Researching Reflexivity: Negotiating Identity and Ambiguity in a Cross-Cultural Research Project

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Abstract

This article examines a multidisciplinary, ethnically diverse team of researchers and their relationship with the research in which they were engaged: a study of overseas trained doctors (OTDs) recruited to work in health services in Aboriginal and Torres Strait Islander communities across four Australian states. The reflexive analysis presented in this article is based on interviews of 13 of the 15 researchers engaged in that project, examining the ways in which the researchers construct their own identities in relation to the research and the commonalities and differences evident within and between clusters of researchers based on their own social and cultural backgrounds and migration histories. The analysis also identifies ways in which discourses emerging from this analysis influence further engagement with the research process itself and the findings of that research by making explicit the assumptions underlying qualitative observations and insights.

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Introduction

This article examines a group of multidisciplinary, ethnically diverse researchers and the way in which a reflexive analysis of our relationship with the subjects of our research changed our understanding of ourselves and reshaped the knowledge arising from the research in which we were engaged.

That research was a study of overseas trained doctors (OTDs) recruited to work in health services in Aboriginal and Torres Strait Islander communities across four Australian states, which was built on a previous collaboration examining the recruitment and retention of Indigenous health managers in these services (Wakerman et al. 2000; Hill et al. 2001). Expanding the research collaboration allowed us to link this research

to related research agendas: global medical migration (Zwi and Yach 2002; Scott et al. 2004; Whelan et al. 2004) and, at a more intimate level, the impact on doctors' families of migration to rural Australia (Durey 2005, 2006).

This expanded framework provided a heuristic space in which to explore our own positioning in relation to Indigenous health and international medical migration. Examining the motivations of OTDs in the context of medical migration raised issues of researcher subjectivity—our identification with those being researched—and the motivations driving our own research trajectories. Such themes go to the heart of reflexivity and the researcher's inevitable implication in their research (Clifford and Marcus 1986; Jennaway 1990; Hall and Callery 2001; Adams 2003).

Background to the Reflexive Study

In setting our case definition for the overall research project as “the OTD in the context of the health service of an Aboriginal community,” we recognized that this locates the subject of the research (and our reflexive enquiry) within three sociocultural domains. Despite the reality that health services in rural Australia are heavily dependent on medical staff recruited internationally, the cultural domain of the OTD is clearly defined as other: overseas trained, not “of this place.” The Indigenous cultural context is explicit—emphatically so in Aboriginal community-controlled health services. The

third domain—that of non-Indigenous, Anglo, mainstream Australia—is less readily identified, largely because of its pervasiveness. Despite this, it continues to assert its dominance, with Aboriginal and Torres Strait Islander health services seen as exceptional and “locally trained” the norm against which “overseas trained” trained doctors are judged (Rowse 1992; Ganguly 2001; Hill et al. 2001).

The three domains were evident in the institutional and personal composition of the research team. We comprised 15 members across four academic institutions and one Aboriginal Medical Service in four Australian states. One of the institutions included an Indigenous health unit; another specialized in rural and remote health. Our disciplinary backgrounds included public health medicine and general practice (GP) (5), public health (5), and the social sciences (5). Five of our team were Indigenous Australians; of the remaining 10, 4 were Australian born and 6 were born overseas. One born overseas migrated to Australia as an infant and identified as Australian; two were originally from South Africa, and another two were from England. The final overseas-born team member migrated from Singapore in adolescence, with education and formative life experiences shared between Singapore and Australia. The gender balance was 10 female researchers to 5 males.

Interactions between members of the research team were complex and grounded in previous positive research collaborations. Face-to-face meetings to

determine methodology and develop instruments were complemented by regular teleconferences, but the case studies themselves were managed with relative independence. Researchers met to identify preliminary themes from the case studies; analysis and write-up was allocated to subteams, with representation from each state cluster whose members collaborated by e-mail and phone contact. Despite these constraints, a critique of the available literature, documentation of OTD experiences, and analysis of the implications for health services were completed (Arkles 2006; Arkles et al. 2007; Durey et al. 2008; Gilles et al. 2008).

We became aware of issues of identification with the subjects of the research from our earliest discussions, and anecdotal exploration indicated greater complexity in the relationships between researchers and the research than had been anticipated in the team's recruitment. The team included researchers trained overseas, including OTDs, who had personal and research experience of the international migration of health professionals.

Indigenous researchers (IRs) had developed orientation programs for OTDs and their Australian counterparts and understood personally the demands of working across cultural domains (Rowse 1992; Hill et al. 2001). The Australian-trained researchers had worked in a range of cross-cultural contexts, both in Australia and internationally. It was clear from initial discussions that this diversity not only had the potential to influence the research itself, shaping our investigation and analysis in

terms of our divergent but complementary experience, but also offered rich research data in their own right.

Reflexivity, defined as “thoughtful, conscious self-awareness,” allows a more open exploration of the impact of the personal perspectives of the researchers and their relationships—both with the subjects of the research and also with each other (Banks 1998; Finlay 2002; Mauthner and Doucet 2003). As such, reflexivity is linked to the construction of identity (for both research subjects and the researchers themselves), relationality, and objectivity (Jennaway 1990; Malterud 2001). Identity itself is complex, fluid, context specific, and open to redefinition both by individuals and those engage with them (Howard 2000; Malam 2003), with dominant groups commonly defining the identities of less powerful groups as “other” (Fine 1994; Schwalbe et al. 2000; Grove and Zwi 2006).

Methodology: The Reflexive Component

The reflexive component used a semistructured interview format, lasting approximately 40 minutes, with four specific questions asked of all researchers-subjects and the option to add questions to clarify responses or elucidate issues. Recognizing that, as researchers, we shared the same cultural and professional interfaces as OTDs, we structured the four key questions to parallel those asked of the OTDs, who had been questioned about their identity, motivation, preparation, and concerns regarding their roles in

Aboriginal health. Researchers were asked: Can you introduce yourself in relation to the research? Can you describe what attracted you to this research on OTDs in health services in Aboriginal communities? What specific professional and life experiences have prepared you for your role in the project? What assumptions and expectations do you have in commencing this research?

The reflexive interviews were conducted before commencing the main research. An information sheet was distributed to all researchers, and consent was obtained verbally. Thirteen researchers agreed to participate as subjects in this component of the research, with two non-Indigenous Australian researchers (ARs) declining to be interviewed. To maintain consistency, one researcher (P.S.H.) conducted the 13 interviews, using the question guide, either in face-to-face discussions (eight) or by teleconference (four), and then dictated his own responses to the same question guide for transcription and analysis. The implications of the issues raised in the interviews were subsequently discussed in two face-to-face team meetings and by phone and e-mail between researchers.

To increase reliability (Guest and MacQueen 2008), the analysis of all transcribed interviews was undertaken by one IR (V.L.) and one non-Indigenous Australian (P.S.H.), with an independent third researcher not engaged in the research project (M.J.) reviewing the overall cohesion of the themes and subthemes and assisting in providing a theoretical framework for the analysis. The

thematic analysis was undertaken using the N-Vivo 7 qualitative analysis software program (QSR International 2008). The structure implicit in the key questions provided the initial themes: self-identification, identification with the research, and motivation. Within these three themes, the researchers identified subthemes using an inductive process (Corbin and Strauss 2008:162–63). The researchers compared subthemes and coded text: Where subthemes coincided, the text coded under these were checked to ensure agreement and a comprehensive listing; where a subtheme had been identified by one researcher but not the other, the coded texts were examined and consensus reached as to whether the additional subtheme was required or whether the text should be allocated to existing subthemes (Carey and Gelaude 2008).

The three researchers analyzed the content of each theme for patterns, using the characteristics coded for each respondent—gender, age (<45 years/>45years), professional discipline, Indigenous/non-Indigenous. Although gender and professional discipline provided no common trends, distinctive patterns of response were evident among three broad categories: IRs (five), non-Indigenous ARs (three, including one born overseas), and researchers who had been trained overseas (five).

Identities are complex and multiple, but the researchers-subjects have been clustered on the basis of their self-expressed identity as IRs, ARs, and overseas

researchers (ORs). One researcher, already identified, shared life experiences characteristic of other overseas trained researchers, despite having had professional training in Australia, and has been included with the ORs for the purposes of discussion. This exception suggests that any attempt to classify is necessarily a simplification of our actual identities, which are multiple, layered, complex, and intersecting (Adams 2003; Malam 2003). Although some of the researchers-subjects will inevitably be identifiable, identifying characteristics have been avoided to reduce this risk, with the responses aggregated and presented using the groupings identified above. All members of the research team have approved the final draft of the article and any requested changes to maintain confidentiality have been made.

Findings

The findings were grouped according to the identified themes: (1) self-identification, (2) identification with OTDs, and (3) motivation.

Self-Identification

Interviews with researchers were initiated by inviting them to introduce themselves in terms of the research. All the responses emphasized professional identity to some extent, but IRs identified themselves primarily in terms of their Aboriginal or Torres Strait Islander

cultural identity, qualified by links to birth place or kinship.

For ORs, their own cross-cultural experience contributed to their identification with the research. One confessed to having “a longstanding interest about ‘how do marginalized groups, patients, hit the systems? How are they treated?’” Another OR rationalized his or her ¹ professional orientation as a product of his or her background, growing up in the cross-cultural environment of South Africa. A third saw his or her own “complex, multicultural” identity shaped by his or her own migratory journey from England to a small Australian country town, integrating multiple roles, including that of an “OTD spouse” in his or her partner’s professional transition into rural GP.

Two of the ORs met the criteria as OTDs, though the degree to which they were comfortable with this identity differed. One researcher responded:

I guess I’m an overseas trained doctor and I work with overseas trained doctors and I’ve been involved in the recruitment of overseas trained doctors. ... As a researcher you might have a more distant relationship with your subject material ... to me it’s part of myself and it’s my friends, and it’s my community.

For the second OR, well published in terms of international research on medical migration, self-identification as an OTD was equivocal: “I suppose I should declare that I’m an overseas trained doctor in a

way, although I don't think that this has explicitly come into my thinking in relation to this particular project." The interview clearly recalled previous dissonance around explorations of identity, raised in an interview on medical migration for *In the National Interest*, a radio program on the Australian national broadcaster, where the respondent was confronted by being labeled not as an internationally recognized researcher on medical migration, but as "a drained brain ... from South Africa ... one of the countries which has pleaded with the rich world to stop plundering their trained medical professionals" (Australian Broadcasting Corporation [ABC] 2005).

For this OR, issues of identity have been revisited repeatedly since early postgraduate emigration. Identity as an OTD has been long transcended by an alternative identity that subsumes issues of country of origin, or the countries in which training was completed, or employment undertaken. This OR and an overseas-trained social sciences researcher in the team prefer to self-identify as "global citizens," engaging responsibilities at a global level, rather than at specific and local ones.

Identification with OTDs

Identification and Differentiation for ORs

Not surprisingly, identification of researchers with OTDs reflected some of the issues raised by self-identification.

The personal was prominent—both in terms of individual and family histories. For one OR, the tensions of social and professional adaptation as an OTD echoed a childhood shaped by the need for his or her family, migrating to Britain at the turn of the nineteenth century, to suppress his or her German identity in the hostile climate surrounding World War I:

[It's] the reason why my family were so utterly English and snobby, insisting on the Queen's English at all times. ... As a child I just absorbed the need to behave correctly but only later realized that the family attitudes were born out of a need to survive, not exactly as refugees, but certainly facing many of the issues that face me and others as OTDs.

One OR—a former partner of an English OTD—noted the importance of spouses in integration into local communities and the need to take account of the demands of families when considering recruitment strategies. Several articulated the professional satisfaction they derived from the richness of clinical practice and the variety and autonomy of rural GP and the relative privilege of the GP in rural society, recognizing that such social privilege is not universal and that the experience of OTDs from other ethnic backgrounds may be substantially different:

But I think they face enormous barriers from other people's perceptions, colleagues' perceptions. There is a sort of hidden racism I guess that maybe I see. ... I've seen it from patients, you know: "I

don't want to speak to that Paki doctor—I'm glad it's you, not so and so."

But regardless of ethnic origin, OTDs represent the educated elites within their own societies, and ORs were quick to recognize that issues of class—as well as race—may underlie some misunderstandings in OTDs negotiating their new rural, Indigenous context. For Indian and South African OTDs in particular, the expectations that migration to Australia would follow their previous rising trajectories to better social and economic futures were often confounded by the professional and social isolation of general practice in rural Aboriginal communities and the abject health and social circumstances of Aboriginal communities.

ORs made it clear in their responses that although their experience was similar to that of OTDs, it was qualitatively different, differentiating them from the subjects of their research. In one example given, migration to Australia had eliminated the discrimination the OR had experienced as a perceived "European" in Singapore, though their more conspicuously Asian relatives now suffered local prejudice:

I grew up in Singapore: my mother's Malaysian, my father's Danish ... my mother's family are a classic mixture, some Chinese, some Malay—so all my cousins are this hodge-podge of mixed colours. So I grew up in this environment where I didn't see any difference in terms of colour, but ... when we migrated to Australia ... the cousins came to university here, and we experienced racism [again]

... I just couldn't understand it ... why would these people in Australia accept me but not my cousins?

Regardless of ethnic identity, country of origin, or primary language, ORs who were OTDs expressed a sense of persisting prejudice around the OTD identity. ORs pointed to essential differences between OTDs and their Australian-trained equivalents in terms of the legislated protection that Australian doctors enjoy from civil conscription and the health system's inability to coerce Australian doctors into compulsory service in rural areas. The apparent advantage of facilitated entry into Australia for OTDs is diminished by the limited positions (and locations) they may be recruited to, largely in "areas of need," which fail to attract Australian graduates.

That sense of essential difference—of not being treated the same as their Australian counterparts—persists even after registration has been granted and Australian citizenship awarded. For instance, after 5 years of practice as an OTD for one OR, a miscommunication over Medical Board registration resulted in summary suspension of the necessary provider number to practice. The OR complained:

My qualifications are recognized, I speak the same language, the course that I trained under was not that different. Here am I, there's a desperate shortage of doctors in town, and the system just sort of seems to kick you, even when you think that you're fully integrated and I'm now an Australian citizen, I still have to go through that ... every now

and then, it kicks you, and they let you know you're not actually a "proper" doctor.

Interviews with ORs disclosed a considerable level of self-awareness and introspection with regard to identity and an eagerness to think reflexively, to articulate—even theorize—from their own experience. The issue of choice was integral to their explorations of OTD identity. For some, reframing their own identity as that of global citizen reflected their "considerable choice" compared to OTDs, constrained by their terms of recruitment and residency status. For ORs, their own international mobility, the "luxury" of being able to choose between different roles at different times, and their capacity to take some reflexive distance from their own situation and frame it in the broader politics of professional migration positioned them very differently from OTDs.

Identification and Differentiation for ARs

For ARs, their identification with OTDs tended to be framed in terms of their own analogous experience. Reference was likely to be made to their engagement in parallel cross-cultural contexts or to the similarities of working as a non-Indigenous person in an Aboriginal and Torres Strait Islander context. For ARs, previous experience internationally and in rural and remote Australia had made them aware of issues of isolation, the lack of professional support, and the "uncertainty

about professional directions and the landmarks that you use to track professional progress.”

Just as the migration to Australia had confronted ORs with racist judgments, ARs’ experience in other ethnic and cultural contexts had exposed some of them to the possibility of themselves being the subjects of discrimination:

I guess I’ve experienced, in a very mild way, a sense of discrimination or prejudice against my training and qualifications simply because I was working in a different cultural context. I’ve known what it is to be ethnically different, particularly in Nigeria where my skin colour was conspicuous. I know what it is to actually acquire local language and be able to speak it and the trans-formative power of that act. I know that sense of alienation and difference when you’re not working in your own cultural context even when you’re beginning to recognize the important elements of other cultural contexts.

The inadequacy of preparation to work in Aboriginal health was recognized as another point of commonality for ARs with OTDs—with undergraduate medical education in Australia until recently providing little orientation to Indigenous health (Rasmussen 2001:21–28), and urban social life providing limited interaction with Aboriginal and Torres Strait Islander people.

In contrast to ORs, ARs showed less concern to differentiate themselves from OTDs, with relationships

with OTDs framed in terms of their professional judgment. Although recognizing a range of competence within the spectrum of OTD practice, those ARs who were doctors responded in terms that assumed their own competence, despite previous admissions of their own inadequate preparation and orientation (Rasmussen 2001:21–28). They recognized the particular social norms that underpin GP in Australia—the positioning of the GP “alongside” his or her patient, with a more consultative than directive relationship, offering advice rather than instructions. They questioned whether some OTDs would be cognizant of these, or, more importantly, whether OTDs recognized the different norms operating in practices with Aboriginal and Torres Strait Islander clients. One said, “I’ve encountered some doctors with relatively poor clinical skills, and who were unable to recognize that their own cultural norms were quite different to the patient that they were dealing with, and really struggled to operate effectively in this environment.”

For one AR—a social scientist—OTDs represented the same continuum of competence that is distributed across Australian medical practitioners, “They’re as professional, they’re as caring, and they have enormous difficulties which are not recognized or addressed through relocating to not just another culture, but another medical culture.”

Identification and Differentiation for IRs

IRs saw the immediate point of commonality with OTDs as the experience of working across two cultural domains, “I suppose it can be a clash of cultures, a clash of two worlds type of thing. ... I grew up, sort of, in those two worlds.”

For them, the trauma of the cultural transition from mainstream practice to working in Aboriginal and Torres Strait Islander communities was self-evident—both for Australian and international graduates. IRs recounted their conversations with OTDs, friends, and colleagues working in Aboriginal health and what they describe as the “grief they have when they’re working in communities”; “I’ve seen a lot of doctors go through transitions when going into [Indigenous health], overseas trained or not. I think [they] have a lot of cultural smashes around their heads and shoulders when it comes to working in Indigenous communities.”

IRs felt that the poor health status of Aboriginal people, particularly compared to other Australians, would be confronting to OTDs, who may already be experiencing a sense of cultural disjuncture. This is tempered, in part, by IRs imagining that OTDs may have encountered similar issues in their own countries of origin, particularly as migrants from less developed countries, an assumption that equates Indigenous Australians with the marginal or disadvantaged.

I could understand how they possibly feel,
especially coming over from a different country

into Australia, with a history of coming from a country where they were Indigenous. ... You know, they may have experienced some of the same health disparities, or same health problems in their own country.

Although the more experienced IRs positioned both OTDs and non-Indigenous Australians similarly in their relationship to communities, there was an assumption among the two junior academic IRs that some Aboriginal clients may “read” the darker skin color of some OTDs as a marker of shared social disadvantage and an indicator of their capacity to empathize with Aboriginal people:

Sometimes I think that, you know, Indigenous people may tend to warm towards doctors of the same skin colour ... this is just my own experience— there’s a sense that you’ve got the same skin colour, there’s a sense of understanding, an experience that’s the same, of the situation, [the same] marginalised situation.

IRs recognized the challenges of working in communities where English is not the primary language of communication, particularly for OTDs from non-English-speaking countries. For one very experienced IR—a medical educator—the issue of communication and cultural orientation was about being grounded locally and having personal and professional strategies that allow one to work in ways that protect one’s own cultural identity and the cultural identity of others in Indigenous communities:

The big thing ... for thirty odd years has been cultural awareness—which is knowing about a person’s background, which is incredibly important, but in a sense a local issue, that local people can provide. Because, with 200 distinct language groups in Australian Aboriginal situations, it’s very hard to be across all those languages, those cultures—far better to have some good local knowledge, but look very much at cultural competence and the skills you bring to the service and cultural safety.

These strategies demand an engagement with what one IR termed the “misconceptions/myths/stereotypes” that have to be overcome for Australian graduates working in Indigenous communities—and more so for OTDs. Although Australian graduates tend to either confront their inexperience or assume their capacity to “muddle through,” the perception of OTDs is that they are much more apprehensive.

Motivation

Motivation for ORs

Motivation for ORs was grounded again in their own experience but interpreted in terms of personal, professional, and theoretical analyses. For one OR, the impetus for involvement was shaped by a desire to validate her professional insights and to gain concrete evidence of the prejudice against OTDs and the abuses

to which OTDs are subjected by the system. Personal experience of cross-cultural transitions provided an understanding of the ambiguous positioning of OTDs and their spouses, with their relative advantage, but obvious personal and professional constraints, “One of the reasons is again an opportunity to study doctors. I think in research, for me I’m interested in the notion of studying up, as opposed to studying disadvantaged groups, and I thought this was a way to really marry the two.”

These perspectives contributed to an interest in examining these issues in their broader international context, to locate the experience of OTDs in the global network of medical migration, and to help understand the application of these international issues to Australia’s health system. ORs were more likely to frame the particular issue of OTDs in Aboriginal health services in the broader context of the international political economy of medical migration and to link it to the questionable ethics of the current international recruitment of health professionals from countries whose health systems are already vulnerable.

Complementing their desire to understand their own experience as ORs and that of OTDs in the international context, ORs expressed a commitment both personally and on behalf of their academic institutions to what is clearly a priority for them, “I haven’t met a lot of Aboriginal people at all, but I’m intrigued. I do feel that in this country Aboriginal people are much more

marginalised than any people of colour in South Africa, situations are quite different.”

Where ORs expressed hesitation, it was in relation to a lack of experience with Australian Indigenous communities, addressed in terms of caution in approaching what is clearly a complex but compelling issue. For them, the “difficulties” associated with Indigenous health research were frequently seen as the projections of other Australian colleagues, rather than the product of their own engagement, “I haven’t worked in Aboriginal health. ... I was doing a PhD and I was told, ‘don’t touch it with a barge pole. It’s far too difficult—blah, blah, blah.’”

Motivation for ARs

In each case, ARs were able to identify other factors that lead them to override this apprehension: the significance of the issue—“the issue of international graduates is a critical one for rural and particularly remote areas,” the implications for the workforce, the complexity of the cross-cultural dynamics, and experience working with OTDs and a sense of empathy with them.

A key motivation among ARs to participate in the project was a previous successful, productive, and enjoyable collaboration on research around issues affecting the recruitment and retention of Indigenous health managers and the opportunity to refresh

collegial links (Wakerman et al. 2000; Hill et al. 2001). For one AR with a commitment to Tibetan Buddhism, the invitation to participate simply fell on an auspicious day, “It was Tibetan New Year, and I thought: Oh, maybe I am meant to do this!”

Despite their eagerness to engage, ARs expressed ambivalence around “the ethics nightmare” and “the political nightmare” of Indigenous health research, and a desire to avoid, if possible, the tensions they had previously experienced.

For at least one AR, a return to research in Aboriginal health was motivated by the possibility of framing this in terms of his or her current research interests in human resources for health in developing countries, with the potential for the local to inform the international, offsetting any residual anxieties.

I’m interested in retaining some contact with Aboriginal health but I have a very ambivalent relationship with Aboriginal health ... the thing I think that attracted me to this was that it bridges my two worlds now, so that it actually deals with international health ... and it also retains that connection with Indigenous health.

This ambivalence was not limited to Indigenous issues, but, in the case of one researcher, applied also to engagement with GPs (though specifically not OTDs):

In working with my fellow researchers, and some other things that have occurred over this year have

led me to realise that I actually serious dislike GPs as a group, and female GPs in particular, so that's a little bit of, almost a contradiction, because the overseas trained doctors of course in this project are GPs, so I'm very aware of that.

Motivation for IRs

Personal networks—"an opportunity for like-minded people to do the research"—were again an important factor in the motivation of IRs. Implicit in this was a sense of cultural safety within the group, based on previous experience of how these researchers engaged research in Aboriginal health.

The absence of an identified IR in the original proposal was noted by one IR, who also raised concerns regarding their positioning within the team, when, in fact, their perspectives and experience were integral to the analysis: "I suppose my concern is that some of us may feel that we came onto the project as an afterthought."

The lack of initial Indigenous leadership in the project was an issue that the reflexive component highlighted, though priority had been given to inclusion of IRs in the team and provision was made for capacity-building for junior Indigenous academics. Clearly, for IRs, although the primary subjects of the research were OTDs, the research raises significant questions around services to Indigenous Australians and is seen as "a necessary step

in bettering health,” with practical consequences for the effectiveness of practitioners in Aboriginal health services.

Discussion and Conclusion

In a sense, the framing of the research defined the composition of the team, and the composition of the team has shaped our findings. All domains— “overseas trained,” “Australian,” and Indigenous—are represented, and although there is considerable overlap among individuals and their domains of identity, no individual identifies with more than two domains. All of us, as researchers, are simultaneously insiders and outsiders, the boundaries blurred by our polyvalent, hybrid identities (Merriam et al. 2001; Sherif 2001; Moore 2005; Paradies 2006). Because of this, our ambiguous status erodes any easy ownership or certainty. What we have been able to do through the reflexive study is open up this uncertainty around ourselves and show more clearly what it means for the knowledge we have produced. We have a better understanding of who we are and how this shaped the research and of our ultimate understanding of OTDs’ experience.

First, as researchers we have recognized in ourselves the tension between providing “individual narrative testimony and evidence presented in the form of more objective ‘data’ ... [and] the extent to which one affects the formation of the other” (Redfield 2006). Our

narratives are implicitly influenced by our experience, and within the research team that experience is diverse, complex, and, at times, in tension. Our task has been to maintain that subjective tension in presenting an objective representation of the experience of those working in a complex sociocultural context, a truth that is both “universal and restricted, impassioned and removed” (Redfield 2006).

For our ARs, straddling the Indigenous-non-Indigenous divide reiterates the perceived “difficulty” of working in Aboriginal health (Sibthorpe et al. 2002). The ARs have had to confront their repeated attempts to conceptually reframe this research away from its literal Indigenous location. Their ambivalence has been described by Kowal and Paradies (2005) in non-Indigenous health professionals working in Aboriginal health. They argue that their desire to intervene for change in Aboriginal and Torres Strait Islander communities relocates them as agents in their own colonial history, but they are reluctant to assert themselves in ways that conflict with their philosophical commitment to self-determination for Indigenous Australians and resent the resulting impotence.

The corollary to this ambivalence lies in the lived experience of our IRs. Although ARs share ambivalence around their roles, our IRs share to varying degrees the overt resistance to research expressed by Aboriginal communities: the objections to the intrusiveness of research, the perceived lack of demonstrable benefit, and the resentment at the representation of Indigenous

issues by outsiders (Humphery 2001). For them, this research is a “politics of life” (Fassin 2007) directly affecting their own lives and communities.

Paradoxically, as researchers, their roles are shaped by values largely alien to those communities. Their advantage to the research team is exploited in their identity as “indigenous-insiders” (Banks 1998:7–8) and the access that this provides the research team, yet their engagement with that team—particularly in positions of leadership—increasingly positions them as “indigenous-outsiders.”

For the ORs in this team, the interface between Indigenous and non-Indigenous Australian domains is less problematic—though their own (divergent) colonial histories are acutely present, and had been explored in other contexts (Martins et al. 2006). Yet, although they share experience intrinsic to the research on OTDs, there is a reluctant to claim this identity, to speak for OTDs (Sherif 2001). The adoption of the “global citizen” identity—although offering a desirable alternative to “discourses that have historically been bound by tribalistic, nationalistic and sectarian identity constructs” (Karlberg 2008:311)—is problematic in its own way, offering a universal identity that does not engage readily in the local.

Second, we recognized that the framing of this research in terms of cultural domains, as a mechanism for understanding the interactions between researchers and those researched, is itself potentially problematic (Paradies 2005). The domain approach is useful in

heuristic terms, but it risks reinforcing the stereotypical relationships that the research is attempting to unpack (Gilroy 1998; Schwalbe et al. 2000; Bridges 2001). The crucial question that arises from this is whether this framing gives advantages to some perspectives over the others. Whose vision is dominant in the research? Who are the “insiders” and who are the “outsiders” in this research team? In defining both Indigenous and OTD domains as “other,” there is a propensity to normalize and privilege the perspectives of the dominant cultural grouping— non-Indigenous Australians (Schwalbe et al. 2000). Through this reflexive study, we have been made aware of this and have needed to respond.

Our awareness of the absence of an IR in the initial proposal resulted in change, with a deliberate inclusion of an IR as a principal investigator in this reflexive study. We have provided opportunities to ensure that senior IRs have exercised leadership in the process of research analysis and publication. We have recognized that from Indigenous perspectives, ARs and ORs have a common positioning with OTDs in relation to Aboriginal and Torres Strait Islanders. Regardless of how recent their arrival, they share a history of migration, and, in engagement with Indigenous culture, an underlying sense of dislocation and lack of belonging (Ahmed 2000:85). In this perspective, OTDs, ORs, and ARs are all “other”—part of a broad non-Indigenous continuum, with similar needs and obligations when entering Indigenous space.

As a result of these explorations, we have experienced a growing discomfort with the implicit confidence of ARs that they can speak to what is needed in health services for Indigenous Australians. The unquestioned acceptance of Australian professional standards has similarly been challenged, together with the corollary that this was the standard against which international qualifications should be judged. The ARs have recognized that their own preparation for Indigenous health was inadequate; that Australian medical curricula have only recently addressed Aboriginal and Torres Strait Islander health issues; that OTDs skills in managing trauma are frequently superior; and that the rural versus urban medical training may be more explanatory of difference than “overseas” versus local training. Australian graduates were conspicuously unavailable for the vital rural and remote service positions that OTDs filled (Gilles et al. 2008).

Finally, we recognized that the rich complexity we had discovered among the researchers had application to the subjects of our research, the OTDs. To overemphasize the apparent commonalities of researchers and their identification with the research discounts their evident diversity: differences in self-identification, professional background, gender, ethnic heritage, religious background, and country of origin. For ORs, “overseas” is not a homogeneous category; for IRs, being a Torres Strait Islander is culturally distinct from the multiple Aboriginal cultures; and for ARs, deeper enquiry raises questions around the simplistic construction of that category.

In the same way, we recognized that we had “coproduced” OTDs as an organized entity, as if their limited commonalities—the location of their primary medical training and their desire to practice medicine in Australia—formed an organizational “presentification” (Cooren et al. 2008:1342–47) that corresponded with our preconceptions. Rather than use the more recent term “international medical graduate,” we persisted with OTD, with its anachronistic connotations of sea travel and hints at a colonial past because of its continued usage in Australian recruitment, employment, policy, and research contexts. Increasingly, we realized that this usage was one of the ways in which we had shaped our imaginings of OTDs—imaginings that necessarily positioned them as Other.

Mauthner and Doucet (2003:423) argue that the subjects of research “are reflexively constituted between the researcher and the researched.” As we recognized the diversity within ourselves, we sought it in our subjects: The easy assumptions that their trajectory differed from ours in terms of choice, or competence, or social adaptability were replaced by a more nuanced understanding of their lives and a deeper understanding of the complexity of their relationships with Aboriginal and Torres Strait Islander communities. In the words of the Aboriginal director of one of these health services, “If it wasn’t for OTDs, there would be no Aboriginal Medical Service.”

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Note

1. Because of small numbers, gendered pronouns increase potential to identify. The use of “his or her” is intended to reduce this possibility.

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