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Discourses of loss of professional status and gender discrimination among migrant physicians in Chile

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ENG **Abstract:** Cultural transitions are sites of identity struggle since professionals often need to revise their disciplinary values and ideologies, their professional identity stance and claims and their professional practices in the light of the beliefs and expectations of their peers in the host culture. Drawing on data from sociolinguistic interviews, this study explores the role and discursive construction of professional identity in discourses of status loss and gender discrimination of migrant physicians (mainly of Latin-American origin) who have faced challenges that not only damaged their professional image but also constrained their ability to practice medicine during their cultural transition in public hospitals in Chile. Adopting an interactional sociolinguistic perspective, the study discusses how related disempowering actions may affect migrant physicians' self-esteem and how some employ their professional identity as a resource to cope whenever their integrity as people and as professionals is threatened by local physicians' discriminatory behaviour and/or their loss of professional status.
Keywords: discourse analysis, identity, forced migration, positioning, healthcare, interactional sociolinguistics

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1. Introduction

Sociolinguistic interest in cultural transitions (that is, the process of transitioning from one culture to another) (Zayts and Lazzaro-Salazar, 2020) in workplace settings has often emphasised the social outcomes of language proficiency issues by investigating the ways in which migrants overcome the latter in order to adapt to practices of the host culture and integrate into the new workplace community. However, in intercultural workplaces where both locals and migrants speak the same language, language barriers are minimal (commonly causing minor disruptions only at the lexical level), and, yet the contrast between the cultural norms (rather than language proficiency) of local and migrant groups regarding, for instance, professional roles and identities, may take central stage. This is particularly the case of public healthcare institutions in Chile where most migrant physicians come from other Latin-American countries (such as Venezuela, Colombia and Cuba) and, thus, also speak Spanish, but whose otherwise cultural differences have been acknowledged to be major. In this context, the overall perception is that locals and migrants belong to very different cultural groups, as migrants in Chile perceive themselves as having a more humorous approach to life (Lazzaro-Salazar, 2021a) and being more extrovert and direct, for instance, than Chileans (Zayts and Lazzaro-Salazar, 2020; also see reported lay perceptions in Marcelle de Andrade, 2015). Thus, for migrant physicians in Chile, adapting to new workplace contexts does not involve acquiring proficiency in a new language (as is often the case in studies of this nature), but rather adjusting and adapting to new workplace norms, routines and practices. This, in turn, commonly results in professionals having to prove themselves and show their professional value in a new organizational context. In this light, cultural transitions should be seen as a site of identity struggle, where conceptions of the 'old' self are challenged by the new ways of doing things that embody new beliefs and ideologies. And, while for some migrants the process of transitioning from one culture to another may encompass a fairly short period of cultural adaptation, for others it may entail a life-long process as they find it hard to adapt and adopt new cultural practices (Zayts and Lazzaro-Salazar, 2020; Lazzaro-Salazar

et al., 2025). Yet, regardless of the duration of this process, during cultural transitions then these migrant physicians often need to revise their disciplinary values and ideologies, their professional identity stance and claims, and their professional practices in light of the beliefs and expectations of their peers in the host culture in order to fit in (Lazzaro-Salazar and Zayts, 2021).

Moreover, identity struggles may become even more burdensome and maybe also challenging to integration processes when the attitudes of both locals and migrants towards the cultural transition experience are not favourable. Then, on the one hand, while some local physicians naturally welcome the arrival of foreign colleagues as a measure to cut down staff shortages in the public healthcare system, others seem to resent it on the basis of the perceived threats this may impose on the local job market (Lazzaro-Salazar, 2021b). This, coupled with locals' lack of recognition of foreign credentials and qualifications, may sometimes result in hostility and acts of marginalization and discrimination against migrant physicians. In the case of migrant physicians' attitudes towards their cultural transition experience, on the other hand, a good number of migrant physicians in Chile feel that the social and political circumstances of their countries of origin *forced* them to leave (Lazzaro-Salazar, 2021b) in search of a safer and more socially stable place to live (Lazzaro-Salazar and Pujol-Cols, 2017; 2019; 2020). As shown in previous studies, these migrant physicians often made sense of this adaptation process within the conversational context of research interviews by reflecting on how the identity boundaries of 'us' (migrant doctors) and 'them' (Chilean doctors) emerge and conflict, as migrant physicians re-signified their sense of 'self' *vis á vis* those practices and realities that are new to them (Lazzaro-Salazar and Zayts, 2021). In this light, as these migrant physicians actively compared and contrasted their 'old' practices and realities with their new ones, they also recurrently resisted identity transformation by defying the cultural order of the profession in the host country whenever they disapproved of local professional practices (2021).

This article builds on previous studies of cultural transitions involving migrant physicians in Chile to advance sociolinguistic discussion on the role and discursive construction of professional identity by exploring participants' experiences of status loss and discrimination. Adopting an interactional sociolinguistic perspective that combines micro (that is, linguistic) and macro (ideologies and societal norms) analytical standpoints, the article investigates identity constructions of migrant physicians who held leading positions (e.g. director of medical institutes) in their country of origin but who have had to face (sometimes gendered) challenges that not only damaged their professional image but also constrained their ability to practice medicine during their cultural transition in public hospitals in Chile. The study discusses how related disempowering actions may affect migrant physicians' self-esteem and how some employ their professional identity as a resource to cope whenever their integrity as people and as professionals is threatened by discriminatory behaviour and/or their loss of professional status.

2. Background

Migrant physicians have, during the last two decades, arrived in Chile mainly in two major migration waves. The first one began shortly after the 8.8 massive earthquake that hit central Chile in 2010, when hospital authorities actively recruited foreign medical physicians to overcome the shortage of healthcare professionals. The second migration wave occurred between 2015-2018, and was motivated by the social, political and economic crises in countries such as Venezuela and Ecuador. Results of a sociodemographic survey conducted in 2016 showed that 33.33% of migrant physicians came to Chile to foster their professional development, as in Venezuela, for instance, the shortage of medical supplies and reduced budget prevented them from practicing 'good medicine' (Lazzaro-Salazar and Pujol-Cols, 2017; Lazzaro-Salazar, 2019). It is this second wave that brought about a significant change in the demographics of the healthcare workforce in Chile, and on which this study focuses. According to the Ministry of Health, from 2015 to 2018 alone the number of foreign physicians authorized to work in the country grew 63.6% (La Tercera, 2018). By 2019, foreign physicians made up 19% of the total medical workforce of the country and over 32% of the medical staff working in public healthcare institutions (Superintendence of Health Report 2019). These figures put Chile among the top ten countries in the OECD with the highest percentages of foreign physicians (OECD, 2023).

The arrival of migrant physicians fuelled much controversy in the Chilean society and public opinion has often been divided among those who considered that migrant physicians were much needed to overcome the shortage of healthcare professionals (Fuentes, 2019) and believed they were often more caring and empathic than local doctors (Ubilla et al., 2015), and those who saw them as a threat to local job markets (Lazzaro-Salazar and Pujol-Cols, 2017). Yet one of the most controversial issues that sparked off national debate revolved around whether migrant physicians needed to sit qualification exams to be able to practice medicine in the Chilean public healthcare system. According to the Bill 20.261 (in force since April 2009), all medical graduates (from either national or foreign universities) must sit and pass the *Examen Único Nacional de Conocimientos de Medicina* (henceforth, Eunacom; in Eng., Single National Exam of Knowledge of Medicine) (consider Thomazy, 2020). However, this exam has been designed for recent graduates rather than for already practicing and/or senior physicians. The situation is then problematic for migrant physicians, as previous studies have shown that at least 49% of these migrant physicians had practiced medicine for 11-20 years and 9.80% had done so for over 20 years at the time of their arrival in Chile (Lazzaro-Salazar and Pujol-Cols, 2017). The exam has then been highly criticized for being unsuitable for experienced physicians in popular media, to the point that some consider this requirement an act of covert xenophobia against migrant physicians (Maturana, 2017). Yet, for almost a decade now, continuous staff shortages has prompted the State to constantly revise the situation and issue exceptional national measures whenever needed so that

migrant physicians would not have to sit the exam to practice medicine and could, thus, alleviate the systems' demand for physicians in times of crises. This has been particularly notorious during the COVID-19 pandemic (Caro, 2020), when a number of decrees have been issued to hire migrant physicians who have not yet taken the exam (Equipo EUNAMed, 2021).

However, though these are practical State solutions and the general public embraces them (e.g., by nicknaming the front line of migrant physicians as the Migrant Health Brigade, in Andrade, 2020), the opposition to such measures remains fierce and acts of segregation and discrimination against migrant physicians are daily reported (e.g. La Prensa Austral, 2021; Observatorio Ciudadano Report, 2020). Negative attitudes towards migrant physicians stem not only from the fact of whether they passed the Eunacom exam, but also from, as discussed above, the idea that these physicians may pose a threat to local job markets and also may not have received adequate medical training in their countries of origin (Bohle and Llantén, 2019). Giving voice to these migrant physicians and investigating their experiences of cultural transition as they cope with discrimination and/or loss of their professional status in the workplace will not only advance sociolinguistic debate on the discursive construction of professional identity in intercultural healthcare settings, but also hopefully contribute to a wider public policy discussion that promotes global inclusion in healthcare settings in Chile.

3. Methods

This study followed an interpretive-descriptive design guided by the principles behind the framework of interactional sociolinguistics (Gumperz and Gumperz, 2006), which has a long-established tradition of being employed in intercultural workplace studies (e.g. Lazzaro-Salazar, 2022). Attesting to its anthropological roots, interactional sociolinguistics is interested in how language is used to achieve relational goals, that is, how a language is used to maintain, develop, change and/or contest social relationships in interaction (Trudgill, 2003). In this light, interactional sociolinguistics is a suitable methodological and analytical framework because it allows the researcher to explore communication practices in close relation to the contextual and cultural features of situated interaction (Gumperz and Gumperz, 2006), which are central aspects in this exploration of migrant physicians' discourses of discrimination and loss of professional status.

3.1. Participants

The data in this paper involves forty migrant physicians of public healthcare institutions in Chile who participated in two studies conducted since 2016 (Postdoctoral Fondecyt N° 3160104 — 2016-2018, and Initiation Fondecyt N° 11190052 — 2019-2023). Key informants were identified to help gain access to healthcare institutions (see Lazzaro-Salazar, 2013) by employing the 'snowball technique', which involved asking participating migrant physicians to provide the contact of other migrant physicians potentially interested in this study (Goodman, 1961; Zayts and Lazzaro-Salazar, 2020).

Though other examples of marginalization and discrimination have been included elsewhere for different analytical purposes (see Lazzaro-Salazar and Zayts, 2021), this paper focuses on two case studies of migrant physicians in Chile (one male, one female) who shared their experiences about their loss of status and discrimination more openly and extensively. The female participant, Olivia, is Venezuelan and had lived in Chile for two and a half years at the time of the interview. She is a general surgeon and is forty-five years old. The male participant, Oscar, is Cuban and he had lived in Chile for over three years. He is a cardiologist and is fifty years old. Both physicians were highly recognized professionals in their countries of origin, where they held leadership positions in their respective workplaces.

3.2. Data collection

In-depth research interviews were conducted to investigate foreign physicians' reasons for migrating and their migration experiences. Interviews are a common data collection method when the aim is to gather (auto) biographical information that will help researchers' characterise their participants (see Zayts and Lazzaro-Salazar, 2020). In particular, sociolinguistic interviews have often been employed in migration studies for their contribution to understandings of migration processes and contexts (see Diskin-Holdaway, 2021; De Fina, 2003). Thus, the interviews in this study adopted a sociolinguistic approach with the aim of gathering data that were as casual and natural as possible. Interviews were conducted in Spanish (see Appendix with the analysed Extracts in the original language), and their duration ranged between 20 minutes to 1 hour and a half. They were guided by a topic guide about participants' working experiences in their countries of origin and of destination (i.e., Chile), and they were audio-recorded and transcribed verbatim. It is worth mentioning that while the interviews included in this study focused on the adjustment and the adaptation processes undergone by the migrant physicians in Chile, physicians' reflections on their loss of professional status and, in the case of women, also of gender discrimination, were not purposefully solicited by the interviewer; they occurred naturally in the examined interactional context and in that sense they provide real insights into how professional identities can be used as a resource that helps migrant physicians to cope with loss of status and discrimination during cultural transitions. This study and the informed consent form that all participants signed at the start of the interview were approved by the Ethics Committee of Universidad Católica del Maule (records #28/2015, #57/2017 and #220/2019).

Last but not least, the two physicians and their interactional examples in this article were selected following the considerations of authenticity, representativeness and their potential to illustrate recurrent phenomena

suggested by Lingard (2019). These examples then are representative of the kinds of values, practices and reflections that were commonly observed in these interviews.

4. Analysis and discussion

As in sociolinguistic studies more broadly, in this study identity is viewed from the perspective of social constructionism, by which a person's identity construction involves a process through which they manage certain positionings and make certain discursive choices regarding their preferred self orientation when interacting with relevant others (Pennycook, 2004; see 'positionality principle' in Bucholtz and Hall, 2010). Identity then is viewed partly as a dialogical construction of the self (Foucault, 1988) shaped by the contextual conditions of the interaction (Hall, 2012) and is, therefore, compatible with the principles of Interactional Sociolinguistics. In particular, this study explores the professional identity of migrant physicians in Chile, which is viewed as one of the social identities that often emerges in workplace contexts and/or conversations about work (see Lazzaro-Salazar, 2013 for an in-depth discussion). According to social constructionist views, professional identities often stem from the negotiation of individual and collective disciplinary beliefs, and those regarding institutionally and culturally appropriate ways of behaving (Lazzaro-Salazar, 2017).

Challenged by a favourable public opinion of migrant physicians and patients' overall preference of migrant physicians over local ones (as discussed above), some local physicians strive to maintain their cultural dominance across the professional context. In so doing, a number of disempowering actions are in place that aim to not only weaken migrant physicians' positive attitudes to their cultural transition experience (see Lazzaro-Salazar, 2025) but also prevent them from accessing specialists' professional spaces by: 1) not recognizing (or, in legal terms, validating) migrant physicians' professional titles and qualifications, which causes them to lose professional status, and 2) discriminating them professionally based on their gender. The examples below show that, as migrant physicians reflect on their professional struggles to adapt to the new workplace and host culture, their professional identity plays a vital role as a resource to cope with such difficulties.

4.1. Loss of professional status

Over 37% of the physicians in this study reported loss of professional status when starting to work in Chile. As mentioned in the interviews, their loss of status is related to two moments: a) sitting the Eunacom exam, and b) taking specialty examinations. Oscar reflects on these two phases towards achieving professional recognition as he explains what his experience integrating into the new workplace environment has been like:

Extract 1
1. It was requested that we had to have the revalidation of accreditation of the general practitioner
2. degree. That was a great challenge because we have been specialists for almost thirty years.
3. I graduated as a specialist in 93 and as a doctor in 83, therefore many more years
4. after graduating as a doctor. So it was a tremendous challenge. In addition, I worked at the
5. cardiology institute in a sub-specialty doing research on that, therefore it was quite difficult
6. because I had to convert from a super specialist cardiologist to a general cardiologist. Then,
7. I had to, from being a cardiologist, to become a doctor again in six months! Certainly that
8. required superhuman effort.

The first step towards achieving professional recognition in public healthcare institutions in Chile requires migrant physicians to sit the Eunacom exam. In his framing of the situation (as in Tannen, 1993), Oscar recurrently reflects on his experience of sitting the exam as a great and tremendous challenge (lines 2 and 4) mainly because, for experienced physicians, it involves going downwards on the professional ladder by having to re-learn how to be general doctors. This naturally prompts them to reposition themselves professionally, to somehow undo their professional trajectory as specialists, and faces them with the unrecognition of their professional status. Oscar stresses this fact by proving the amount of years he has practiced as a specialist, drawing on the collective identity of those affected by this requirement (see 'we' in line 2) in what seems to be a discursive effort to claim the epistemic right to discuss or maybe even protest about this situation. He then finds it also necessary to put his professional trajectory on record in order to reassert his old self as a leading specialist. To achieve this, he provides the years in which he graduated as a general doctor and then as a specialist (line 3), and the professional roles and positions he held in his country of origin (lines 4-5) to strengthen his identity claims and his argument of the kind of challenge this posed on him. Oscar then continues to emphatically reflect on the fact that this challenge had to be met in a very short period of time (line 7) and uses the adverb 'certainly' as a marker of epistemic modality (see Arrese, 2011) to build his epistemic stance regarding the kind of strain this situation imposed on him (lines 7-8). As his turn finishes, he strengthens his epistemic stance by using identity boosters such as 'super' (line 6) to refer to his 'old' self and by describing his current efforts as 'superhuman' (line 8) to emphasise not only how difficult sitting the exam was, but also what he is capable of, that is, his professional value.

Thus, by sitting the Eunacom exam, migrant physicians such as Oscar are momentarily stripped of their specialty. The tension between having to become a general doctor again and leaving their expertise aside to be able to take this exam disempowers migrant physicians like him to the point that sitting the exam then becomes a source of stress that poses a psychosocial risk, affecting their wellbeing (as extract 2 will show). It also prevents them from integrating into the host community with the appropriate recognition of their professional status and interests (consider Lazzaro-Salazar and Pujol-Cols, 2017).

As the conversation continues (Extract 2), Oscar reveals how he managed to be able to meet job and exam demands at the same time to be able to pass the Eunacom (lines 1-3). His account is still framed as a 'challenge' and lexical choices such as 'tremendous' (line 1), 'beat it', 'huge' (line 2) and 'gruelling' (line 3) continue to help him construct this enduring and resilient aspect of his professional identity:

Extract 2

1. At that time I had to take Ritalin in a tremendous amount. But that's how we faced that
2. Eunacom and we managed to beat it. We passed the Eunacom. In the first round. A huge
3. challenge. It's a gruelling test. [...] Then you have to go through the practical exams, which is
4. another challenge. [...] You spend a week, where they evaluate you, where you go with each
5. one of the specialties and then finally to the large committee, a terrible committee. There, I was
6. lucky too. We did well there, thank God. We also prepared for it a lot, very hard, we made the
7. absolute decision that this was an inevitable situation, that it had to be passed and that it had to
8. be faced. And we did it.

Oscar reflects on yet a new challenge (line 4), doing the second part of the exam, that is, the practical (lines 3-5). As difficult as the first part of the exam (consider 'terrible committee' in line 5 and preparation details in line 6), Oscar introduces the notions of luck and of religious gratitude (line 6) to reflect upon this second part of the exam. According to Broncano-Berrocal (2015), this notion of luck (and in this case, also the notion of religious gratitude) is used to display a lack of control over a relevant event. This idea of being 'lucky' and somehow 'blessed' throughout the examination process is a new facet of Oscar's professional identity, and while it may be in tension with the 'superhuman' side of his identity (ability/capability vs. fate), it has also been observed to be part of these migrants' discourse when making sense of cultural transitions (Lazzaro-Salazar and Zayts, 2021). The 'luck' and religious gratitude discourse has been observed to be particularly relevant in this dataset when migrant physicians seem to wish to downplay their professional success in Chile. In this context, it is important to remember that only 26.8% and 32% of the migrant physicians passed the Eunacom test in 2019 and 2018, respectively (Leiva, 2019). With this in mind, discussing how well he did in the first round of the exam may be too bold a move in the eyes of other migrant physicians and Oscar is all too aware of that as he discusses how hard passing this exam is for most migrant physicians in other parts of the interview. In addition, discourses of religious gratitude have been found to play a vital role in migrants' stories of endurance and resilience (e.g. Vázquez and Orozco, 2021), as those discourses provide an appropriate cultural framework of beliefs that support the overcoming of difficult and/or traumatic events based on ethic and morality principles and that allow migrants to face and make sense of the hardships of cultural transitions.

Overall, discourses of luck and religious gratitude help Oscar build an identity of humbleness, which contrast 'privileged discourses of competence' (cf. 'superhuman' qualities in Extract 1) and may be more positively valued by fellow professionals (MacLeod, 2011). This is not, however, done at the expense of relinquishing previous identity claims. On the contrary, as the conversation develops, he continues to construct himself as a hard-working, resolute and resilient professional (lines 6-8). This all then seems to be indicative of the multiple alignments Oscar displays as he manages his self-orientations to cope with the difficulties of taking the Eunacom exam and his own identity struggles as he does so.

Yet taking the Eunacom exam is only the first step towards gaining official recognition of migrant physicians' qualifications. The second part involves taking the Conacem exams. Conacem stands for *Corporación Nacional Autónoma de Certificación de Especialidades Médicas* (in Eng., National Autonomous Corporation for the Certification of Medical Specialties) and it is responsible for granting the certification and revalidation of specialist qualifications in Chile. As Oscar explains in Extract 3, once migrant physicians pass the Eunacom exam, they need to take the Conacem exams to be revalidated (and thus recognized) as a medical specialist, a very important step for senior physicians like Oscar:

Extract 3

1. Now I ran into a problem that is the situation of the specialty certification. I AM a cardiologist,
2. and I have a certificate from a recognized university, well they should either have me take the
3. skills test or homologate it, period. If the university is recognized. Ok? My degree is from
4. [name of university], which is a training institute, within the national health system. [...] I
5. worked for two years in Peru and I am a doctor in Peru and a recognized cardiologist in Peru
6. approved by the assembly of chancellors and by the medical college. Ok? [...] Here, well, we
7. find that the curriculums don't coincide in the sense that I did a specialty in Cuba that is
8. comprehensive general medicine, which is when I became a doctor. I did a three-year specialty,
9. which is called comprehensive general medicine. Then after that, I became a family doctor
10. for two years and then I did the second specialty that I did cardiology, three years in the
11. institute of cardiology, which here is two years of cardiology. I spent three years doing
12. cardiology. However, I am not allowed by the Conacem to take the cardiology exam. Why?
13. Because here in this country, uh, cardiology is a derivative of internal medicine. Ok? So I don't
14. have a degree in internal medicine, so I can't get to cardiology. [...]
15. So I am in a tremendous crossroads ummm I work as a cardiologist in the cardiology service of
16. the hospital. So there is a clause about this in the Conacem's regulations that says that if you
17. spend five years in a cardiology service with at least 22 hours, in a type-1 hospital, then they
18. give you the possibility of taking the exams. So I find myself in that limbo that I have been in
19. for three years, I have two more years left. That's difficult for me because in two more years
20. I am older. Then what I can do today and perform better is going to be more difficult for me.

In the first lines of his turn (1-3), Oscar reflects on how problematic the unrecognition of his medical qualifications is and shares his opinion that he should either be allowed to take the cardiology test or have his certifications homologated and validated. As he does this, Oscar again builds an assertive self, emphasising his professional identity as a cardiologist (line 1), using the official professional identity term, emphasizing that his qualification is from a recognized university (line 2) and, to support this, he outlines his professional trajectory in his own and in another foreign country (lines 3-12). This trajectory (including the number of years and the different specialties he trained in) forges his professional identity and builds him as a valuable human resource. Moreover, comparing his recognition status in other foreign countries like, in this case, Peru, seems to serve at least two more purposes: 1) it establishes the truthfulness of his proposition in line 2 ('I have a certificate from a recognized university'), and 2) it provides grounds to argue that Chile's unrecognition of his qualifications is unfunded and localized (see also 'here in this country' in line 13). This use of deictic markers such as 'here' and 'in this country' helps Oscar build ingroup (us) and outgroup (them) boundaries to assign a negative value to 'them' and possibly to display his disagreement and/or discontent with this matter (consider Cap, 2018).

Moreover, as he lays out the local norms for why he is not allowed to take the cardiologist exam (lines 12-14), he takes up his initial argument to emphasise and provide further details as to why this situation is problematic, using the intensifier 'tremendous' (line 15) and what seems to be his only option to overcome it (line 16-18). This unrecognition, the uncertainty of his future specialist status and the prospect of the difficulties ahead (lines 18-20) evoke feelings of being 'in limbo', which have been previously reported as an initial phase of cultural transitions when migrants hold temporary statuses (e.g., Robertson and Runganaikaloo, 2014). However, Oscar has worked in Chile for over three years (lines 18-19), which means he has legally transitioned from a temporary to a permanent residence status. In this regard, loss of professional status in studies of forced migration (though often involving refugees) has been found to be rather common and subjectivities are often found to be misplaced as identities are reconfigured to adapt to the new cultural context (Jansen, 2008). In the case of migrant physicians in Chile, however, expectations of professional integration and recognition are higher because 1) medicine is a highly valued profession, 2) there is a shortage of physicians in the Chilean public system, and 3) most of these migrant physicians have a wealth of experience as heads of their departments in their home countries. The unrecognition of their professional status then hits them hard, and it certainly influences their social/professional positioning and sense of self. In this context, migrant physicians such as Oscar are left with the 'old' version of their professional self to resist identity changes (that is, to resist a 'new' self in this new culture) by actively deciding not to adopt professional views and practices of the host professional culture, and by reminding themselves of who they are ('I AM a cardiologist', in line 1 of Extract 3), drawing on previous conceptions of self.

At this stage, it is worth mentioning that, for migrant physicians in this study, loss of professional status is not gendered as both male and female physicians shared similar perceptions and experiences in the interviews as Oscar above. However, while most physicians interviewed (both male and female) discussed the hardships of sitting the Eunacom and of gaining recognition as a specialist, crucially only women report being openly and actively discriminated against in the workplace.

4.2. Gender-based discrimination

Gender discrimination in medical contexts is far from uncommon. Women in medicine have historically endured gendered encounters and experiences during their medical education (e.g. Babaria et al., 2012), their clinical training (e.g. Kristoffersson et al., 2018) and, as shown in extract 4, their medical practice:

Extract 4

1. Well, it's been different for him [husband] and me. The things that made the difference were
2. first sex, the fact that he is a man and I am a woman. That made a big difference. The fact that
3. he's Chilean and I am a foreigner. And the specialty, the fact that he's an internist and I'm a
4. surgeon. So I've always felt it, saw it. It's no hearsay. I lived, that is, like discrimination for
5. being a woman in an environment of men and a FOREIGN woman, in an environment of men.
6. I've felt discriminated as a woman and as a foreigner, from a professional point of view,
7. because I haven't been able to advance, since I arrived here I'm doing exactly the same. I've
8. spent two and a half years here, I've already passed all the necessary exams, general medicine
9. and the specialty one. I've shown who I am, the person I am, how committed I am to my work,
10. how responsible I am, my interests, then one expects to receive something in return. But it
11. hasn't been my case. I continue doing exactly the same as when I arrived. You can be a
12. surgeon, but you are not a surgeon here.

Olivia explains and emphasises how she is discriminated against at multiple social identity levels for being a woman, a foreigner and a surgeon (lines 1-5). These levels relate to different ideological assumptions and understandings, some of which are more situated (such as how she is discriminated for being a foreigner in Chile), while others (such as, being a woman surgeon) reflect disciplinary-bound ideologies and gendered stereotypes that have been reported globally (de Costa et al., 2018). Olivia establishes her epistemic right to affirm she has been discriminated against — consider 'felt', 'saw' and 'lived' as indications of her actual experiences (line 4), because she has not had the chance to advance professionally since she has arrived in Chile (lines 6-7, reinforcing the idea in lines 10-11), despite, unlike Oscar above, having passed all the required exams (lines 8-9). Lack of chances of professional development silences these migrants' identity needs and

damages their professional self-image. Olivia then lists her unsuccessful attempts to show her professional self-worth and to build a positive professional image of herself (lines 9-10). The reports of the acts of discrimination against her, the unrecognition of her professional self-worth and of her identity claims and needs marginalize her in the workplace, to the point of implying she has lost hope of ever being considered a surgeon in Chile (lines 11-12). As in Extract 3, she makes a geo-political reference using a deictic marker ('here' in line 12) to share migrant physicians' perceptions that this situation applies only to Chile, which by comparison this is not the case in other countries.

As the conversation continues in Extract 5, Olivia provides further reports of open discrimination that she has personally experienced at work (lines 1-3) and how this made her feel (lines 3-4). She draws on personal values (lines 4-6) and professional ideologies of what it means to be a physician (lines 6-7) as she reports coping with the situation:

Extract 5

1. Doctors, just like me, colleagues, same specialty, they ignored me, they knew who I was and if
2. I was talking to someone, they would talk to them and not to me. As if I wasn't there. Things
3. like that happened to me. At the moment one feels super humiliated, super abused and also
4. unnecessarily because nobody should be treated like that. We are not talking about career,
5. profession, nothing, we're talking about being human. Of that education they teach you at
6. home. Or of those principles and values that nobody teaches you at university. Being a doctor
7. for me is an attitude of life, it's a way of seeing things, it's a way of treating people, of facing
8. situations. We come from a country where no Chilean was asked where they came from.
9. So you wonder what you're doing wrong. Am I crazy?

Discriminatory experiences and her struggle to achieve recognition threaten Olivia's professional identity coherence (consider Mackenzie Davey and Jones, 2020) to the point that she questions her sanity in the way she acts upon and interprets her work situation (line 9). Regaining professional identity coherence is core to maintaining a coherent social self more broadly as well as her mental health (Jansen, 2008). Conscious identity regulation then is paramount to achieving such coherence (Ortlieb et al., 2020) and so she finds solace in reminding herself of who she is, recognizing her own self-worth through her home values and her own sense of professional self (lines 4-8), all of which may work as a defence mechanism to reassert her own professional identity so she is able to face difficult situations (see similar findings for refugee physicians in Mackenzie Davey and Jones, 2020). Interestingly, Olivia's identity work also involves drawing on human rights ideals of international reciprocity and equity when she shares her expectations of solidarity towards a country (Venezuela) that has opened their doors to Chilean migration (line 8) during its period of dictatorship. This discursive move strengthens the recurrent geo-political argument (and perception) that migrant physicians' sense of unrecognition and discrimination is localized in Chile.

Professional recognition gives us a sense of dignity and purpose, and boosts our self-worth, which has an impact on all spheres of our lives (Anna, 2018). Without a doubt, this kind of unrecognition of someone's professional self-worth and the acts of discrimination against them can potentially harm professionals' self-esteem and their mental health (2018), as Olivia reflects below:

Extract 6

1. After two and a half years, I feel that my work is of good quality. I feel confident in what I do.
2. I've been a surgeon graduate for more than eight years and nobody can tell me that I am not a
3. surgeon, I can't allow it, due to my status, my mental and personal integrity, my self-esteem
4. [...] I cannot let myself be broken, belittled. I am a human being. Nobody is going to take it
5. away from me but it's hard because one has to put on an armour because even if you are
6. confident, you are vulnerable too, you are a human being so there are things that block you, but
7. I know who I am and I have to value myself so that others can value me as well. This is the
8. work that I have done over the years that I've been here. It's that mental work, not allowing
9. them to step on me because it is not my way of being, nor my training. I can't allow it. I have to
10. know who I am and what I'm doing here. And what's my goal and my mission here.

In this extract, Olivia reveals herself as an agent of her own destiny as a professional. Rather than accepting the consequences of the discrimination acts she has been subjected to, Olivia works on constructing herself as a confident human being *and* physician, and on building boundaries between herself and her local colleagues to safeguard her personal and professional integrity, fight human vulnerability and protect her mental health. To achieve this, Olivia builds herself as critical of her own work and draws on her professional worth revisiting her own professional trajectory to support her feelings and arguments of self-worth (lines 1-2). She also distances herself from the painful situation by making impersonal references of those who have hurt and discriminated her using discursive constructions such as 'nobody can tell me' and 'nobody is going to take it away from me' which have also been found in refugees' discourses when dealing with traumatic experiences (Marlowe, 2010; consider also migrants' discourses of 'survival employment' in Canada in Creese and Wiebe, 2012) (also see 'one' and impersonal 'you' in lines 2, 4, 5-6). As the conversation continues, her reflections of who she is as a human being seem to aim to transcend concerns of the professional sphere to appeal to the most basic values of human self-worth and respect for people's integrity (lines 4-7). In this regard, the criticism regarding the values and practices of her local colleagues that underlie these reflections work to disempower those who marginalise her.

As with their professional trajectories (e.g. Extracts 1 and 3), reflections of migrants' trajectories of personhood (e.g. Extracts 5 and 6) have been found to help them structure early coping strategies when faced with downward professional mobility (consider Jansen, 2008). This is particularly the case of global middle-class migrants whose trajectories of personhood have been found to help re-establish their sense of selfhood (Pu, 2014). In this light, Oscar and Olivia build their sense of self by constructing multiple dimensions of their professional status, one of which is more discursive and pragmatic in nature (e.g., as Oscar uses discourses of challenge and difficulty to signify his loss of status) and another one which is rather interactional (e.g. as Olivia reflects on the way she is ignored by local fellow physicians). Moreover, as they reflect on work experiences of cultural transitions, these trajectories and Olivia's (as well as Oscar's) sense of professional self are revisited and reasserted to serve as protective resources (consider Chen et al., 2012) that foster these migrant physicians' resilience as they cope with loss of status and discrimination during cultural transitions.

5. Conclusions

This study adopts a sociolinguistic approach to contribute to research on cultural transitions and forced migration by showing how migrant physicians in Chile rely on their professional identity claims as a protective resource to help them build resilience and to cope with loss of professional status and gender discrimination. To achieve this, migrant physicians outline their professional and personhood trajectories to reassert their sense of self and maintain their confidence. As Jansen (2008: 195) claims, migrants "cling to their remembered personhood" to remind themselves of what they are capable of and to hold themselves together.

The lack of status recognition (be it related to their formal qualifications or to their professional self-worth) and acts of gender discrimination to which they are exposed in the workplace disempowers migrant physicians such as Oscar and Olivia by stripping them of the opportunity to negotiate preferred status claims and hierarchies that allow them to position themselves back into the upward professional ladder. As a consequence, they find themselves trapped in stereotypes of the discipline, of gender, and/or of nationalistic/geo-political biases that affect their self-esteem, their mental health and their chances of professional development. In the best of cases, for some migrant physicians, the actions and regulations described in this study contribute to marginalizing them for some years only until they are able to comply with all the requirements. Yet for others, recognition may not be achieved and discrimination may not cease even after they have met all the requirements. In both cases, identity claims seem to help these migrant physicians cope with status loss and gender discrimination, as they boost feelings of self-worth, when reflecting on the adverse situations they have had to face during their cultural transitions in public healthcare institutions in Chile. Acknowledging and acting upon migrant physicians' identity needs, helping them to gain professional status recognition and, naturally, avoid discriminatory actions is key to developing a sense of belonging and to fully integrating into their workplace.

To conclude, a reflection should be offered regarding the fact that several of the discursive moves described above have been compared with the findings of refugee studies. What all these studies have in common with migrant physicians such as Oscar and Olivia is that they have all walked the journey of forced migration (whether they were physically forced to leave their countries as in the case of refugees, or whether they felt the professional, social, economic and political circumstances of their country of origin forced them to make this decision). Future studies should further explore discursive and identity distinctions according to professionals' reasons to migrate to further show the social and discursive complexities of migration phenomena in the workplace. Moreover, regarding migrant physicians' professional trajectories, future research in this field should be conducted through longitudinal studies that explore physicians' levels of acculturation to determine whether they achieve a sense of 'regained professional status' at some stage of the cultural transition process.

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Transcription conventions

ME	Capital letters to indicate emphatic stress
?	Question intonation
[hello]	Clarifications
[...]	Deleted dialogue

All names are pseudonyms.

Appendix of Extracts in Spanish

Extract 1

Se solicitaba que teníamos que tener la acreditación del revalida del médico general. Eso fue un gran reto porque nosotros somos especialistas hace treinta años. Yo me gradué de especialista en el 93 y me gradué de médico en el 83 por lo tanto muchos más años de haberme graduado como médico. Entonces fue un reto tremendo. Además, yo trabajaba en el instituto de cardiología en una sub-especialidad haciendo investigaciones de eso, por lo tanto fue bastante difícil porque me tuve que convertir de un cardiólogo super especialista, a un cardiólogo general. Entonces tuve que de ser cardiólogo volverme a ser médico, volverme a hacer medico en seis meses! Eso sin dudas requirió un esfuerzo sobrehumano.

Extract 2

En esa época tuve que tomar Ritalín con una cantidad tremenda. Pero así nos enfrentamos a ese Eunacom y lo logramos vencer. Pasamos el Eunacom. En la primera. Un gran reto. Es una prueba extenuante. [...] Después tienes que pasar por hacer los prácticos, que es otro reto más. [...] Pasar una semana, donde te evalúan, donde pasas con cada una de las especialidades y después al final al tribunal mayor, un comité terrible. Ahí tuve suerte también. Ahí pasamos eso bien, gracias a Dios. También nos preparamos mucho, muy fuerte, nosotros tomamos la decisión total de que eso era una situación inevitable, que había que pasarla y que había que enfrentarla y afrontarla. Y así fue.

Extract 3

Ahora después choco con un problema que es la situación de la certificación de la especialidad. Yo SOY cardiólogo, y yo tengo un certificado de una universidad que es reconocida, bueno si quieren me hacen el examen de competencias u homologarlo, punto. Si la universidad es reconocida. ¿Ya? Mi título es del [nombre de universidad], que es un instituto formador, dentro del sistema nacional de salud [...] Trabajé dos años Perú y yo soy médico en Perú y cardiólogo homologado en Perú por la asamblea de rectores y por el colegio médico. ¿Ya? [...] Aquí bueno nos encontramos con que las mallas curriculares no coinciden en el sentido de que yo hice en Cuba una especialidad que es medicina general integral que es cuando soy médico. Hice una especialidad de tres años, que se llama medicina general integral. Entonces después de eso, hice médico familiar por dos años y después entonces hice la segunda especialidad que hice la de cardiología, tres años en el instituto de cardiología, que aquí son dos años la cardiología. Yo estuve tres años haciendo cardiología. Sin embargo, a mí no se me permite por las leyes del Conacen hacer el examen de cardiología. ¿Por qué? Porque aquí en este país, eh cardiología es una derivada de medicina interna. ¿Ya? Entonces yo no tengo título de medicina interna por lo tanto no puedo llegar a cardiología. [...] Entonces yo estoy en una disyuntiva tremenda ehhhh trabajo como cardiólogo en el servicio de cardiología del hospital. Entonces hay una cláusula en esto del Concacen que dice que si usted está cinco años en un servicio de cardiología con al menos 22 horas, en un hospital tipo 1, pues entonces le dan la posibilidad de rendir los exámenes. Entonces yo me encuentro en ese limbo que llevo tres años, me quedan dos años más. Eso para mí es complicado porque en dos años más estoy más viejo. Entonces lo que puedo hacer hoy y rendir más, me va a ser más difícil.

Extract 4

Bueno, ha sido diferente para él [esposo] y para mí. Las cosas que marcaron la diferencia eran primero el sexo, el hecho de que él sea hombre y yo sea mujer. Eso marcó mucho la diferencia. El hecho de que sea chileno y yo sea extranjera. Y la especialidad, el hecho de que es internista y yo soy cirujana. Entonces yo siempre lo sentí, lo vi. No me lo contó nadie. Yo viví, o sea, como la discriminación por ser mujer en un ambiente de hombres y mujer EXTRANJERA, en un ambiente de hombres. Yo he sentido la discriminación como mujer y como extranjera, desde el punto de vista profesional, porque yo no he podido avanzar, yo desde que llegué estoy haciendo exactamente lo mismo. Yo he pasado dos años y medio aquí. Ya yo tengo todos los exámenes necesarios aprobados, medicina general, y el de especialista también. He mostrado quien soy, la persona que soy, lo comprometida que estoy con mi trabajo, lo responsable que soy, mis intereses, entonces uno espera recibir algo a cambio de eso. Pero no ha sido mi caso. Yo sigo haciendo exactamente lo mismo que cuando llegué. Tú puedes ser cirujano, pero no eres cirujano de aquí.

Extract 5

Médicos, iguales que yo, colegas, misma especialidad, me ignoraban, sabían quién era yo y si yo estaba hablando con algún otro, le hablaban al otro y a mí no. Como si yo no estuviera. A mí me pasaron cosas como esas. En el momento uno se siente super humillado, super maltratado y además innecesario porque a nadie se trata así. No estamos hablando de carrera, de profesión, de nada, estamos hablando de ser humano. De esa educación que te enseñan en la casa. O de esos principios y valores que nadie te enseña en la universidad. Ser médico para mi es una actitud de vida, es una forma de ver las cosas, es una forma de tratar a la gente, de enfrentar a las situaciones. Nosotros venimos de un país que a ningún chileno se le preguntó de dónde venía. Entonces te cuestionas qué estás haciendo mal. ¿Estoy loca?

Extract 6

Después de dos años y medio, yo siento que mi trabajo es de buena calidad. Yo me siento confiada en lo que yo hago. Llevo más de ocho años de graduada de cirujana y es que nadie me puede decir que no soy cirujana, no lo puedo permitir, por mi estatus, por mi integridad mental, personal, mi autoestima [...] no me puedo dejar quebrantar, ser menospreciada. Soy un ser humano. Nadie me lo va a quitar, pero es duro porque uno tiene que armarse de esa coraza pues porque por más que tú seas segura en ti misma, eres vulnerable también, eres un ser humano entonces hay cosas que te bloquean, pero yo sé quién soy y yo me tengo que valorar yo para que los demás me puedan valorar también. Es ese el trabajo que yo he hecho a lo largo de estos años que yo llevo aquí. Es ese trabajo mental, de que no me pisen porque no es mi forma de ser, ni mi formación. No lo puedo permitir. Yo tengo que saber quién soy yo y lo que estoy haciendo aquí. Y cuál es mi objetivo y mi misión aquí.