the dynamic of managed care.

Figure 4: Valuing all cultures for communal good. Source: (Cullor, 2016).

By disrupting exclusion by appropriating the assemblage of ways of knowing of immigrants in the cultural mosaic to reclaim the brains of IMGs from being wasted, the

licensing process in the U.S. will enable talents from competent international medical graduates to be utilized in a culturally appropriate manner. The American society and the public will be better protected. This amalgam of medical knowledge and cultural competence would sustain public health care needs in U.S. The IMGs would be given an opportunity to serve as qualified physicians in an equitable manner. On the other hand, they would refresh their medical education through hands-on practice in residency. This approach would strengthen the health care system in the U.S.

Another approach is to institute inter-cultural communication skills as a professional development requirement for staff members. Workshops on cross–cultural communication would help build bridges in the workplace and also enable staff members to accommodate each other for the purposes of developing learning communities and promoting a good working environment.

5) Preparing the future workforce. The future workforce needs to be prepared today. In the context of this study on FTBIMDs, new IMGs and children of IMGs are considered to be the future workforce. Therefore, they should be adequately prepared to take on challenges that may arise as future professionals.

Professional and Family Literacies. New IMGS (FTBIMDS). For the New IMGs, reviewing and expanding the residency and licensing system would offer many IMGs, including FTBIMDs, the opportunity to be licensed. Licensing IMGs would lead to more stable families who are financially capable to take care of their families.

EDUCATION AND EMPLOYMENT

The children of FTBIMDs. The children of FTBIMDs as seen in the study deserve specific care and attention to help them perform well at school and become part of a productive workforce in the future. Children from homes whose parents are gainfully employed as skilled professionals would have a better chance of flourishing and succeeding at school. Their children's success prepares them for a better future in the workforce. These children have only one option, which is to be hard working at school and succeed because they have the attention from parents who serve as role models, in addition to the support from the school.

Being serious at school is a good investment that can lead to important career advancement. These children's parents are educated and were able to obtain good jobs. Career advancement has rendered their parents financially capable of providing for their family. Since their parents help them with school work and they are role models for them, this will promote a culture of upward mobility in these immigrant communities. School success logically follows because of the time and human capital investment. The achievement gap will not be connected to them and the stereotype of un-achieving children or youth at risk will not be associated with them because of the opportunity gaps in investment.

When parents have stable employment, they have more time to attend parent teacher conferences, and build relationships with schools as partners in the human development of their children. Therefore, parents are more involved or engaged in the education of their children. Participants in the study expressed concerned about their

children's education. This is why one of the FTBIMDs in this study had to "put down her education," and prioritize the education of her children. If she had transitioned into the licensing workforce easily, she would not put down her medical degree. She would have been using her medical skills for what she had received her training in. The need therefore for policy makers to consider the transition of the IMGs into the workforce lies in the fact that their underemployment affects the children negatively. For example, when a child says "Daddy, I will miss you" to a parent who has an international job, it is because the father's presence means something great to the child. In contrast, the father's absence creates a gap in his life that his mom cannot fill. This set of affairs creates a psychological imbalance in the mind of the child who should be wondering why his dad who was a doctor in their home country can no longer work as a doctor. He should be wondering why his dad has to work far away from home. His time will be spent worrying about his father and this can subsequently affect his academic performance.

Thandeka's prayer. Thandeka's reflection in the preface of her book *Learning to be White* where she prays that we should walk together is instructive as a way forward. She writes, "I look behind me and I see new travelers journeying forth. These sojourners are America's children. The image fades as I offer a prayer for all of us. Let us walk together children" (Thandeka, Preface, 1999).

Ubuntu, an inclusive pedagogy. Ubuntu, the African philosophy of education, offers the West an opportunity to explore an inclusive pedagogy because our collective good matters**.** Like Thandeka, Desmond Tutu would say let us walk together because *if*

you have no Ubuntu, you have no life and "I am because we are". President Mandela would say let there be a truth and reconciliation commission where compassion, love, reconciliation would prevail, and not revenge. President Mandela enacted Ubuntu during the Truth and Reconciliation Commission in South Africa in 2005 to bring peace and by pardoning the perpetrators of Apartheid. In enacting Ubuntu, President Nelson Mandela used the African philosophy of humanness and togetherness in a sense of family hood. When love overflows, the world's children would look into the future with an aspiration of becoming part of a peaceful and productive workforce.

6) Appropriating relevant resources. The findings revealed that FTBIMDs made use of available resources to assist them in their trajectory of finding work and working in the U.S. As a result, it is recommended that relevant resources be appropriated to tackle the issues of Black identity construction in education and employment.

These resources are community based organizations serving immigrants in the U.S., spiritual connectedness, and persistence in the pursuit of the career and the American Dream. The role of Community Based Organizations.

Community-Based Organizations. Community based organizations are instrumental in serving as entry points for new immigrants. Some CBOs offer referral services to new immigrants. Other CBOs teach English and also advocate on behalf of immigrants. Amplitude scholars have undertaken the work of investigating the employment situation of immigrants. For example, Ruth Milkman (2011), in her work

organizing immigrant labor movements, refers to one of her works as *the precarious situation of immigrant labor*. She notes that Non-Governmental Organization (NGOs) have become involved in organizing initiatives geared toward legislating for public policy issue. Such is the case of the CBOs that educate immigrants and advocate for foreign-trained immigrant medical health professionals. It is in this light that some states such as California, Minnesota, and Florida have started paying attention to the plight of skilled workers, including foreign-trained immigrant doctors, by formulating public policy regarding their transition into the workforce. It took organizing and advocating with the legislators to pass the Bill in 2015 (in a state in the Midwest) that authorized funding to support the admissions of some International Medical Graduates into residency programs. This was a gesture of good faith that gave the FTBIMDs hope of getting into the residency. Such funding needs to be sustainable to ensure that more FTBIMDs will have the opportunity of getting into residency. The implementation of such legislation has proven to be tricky (Fine, 2006). Furthermore, skilled and non-skilled immigrant workers have similar challenges adjusting to the U.S. workforce system and "employer practice" (Milkman, 2011, p. 363). It could be inferred that it is such employer practice in the licensing system that is affecting International Medical Graduates as a whole, and Foreign-Trained Black Immigrant Medical Doctors in particular.

The ramifications in the match program and eventual residency need further dissection, if I may use medical terminology. Such dissection could lead to decolonizing (Smith, 2012) the licensing system in the U.S. and offering IMGs the opportunity to

utilize their qualifications as medical doctors in addition to their cultural expertise to better serve diverse populations in the U.S.

In sum, the adjustment of IMGs in general and FTBIMDs in particular as demonstrated in the analysis of findings do not conform to a specific timeline because of the complex residency system and the challenges individual IMGs (and especially FTBIMDs) encounter finding work and working in the U.S. Therefore, IMGs and FTBIMGs assimilate differently as a result of the variation in human capital and social context (Alba, & Nee, 2003, Brown & Bean, 2006).

Despite the investment in education and training of FTBIMDS, their successful employment remains tenuous because of the obsolete and complex residency system and also their racialized identity as Black. Blackness therefore stands in the way of FTBIMDSs finding work and working in the U.S. Witting (2003) asserts that "They are seen as black. Therefore they are black: …. before being seen that way they had been made to be that way (p. 159).

Limitations

A study like this would be deceptive if there were no limitations. Embarking on analyzing the phenomena finding work and working without mentioning class is a limitation. Global health is jeopardized as IMGs seek licensing in the U.S.

All participants indicated the need to send money "back home." This implies that migration has enabled transnationalism and global connectedness. As a result, utilization of skilled workers in the U.S. would help them become financially viable and help their

extended family members back home. This support would bring life to their families who are dependent on the IMGs. There is apparent confusion, should class or race be the key determinant of access to work and working in diverse society

Interpretation of data is subjective, and data could be given various interpretations. The results are not generalizable - they have to do with intentional connectedness of subjects to their lived world. Only thirteen participants were interviewed for the study. Furthermore, the methodology is new and needs clarifications to make the case for the fleeting nature of knowledge in post–intentional phenomenology.

The pedagogy of fear of the unknown seems to have restricted the telling of participants' lived experiences. The participants appeared to hold back a lot because of the lack of confidence in me as a researcher who was not related to the medical field. The fluidity of analysis is also a limitation.

How this study contributes to research because of the corpus of the study is unique, as I have isolated a group of IMGs (FTBIMDS) who have hardly been studied. This is pioneering research, and requires a comparative analysis of other studies to examine the validity of the study's findings in tentative manifestation.

Theoretically, I have used the Gilles Deleuze and Gauttari's concept of the rhizome to explain the phenomena of finding work by FTBIMDs in a nomadic situation. This was done to study a phenomenon which phenomenologists have "looked at" instead of "looking through." I am using a theoretical eclectic racial formation theory, postcolonial theory, borderland theory and forms of capital to understand the unique

situation of FTBIMDSs becoming doctors a second time in the U.S. I have used a combination of theories to explain a nomadic phenomenon, finding work and working, and the entanglements in the lived world of FTBIMDs in the U.S.

FTBIMDs would benefit from refresher courses in the immersion program to transition smoothly into the physician workforce in the U.S. They have studied medicines but are in cultural transitions and are always crossing borders.

Since the FTBIMDs have carried the coloniality over to the U.S., the feeling that they are always being oppressed and marginalized is still present in their daily lives. They are people who have been inferiorized in Africa by colonialists. Similarly, in America they have become Black and are victimized by the unhealthy experiences of racism, discrimination and marginalization.

Further Research

Further research is needed in the arena of experiences of black immigrant health professionals in the workplace in the U.S. to understand how they fair in the workplace. In addition, more research is needed in the construction of black identity in education and employment in North America. Future research could investigate the institutions and administrative structures that oversee the residency and licensing of physicians in the U.S. Data gathered from such a study would further inform physician workforce policymakers about the complex residency system. Additional research is needed about the experiences of international medical graduates (IMGs) as a whole, even for comparative research purposes.

These research exploits may be useful specifically for those who are licensed, those in residency, and those preparing to get into residency. For those licensed IMGs, more research is needed on their experiences in the workplace to understand how best to build a more inclusive workforce that benefits from global talents. Also, further research is needed in the bipartisan Resident Physician Shortage Reduction Act of 2013 that suggested an expansion and increase in the slots for medical graduates (Fodemen & Factor, 2015). This is an opportunity to expand residency slots for IMGs in the U.S. More research is required about the cultural challenges the IMGs encountered in their adjustment process before, during, and after residency. More research is needed with Foreign-Trained Black Immigrant Medical Doctors on their emotional health and that of their families. Finally, more research is need on how the underemployment of skilled immigrant professionals affects professional and family literacies, and children's school success.

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