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**Author**

Terry, DR

**Bibliographic citation**

DR Terry (2014). Health and wellbeing of international medical graduates: Acculturation into the Tasmanian rural and remote context. University Of Tasmania. Thesis. <https://doi.org/10.25959/23240786.v1>

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**Health and Wellbeing of International Medical Graduates:  
Acculturation into the Tasmanian Rural and Remote Context**

by

**Daniel Robert Terry BN, Dip Mngmnt, GradCert IntlHlth,  
GradCert Research Management, MIntlHlth, RN**

Submitted in fulfilment of the requirements for the degree of

Doctor of Philosophy

**Centre for Rural Health  
University of Tasmania**

**November 2014**

# Declaration

I, Daniel Robert Terry, am the author of the thesis titled *Health and wellbeing of international medical graduates: Acculturation into the Tasmanian rural and remote context*, submitted for the degree of Doctor of Philosophy. I declare that the material is original, and to the best of my knowledge and belief, contains no material previously published or written by another person, except where due acknowledgement is made in the text of the thesis, nor does the thesis contain any material that infringes copyright. The thesis contains no material which has been accepted for a degree or diploma by the University or any other institution.

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**Date 12<sup>th</sup> November 2014**

# Statement of authority of access

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**Date 12<sup>th</sup> November 2014**

# Statement of ethical conduct

The research associated with this thesis abides by the international and Australian codes on human and animal experimentation, as approved by the Human Research Ethics Committee (Tasmania) Network – Social Science, Ethics Reference No. H0012008.

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**Daniel Robert Terry**

**Date** 12<sup>th</sup> November 2014

# Abstract

Australia has experienced health workforce shortages, especially in rural and remote areas. In addition, rural and remote populations suffer the lowest levels of health access, the highest levels of medical practitioner maldistribution and the greatest health disadvantage in Australia. As a result, the recruitment of overseas trained doctors, also known as international medical graduates (IMGs) is one government strategy to fill these gaps. Currently, the medical workforce remains heavily dependent on IMG recruitment; however, their retention in these areas remains challenging. It is reported, IMGs seek to relocate into more metropolitan areas once compulsory services obligations are complete. This requires continued recruitment of new IMGs; however it remains an implausible solution.

The study aims to examine the experiences and challenges of IMGs living and working in rural and remote Tasmania. As such, the research attempts to respond to the following research questions: 1). What are the enablers and barriers IMGs face as they live and work in Tasmania? 2). What are the acculturation process and strategies which facilitate trust, co-operation and connections between IMGs, other health care professionals and the community? 3). What are the strategies used by IMGs to improve community engagement and integration? and 4). What acculturation strategies and barriers are observed by key informants who support IMGs in Tasmania?

A number of key theoretical concepts and frameworks underpin this study to address the aims of the study. This includes the internationalisation and globalisation of health workforce; acculturation; and human and social capital of migrants in new social and workplace environments. These theories draw attention to the challenges of acculturation and identity, which migrants, those in the health workforce and particularly IMGs face in new cultural and healthcare contexts.

The study used a mixed method approach employing a double stage sequential explorative design to collect data for the study. Data were collected through an IMG

questionnaire, and face-to-face semi-structured interviews with Tasmanian IMGs and key informants, who recruit, support and act as educators and advisors to IMGs. The study gathered 105 returned questionnaires (response rate 30%), while interviews were conducted with 45 participants recruited through purposive snowball sampling. The interview data were analysed using thematic analysis and Critical Discourse Analysis by way of NVivo v10.0. In addition, descriptive statistics and inferential statistics were used to analyse the questionnaire data using Statistical Package for Social Science (SPSS) 20.0.

The study provided insight into the everyday experiences of IMGs within hospital and rural community settings and how this impacts acculturation, cultural shock and adaptation. It provided a comprehensive understanding of the social and psychological indicators of successful integration, settlement and life satisfaction while highlighting hospital and community challenges. Lastly, it has outlined the importance of identity-community transformation and how connections within a community are vital in establishing extensive social and support networks and the development of greater social capital; greater cross-cultural adaptation; reducing local stigma; and increasing positive cultural attitudes.

The research provides insight into the complexities and principal motivators why IMGs are staying or leaving Tasmania. The study delivers greater insight into the needs, desires and challenges encountered by IMGs locally, nationally and internationally, while offering an understanding for policy augmentation to not only aid recruitment and the retention of IMGs, but also to maintain their and the community's health and wellbeing.

# Acknowledgements

This thesis has been the culmination of uncompromising persistence, diligence, a number of sleepless nights and years of ambition.

My fascination with research was developed at an early age. I can still recollect the announcement to my 5<sup>th</sup> grade teacher that I was about to embark on an experiment that was going to change the world. I wanted to be just like Einstein and pronounced I was wanted to go to University to complete my PhD, which was very uncharacteristic of an eleven year old. It is this teacher of more than two decades ago which I would like to thank for her motivation, encouragement and patience.

Despite these initial motivations, much of this work has been achieved through the foresight, encouragement and tenacity of my primary supervisor, Dr Quynh Lê, who unbiasedly looked beyond my superficial limitations to participate in the 2010 Primary Health Care Research, Evaluation and Development (PHCRED) program. At the time she motivated me to complete my Masters early and enthusiastically convinced me to undertake a PhD with the Centre for Rural Health (CRH), despite my initial objections. Her persistence has led me to complete this higher research journey in ways which may have not been achieved elsewhere. Thank you for your example, observing in me, what others have not and motivating me from day one to work tirelessly for the pursuit of knowledge. My only hope is that this is the beginning and not the end of the journey of working with you.

Thank you also to Dr Ha Hoang, for your ability to step in at a moment's notice and being the vivacious supervisor which made all the difference. Thank you for your time and input into the research process – I continue to value your input. Your insight and evaluation have been instrumental throughout my research journey, particularly at the climax of the thesis writing process. It is a privilege to have you as part of the team.



Thank you to all the students I have worked around and with over the past three years. You have made each day like sunshine, particularly at those times when it all seemed dark and bleak. I am especially grateful to Yun Yue (Maria) for your kindness, Hoang Boi Nguyen for your time and guidance, Thao Doan (Little Thao) for your laughter, Joanne Yeoh for your sweet nature and Chona Hannah for your kind words.

Also thank you to each of the CRH staff, University of Tasmania employees and other graduate research students in whatever capacity that you have provided assistance and words of encouragement. At times it is the smallest things which have made the largest impact.

A sincere thank goes out to each of the early IMGs of the 1930s-1950s, who paved the way for today's IMGs, thank you to your children for sharing your stories with me. In addition, I would like to especially thank those IMGs who participated in the current research, many of whom I have never met. I have come to deeply appreciate the sacrifice and dedication each of you and your families have undergone to immigrate, live and work in Tasmania. It is your enthusiasm and commitment which has provided services to many in their time of need. My only hope is that your dedication does not go unnoticed and that this research in some small way aids your on-going commitment and that it provides in some measure better outcomes for future IMGs.

Lastly, as I traverse the post-graduate research journey, my greatest achievement has been to do it while raising four young children. Two of which were born while I was undertaking my Masters; were both under two years old when starting my PhD; and have only ever known that daddy 'still' goes to school. Thank you Hannah, David, Rachel and Esther, for being patient with daddy each day as he studied and for sleeping long enough so I could get the work done that I needed which sometimes extended into in the wee hours of the morning. Finally, thank you to Melissa, my wife, my rock, who has seen in me more than I ever could. Thank you for your patience, your words of motivation when I was down and for seeing in me how I could be rather than what I was. I only hope that I can continue to motivate

and support you in the same capacity now that you have returned to University to commence your Masters and in time your doctoral studies.

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# Abbreviations

ACCC	Australian Competition and Consumer Commission
ACCHS	Aboriginal Community Controlled Health Service
ACT	Australian Capital Territory
AIHA	Australian Institute of Health and Welfare
AHPRA	Australian Health Practitioner Regulation Agency
AMA	Australian Medical Association
AMC	Australian Medical Council
AMG	Australian medical graduates
AoN	Area of need
ARIA	Accessibility/Remoteness Index of Australia
ASGC – RA	Australian Standard Geographical Classification - Remoteness Areas
BMA	British Medical Association
CALD	Culturally and linguistically diverse
CDA	Critical Discourse Analysis
COAG	Council of Australia governments
CPMEC	Confederation of Postgraduate Medical Education Councils
CS	Compulsory scheme
DHHS	Department of Health and Human Services
DoHA	Department of Health and Ageing

DWS	District of workforce shortage
EAP	Employment assistance program
ECFMG	Educational commission for foreign medical graduates
FGAMS	Foreign graduate of an accredited medical school
FMG	Foreign medical graduates
FTE	Full-time equivalents
FTW	Full-time workload equivalent
GP	General Practitioner
GPTT	General Practice Training Tasmania
HR+	Health Recruit Plus
IMG	International medical graduate
ILTS	International English Language Testing System
IT	Information technology
LGH	Launceston General Hospital
MCQ	Multiple choice question
NHS	British National Health Service
NSW	New South Wales
NT	Northern Territory
NWRH	North-West Regional Hospital
OTD	Overseas trained doctor
OTDNET	Overseas trained doctor national education and training program

PLWA	People living with AIDS
PMC	Postgraduate Medical Council
PMCT	Postgraduate Medical Council of Tasmania
PMEC	Postgraduate Medical Education Councils
QLD	Queensland
QUAN	Quantitative
QUAL	Qualitative
RACGP	Royal Australian College of General Practitioners
RHH	Royal Hobart Hospital
RHWA	Rural Health Workforce Australia
RMO	Resident medical officer
RRMA	Rural, remote and metropolitan area
RWA	Rural Workforce Agency
SA	South Australia
SPSS	Statistical package for social science
STI	Sexually transmissible infection
Tas.	Tasmania
UK	United Kingdom
US	United States of America
Vic.	Victoria
WA	Western Australia



# Definitions

## **Acculturation**

A contemporary definition of acculturation is the maintenance of the original culture and the development of relationships with the new culture. Acculturation is a continuously redefined multifaceted bi-directional process where migrants adopt aspects of the new culture while retaining elements of their original culture. It can lead to changes in the cultural patterns of both migrant and host communities however, it occurs prominently in the less dominant group.

## **Area of need**

Area of need (AoN) refers to a medical positions, which falls under section 21(2) (g) (Area of need) of the *Medical Practitioners Registration Act 1996*. This states a medical practitioner is conditionally registered and can be placed in positions, where a need exists. This is not related to geographical location, but rather an AoN in public or private services. It can include positions such as general practitioner, non-specialist and specialist position within hospitals

## **District of workforce shortage**

District of workforce shortage (DWS) are similar to AoN, where a population's need for healthcare has not been met. However DWS are determined by the Department of Health and Ageing (DoHA), whereas AoN are determined by the State and Territory Governments. An area of Australia is deemed DWS if medical services in the area are below the national medical services average.

## **General Practitioner**

A term used in Australia to denote a medical practitioner who has specialised training in general practice and often referred to as a GP. Terms used in other countries to describe a general practitioner include family physician, physician or family doctor.

## **Globalisation**

A term used to define the flow of technology, economy, knowledge, people, values, and ideas across borders and has affects each country in a different way due to a nation's individual history, traditions, culture and priorities

## **Internationalisation**

Internationalisation is a commonly used term within economics to denote an increased involvement of enterprises in international markets. However, this term is also about embracing diversity and a greater understanding of cultures which exists within a community and country. In addition, it deals with building and developing worldwide relationships between and among nations, cultures, or countries.

## **International medical graduate**

This is a commonly used term used for a medical practitioner who has acquired their primary medical qualification in a country other than Australia. This term must not be confused with international students who have or are training in Australia. A previously used term for international medical graduate (IMG) in Australia was overseas trained doctor (OTD). In addition, many other countries have used terms such as foreign medical graduates (FMG) or foreign graduate of an accredited medical school (FGAMS).

## **Medical practitioner**

A term used to denote an individual who is a member of the medical fraternity and is synonymous with the term 'doctor.' Under Australian national law, a medical practitioner is a person who holds registration with the Medical Board of Australia. In this thesis the term medical practitioner or doctor will represent all medical practitioners regardless of their specific specialised training. When speaking of specific specialties or to indicate different types of medical practitioners their respective terms will be used.

### **Medicare provider number**

Medical practitioners who work in Australia require a Medicare provider number which uniquely identifies a medical practitioner and their place of employment. It allows patients who see the medical practitioner to receive a rebate for the service provided and allows a doctor to treat private patients. The Medicare provider number also allows medical practitioners to refer patients on to specialist services and request pathology or diagnostic imaging services.

### **Overseas trained doctor**

In Australia it is used synonymously with IMG; however, this antiquated term will not be used as the principal definition within this thesis.

### **Stakeholder**

There are many definitions of a stakeholder. Nevertheless, the Australian Rural and Remote Workforce Agency Group (ARRWA) has used this term to define those individuals and organisations whose direct role is the recruitment or support of IMGs. However, for the purpose of the thesis this term will not be used to discuss individuals, however 'key informant' or 'informant' will be used to distinguish between individual stakeholders and stakeholder organisation.

### **10-year moratorium**

This policy instrument is used by the Australian Government to ensure IMG mandatorily practice in rural locations for a set amount of time. This is achieved by restricting IMG access to Medicare provider numbers and subsequent cash rebates for up to ten years until mandatory rural practice has been fulfilled.

# **Chapter one: Introduction**

## **1.1 Introduction**

Due to the shortage and maldistribution of health professionals in Australia, particularly in rural and remote areas, the recruitment of international medical graduates (IMGs) has become a significant trend in meeting the demands of this need. IMGs are those medical practitioners who have completed their medical qualifications in countries outside Australia, such as India, Iran and Myanmar. The registration requirement for IMGs to work in Australia remains that they have to initially undertake compulsory service obligations in remote and rural areas. IMGs experience challenges, both culturally, socially and emotionally as these migrant professionals enter these new cultural and remote environments, such as Tasmania.

To examine many of these challenges, this study centres on understanding the acculturation process and strategies which facilitate trust, co-operation and connections between IMGs, other health care professionals and communities in which they live and interact. The study also focuses on what and how IMG needs may be met and the processes they use for community engagement and integration. It will also examine the complexities regarding why IMGs are leaving Tasmania and how their recruitment and transition may be augmented to improve integration, retention and guide future policy directions.

This chapter gives an overview of the study by providing the background, purpose, significance of the study, and theoretical as well as contextual rationale of the research. In addition, the chapter outlines the research aims and questions, research methodology, ethical considerations and study limitations. The contents of each chapter are outlined and presented to conclude the introduction chapter.

## **1.2 Background of the study**

Worldwide recruitment of IMGs, also known as overseas trained doctors (OTDs) continues to be central to health workforce planning in developed countries

including Australia, which has the highest number of IMGs per capita in the world (Alexander & Fraser, 2007; Audas, Ross, & Vardy, 2005; Han, 2010; Hawthorne, 2010; Iredale, 2009; Lim, 2010; Rabinowitz, Diamond, Markham, & Paynter, 2001; Spike, 2006). Australia's effort to increase IMG numbers is due to the necessity to redress restrictions placed on medical student enrolments and IMG registrations in the 1990s (AIHW, 1996). This restriction was triggered by a speculative high doctor-to-population ratio to occur in the twenty-first century, on-going rural health disparity and doctor maldistribution (Elkin & Studdert, 2010; Harding, Parajuli, Johnston, & Pilotto, 2010; Van Der Weyden, 2005).

One such restriction was demonstrated in 1992 when "the Medical workforce Supply Working Party documented concern at Australia's 'persistent over-supply of doctors', with doctor/patient ratios rising by around 67 percent over a 20 year period" (Hawthorne & Birrell, 2002, p. 55). In that same year, the Commonwealth Government conducted an inquiry into a national competition policy for Australia. The inquiry produced the *Hilmer Report 1993*, a national competition policy review and led to the enactment of the *Commonwealth Competition Policy Reform Act 1995*. The reform had implications for industries nationwide, including health (National Competition Council, 2012; National Competition Policy Review, 1993).

Under the agreement, each Australian state and territory had enacted competition codes mirroring part IV of the *Trade Practices Act 1974*, which concerned the anti-competitive restrictions. These codes gave the "Australian Competition and Consumer Commission (ACCC), an independent, statutory authority responsible for monitoring compliance with, and enforcement of the [*Trade Practices Act 1974*]... authority to sanction anti-competitive behaviour provided that a clear public benefit can be shown" (DoHAC, 2001, p. 59).

Thus, a restriction was imposed on the number of medical practitioners able to practise in Australia. Subsequently, medical school graduates were restricted from 1,200 to 1,000 per year and only 200 IMGs were permitted to register per annum. It was anticipated these restrictions would reduce medical practitioners by 7,500 in

Australia by 2025 and reduce the forecasted over-supply while meeting the growing need of medical practitioners into the future (AIHW, 1996).

These moves also strengthened the basis for the Australian government's *Medical Practitioners Registration Act 1996*. This Act required all future medical graduates who wished to practise as general practitioners (GPs) to complete post-graduate study and limited enrolment in these courses to 400 places a year Australia wide (Bialystok, 1991; Birrell & Schwartz, 2006; Birrell, 2004; Hawthorne, 2007; Hawthorne & Birrell, 2002; Van Der Weyden & Chew, 2004).

These various policies largely limited medical school places and led to the on-going under production of medical graduates in Australia (Elkin & Studdert, 2010; Harding et al., 2010). The shortages, which exist today, are due to this decrease in Australian medical graduates, an ageing medical workforce and the growth in population. This has led to

a number of policy responses from the Australian Government including... a greater reliance on [IMGs].... However, while gains have been made, a maldistribution of health workers remains, and access to medical professionals by the population in regional and remote areas continues to be below the access in major cities. (Deloitte Access Economics, 2011, p. 2)

The key policy responses to counteract these initial restrictions led to a relaxation of skilled migration for IMGs and permitted temporary resident IMGs to enter Australia and work in greater numbers (Birrell, 2004; Harding et al., 2010; Hawthorne & Birrell, 2002; Hawthorne, Hawthorne, & Crotty, 2007; Laurence, 2008). To control the increase in the number and the distribution of IMGs, regulatory immigration rules and a restriction were introduced regarding access to Medicare provider numbers<sup>1</sup>.

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<sup>1</sup> Medical practitioners who work in Australia require a Medicare provider number which uniquely identifies a medical practitioner and their place of employment. It allows patients who see the medical practitioner to receive a rebate for the service provided and allows a doctor to treat private

Beyond a relaxation of IMGs entering Australia, an increase in medical self-sufficiency within Australia has also commenced with a projected 60 - 85% increase in medical school graduates by 2012 (Elkin & Studdert, 2010; Joyce, McNeil, & Stoelwinder, 2006). In 2010, \$632 million in funding over 10 years was announced to train more than 5,000 new doctors and a greater number of specialists in general surgery, pathology, radiology, obstetrics and gynaecology. The funding was announced to also support more than 5,400 junior doctors to participate in general practice placements. The announcement was said to maintain current levels of medical practitioners needed for the next 10 years (Rodgers, 2010). Since this announcement, medical school entrants increased by 25.8% between 2007 and 2011 (AIHW, 2013). This significant increase brings with it a spectrum of issues that will inevitably impact on the future recruitment and placement of IMGs in Australia (Elkin & Studdert, 2010; Joyce et al., 2006).

Notwithstanding the future of IMGs in Australia, it is currently a global era of increasing urbanisation, where rural communities are undergoing health workforce shortages (Grenfell & Erler, 2007; Han & Humphreys, 2006). Thus, it is vital to evaluate the methods and processes used to help IMGs in these workplaces and communities. This evaluation will ensure IMGs integration, or rather acculturation, in rural settings will be better understood while maintaining Australia's competitiveness in the global IMG market (RHWA, 2011a).

A literature review was conducted to comprehend IMG acculturation in rural settings and to understand the history, legislation and policies which guide how IMGs entered and practised in Australia. This literature review also identified the placement and retention issues faced by IMGs in rural practice and how these and other complex issues impacted rural community acculturation.

A wealth of research has been undertaken to understand the health and wellbeing of internally displaced people, refugees or individuals who migrate, reside and settle in new countries. From this large body of work, there are relatively few

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patients. It also allows medical practitioners to refer patients on to specialist services and request pathology or diagnostic imaging services (Department of Health and Ageing, 2011b).

studies that explored the issues and challenges relating to the recognition or transferability of professional occupations upon migration (Colic-Peisker, 2009; Colic-Peisker & Tilbury, 2006; Kilpatrick, Johns, Vitartas, & Homisan, 2011). These issues and challenges identified include medical practitioners who have encountered complex legislation and obstreperous lobby groups over many decades (Frehywot, Mullan, Payne, & Ross, 2010; Kunz, 1975). These challenges have created obstacles including expensive examinations and compulsory schemes to navigate, which enable doctors to practise their chosen profession in countries, such as Australia (Frehywot et al., 2010).

### **1.3 Rationale of the study**

International medical recruitment remains essential to sustain rural access to health services. These regions suffer the lowest levels of health access, the highest levels of medical practitioner maldistribution and the greatest health disadvantage in Australia (Deloitte Access Economics, 2011; Scott et al., 2012). The medical workforce remains heavily dependent on the recruitment of IMGs; however, their retention in rural and remote areas remains problematic. It is reported that IMGs seek to relocate into more metropolitan areas once compulsory service obligations are complete (Harvey & Faunce, 2005; Kilpatrick et al., 2011; Lim, 2010; McGrail, Humphreys, Joyce, & Scott, 2012; Russell, Humphreys, McGrail, Cameron, & Williams, 2013). As such, continued recruitment of new IMGs remains an implausible solution. It has been observed as “a quick fix and/or a distraction from other home-built solutions to health resources management” (Organisation for Economic Co-operation and Development, 2007, p. 200).

To date the research that has been conducted regarding IMGs and rural retention has focussed primarily on employment issues. Workplace integration, satisfaction and practice support were used as measures of acculturation and settlement success in rural contexts. Very few studies examined the quality of life, social needs and the health and wellbeing of IMGs and their families (Alexander, 1998; Colic-Peisker, 2009; Durey, 2005b; Gilles, Wakerman, & Durey, 2008; Han & Humphreys, 2005; Hawthorne, Birrell, & Young, 2003; McGrail, Humphreys, Scott, Joyce, & Kalb,



2010; Stanley & Bennett, 2005). These crucial factors, which have been less represented within the literature, may impact the acculturation, retention and length of stay in rural areas.

## **1.4 Significance of the study**

Issues and challenges regarding the health, wellbeing and acculturation of IMGs in rural and remote contexts have not been clearly explored. Such issues include the psychosocial indicators of successful integration, settlement and life satisfaction of IMGs and their families living and working in rural areas of Australia. Therefore, this study adds to existing knowledge and generates new knowledge and insights that are potentially useful locally, nationally and internationally. The study contributes to the current body of knowledge concerning IMGs both contextually and theoretically.

### **1.4.1 Contextual significance**

Current issues encountered by IMGs, Australian medical graduates (AMGs) and allied health professionals in rural Australia include long working hours; poor employment opportunities for spouses; a lack of educational opportunities for children; and physical and social isolation (Keane, Lincoln, & Smith, 2012; McGrail et al., 2012; Stanley & Bennett, 2005). Specifically, these factors further impact cultural and psychological barriers experienced among IMGs that also lead to low retention rates in rural areas. For example, in Tasmania, migrant communities, which often do not exist, are much smaller and arguably less cohesive than those found elsewhere in Australia (Wu, 2001). These smaller and less cohesive communities may further exacerbate the retention of IMGs within the state.

It has been indicated that it is the non-professional, social barriers which have the greatest impact on an IMGs' decision to stay or relocate (Carlier, Carlier, & Bisset, 2005; Durey, 2005a; Gilles et al., 2008; Han & Humphreys, 2005; Hancock, Steinbach, Nesbitt, Adler, & Auerswald, 2009; McGrail et al., 2010; McGrath, Henderson, & Phillips, 2009). Nevertheless, it has also been shown that professional support remains critical for an IMGs' inevitable integration and retention in a rural community (Alexander & Fraser, 2007; Carlier et al., 2005; Durey

et al., 2008; Gilles et al., 2008; Han & Humphreys, 2005; Hawthorne et al., 2003; Kilpatrick et al., 2011; McGrath et al., 2009; Mpofu, 2008; Wright et al., 2012).

To date, other IMG studies have been focused on employment satisfaction as a measure of integration and settlement success. This study attempts to provide insight into the psychosocial needs, desires and challenges encountered by IMGs in the rural context. This may provide further understanding regarding the social and psychological indicators of successful integration, settlement and life satisfaction among IMGs, who continue to migrate to Australia, despite the current increased domestic production of AMGs. The present study seeks to provide some indication of the challenges which may be encountered by other professional migrants in the ever increasing globalisation of the health care workforce (Brown & Connell, 2004; Oman, Moulds, & Usher, 2009).

The study aims to provide insight into whether there is a difference between the actual challenges experienced by IMGs and the perceived challenges of IMGs from the perspective of key informants, who recruit, support and act as educators and advisors to IMGs. Further, the research aims to provide insight into the complexities and main motivators why IMGs are leaving rural areas, specifically Tasmania. These insights will provide essential data for policy augmentation to further aid the recruitment and retention of IMGs (McGrail et al., 2012). An examination of those IMGs who stay longer in communities also cast light on what capacities determine IMGs to persevere despite potential elements of stigma and ethnocentrism. The analysis also determines what role effective communication has in reducing frustration and intolerance of others. Lastly, the research attempts to highlight any underlying hegemony between informants, IMGs, the institutions in which they work and associated professional bodies, which had been indicated to occur in the past (Kunz, 1975; Rutland, 1987).

#### **1.4.2 Theoretical significance**

Many commensurate IMG studies are framed by various theories. These include social critical theory, critical realist theories, socio-cultural educational theory with the most common frameworks being human, social and cultural capital theories.

The remaining studies were relatively silent regarding their theoretical framework. Each of these studies, although valuable, focussed on the professional transition and acculturation of IMGs. At least four studies analysed the impact of IMGs working and their families living in rural or remote settings and the factors which affect IMGs' professional, cultural and social integration (Durey, 2005b; Gilles et al., 2008; Han & Humphreys, 2005; Hawthorne et al., 2003). However, many were inadequate to provide an understanding and insight into the deeper issues faced by IMGs in the communities they were living and working.

In this study, human, social and cultural capital theories are used, while being informed by acculturation. These theories and concepts allow a more developed understanding of the complexities of IMGs as a 'global commodity' and once migrated, the coping strategies they use and how and by what means they acculturate into rural communities.

### **1.4.3 Methodological significance**

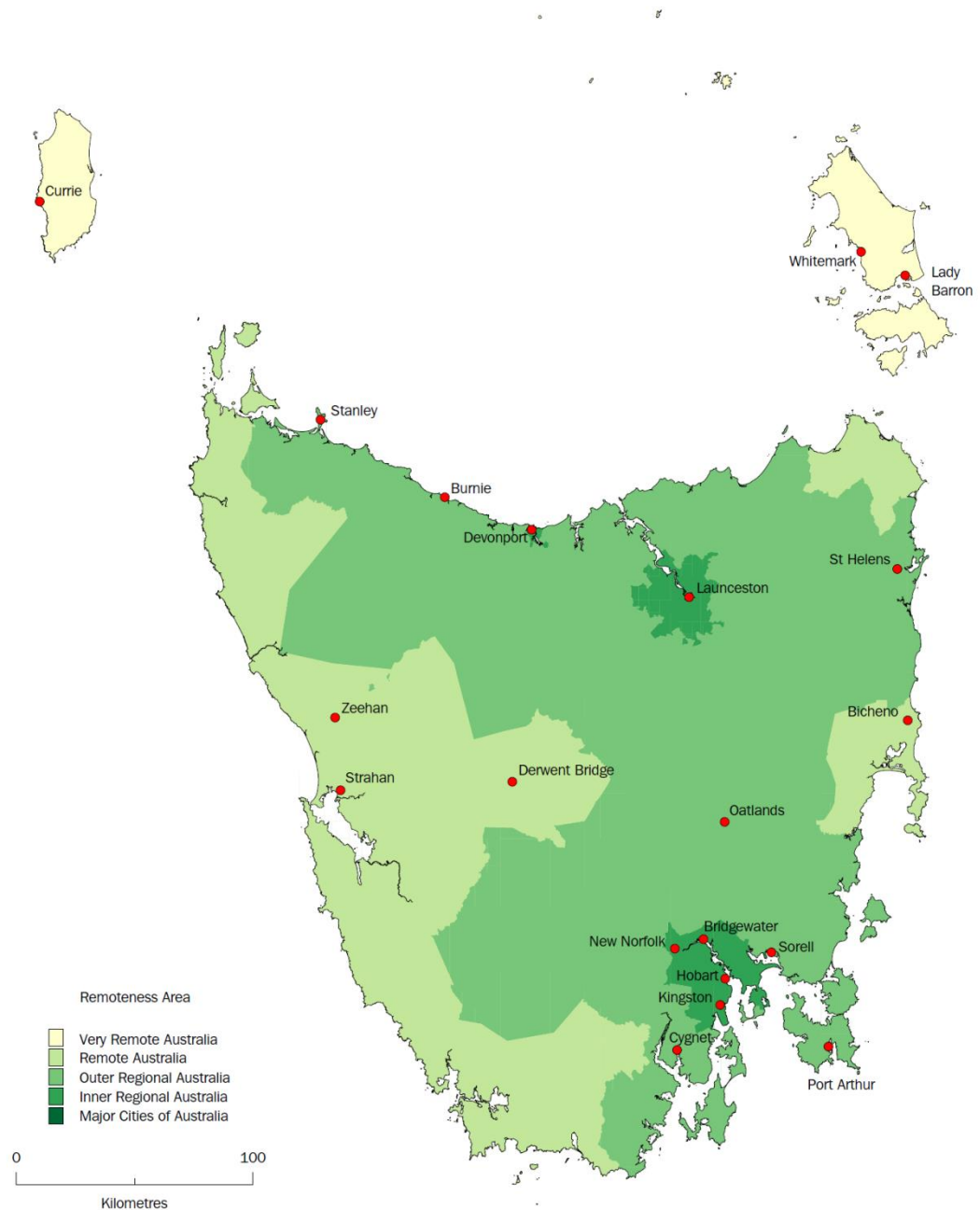
This study also draws on phenomenology as the vehicle to understand the everyday subjective experiences of the lived world of IMGs. This insight will provide a better understanding of the meaning of the events which IMGs experience and how this impacts on their acculturation process as they migrate (Berry, 1997; Bowling, 2005; Greenhalgh, 2007; Liamputtong & Ezzy, 2005; McConnell-Henry, Chapman, & Francis, 2009). Moreover, the study has the potential to benefit health care settings where an increased internationalisation and the diversity of cultures exist. When greater intercultural awareness is more fully embraced, it is beneficial to hospitals, primary health care settings and the wider community (Knight, 2003, 2004).

Lastly, the current research examines the emerging concept, 'social ties through common interests.' This concept is where an individual is initially drawn to participate in a group due to the interest which is in common with other members of that group, rather than being drawn to the group by any one individual within the group. The connections and social ties made within the group who share the common interest are primarily secondary to the initial motivation, yet become essential in establishing extensive social and support networks and the

development of greater social capital. These connections lead to greater cross-cultural adaptation among migrants and also reducing stigma while increasing positive cultural attitudes .

## **1.5 The context of the study**

Tasmania is a small island off the South-east coast of mainland Australia and has a social and cultural environment, which is vastly different to large Australian cities. Tasmania lacks the large, dense and dynamic cultural and linguistic diverse communities (CALD) which occurs in larger Australian cities, such as Melbourne and Sydney (ABS, 2012). An estimated 42.2% (214,705) of Tasmania's total population (507,643) live within Hobart, the capital city, which is not considered major metropolitan city, but an 'inner regional' centre (AIHW, 2011c). The remainder of Tasmania's population is scattered across Launceston, the second largest inner regional centre, Devonport, Burnie and the many other small towns, which are considered outer regional or remote areas across Tasmania, as shown in Figure 1.1 (ABS, 2006; AIHW, 2011c).



**Figure 1.1: Tasmanian and level of remoteness**

Source: Australian Bureau of Statistics (2006).

### 1.5.1 The current health climate in Tasmania

The commencement of the twenty-first century has brought about many changes in the economy that have shaped the global community. It has warranted governments to adapt to these changes and to undertake economic rationalisation and in many cases austerity measures (Humphreys, 2009; Oberlander, 2011).

Healthcare, one of the highest spending public sectors of most westernised economies, has implemented greater budgetary restraints recently. These measures have involved bed closures, job losses, longer waiting lists and ever increasing costs to access health services, which have contributed to deteriorating health outcomes (Humphreys, 2009). Health remains the object of governments who aim to downsize and cost shift (Oberlander, 2011).

It is within this context of the current health climate that this study was conducted. Moreover, the current Tasmanian government is placed in a situation where the current \$1.3 billion health budget needs to find \$100 million worth of savings in 2011 -2012, increasing to \$150 million by 2014-15 (Giddings, 2011a). It is anticipated this could be achieved through a number of measures. These measures include reducing the duplication in areas such as payroll; reducing expenditure on locums, travel, motor vehicles and conferences; reforming procurement; and reducing the number of employees up to 2300 full-time equivalent jobs (between 7.0-9.0% of the workforce) and includes frontline services (Brown, 2011; Giddings, 2011a, 2011b; Poskitt, 2011). In addition, a reduction of elective surgery and a cutting of other services have occurred over this time leading to increased waiting times and delays in diagnosis (Glumac, 2011; Poskitt, 2011).

These measures have raised concerns among many Tasmanian specialists, who because of budget cuts or worsening workplace conditions, are considering the withdrawal of their services and moving interstate (Glumac, 2011; Poskitt, 2011). These issues impact not only service delivery but also the supervision and education of medical students, interns, resident medical officers (RMOs) and IMGs (Glumac, 2011). It is, therefore, within this climate of fear, anger and frustration of both medical practitioners and other health care employees that much of the data has been framed. The fear and anger have been reflected within a significant proportion of the dialogue, text and discussion throughout the study.

### **1.5.2 Lost in the labyrinth and recent debate**

In addition to the current financial climate, it must be noted within ten months of commencing the current study, 'Lost in the labyrinth', an extensively detailed

Parliamentary inquiry regarding IMGs was published in March 2012 (House of Representatives Standing Committee on Health and Ageing, 2012a). The inquiry was conducted by the Standing Committee on Health and Ageing between December 2010 and March 2012, where 184 submissions were received from key informants, peak bodies, stakeholder organisations, government bodies and individuals across Australia. In addition, 22 public hearings were held between February 2011 and January 2012 to gather additional evidence. The objective of the inquiry was

to explore the registration process and support available for those [IMGs]... and to explore ways to remove impediments and promote pathways for [these] doctors to achieve their full Australian qualification, particularly in regional areas, without lowering the necessary standards required by colleges and regulatory bodies. (House of Representatives Standing Committee on Health and Ageing, 2012b, p. 1)

From the inquiry, there were 45 recommendations made to improve IMGs' experiences and achieve Australian qualification. One such outcome, promoted by the Federal Government, was the commencement of an Overseas Trained Doctor National Education and Training program (OTDNET) in 2013. The program, conceived by General Practice Education and Training, "aims to provide a cohesive training scheme for IMGs in rural areas" (Cesta, 2012, p. 1). In addition, another recommendation of the inquiry is to evaluate IMGs assessment methods to achieve accreditation. One such evaluation was conducted between October 2012 and June 2013 at the Launceston General Hospital (LGH), one of the three major hospitals in Tasmania (Barnett, Terry, Mulligan, & West, 2013).

Also as a result of the inquiry, research was conducted and published showing formal complaints to medical regulatory authorities were 24% higher among IMGs than non-IMGs, which attracted 41% higher odds of adverse findings (Elkin, Spittal, & Suddert, 2012). This research has provoked debate and prompted doctors to call upon "the government to place an embargo on new international medical graduates entering Australia until it provides adequate support during their

practice, training and accreditation” (Cesta, 2012, p. 1). Thus, it is within the context and in light of the Parliamentary inquiry, current research and public debate regarding IMGs in Australia, that the study was conducted.

## **1.6 Theoretical framework**

Due to the nature of this study, a number of theories are used as a framework and lens to guide the study and understand the data. As previously indicated, theories such as human, social, cultural capital theories will be used to develop an understanding regarding the complexities IMGs encounter as they migrate and the coping strategies used. These theories will help to frame and understand the complex interplay that impacts and determines both IMG and their family’s acculturation and retention.

Acculturation has been described as a concept or process (Berry, 2001), whereas others define it as a theory (Colic-Peisker & Walker, 2003). Regardless of the debate, acculturation is a multifaceted bi-directional process where migrants adopt aspects of a new culture, while retaining elements of their original culture. The acculturation of migrants remains a continuously redefining process, which can lead to changes in the cultural patterns of both migrant and host communities (Berry, 1997; Hunt, Schneider, & Comer, 2004; Salant & Lauderdale, 2003; Thompson, Manderson, Woelz-Stirling, Cahill, & Kelaheer, 2002). This concept will be used within the research as a framework to generate a depth of understanding relating to acculturation and the health and wellbeing of IMGs as they live and work in Tasmania.

As previously indicated, phenomenology was used to understand the everyday subjective experiences of the lived world of IMGs. It will provide an understanding regarding the meaning of the events which IMGs experienced and how these events, incidents and experiences impact the acculturation process of IMGs as they migrate, live and work in rural Tasmania (Berry, 1997; Bowling, 2005; Greenhalgh, 2007; Liamputtong & Ezzy, 2005; McConnell-Henry et al., 2009).



## **1.7 Research aims and objectives**

When considering the background, significance and theoretical framework of the study to examine the health, wellbeing and acculturation of IMGs in rural and remote contexts, as a means to inform retention, further and more developed research is required. Both international and Australian IMG literature highlights the challenges encountered by IMGs as they live and work in rural communities. This includes employment integration, satisfaction and practice support, while very few address the psychosocial needs, desires and challenges encountered by IMGs and their families, which remains relatively silent within the literature.

### **1.7.1 Research aim**

These silences will be answered in the current study as it aims to examine the experiences and challenges of IMGs living and working in rural and remote Tasmania, and how this informs their acculturation process.

### **1.7.2 Research questions**

In relation to the research aim, the study attempts to respond to the following research questions

1. What are the enablers and barriers which IMGs encounter as they live and work in Tasmanian communities?
2. What are the acculturation process and strategies which facilitate trust, co-operation and connections between IMGs, other health care professionals and the community?
3. What are the strategies used by IMGs to improve community engagement and integration?
4. What acculturation strategies and barriers are observed by key informants who support IMGs in Tasmania?

### **1.7.3 Research objectives**

To guide the research questions, the study focuses on the following research objectives.

1. Examine IMGs' cultural views on health care, particularly the influence of their cultural backgrounds on health provision and its acceptance in their new country;
2. Ascertain how IMGs' perceive and manage their health care and community experiences in rural western society, particularly the strategies they use to manage their experiences;
3. Examine IMGs' views about workplace and community engagement and integration, particularly in sparse and less dense culturally and linguistically diverse communities;
4. Identify and provide direction for increasing integration and acculturation for IMGs and their families in rural Tasmania, in ways that address the identified gaps; and
5. Examine the current policy and support services for IMGs in rural areas.

## **1.8 Overview of research methods**

The methodological framework aims to inform and guide the research aims and questions. Both qualitative and quantitative methods were used in this study. In relation to the qualitative aspect, phenomenology was adopted as a research theoretical framework for examining the everyday subjective experiences of an individual's lived world, where meaning is shaped and produced continuously (Bowling, 2005; Greenhalgh, 2007; Liamputtong & Ezzy, 2005). Phenomenology is both a philosophy and research approach in which phenomena are explored (Carpenter, 2010; Creswell, 1998; McConnell-Henry et al., 2009). Phenomenology's strengths are in its ability to provide a "rich, in-depth understandings about social phenomena in their natural settings, which cannot be captured by quantitative methodologies" (Wong & Lohfeld, 2008, p. 54).

### **1.8.1 Research design**

The study utilised a mixed method design, which collects, analyses, and integrates quantitative and qualitative data to address the research aims and questions (Ivankova, Creswell, & Stick, 2006, p. 3). Using mixed methods in the current study enhanced the understanding of the lived experience, the challenges IMGs encounter as they migrate, work and live in rural Tasmania. This study employed both questionnaires and semi-structured interviews to address the research aims and answer the research questions.

To achieve the aims and objectives, the research was framed by a *concurrent triangulation design* to confirm and cross-validate research findings. This is one of the more simple mixed method designs where the dominance is neither given to the qualitative or quantitative methods, but used to strengthen the knowledge claims of the research (Creswell, Plano Clark, Gutmann, & Hanson, 2003). The two data sets are combined in the interpretation stage of the study to combine their strengths inherent within both methods (Creswell, 2009; Creswell et al., 2003; Creswell & Tashakkori, 2007; Morse, 2005; Tritter, 2007).

### **1.8.2 The sample**

The concurrent triangulation design facilitated the semi-structured interview and questionnaire data collection to occur at three different stages within the timeframe. Initially, stage one of the data collection commenced with semi-structured interviews with key informants, those individuals who recruit, support and act as educators and advisors to IMGs in the Tasmanian public and private health workforce. This approach generated a depth of understanding of the challenges and issues regarding IMGs from the perspective of informants, who are in close contact with IMGs. This process also ensured an opportunity for greater responsiveness to stage two, the IMG questionnaire and stage three, the semi-structured interviews with IMGs. The initial contact through stage one enabled the establishment of meaningful connections with key individuals to further assist with the future distribution of information and questionnaires. This approach allowed

subsequent interviews with IMGs to occur which completed the data collection process (Gaglio, Nelson, & King, 2006).

- *For the semi-structured interviews with key stakeholders:* The sample included 23 key informants with clinical and non-clinical backgrounds who worked full or part time in various capacities such as medical educators, directors of clinical training, program officers, organisational heads and recruitment management and staff. The study employed a purposive snowball sampling method, where individuals and groups are identified through other sampled individuals and their networks. It was the most practical sampling method in this case when individuals or groups were hard to access (Abramson & Abramson, 1999).
- *For the IMG questionnaire:* 105 IMGs across Tasmania participated in the questionnaire. A simple random sample of the IMG population would have been optimal for the study. However, due to the complexities of making contact with IMGs, distribution of the on-line and hardcopy version of the questionnaire was made through key informants. Snowball sampling was used as the principal means to ethically distribute the questionnaire and information regarding the study to IMGs.
- *For the semi-structured interviews with IMGs:* The sample consisted of 22 IMGs who were recruited and elected to be interviewed through the questionnaire. The sample of IMGs came from many areas across Tasmania within both the public and private health workforce.

### **1.8.3 Instruments and data analysis**

To address the research aims and questions pertaining to the experiences and challenges of IMGs living and working in rural and remote Tasmania, an outline of the research instruments together with the data analysis is discussed below.

#### **1.8.3.1 Quantitative stage**

The anonymous self-administered 'Tasmanian IMG questionnaire' used in the study was based on the 'Victorian IMG Rural General Practice questionnaire' used by Hawthorne, et al. (2003). Within the Tasmanian context, adjustments were made to

the questionnaire, to ensure relevance to both the context and the general IMG population undertaking the questionnaire. The Tasmanian questionnaire had 42 questions across six sections such as IMG demographics including current employment and location; motivation for migration; qualifications and Australian registration; medical employment history; and current professional and non-professional lifestyle. The remaining section of the questionnaire included three Likert-scale questions which focused on IMGs' satisfaction of their current professional position and non-professional lifestyle.

Once developed, the Tasmanian IMG questionnaire underwent face and construct validation. In addition, the psychometric properties of the Likert-scales in the questionnaire were evaluated. The 43 items from the three Likert-scales were subjected to Principal Components Analysis (PCA) with a Varimax rotation using Statistical Package for Social Science (SPSS) version 20.0 (IBM, 2012). The analysis was conducted to extract the maximum amount of variance across each of the Likert-scales questions (Pallant, 2011).

The questionnaire data were analysed using SPSS 20.0 (IBM, 2012), to ascertain and present findings from the various quantitative responses (Calnan, 2007).

Descriptive statistics were used to initially examine the demographic and frequency data (Munro, 2005). The chosen statistical test reflected the data gathered from the questionnaire, which includes categorical data and ordinal scales. Chi-square ( $\chi^2$ ) tests were performed between gender, age group, region of origin and current employment in Tasmania and each Likert-scale outcome variable relating to the future employment, professional and non-professional satisfaction of IMGs. If Chi-square assumptions were violated a Fisher's exact test was used. Chi-square ( $\chi^2$ ) tests only indicate an association, they do not give a measure of the strength of the association between the variables nor does it give any information about what the nature of the differences between the groups were (Munro, 2005; Pallant, 2011). Those factors that were indicated to be significant ( $p < 0.05$ ) underwent ordinal logistic regression using the GENLIN procedure. Overall test of significance between variables, odds ratios (OR) and 95% confidence intervals were calculated. Finally,

Spearman's correlation test was used to measure statistical correlation between dependent variables.

### **1.8.3.2 Qualitative stage**

The qualitative data itself could provide deep insights in the pursuit of the research objectives. However, it can be used to complement and enrich the quantitative analysis and to enrich the findings with intricate meanings (Bernard, 2000; Broom & Willis, 2007; Calnan, 2007; Davis & Scott, 2007). Qualitative data were sourced from open-ended sections of the questionnaires and individual interviews. Both key informant and IMG interview questions were based on interview questions used in the studies conducted by Hawthorne, et al. (2003) and Han and Humphreys (2005). These studies examined the community integration of IMGs and their intention to stay in rural communities. In this study questions were customised for the Tasmanian context and were further informed by a number of previous studies, which explored the acculturation, community integration and community support of IMGs and migrants (Carlier et al., 2005; Colic-Peisker, 2009; Laven, Beilby, Wilkinson, & Mc Elroy, 2003).

For the purposes of this study, two analytical approaches were used to analyse the qualitative data. These included thematic analysis and Critical Discourse Analysis (CDA). The former approach was used to identify recurring themes, patterns of living, behaviour and experience which then become a description of the phenomenon within the data (Aronson, 1994; Braun & Clarke, 2006; Fereday & Muir-Cochrane, 2008). The latter approach was used to critique the social order of power and inequality among participants (Blommaert & Bulcaen, 2000; Van Dijk, 2001). In addition, CDA was employed to observe and determine the areas where social power, dominance, and inequality are enacted, reproduced, and resisted through the text and talk of colleagues and informants of IMGs.

## **1.9 Ethical considerations**

The present research was granted ethical approval (Ethics Reference No: H0012008) by the Human Research Ethics Committee (Tasmania) Network (see Appendix A).

The National Statement on Ethical Conduct in Research Involving Humans (Commonwealth of Australia, 2007) indicates there are four principals to ensure the research is conducted in an ethical manner. These principals or guidelines include research merit and integrity, justice, beneficence and respect for human beings, which are discussed below.

Research merit and integrity was suitably addressed by conducting a thorough literature review, weighing up the possible benefits of the research and assessing its contribution to knowledge to improve the welfare and wellbeing of IMGs. The study was designed using appropriate methods to achieve the aims of the research. Lastly, the integrity was maintained by having a broad and collaborative research supervisory team which had adequate qualifications and competence for the research to be conducted.

In relation to justice, the research was conducted in a manner that addressed fairness without exploiting participants or placing any unfair burden upon participants. Opportunity was given to all known IMGs to participate in the study. Preparations were in place for those participants of non-English background who may have had difficulty in understanding the information sheets and consent forms. In this case, they would have had the opportunity to withdraw from the study or the local interpreting service support would have been engaged to facilitate data collection.

To further enable fairness of recruitment and distribution, third parties such as the University of Tasmania, Department of Health and Human Services (DHHS), medical practices and IMG recruitment agencies were invited to assist with the study. Their roles were to disseminate information regarding the questionnaire and subsequent interviews to all known IMGs. In addition, the findings of the research were disseminated to the public and those who participated in the research through conferences and journal publications. As these publications have become available, key organisations and individuals were made aware to ensure further dissemination of the findings.

Beyond addressing justice, beneficence and minimising the risks of harm or discomfort to research participants was central to the research. The study was designed to minimise possible risks for all participants. Special care was provided to ensure respect for the participants' rights, beliefs, perceptions, and customs. The researcher ensured that the welfare of the participants was at the forefront of the research. In addition it was vital to minimise any harm, risks of harm or discomfort to participants when undertaking the research and ensure participants were aware of the potential benefits and risk from their participation. Participants were made aware they could discontinue their participation at any time of the research.

In the case of harm, risks of harm or discomfort being experienced by participants, the research would have been suspended. The researcher had designed the research to minimise the risks of harm or discomfort to participants; report promptly to the relevant ethical review body if a problem arose; and take prompt steps to deal with any unexpected risks. This design included whether the research should be discontinued or at least modified. If required, counselling services could be arranged to address any discomfort or distress caused to the participant.

Lastly, the respect for human beings is encompassed in each of the National Statement's principals and included the privacy, confidentiality and cultural sensitivity of each participant. Also it was made clear that participation in the questionnaire and interviews was voluntary and participants were able to withdraw their participation and data at any time without providing an explanation or reprisal. A key element of respect is the protection of participant identity. This protection of identity was achieved by assigning numerical codes to conceal each participant's identity. As citations from the interview and questionnaire data are used it is presented in such a way that the background and identities of each participant are protected. All raw data obtained in the study is maintained locked and secure filing cabinets, while all electronic data remains on password protected computers at the Centre for Rural Health, University of Tasmania.



## **1.10 Limitations of the study**

Within the research, there were a number of limitations. Firstly, the views and experiences of IMG spouses or families were not gathered directly in the study. This data would have provided an additional layer of understanding and greater depth to the acculturation of IMGs and their families as they live and work in Tasmania. In addition, the study was focussed on all IMGs within Tasmania, which were a vast heterogeneous group of individuals. These factors impact the generalisability of the findings, particular those living and working in very remote contexts. In this case, the data may not be transferrable to all IMG populations; however, the results of the study sample may be more generalised back to the population. Nevertheless, the study does provide extensive insights and understanding into the motivations and desires of IMGs who live and work in rural communities.

Beyond these challenges, a substantial limitation was highlighted when IMGs were reluctant to participate in or complete the questionnaire. IMGs were concerned that by completing the questionnaire this may somehow impact their ability to gain full medical registration. This reluctance to participate in the questionnaire was occurring more among the newly arrived IMGs as they were fearful of any consequences. This factor may indicate why there was a low questionnaire response rate and why those with less than five years medical experience were less likely to indicate their willingness to be interviewed. This may highlight the fear and insecurity which some IMGs experience as they attempt to live, work and undertake examinations to become registered in Australia.

In other cases, discrepancies arose between interview data and questionnaire data. For example, when discussing stigma within the workplace, those IMGs who were interviewed felt their experiences were overall positive. Conversely, within the 'open' written responses from the questionnaire a different story emerged which was less positive. This difference may be due to the questionnaire being a more anonymous method than the interview to relay the concerns a number of the IMGs experienced. However, only those IMGs with more positive experiences may have been elected to be interviewed.

Lastly, underlying much of the interview data were the current financial climate and in a number of cases the key informants and IMGs, particularly those employed through the DHHS were concerned they were going to lose their jobs. This fear may have created some hesitation or reluctance for some individuals to participate in the study.

## **1.11 Thesis structure**

The thesis is divided into nine chapters to provide insight into the research aim, objectives and questions. It is structured to provide a background to IMGs nationally and locally while highlighting previous research. It will provide a comprehensive discussion regarding the theoretical framework underpinning the study; the design of the study; and the results, inferences and discussion pertaining to the current research. A more detailed outline of each chapter is provided below.

- *Chapter 1 – Introduction:* introduces the study by providing the background, rationale, purpose and theoretical framework of the research. It outlines the research aims and questions that provide the framework for the research the issues which the study has identified.
- *Chapter 2 – Medical labour force in Australia:* provides insights into the legislation and policies which have guided how IMGs have entered and practised in Australia throughout the twentieth and the twenty-first centuries. This discussion provides the basis to understand many of the other issues encountered by IMGs.
- *Chapter 3 – Current research on international medical graduates:* provides an overview of both international and Australian IMG research and highlights the specific barriers and enablers encountered by IMGs as they live and work in rural communities.
- *Chapter 4 – Theoretical framework:* introduces human, cultural and social capital theories followed by acculturation that are employed as a framework and lens to guide the study.

- *Chapter 5 – The study design:* describes the research framework and mixed method design of the study to address the research questions; the reliability and validity of the tools used; and the data collection, management and analysis process.
- *Chapter 6 – Quantitative data analysis and results:* reports the data collected from IMG respondents of the Tasmanian International Medical Graduate questionnaire.
- *Chapter 7 – Qualitative data analysis and results:* reports the data collected from interviews conducted with IMG respondents, key informants and the written comments from the Tasmanian International Medical Graduate questionnaire. It also provides insights into the linguistic patterns; how discourse was used; and the power and hegemony highlighted within informant discourse.
- *Chapter 8 – Discussion:* discusses the results of the quantitative and qualitative data analysis. It outlines the experiences and challenges of IMGs living and working in rural and remote Tasmania, how this informs their acculturation that contributes to the outcomes of IMG retention.
- *Chapter 9 – Conclusion:* provides an overview of the research findings, their significance and how the research findings have been disseminated. In addition, the chapter discusses the strengths, limitations and future directions for research concerning IMGs. The chapter concludes by providing a number of recommendations to aid the acculturation and retention of IMGs in rural contexts.

## **1.12 Conclusion**

This chapter has provided an overview of the thesis that was achieved by first introducing the background and purpose of the study, while highlighting the significance of the study. Moreover, the context in which the study was conducted was provided to give an insight into the challenges encountered by IMGs and what other research or inquiries were occurring at the time of the study. This insight was

followed by a discussion of the theoretical framework, the research aims and questions of the study. In addition, the research methods, ethical considerations and limitations were highlighted. Finally, the thesis structure was provided which encapsulated each of the chapters and provided a brief overview of the thesis. The following chapter introduces the development of legislation and policies which have and now guide IMGs as they practise in Australia. The chapter also provides a background to the other challenges which are encountered by contemporary IMGs.

# **Chapter two: Medical labour force in Australia**

## **2.1 Introduction**

Chapter one introduced the background and purpose of the study, while highlighting the study's significance. The introduction also provided an overview of a number of challenges that IMGs encounter when practising in Australia. It has also highlighted the theoretical framework and discussed the research aims and objectives of the study. This chapter provides an understanding of the medical and IMG labour force, including the legislation and policies which have guided how IMGs enter and practise in Australia. This context then forms the basis for understanding many of the other issues encountered by IMGs as they work and live in rural Australia, which is discussed in the subsequent chapters.

## **2.2 Medical practitioner definition**

Prior to discussing Australian medical labour force and legislation pertaining to IMGs, the term 'medical practitioner' is defined. A medical practitioner is "an individual who is registered with a state, territory or national medical board to diagnose physical and mental illnesses, disorders and injuries and prescribe medications and treatment to re-establish and promote good health" (AIHW, 2009, p. 1). They are described generally as a "medical expert and healer, enriched with other roles...and whose expertise is underpinned by broad and rigorous training" (Van Der Weyden, 2005, p. 561). These roles include and are not limited to manager, scholar, collaborator and advocate (Van Der Weyden, 2005).

Medical practitioners can be further classified as either a clinician or non-clinician depending on the medicine they practise. As such, a clinician works in clinical practice such as primary care practitioner (i.e. general practitioner), hospital non-specialist, specialist-in-training or specialist. A non-clinician is generally a medical practitioner who spends less time in clinical practice and more time participating in

activities such as administrator, educator, researcher, public health physician or occupational health physician (AIHW, 2009).

Prior to 2011, medical practitioners in Australia either possessed a general registration or conditional (non-general) registration. General registration was granted when medical practitioners had fulfilled the requirements of the state, territory or national medical board to practise and allowed a medical practitioner to work unsupervised. If a medical practitioner did not meet these requirements, they obtain conditional registration until they met the requirements of general registration. A number of examples of individuals who held conditional registration include interns; IMGs when they first practised in Australia; IMGs who were completing post-graduate or supervised training; IMG specialists with qualifications recognised by the relevant Australian specialist college; non-practising medical practitioners; and medical practitioners facing disciplinary action (AIHW, 2009).

A key change occurred in 2011, as part of the registration process brought about by the Australian Medical Board and the Australian Health Practitioner Regulation Agency (AHPRA). In this case, medical practitioners were to achieve general registration after completing Internship or moving through one of several pathways as an IMG. A typical Australian Graduate will then complete a specialist training program in General Practice or another specialty and will then hold general and specialist registration (MBA, 2011).

Within this thesis, the term medical practitioner will be used synonymously with the term doctor. The term will represent all medical practitioners regardless of their specific specialised training unless otherwise indicated. Nevertheless, those medical practitioners who have trained within Australia will be delineated as Australian medical graduates (AMG), while those trained overseas will be defined as international medical graduates (IMG).

## **2.3 International medical graduates: definitional issues**

IMGs have been referred to and presented in a number of ways by the media, by the public and policy makers over the past few decades. This coverage has

generated imagery, connotations and inferences to further stimulate public and political debate, ambivalence, fear, stereotypes and innuendo regarding IMGs in Australian society and their role as healthcare providers (Harvey & Faunce, 2005; Huang, 2000; Iredale, 2009; Kamien, 2007; Kunz, 1975) (see Appendix B). Despite the historical views and perceptions of IMGs, a review of the literature reveals a number of challenges in defining an IMG.

The name and definition of an international medical graduate remains ambiguous (Foster, 2008; Majumdar, Keystone, & Cuttress, 1999; Rutland, 1987; Shuval, 2000; Shuval & Bernstein, 1997). For example, other terms used to denote IMGs include displaced persons doctor, alien doctor, migrant doctor, foreign doctor, and foreign graduate of an accredited medical school (FGAMS) (Foster, 2008; Whelan, 1999; Whelan, Gary, Kostis, Boulet, & Hallock, 2002). However, in a recent Deloitte Access Economics report commissioned by the Australian Department of Health and Ageing (DoHA), the acronym FGAMS was used. The acronym was used to denote “a person who received their primary medical qualification from a medical school within Australia, and who was not a permanent resident or Australian citizen when they were first enrolled” (Deloitte Access Economics, 2011, p. 3).

Conversely, according to Kyriakides and Virdee (2003), in the 1970s, the British National Health Service (NHS) used the term overseas doctor. However, this term “was used increasingly as a euphemism for ‘black doctor’ whose medical standards were inferior to those doctors signified as non-white” (Kyriakides & Virdee, 2003, p. 294). Despite this term and other ambiguities, the most common title used to describe an IMG today remains ‘overseas trained doctor’ (OTD); however, it is often used synonymously with IMG (Foster, 2008; Hawthorne, 2007; Majumdar et al., 1999; Rutland, 1987; Shuval, 2000; Shuval & Bernstein, 1997; Whelan, 1999).

In Australia, an IMG is defined as a doctor who has acquired their primary medical qualification in a country other than Australia or New Zealand (ARRWAG, 2004; Han & Humphreys, 2005; Harvey & Faunce, 2005; Sullivan, Willcock, Ardzejewska, & Slaytor, 2002). However, section 19AB of *The Health Insurance Act 1973* identifies doctors from New Zealand as IMGs. While this definition is the most widely used

within Australian literature and policy, it should be acknowledged that this definition remains problematic (Laurence, 2008). It has a propensity to focus on the geographical location of where primary medical education has taken place. It does not consider the complexities of cultural background, views of health, meanings of illness, and models of care.

Despite these many differences in terms and definitions, this study recognises that the term 'international medical graduate' remains the most universal term. In addition, within this study, the definition of an IMG must take on a more complex notion of what it means to be an IMG or at least anticipate being an IMG is more than place of education and training. Nonetheless, for the purpose of this research, the focus will be on IMGs who have obtained their primary medical qualifications in all countries outside Australia (ARRWAG, 2004; Han & Humphreys, 2005; Harvey & Faunce, 2005; Sullivan et al., 2002).

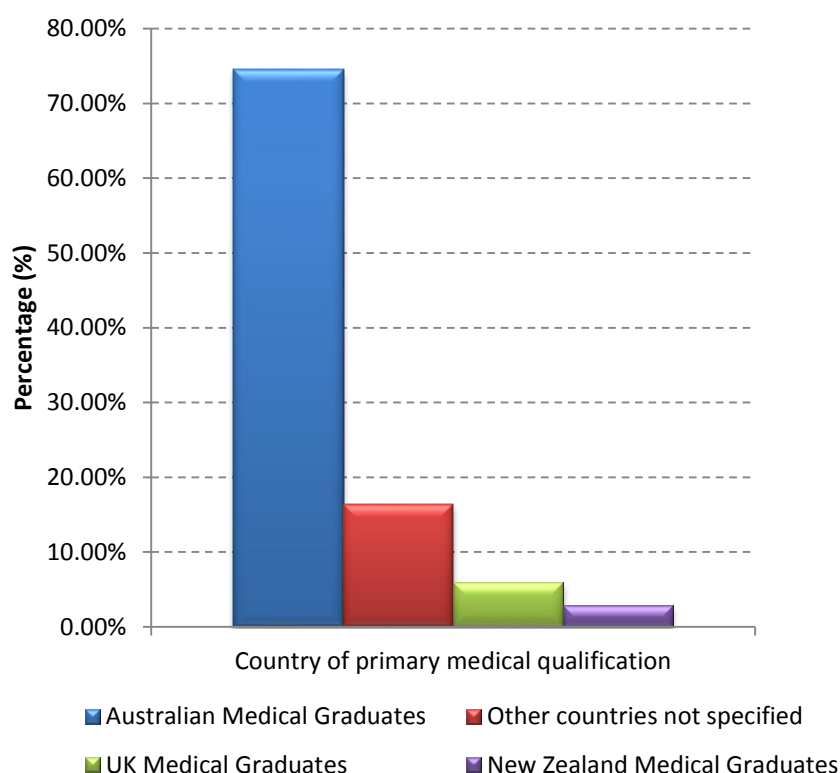
It must be noted the definition excludes international students who obtained their medical degrees in Australia. Between 1996-2004, enrolment was reported to be as high as 15 - 30% (Hawthorne et al., 2007). As such, international medical students trained in Australia are classified as AMGs, yet they may have cultural similarities which are cognizant with IMGs (ABS, 2006). This group of medical graduates is not included in the study as they are not recognised as IMGs. However, their contribution to the research in terms of acculturation and the challenges of working in the Australian and rural Tasmanian context would be invaluable.

## **2.4 The Australian medical labour force**

Within Australia, the most recent medical practitioner registrant data shows there are currently 91,745 registered medical practitioners (MBA, 2012). Despite the current data, country of origin and place of first medical registration were not collected or reported respectively in the Medical Practitioner Registrant December 2012 report or the Medical Workforce 2011 report (AIHW, 2013; MBA, 2012). Thus, the most recent data regarding IMGs is from The Medical Labour Force surveys 2009 provided by the Australian Institute of Health and Welfare (AIHW) (2011b). This data shows 74.5% (53,843) medical practitioners had trained in Australia, 2.9%



(2,112) in New Zealand, 6.0% (4,398) in the United Kingdom with the remainder 16.4% (11,948) consisted of IMGs from many other countries, as indicated in Figure 2.1.



**Figure 2.1: Percentage of medical practitioners by place of primary qualification in Australia**

Source: Australian Institute of Health and Welfare Medical Labour Force Survey 2009.

The Medical Workforce Survey 2009 (AIHW, 2011b) also revealed significant growth in the number of IMGs from 20.4% (9,873) of the Australian medical workforce in 1998 to 22.2% (18,458). In addition, it showed that 30% of the rural GP workforce were IMGs in 2001, which increased to 40% in 2009 (AIHW, 2010, 2011a; Han, 2010; Iredale, 2009; Lim, 2010; RHW, 2011a). Lastly, in 2007, it was reported that a number of Australia states, such as Western Australia, had a rural workforce which consisted of more than 50% IMGs, which was much higher in the more remote areas of the state (AIHW, 2010, 2011a; Han, 2010; House of Representatives

Standing Committee on Health and Ageing, 2012a; Iredale, 2009; Lim, 2010; RHW, 2011a).

#### **2.4.1 Australian medical labour force within ASGC-RA**

A number of methods are employed to determine the rurality or remoteness of the various Australian states, such as the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA). The ASGC-RA was first introduced in 2001 and subsequently updated on 1<sup>st</sup> July 2010 (AIHW, 2011c). The ASGC-RA is based on Accessibility/Remoteness Index of Australia (ARIA), developed in 1997, which determines remoteness in terms of road distance from goods and services across Australia. However, the ASGC-RA has slight differences, such as the use of five categories of service centre, rather than four used in ARIA (AIHW, 2004). The ASGC-RA categorises areas as ‘major cities’, ‘inner regional’, ‘outer regional’, ‘remote’ and ‘very remote’ (AIHW, 2004, 2011c).

#### **2.4.2 Employment within ASGC-RA**

In terms of the ASGC-RA, the number of employed medical practitioners in Australia is highest in major cities, which includes, Adelaide, Brisbane, Canberra, Melbourne, Perth and Sydney (62,289), followed by inner regional areas, such as Hobart and Darwin (10,787), outer regional areas (4,496) and remote/very remote areas (1,236). Thus, 20.9% of the medical workforce is outside major centres, while 7.3% are working in outer regional, remote and very remote areas of Australia (AIHW, 2013).

In addition to employment within the ASGC-RA, the rate of employed medical practitioners per head of population, outlined in the Medical workforce 2011 report was 360.4 FTE per 100,000<sup>2</sup> population Australia wide. Table 2.1 demonstrates this rate was highest in major centres with 433.4 FTE per 100,000 population and lowest in outer regional areas with 247.2 FTE per 100,000 population (AIHW, 2013). It was also noted in the report, as remoteness increased from major centres the FTE of medical specialists per head of population decreased (148.7 to 36.9 per 100,000

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<sup>2</sup> FTE (full-time equivalent) is based on a standard full-time working week of 40 hours per head of population; however, it does not demonstrate hours worked above the average 40 hours of services.

population), while the FTE of GPs increased (107.5 to 130.3 FTE per 100,000 population) (AIHW, 2013).

**Table 2.1: Medical workforce data by region (2011)**

Region	Total no.	% Female	FTE per 100,000 population	Average hours	Average age
Major cities	62,289	38.2	433.4	43.0	45.4
Inner regional	10,787	34.1	269.9	43.3	46.1
Outer regional	4,496	36.9	247.2	44.6	45.1
Remote/Very remote	1,236	38.0	274.1	45.8	45.5
<b>Australia</b>	<b>78,808</b>	<b>36.8</b>	<b>381.4</b>	<b>43.2</b>	<b>45.5</b>

*Note.* FTE (full-time equivalents) is based on a standard full-time working week of 40 hours per 100,000 population. Source: (AIHW, 2013).

Moreover, it is also observed in the Medical workforce 2011 report the number of employed medical practitioners per head of population was highest in the Australian Capital Territory with the lowest occurring in Tasmania, as shown in Table 2.2 (AIHW, 2013).

**Table 2.2: Medical workforce data by state (2011)**

State	Total no.	% Female	FTE per 100,000 population	Average hours	Average age
New South Wales (NSW)	25,413	37.5	385.9	43.8	46.6
Victoria (Vic)	19,413	38.2	374.4	42.7	45.2
Queensland (Qld)	15,628	36.4	377.2	43.2	44.5
Western Australia (WA)	7,667	38.0	348.8	42.8	44.5
South Australia (SA)	6,328	36.3	409.4	42.4	45.2
Tasmania (Tas)	1,813	37.5	376.8	42.5	46.1
Australian Capital Territory (ACT)	1,557	41.3	470.0	44.4	45.8
Northern Territory (NT)	972	45.5	463.2	44.1	42.9
<b>Australia</b>	<b>78,833</b>	<b>37.6</b>	<b>381.4</b>	<b>43.2</b>	<b>45.5</b>

*Note.* FTE (full-time equivalents) is based on a standard full-time working week of 40 hours per 100,000 population. Source: AIHW (2013).

The Medical Workforce Survey 2011 (AIHW, 2013) suggests Australia's current doctor-to-patient ratio in many areas of Australia is oversupplied. However, inner regional to remote and very remote areas show a disparity with major cities. Kamalakanthan & Jackson (2006, 2008) argue that the Department of Health and Ageing (DoHA) definition of doctor-to-population ratio (71 FTE per 100,000 population) is misleading as other factors such as population density, distance to services and accessibility need to be taken into account to provide a full and complete understanding.

## **2.5 The Australian IMG labour force**

As indicated in the Australian medical labour force data, IMGs continue to be a part of the workforce, with an increasing contribution. This phenomenon is particularly evident in regional, rural and remote Australia where recruiting and retaining AMGs has been challenging (Durey, 2005b; Han, 2010; Han & Humphreys, 2005; Han & Humphreys, 2006; Harding et al., 2010; Liaw & Kilpatrick, 2008). Birrell & Hawthorne (2004, p. 83) state that "Australian-trained doctors are not available for or are unwilling to undertake [non-metropolitan positions] because they do not find these location or working conditions attractive." There are a number of reasons why AMGs do not find rural and remote practice attractive. These reasons include the high financial cost of running a small practice, no previous experience in rural areas, arduous on-call hours and the necessity for greater skills with less collegial support in rural practice (Durey, 2005b; Ehrman & Oxford, 1990).

Despite these challenges, Iredale (2009) argues that on-going recruiting of IMGs impacts donor countries capacity to provide adequate health services and remains an implausible long term solution for Australia's rural doctor shortage. It has been said to be a "distraction from other home-built solutions to health resources management" (Organisation for Economic Co-operation and Development, 2007, p. 200).

In March 2010, the then Australian Prime Minister, Kevin Rudd, announced \$632 million in funding over 10 years to train more than 5,000 new doctors and to train a

greater number of specialists in general surgery, pathology, radiology, obstetrics and gynaecology. The funding was announced to also assist more than 5,400 junior doctors to participate in general practice placements. The announcement was said to maintain current levels of medical practitioners needed for the next 10 years (Rodgers, 2010). Since this announcement, medical school entrants increased by 25.8% from 2007 to 2011, while domestic medical graduates completing University rose by 69.2% between 2006 and 2010 (AIHW, 2013).

Notwithstanding, these recent increases in the medical workforce currently remains heavily dependent on IMGs and their recruitment as the current solution (Han, 2010; Han & Humphreys, 2005; Lim, 2010; McGrail et al., 2010; Van Der Weyden & Chew, 2004). This on-going recruitment is vital as Australian rural and remote communities have higher rates of illness with a greater requisite for primary care services yet lower levels of access to health services, particularly GPs (RHWA, 2011a). However, the retention of IMGs in rural and remote areas of Australia is not without challenges. Evidence indicates that IMGs seek to relocate into more metropolitan areas once they have completed their compulsory service obligations (Harvey & Faunce, 2005; Kilpatrick et al., 2011; Lim, 2010; Russell et al., 2013).

## **2.6 Australia's IMG regulation and policy development**

Many of the policies and legislation concerning IMGs service obligations were implemented and refined in the 1930s -1950s; however, not changed until the 1970s (Kamien, 2007; Kunz, 1975). In 1973, *The Health Insurance Act 1973* was passed and remains a key piece of legislation today, part of which regulates IMGs practising in Australia. Although enacted in 1973, this legislation was not used specifically for IMG regulation until the late 1990s (see Appendix C).

One year later, in 1974, the abolition of the *Immigration Restriction Act 1901* also known as the 'White Australia' policy occurred. This change in legislation eased migration processes and favoured many individuals including medical graduates across the globe to immigrate to Australia (Dunn, 2005; Dunn, Klocker, & Salabay, 2007; Forrest & Dunn, 2011; Kamien, 2007; Louis, Duck, Terry, & Lalonde, 2010a; McLeod & Yates, 2003). To counterbalance this increase of IMGs in Australia, the

government maintained a quota of IMGs practising in Australia, with the Australian Medical Association (AMA) proposing a restriction of 130 IMGs per annum (Birrell & Hawthorne, 2004; Kamien, 2007).

A decade later, in 1984, the Australian Medical Council (AMC), was established for medical education and training (AMC, 2009a, 2012; Birrell & Schwartz, 2007; MBA, 2010; McLean & Bennett, 2008; Spike, 2006). It was organised to develop “accreditation standards, policies and procedures for medical programs of study... and for assessment of international medical graduates for registration in Australia” (AMC, 2012, p. 1).

One of the greatest changes for IMGs that has occurred in Australia since the 1990s, was the change in IMG ‘source’ countries. Prior to 1990, the majority of IMGs were from English speaking countries such as the UK, Ireland and New Zealand. By the mid-1990s, IMGs from non-English speaking backgrounds (NESB) were migrating from Africa, Asian, Eastern Europe and the Americas while IMGs from New Zealand and UK were dwindling in number (Birrell, 2004; Harding et al., 2010; Hawthorne & Birrell, 2002; Hawthorne et al., 2007; Laurence, 2008).

This increase in IMG numbers was due to changes made to the general skills migration program to overcome the undersupply of doctors in rural areas. Under these changes, doctors were added to the skilled occupations list and a greater number of temporary residency IMGs were permitted to enter and work in Australia (Birrell, 2004; Harding et al., 2010; Hawthorne & Birrell, 2002; Hawthorne et al., 2007; Laurence, 2008). These changes were also influenced by what was occurring elsewhere in the world, such as an influx of eastern European migrants due to social change and conflict. The changes included the fall of the Berlin wall and increased refugee outflows from the breakup of the former Yugoslav Republic (Colic-Peisker, 2009; Hawthorne et al., 2007).

To curb the influx and redistribute the large number of IMGs in Australia, the function of section 19AB of *The Health Insurance Act 1973*, also known as the *10-year moratorium* was implemented on 1 January 1997. The 10-year moratorium is a scheme which restricts IMGs access to Medicare provider numbers, subsequent

cash rebates and the ability to practise independently. The 10-year moratorium was enacted to ensure IMGs worked in areas where there are underserved populations who experience a maldistribution of medical practitioners and services (RHWA, 2011a). This restriction occurs until 10 years of compulsory rural placement has been fulfilled.

In addition to the 10-year moratorium, other related programs were implemented. These programs included the Rural Locum Relief Program (RLRP) and the strengthening Medicare Package and Medicare Plus programs which have increased and allowed IMGs to work in various capacities in Australia (Birrell & Hawthorne, 2004; Van Der Weyden & Chew, 2004). For example, the RLRP was designed to aid permanent resident IMGs to work under supervision in rural general practice while they are working towards their GP Fellowship (RHWA, 2011b). These opportunities provide greater access for medical practitioners to rural communities (Birrell & Hawthorne, 2004; Van Der Weyden & Chew, 2004).

Since its inception, the 10-year moratorium has been argued to be anti-competitive and aimed to safeguard local doctors from foreign competition, which had been one of the many issues from the 1940's (Kunz, 1975; Metherell, 2009; Sweet, 2009). These types of compulsory service schemes were also condemned in the past as breaching an individual's human right to choose the location of employment. However, these allegations were refuted by others who stated participants of the scheme were fully cognizant of the obligations when choosing to participate in such schemes (Frehywot et al., 2010; Lim, 2010). These compulsory service programs are viewed as:

Instruments of social justice, an exercise in health equity, in that they enable governments to direct or augment health services to geographical areas that are not well served and in communities that are not favoured by market forces and health worker preference. (Frehywot et al., 2010, p. 368)

When introduced, the moratorium and the new accreditation and registration system were highly complex and viewed as discriminatory. In most cases an "IMGs

ability to work [in Australia] was largely determined by their visa status rather than their qualifications” (Douglas, 2008, p. 30). The implementation of the moratorium led to a 21-day hunger strike in New South Wales (NSW) with similar hunger strikes being held by IMGs in 1997, in front of the Victorian and Federal parliaments. The aim of the hunger strikes was to lobby governments for changes to the system of the day. These hunger strikes were followed later in 1999 by a 19 day hunger strike by 40 IMGs (Han, 2010; Iredale, 2009; Kamien, 2007).

These strikes prompted the NSW government to commission a research report into the employment concerns raised by IMGs in the state (ADTOA, 1998; Douglas, 2008). The report “The Race to Qualify issued 32 recommendations and confirmed that the differential treatment of IMGs holding temporary visas from those on permanent visas could be considered unlawful discrimination” (Douglas, 2008, p. 30).

The recommendations from the inquiry subsequently led to the introduction of the five-year Overseas Trained Doctor scheme in 1999, which was revamped in July 2010 (Deloitte Access Economics, 2011; RHWA, 2011a). The principal objective of the scheme was the scaling of workforce incentives. This scaling reduces the time an IMG is ineligible to access a Medicare provider number, by electing to live and work in more remote areas. As shown in 2.3, this previously discussed ‘remoteness’ is defined by the Australian Standard Geographical Classification – Remoteness Areas (ASGC – RA) (DoHA, 2010).

**Table 2.3: Scaling incentives – Rural Health Workforce Strategy**

RA Classification	RA Category	Scaling % discount	Reduction of restriction
RA 1	Major City	Nil	10 years
RA 2	Inner Regional	10%	9 years
RA 3	Outer Regional	30%	7 years
RA 4	Remote	40%	6 years
RA 5	Very Remote	50%	5 years

*Note.* RA = Remoteness Area.

Source: Australian of Health and Welfare (AIHW, 2011c).



After the five-year Overseas Trained Doctor scheme was introduced, an additional inquiry was conducted by the ACCC and the Health Workforce Official Committee. They submitted a report in 2005 on the role of the specialist's medical colleges in the assessment of IMG qualifications and accreditation (Douglas, 2008). The report outlined that there was a

lack of procedural fairness, lack of transparency, unreasonably restricted entry to college Fellowship, and rigid assessment processes based on similarities of programs rather than competency-based assessment... [As such,] the ACCC accused the RACS of being a 'closed shop' and too strict over who can enter the college. (Han, 2010, p. 247)

Twenty recommendations were provided with the findings, which included the development of competency-based criteria for assessing IMG qualifications. These competencies were to improve the current qualifying processes in Australia. However, the recommendations were unable to be enforced. This inability was due to each specialist body being self-regulated, while there were no external processes to guarantee recommendations were implemented (Douglas, 2008).

### **2.6.1 Global policy and codes of practice**

Also occurring across the globe, at this time, was the Commonwealth Code of Practice for the International Recruitment of Health Workers outlined by *The Durban Declaration 1997*. The declaration recommended the advancement of the health and the reduction of inequities of the world's rural population. Part of this recommendation was to enhance and sustain health professionals in these rural areas of developing countries (National Health Workforce Taskforce, 2008; World Organisation of Family Doctors, 1997). *The Durban Declaration 1997* introduced the general concepts of the ethical recruitment of IMGs. The declaration was further clarified by and is largely underpinned by *The Melbourne Manifesto 2002*, a code of practice for the international recruitment of health care professionals (World Organization of Family Doctors, 2002).

These two documents state a country must maintain adequate numbers of medical graduates to meet health needs of current and future domestic market. In addition, medical recruitment should not actively or selectively seek doctors from developing countries. *The Melbourne Manifesto*, does, however, recognise individual freedoms and the self-determination of the health care professionals (ARRWAG, 2004; Audas et al., 2005; Han & Humphreys, 2006; Iredale, 2009; Stilwell et al., 2004). It also emphasises that assistance should be provided to support IMGs from developing countries, who without coercion, seek employment in developed countries (World Organization of Family Doctors, 2002).

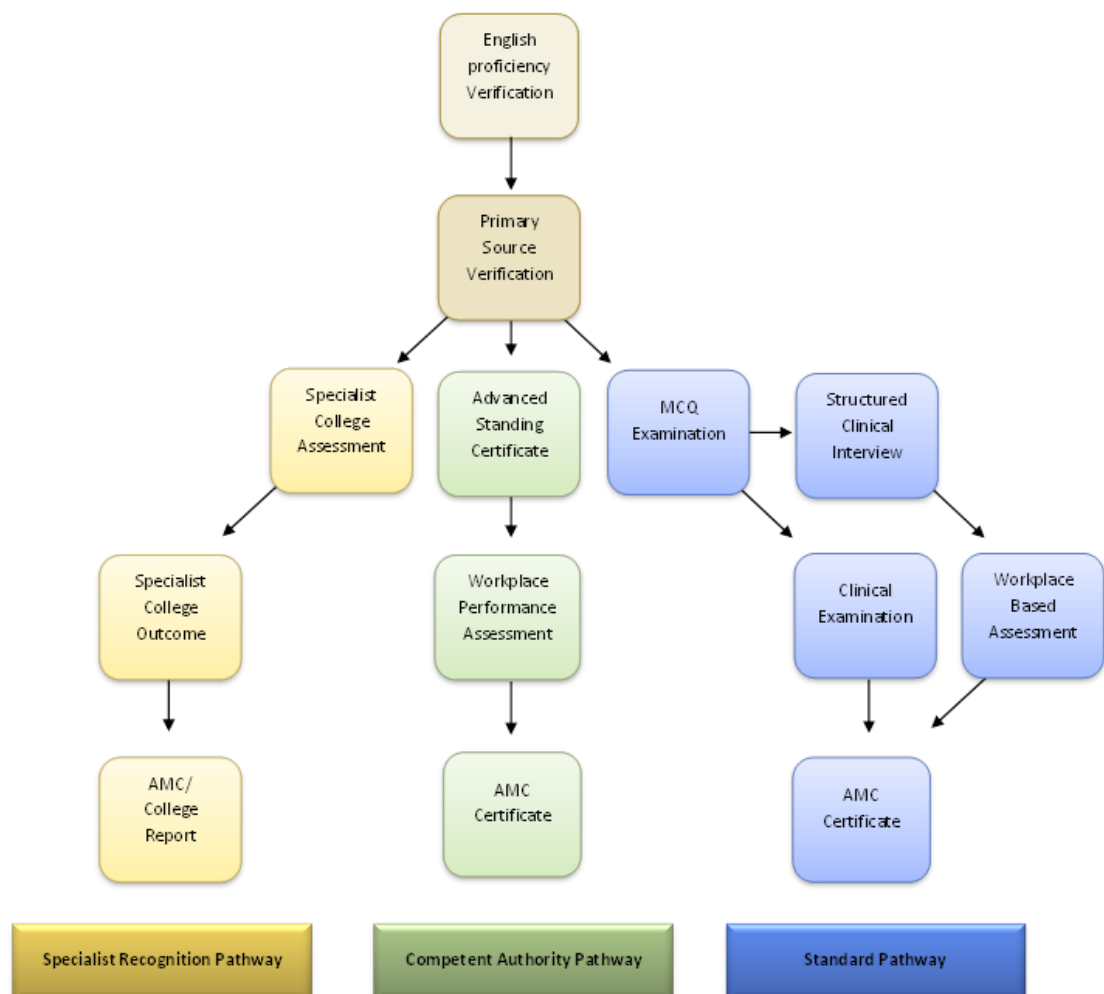
### **2.6.2 The new national process for IMGs**

In addition to the *Durban Declaration 1997* and the *Melbourne Manifesto 2002*, a number of significant changes within Australia were brought about in 2005. These were largely prompted by Dr. Jayant Patel, an IMG who was implicated with 87 deaths occurring at the Bundaberg Base Hospital in Queensland between 2003 and 2005 (Birrell & Schwartz, 2006, 2007; Dunbar, Reddy, & May, 2011; Elkin et al., 2012; Harvey & Faunce, 2005; Moynihan, 2010). In 2010, Patel was found guilty of criminal negligence resulting in three deaths and one case of grievous bodily harm, and sentenced to seven years in jail (Flatley, 2010). Subsequently, Dr. Patel appealed his conviction, which was upheld in the Australian High Court on August 24, 2012. In November 2012, Patel was ordered for separate retrials and was acquitted over the death of a patient in March 2013. He remained on bail and was awaiting the remaining retrials for manslaughter and grievous bodily harm; however, these charges were dropped in November 2013 (Cirrus Media, 2012, 2013a, 2013b; Remeikis, 2012).

As a result of the Dr. Patel case, a single National Registration and Accreditation Scheme (NRAS) was announced in July 2006, at the Council of Australia Governments (COAG). This scheme was first enacted in Queensland as the *Health Practitioner Regulation National Law Act 2009 (Qld)* with other states and territories enacting similar bills between 2009 and 2010. The newly formed Australian Health Practitioner Regulation Agency (AHPRA) and registration process was to decrease bureaucracy, increase the ease in movement of health professionals and protect the

public (House of Representatives Standing Committee on Health and Ageing, 2012a; Queensland Government, 2009).

As part of the national accreditation process it also focusses on the education and training of health professionals, which includes IMGs (House of Representatives Standing Committee on Health and Ageing, 2012a; Queensland Government, 2009). This process is administered by the AMC, which assesses IMGs seeking to practise medicine in Australia (Birrell & Schwartz, 2006, 2007). The assessment has a number of pathways and is dependent on where the IMG has obtained training and will follow one of several alternate pathways for registration, as shown in Figure 2.2.



**Figure 2.2: Australian Medical Council IMG assessment pathways**

Source: (AMC, 2012). Adapted with permission

As part of the process, the AMC rigorously verifies IMGs credentials, the country of origin's examining and accrediting processes and administers a 'multiple choice question' (MCQ) exam. IMGs are to undertake the mandatory International English Language Testing System (IELTS) test prior to participating in an MCQ exam. In a submission to the recent Parliamentary inquiry, *Lost in the labyrinth*, the AMC stated the demand to sit the MCQ exam had increased over the past five years from 1,509 candidates in 2005-2006 to 4,466 in 2009-2010 (House of Representatives Standing Committee on Health and Ageing, 2012a).

Following the MCQ and provisional medical registration, either a clinical interview, workplace-based assessment or clinical examination is conducted (AMC, 2009b, 2012). In most cases, IMGs need to travel to a hospital in a major centre, such as Melbourne to undertake a clinical examination. However, a National Examination Centre in Melbourne was announced to open in April 2013 by the Rural Workforce Agency (RWA) (Austin, 2013). The dedicated centre is to redress the current bottle neck in IMGs waiting to sit an AMC clinical examination. It will ensure there are timely AMC examinations in the future as it has the capacity to provide 2,500 AMC clinical examinations. The centre also has been developed to provide a centre where other professionals, within the NRAS, can undertake examinations (Austin, 2013).

The AMC assessment pathways allow an IMG to apply for full registration once competency has been established and demonstrated (AMC, 2009a, 2012; MBA, 2010). However, Iredale (2009) argues competency must be judged against a universal set of standards, rather than national or state benchmarks. In addition, it has been argued the new assessment procedures may have been causing unfair deregistration of a number of IMGs with bias against a number of IMGs being well documented (Louis, Lalonde, & Esses, 2010b; Moynihan, 2010).

Once full registration has been achieved, an IMG with temporary or permanent resident visa status or citizenship has other restrictions placed upon them (Han, 2010). For example, there are restrictions on where an IMG with a temporary visa can be employed (AIHW, 2008). Often they are employed in short stay

opportunities which are focused on identified gaps in the local workforce. These are called area of need (AoN) positions and district of workforce shortage (DWS) positions (AIHW, 2008; Birrell & Hawthorne, 2004; DIAC, 2012; Laurence, 2008). DWS are determined by the Department of Health and Ageing, whereas AoN are determined by the State and Territory Governments and allow an IMG to receive an exemption on Medicare provider number restrictions (DoHA, 2011b; Laurence, 2008; RHWA, 2011a).

The most common positions are AoN positions, which come under section 21(2) (g) (Area of need) of the *Medical Practitioners Registration Act 1996*. This states a medical practitioner is conditionally registered and can be placed in positions where a need exists. This is not related to geographical location, but rather an AoN in public or private services. It can include positions such as general practitioner, non-specialist and specialist position within hospitals (Harvey & Faunce, 2005).

There were also occupational trainee temporary resident IMGs who entered on occupational trainee visa (Visa 442) for up to 12 months in AoN positions; however, this scheme is now obsolete (AIHW, 2008; Birrell & Hawthorne, 2004; DIAC, 2012; Laurence, 2008). The Temporary Business (Long Stay) - Standard Business Sponsorship (Subclass 457) visa program, has replaced visa 422 (Area of need). It allows an IMG:

to enter Australia for temporary employment or training purposes. To obtain the relevant visa requires employment sponsorship and conditional registration by the state or territory medical registration board... [and]... excludes overseas-trained and Australian-trained medical practitioners with permanent resident or Australian citizenship status. (AIHW, 2008, p. 32)

In addition to the Temporary Business (Long Stay) (Subclass 457) visa, there are also three additional options for IMGs to enter Australia outlined by the Department of Immigration and Citizenship (DIAC). These include General Skilled Migration (GSM) (permanent); Regional Sponsored Migration Scheme (RSMS) (permanent); and Employer Nomination Scheme (ENS) (permanent). These are commonly used to

obtain permanent residency for highly skilled workers (House of Representatives Standing Committee on Health and Ageing, 2012a).

Unlike the AoN positions, DWS positions are only in rural and remote Australia where the population's health care needs are not being met and where less access to medical services than the national average is occurring (DoHA, 2010). Section 19AA of *The Health Insurance Act 1973* allows IMGs with permanent residency or Australian citizenship to access to Medicare benefits through the RLRP. This access to Medicare benefits is on the provision the IMG is not subject to or has sought a 3GA exemption of 10-year moratorium from section 19AB of *The Health Insurance Act 1973*. If all requirements are fulfilled then an IMG can provide locum services in rural and remote areas while they work towards their GP Fellowship (Health Recruitment Plus Tasmania, 2011; Laurence, 2008; RHWa, 2011b).

### **2.6.3 Recruitment, registration and retention support**

When IMGs are working as GPs in rural practice, recruitment and retention support is available through Rural Health Workforce Australia (RHWa). The RHWa is the peak body for each state's RWA. The RWA was established in 2009 through COAG as a national health workforce agency. Their aim is to implement medical workforce recruitment, training and retention programs for GPs in rural and remote Australia (DoHA, 2011b). In addition, part of the modus operandi for the RHWa is the development of a national approach providing on-going education and training support for IMGs as part of the National Strategy for International Recruitment (House of Representatives Standing Committee on Health and Ageing, 2012a). This process is designed to support IMGs with services such as recruitment, relocation and to assist with the immigration processes including family support.

The various RWAs also support IMG assessment and registration, Medicare provider number acquisition and examination preparation (Organisation for Economic Co-operation and Development, 2007; RHWa, 2011a). However, Hays (2004) states that it is complex as there is no single organisation in many Australian states which monitor IMGs recruitment, educational qualifications or retention in rural and remote communities. Despite this complexity, only one RWA operates in Tasmania.

Health Recruitment Plus Tasmania (HR+) is the only Tasmanian RWA, which supports and assists IMGs and their families with GP recruitment, transition and retention in Tasmania. Their purpose is to ensure family and practitioner transition is seamless, which in turn impacts directly on the retention of doctors in a rural practice (Health Recruitment Plus Tasmania, 2011).

Conversely, for those IMGs working in acute care settings, support is provided by the various Postgraduate Medical Education Councils (PMECs) of each state. This support occurs under the auspice of the Confederation of Postgraduate Medical Education Councils (CPMEC). The various State PMECs are responsible for prevocational medical education of all doctors in their second and third year post qualification. An adjunct to the prevocational medical education is the education and support of IMGs working in Australian hospitals. For example, the Postgraduate Medical Council of Tasmania (PMCT) provides support to IMGs working in Tasmanian public hospitals. They too, like RWAs, support IMG assessment and registration, examination preparation, career counselling and personal support (CPMEC, 2011; Hawthorne et al., 2007; PMCT, 2011).

## **2.7 The future of IMGs in Australia**

Despite all the available support for IMGs, the future of the IMG labour force in Australia remains unknown. As previously stated in section five of chapter two, the announcement in 2010 to spend \$632 million over 10 years to train more than 5,000 new doctors and graduate a larger number of AMGs has commenced (Elkin & Studdert, 2010; Joyce et al., 2006; Rodgers, 2010). The increase in AMGs was to maintain existing levels of medical practitioners over the next 10 years (Rodgers, 2010). Those graduates who are Commonwealth-supported are guaranteed an internship placement; however, this has meant those who are Australian fee-paying medical students and international full fee-paying medical students are not guaranteed an intern placement to complete their training (Aizen, 2010; Caldwell, 2010).

It has been argued, since the funding was announced, the conditions were short sighted. Many of the extra medical graduates will need to complete their year of

internship and will be unable to do so as the practical placements required for training will be unavailable (Griffiths, 2010; Kaye, 2012; Kirchner, 2010; Rodgers, 2010). This shortfall in practical placements was coming to fruition as early as 2012 and 2013 (Kaye, 2012). However, in some states of Australia, full fee paying domestic medical students, such as Bond University graduates are guaranteed an internship placement in Queensland, while other Australian states offer internship placement through a random, ballot, priority or merit based process (Kevat & Lander, 2013; Schauer, Woolley, & Sen Gupta, 2014; The Student Doctor Network, 2014). It was indicated in 2007, before the 2010 announcement, an increasing number of state medical schools was occurring (Hawthorne et al., 2007). At this time, PMECs were already “concerned about the ability of state hospital systems to provide sufficient numbers of accredited intern positions to accommodate such numbers” (Hawthorne et al., 2007, p. 99).

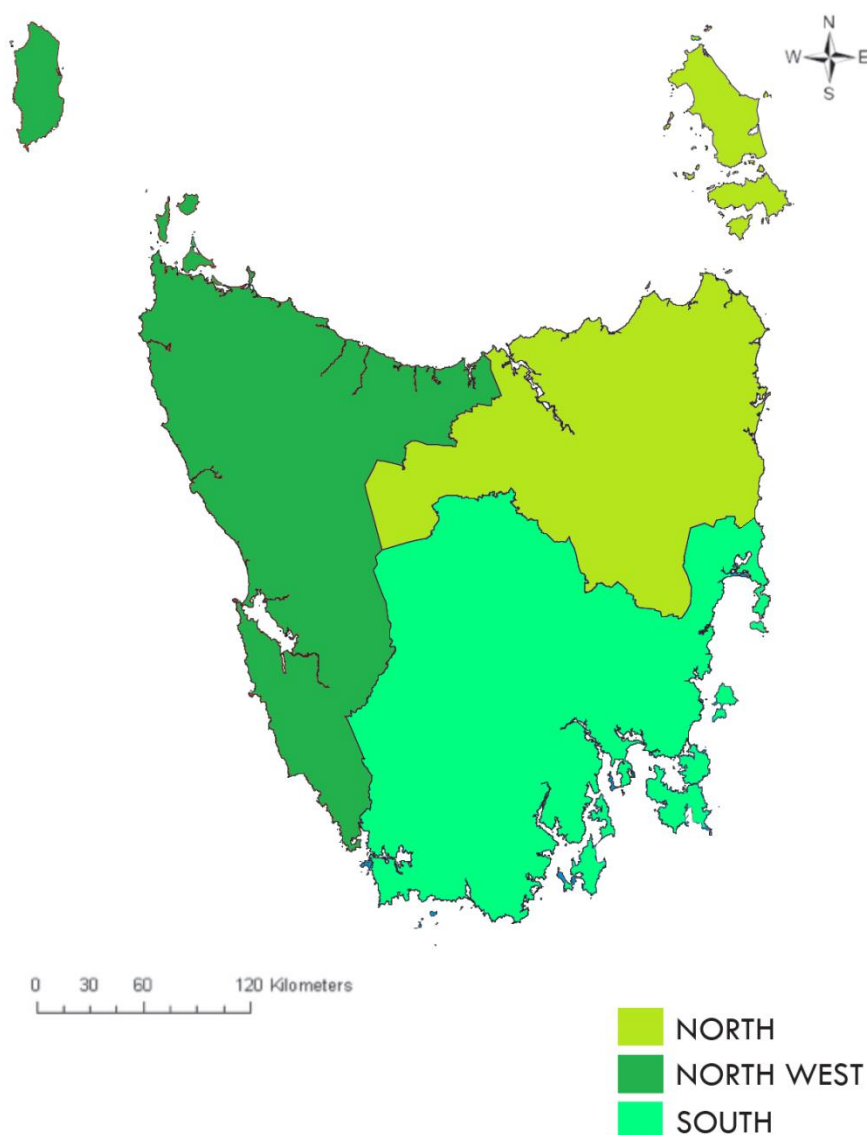
In small states such as Tasmania, it had been highlighted that due to this new announcement, a third of medical graduates would have to leave the state to complete their internship (Griffiths, 2010; Kirchner, 2010). To circumvent the exist of medical graduates occurring a commitment was made by the State Health Minister, Michelle O’Byrne in July 2010, to provide adequate training opportunities for the increased numbers of medical graduates in Tasmania (Griffiths, 2010; Kirchner, 2010). However, with this commitment there is the potential for a reduction in international full fee-paying medical students studying in Australia (Aizen, 2010). In addition, the increase in Australian graduates “will ultimately affect [IMG] access to resident, registrar and possibly career medical officer positions” (Hawthorne et al., 2007, p. 99). This impact potentially leaves the future health and wellbeing needs of rural and remote communities unknown, where retention of local graduates continues to be challenging (Han & Humphreys, 2005; Hawthorne et al., 2007; RHWA, 2011a).

## **2.8 Tasmanian medical labour force**

Tasmania has three Tasmanian Health Organisations (THOs) which each contain a major public hospital. These hospitals include the Royal Hobart Hospital (RHH) in



the South; Launceston General Hospital (LGH) in the North; and the North-West Regional Hospital (NWRH) in Burnie which incorporates the Mersey Hospital campus in Latrobe, near Devonport, in the North-west of Tasmania (DHHS, 2012), as shown in Figure 2.3.



**Figure 2.3: Tasmanian Health Organisations in Tasmania**

Source: DHHS (2012).

Similarly, in 1998, General Practice Tasmania Limited was established to represent and advocate on behalf of general practice and primary care across Tasmania and serves as a link between GPs including allied health professionals. However, as of the 1<sup>st</sup> November 2011, General Practice Tasmania Limited became 'Tasmania

Medicare Local Limited.’ This change occurred due to the national health reform agenda for primary health care, which is to better coordinate primary health care services for local communities. Under the auspice of Tasmania Medicare Local, there currently are three arms or divisions, which also fall within similar boundaries of the three Tasmanian Health Organisations (THOs). These divisions were known as General Practice North, General Practice North-west and General Practice South; however, these divisions were in the process of being changed between 2012 – 2013 as part of the national health reform agenda (Tasmania Medicare Local Limited, 2012).

In 2012, Tasmania’s total medical labour force (clinicians and non-clinicians) was estimated to be 2.2% (or 2021) of Australia’s medical workforce and represents a growth of 9.5% between 2009 and 2012 (ABS, 2006; AIHW, 2010, 2011b; MBA, 2012). The most recent data from the Australian Bureau of Statistics, which looked at medical force distribution, showed in 2006 that 82.0% of the medical labour force in Tasmania was concentrated in inner regional centres. The remaining 18.0% of the medical workforce were in outer regional, remote and very remote areas of Tasmania (ABS, 2006).

The 2012 Medical practitioner registrant data, the most comprehensive data available, demonstrated Tasmania’s medical workforce consisted of 60.5% (or 1221) males and 39.5% (or 800) females. While within specialist occupations, 65.0% (or 799) were male and 35.0% (or 430) were female (MBA, 2012). Nevertheless in General Practice, gender ratios remain more equal with males representing 52.0% (or 260) of GP population and female GPs representing the remaining 48.0% (or 242)(MBA, 2012).

## **2.9 Tasmanian IMG labour force**

The exact number and percentage of IMGs in Tasmania total workforce remains unknown, due to the scarcity of data. However, there is an estimated 350 IMGs living and working in Tasmania. Despite this estimation, there is a large amount of conflicting evidence regarding the number of IMGs actually working in Tasmania. For example, the 2009 Medical Labour Force Survey, the Australian Institute of

Health and Welfare's most recent data, estimates 25.7% (475) of those medical practitioners in Tasmania reported they received first medical qualification outside of Australia. However, there was a low response rate (46.1%) to the 2009 Medical Workforce Survey and the survey did not include those medical practitioners in their first year of registration and temporary residents. Thus, the numbers of IMGs in Tasmania, in the 2009 Medical Labour Force Survey is anticipated to be an overestimation (AIHW, 2011b).

The number of IMGs working within the three major public hospitals, including the Mersey campus in 2011 was an estimated 172, as shown in Table 2.4 (DHHS, 2011). It must be noted that obtaining an accurate number of IMGs within the NWRH was problematic. In addition, IMG numbers in the acute sector were shown to have a propensity to fluctuate quite rapidly over a three to twelve month period.

**Table 2.4: Acute care IMGs in the three major hospitals in Tasmania (2011)**

IMG divisions	RHH	LGH	NWRH	Total
Interns or Junior Doctors	3	26	29	56
Medical Registrar or Consultant	27	20	-	41
DEM Registrar or Consultant	10	-	-	10
Psychiatry	7	-	-	1
Surgical Registrar or Consultant	18	5	-	17
Anaesthetics	-	10	-	10
WAC including OBGYN	17	-	-	13
Total	82	61	29	172

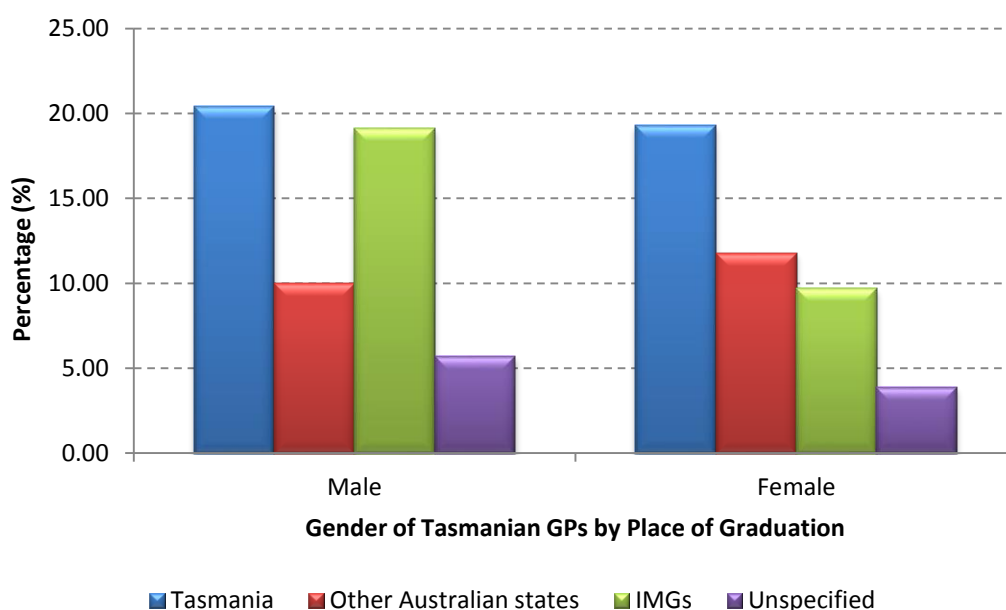
*Note.* Dashes indicate data not obtained. WAC = Women's and Children's service medical practitioners. OBGYN = Obstetrics and Gynaecological services medical practitioners.

Source: DHHS (2011).

Another example of conflicting data is the DoHA's most recent GP Workforce Statistics (2010-2011). It shows an estimated 33.8% (or 243) of the total GPs (or 719) working in the state were IMGs (DoHA, 2012). However, General Practice Tasmania Limited also conducts an annual census of Tasmanian GPs. The 2009 census demonstrated, IMGs accounted for 28.8% (or 161) of the Tasmanian GP workforce (GPT, 2010). The following year, the October 2010 census indicated the

number of IMGs increased to 176 GPs practicing in Tasmania (GPT, 2011). Despite these various reports, the number of IMG GPs in Tasmania has remained relatively analogous over a 25 year period with the lowest number of IMG GPs being recorded in 2003-2004 (187) and the highest in 2009-2010 (228) (DoHA, 2011a).

The most recently published 2010 GP census, in Figure 2.4, highlights a higher male profile of IMGs in Tasmania “due to the intake of male IMGs at double the rate of female IMGs” (GPT, 2010, p. 23). However, the annual census data had excluded Registrar GPs (52) and non-Vocationally Registered GPs (87) (DoHA, 2011a).

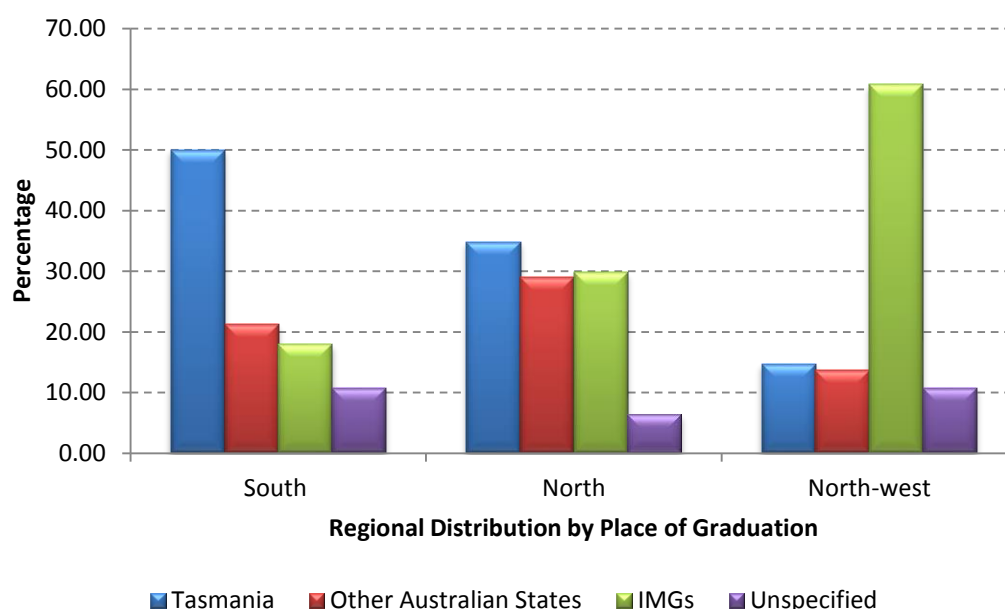


**Figure 2.4: Gender of Tasmania GPs by place of primary qualification**

*Note:* Data excludes Registrar and non-Vocationally Registered GPs. From Census of Tasmanian General Practices October 2010.

Source: GPT (2011). Adapted with permission.

The 2010 GP census showed IMG made up 61% of the GP population in the North-west of Tasmania, which was followed by Northern Tasmania and Southern Tasmania, as shown in Figure 2.5 (GPT, 2010). The higher participation rates of IMGs in these particular areas coincide with the workforce requirements of AoN and DWS placement distribution in the outer regional, remote and very remote Tasmania.



**Figure 2.5: Regional distribution by place of primary qualification**

*Note:* Data excludes Registrar and non-Vocationally Registered GPs. From Census of Tasmanian General Practices October 2010.

Source: GPT (2010). Adapted with permission.

It is also noted within the data Tasmanian based IMG GPs are working increasingly more than their Tasmanian based AMG GP counterparts. For example, DoHA's most recent GP Workforce Statistics data demonstrated that Tasmanian IMG GPs on average worked 0.7 days or 5.6 hours longer than Australian-trained GPs in an average 40 hour week (DoHA, 2011a). In addition, the average FTE per IMG GP has increased over the past 25 years while the average FTE per Australian-trained GP has stayed relatively unchanged over the same period (DoHA, 2011a).

It remains unclear if this is due to the ageing workforce of AMG GPs or reflects the feminisation of the workforce, where female medical practitioners work reduced or more flexible hours while the ageing workforce begins to retire or working more part time. This may explain why there is a continued flow of new IMGs, who may be younger, entering General Practice with a greater necessity to work; however, it yet to be determined (Alexander & Fraser, 2007; Buddeberg-Fischer et al., 2010; Buykx, Humphreys, Wakerman, & Pashen, 2010; Coyle, 2005; Spike, 2006).

## **2.10 Conclusion**

This chapter has strongly documented the increasing dependence upon IMGs to meet demands caused by a worldwide shortage of doctors. Australia continues to experience a shortage and maldistribution of doctors that had been triggered by inadequate numbers of AMGs graduating in the past. This chapter has provided the context and understanding of contemporary IMGs within Australia and Tasmania and the challenges which they encounter, such as the legislation which impacts on their ability to migrate, work and settle within Australia. An overview of IMGs in the Tasmanian context was also provided, which has demonstrated the large proportion of IMGs who are working in the state.

This synopsis and contextual discussion provide the background to the next chapter which focusses on and provides an overview of both international and Australian IMG research. It highlights the barriers and enablers faced by IMGs as they live and work in rural communities. This overview includes employment integration, satisfaction and practice support in addition to the quality of life and psychosocial needs of IMGs and their family, which remain the central factors impacting rural integration and retention.

# **Chapter three: Current research on international medical graduates**

## **3.1 Introduction**

The increasing dependence on IMGs to meet worldwide workforce demand was documented in chapter two. The chapter included an overview of the recruitment and registration issues facing IMGs within Australia. In addition, the policies and legislation which guide IMGs as they practise in Australia have been discussed. Lastly, an overview of IMGs in the Tasmanian context, demonstrated the large proportion that work in the state, yet identified the conflicting evidence regarding their exact number. The chapter provides an overview of both international and Australian IMG research and highlights the specific barriers and enablers faced by IMGs as they live and work in rural communities. This includes employment integration, satisfaction and practice support in addition to the quality of life and psychosocial needs of IMGs and their family, which remain the central factors impacting rural integration and retention.

## **3.2 Methods of literature review**

A literature review was conducted to understand the history of IMGs in Australia including the legislation and policies which were developed to guide current IMGs to enter and practise in Australia. It also reviewed the placement and retention issues faced by IMGs in rural practice and how these complex issues impact on rural community acculturation. In the final phase of the research, the literature will be utilised to compare and contrast the findings of the current study.

A literature review was conducted between July to December 2011 and covered literature from 1936 to 2011. The review provided the context to the study, which is the “Health and wellbeing of international medical graduates: Acculturation into the Tasmanian rural and remote context.” The review was first developed at four levels.

Firstly, this was achieved by searching Google Scholar and Summon search through the University of Tasmania's library for generic literature related to the subject area. This search was worthy for an initial search and highlighted literature which was closely related to the key words and terms used, as shown in Table 3.1. This search, however, lacked the ability to cover the depth and breadth of the literature required.

**Table 3.1: Key words and terms use in the literature review**

Key words and terms	Synonyms and alternative words
<b>International Medical Graduates</b>	Foreign, Migrant, Immigrant, Global, Displaced persons, Alien
<b>OR</b>	AND
<b>Overseas Trained Doctors</b>	Medical, Graduate, Doctor, Physician, Practice OR Foreign Graduate of an Accredited Medical School IMG, OTD, FGAMS
<b>Rural</b>	Remote, Country, Outback, Farming, Isolated, Distant
<b>Acculturation</b>	Integration, Adaptation, Incorporation, Community

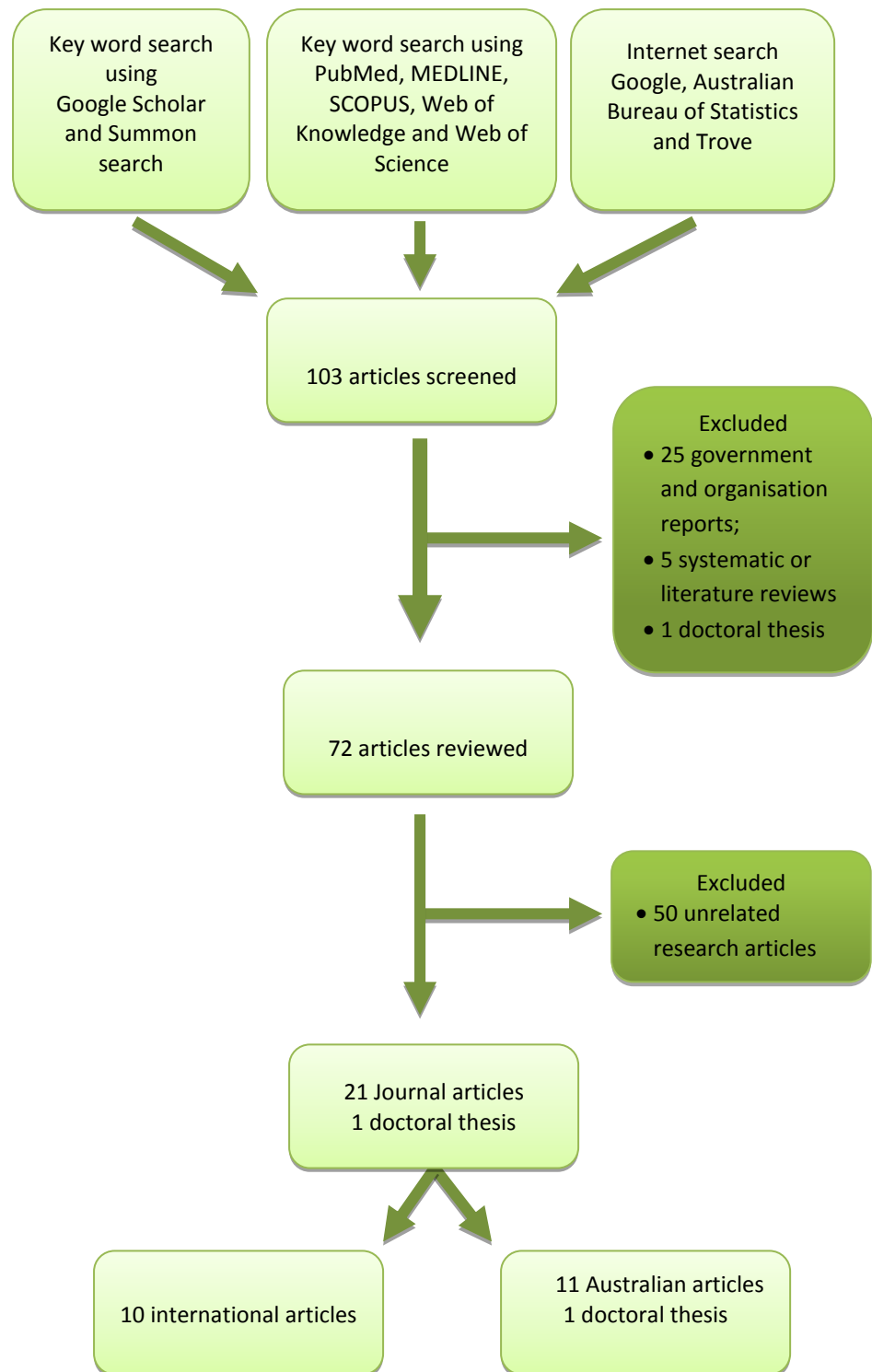
Secondly, databases and academic search engines such as PubMed, MEDLINE, SCOPUS and Web of Knowledge, including Web of Science were used for greater and more in-depth search of the many journal articles relating to the subject matter. Under the advice of the University of Tasmania library staff, ProQuest Medical was to be used with caution as the newly installed system from 2011 had a number of technical and functionality problems. This approach was quickly abandoned as a database search option. These more complex search methods located journals and articles that were more in-depth than the initial literature located.

Thirdly, a later search was conducted within the Internet, which used the key words to search government departments and agencies, including medical associations,



key organisations and stakeholders. Accessing relevant databases, such as the Australian Bureau of Statistics and Trove was also conducted. These searches were conducted to access grey literature, such as newspaper articles, government and stakeholder reports, proceedings and policy documents, many of which are unpublished. These sources were vital to develop and enhance the literature review as it provided greater understanding of the subject matter.

Finally, as the literature was critically reviewed an additional manual search of the identified articles reference list was also undertaken to identify any extra studies which were not captured within the databases. Key citations were observed and were then located by using the simpler search of Summon search or Google scholar. This method of accessing secondary literature enhanced the complexity of the literature under review, which further developed the depth required for the study, as outlined in Figure 3.1. The literature review was a continuous process and occurred periodically through the study period (2011-2014). In addition, a monthly notification from Web of Knowledge and Google Reader was maintained. These websites ensured current literature containing the search parameters, outlined in Table 3.1 were made available. This process allowed the efficient and effective perusal of new articles and ensured new and contemporary literature was available to be reviewed over the life of the study.



**Figure 3.1: Method of literature review**

### **3.3 An overview of current IMG studies**

The literature search captured 103 journal articles and reports, which were screened and selected for their content regarding IMGs. Each article was further reviewed with 25 articles and reports being excluded. They included government and organisational reports, articles that did not contain research or discussed IMG definitions and professional outcomes. A further five articles were excluded as they were systematic or integrative literature reviews (Hagopian, Thompson, Johnson, & Lishner, 2003; Malik & Bhugra, 2011; Miller & Archer, 2010; Nair et al., 2012; Pilotto, Duncan, & Anderson-Wurf, 2007). In addition, one doctoral research paper (Lindström, 2008), although valuable, was excluded as it specifically researched IMG intercultural communication in health care. The remaining 72 articles were read and reviewed and divided into two main groups. There were 28 Australia articles and 44 international IMG articles. Many were commentaries and discussions regarding IMGs, thus 50 were later excluded as they did not contain research or were research that was unrelated to the current aims of this study. The remaining 21 articles and one doctoral study were in some capacity aimed at investigating and understanding the professional experiences, social support, acculturation and retention of IMGs. Ten were international studies while the remaining 12 studies were conducted in Australia, as observed Table D1 and D2 (see Appendix D).

#### **3.3.1 International IMG studies**

As outlined, the literature review identified ten international IMG studies, written in English. The specific focus on English speaking studies was due to these being the largest IMG recipient countries globally and included countries such as the US, UK, Canada, New Zealand and Australia (Organisation for Economic Co-operation and Development, 2007). Overall, two studies were based in Canada (Klein, Hofmeister, Lockyer, Crutcher, & Fidler, 2009; Wong & Lohfeld, 2008), three were conducted in New Zealand (Kearns, Myers, Adair, Coster, & Coster, 2006; Lillis, St George, & Upsdell, 2006; Mpofu, 2008), one study was UK based (Wawdhane, Saraf, Davidson, & Trewby, 2007), while the remaining four were conducted in the US (Atri, Matorin, & Ruiz, 2011; Crouse & Munson, 2006; Polsky, Kletke, Wozniak, & Escarce, 2002).

Although one study was based in the US, it had specifically examined former Soviet Union doctors working in the USA, Israel and Canada (Shuval, 2000).

Each identified study was aimed to investigate and understand the experiences, social support, acculturation and retention of IMGs. Only two of the studies examined the personal challenges of migration of both IMGs and their family in terms of 'fitting in' with their new community. The remaining studies were focussed on the employment context of retention and acculturation. For example, a study conducted by Atri, et al. (2011), examined the effects of social support and acculturation of IMGs on their mental health and wellbeing and their capacity to be professionally integrated within the work setting in the US. What remained lacking in many of the studies was an analysis of IMGs and their families living in rural or remote settings and the factors which affect social integration.

### **3.3.2 Australian IMG studies**

Within the Australian context, there were 12 commensurate studies which relate to this current study. It must be noted the single doctoral study (Durey, 2005a) and one journal article (Durey, 2005b) were reporting the same data, thus they were considered as one study. The 11 identified IMG studies were conducted in various states of rural Australia. This included New South Wales (NSW) (Alexander & Fraser, 2007), Queensland (QLD) (McGrath et al., 2009), two in South Australia (SA) (Carlier et al., 2005; Laurence, 2008), three in Victoria (Vic) (Han & Humphreys, 2005; Han & Humphreys, 2006; Hawthorne et al., 2003) and one in Western Australia (WA) (Durey, 2005b). An additional study examined IMGs in the states of QLD, Northern Territory (NT) and WA (Gilles et al., 2008); while another studied IMGs Australia wide (Laven et al., 2003) (see Appendix D).

Ten studies solely examined IMGs, whereas the eleventh made comparisons between IMGs and AMGs (Alexander & Fraser, 2007). An additional study was located; however, it focussed on the acculturation of Vietnamese-born health professionals, which included three doctors, a dentist, a physiotherapist and a nurse who trained in Australia. Although this study was not focussed specifically on IMGs, it was noted as an insightful study as it was the only one of its kind in Tasmania. In

addition, it resonated with the current study as it was aimed to “examined the life experiences and acculturation strategies of Vietnamese-born health professionals working and living in rural Australia” (Lê & Kilpatrick, 2008, p. 1).

The eleven identified studies had similar aims and objectives, which ranged from examining IMGs training, support needs and improving orientation for IMGs to determining the key factors which influence IMGs to stay in rural practice (Alexander & Fraser, 2007; Carlier et al., 2005; Durey et al., 2008; Han & Humphreys, 2006; Laven et al., 2003; McGrath et al., 2009). In addition, at least four studies analysed the impact of working and living in rural or remote settings among IMGs and their families. These studies also analysed the factors which affect IMGs professional, cultural and social integration (Durey, 2005a; Gilles et al., 2008; Han & Humphreys, 2005; Hawthorne et al., 2003). As such, the workplace and social barriers and enablers which have been identified by these international and Australian studies are outlined and discussed.

### **3.4 Barriers and enablers in rural practice and communities**

As previously highlighted, a critical deficiency of medical practitioners in Australia, particularly in rural communities has caused the Australian Commonwealth Government to respond by introducing specific policies and initiatives (Han & Humphreys, 2005; Han & Humphreys, 2006). One such scheme, previously outlined in chapter two, section six, is the five-year Overseas Trained Doctor scheme. It has been reported to be successful and generally a positive and rewarding experience for IMGs (Carlier et al., 2005; Han & Humphreys, 2006; RHWA, 2011a).

The success of the scheme was demonstrated by a study conducted by RHWA in 2010 for the DoHA. The study involved five states/territories and showed of the 168 IMGs who had completed the 5-year Overseas Trained Doctors Scheme, 118 (70%) remained working in rural areas (RHWA, 2011a). RHWA stated the 5-year Overseas Trained Doctors Scheme program was successful, showing 73% of the 96 IMGs who completed the scheme in Western Australia, continued to practise in rural areas (RHWA, 2011a). Similar results were observed in South Australia with 50% of IMGs willing to stay longer than their contractual commitment (Carlier et al., 2005). There

needed to be more examination to comprehensively understand the factors which impact on professional and social integration in rural communities (Han & Humphreys, 2006).

Despite these positive outcomes, many IMGs have had challenges in rural practice, which has led to high turn-over, particularly in rural and Indigenous primary care settings (Durey et al., 2008). Durey, et al. (2008) examined how IMGs and rural and remote Indigenous health staff worked together and observed how this influenced IMGs ability to transition, integrate and be retained in these settings. Structural and cultural support was illustrated to inadequately prepare IMGs for practice.

In addition, discouragement, frustration and a feeling of being undervalued led to poor retention when working in Indigenous health contexts. Many of these experiences have been criticised as on-going issues, as IMG turn-over occurs frequently when compulsory scheme program agreements are completed (Crouse & Munson, 2006; Frehywot et al., 2010; RHWA, 2011a). These experiences and issues has impacted and continues to challenge future recruitment and retention in many rural communities, not only in Indigenous health contexts, but many other rural health contexts worldwide (Crouse & Munson, 2006; Han & Humphreys, 2005; Klein et al., 2009; McGrail et al., 2010; Mpofu, 2008).

Beyond retention, a number of other issues have arisen regarding the recruitment of both temporary and permanent resident IMGs to rural and remote areas. More attractive international competition caused by population ageing and increasing patient demand is hampering efforts to recruit IMGs to Australia (RHWA, 2011a; Spike, 2006). Moreover, workforce shortages in more attractive urban areas impact IMG rural retention as rural settings, according to the (ARRWAG, 2004, p. 9), have a “lack of facilities... limited schooling options, reduced employment opportunities for GPs’ spouses and shortage of housing problems.”

To address these challenges, financial and non-financial incentives are consistently offered to both AMGs and IMGs to work in rural and remote practices (Kamalakanthan & Jackson, 2008). These key incentives include adequate housing, staying close to family, appropriate supports that include acceptable work hours

and leave, relocation assistance, education and or professional development and opportunities for specialisation. Other professional related incentives include providing intellectual stimulation; practice-based research to develop new knowledge; new technology in care provision; and networking with other practices (Kamalakanthan & Jackson, 2008, pp. 13,20).

These incentives were shown to have little effect, yet a recent study indicated AMG's were willing to go into rural communities with less than 5,000 people if financial incentives were equivalent to 64% of current average annual personal earnings. However, these financial incentives diminished to 37% of current average annual personal earnings for rural communities between 5,000 and 20,000 people (Scott et al., 2012). Nevertheless, newer generations of doctors continue to favour and select urban over rural practice and with financial and non-financial incentives having minimal effect (ARRWAG, 2004; Buykx et al., 2010; Kilpatrick et al., 2011; RHWA, 2011a).

Beyond incentives, it has been demonstrated IMGs are less likely to consider taking up rural placement opportunities as there are a number of additional issues that may discourage such appointments. Many of these key issues relate to professional and social barriers as indicated in Table 3.2 and discussed in detail below.

**Table 3.2: Specific barriers and enablers encountered among IMGs**

Barriers	Specific factors
<b>Professional barriers</b>	<ul style="list-style-type: none"> <li>• Immigration, accreditation, registration and financial challenges;</li> <li>• lack of facilities, long hours and self-education issues; and</li> <li>• Professional support.</li> </ul>
<b>Social barriers</b>	<ul style="list-style-type: none"> <li>• Limited educational and employment options for spouses;</li> <li>• Limited childcare and schooling options;</li> <li>• Limited housing;</li> <li>• Physical and social isolation;</li> <li>• Cultural and religious connectivity; and</li> <li>• Challenges in social support.</li> </ul>

#### **3.4.1.1 Professional barriers**

Many of the Australian and international IMG studies found the central motivation for IMGs to migrate to another country in a permanent or temporary capacity was for the lifestyle opportunities and increased prospects for family (Durey, 2005b; Durey et al., 2008; Gilles et al., 2008; Hawthorne et al., 2003; Klein et al., 2009). However, the motivation for 46% of doctors from the Pacific islands of Fiji, Samoa and Tonga to migrate to Pacific rim countries was strongly associated with income (Brown & Connell, 2004, p. 2200).

Many IMGs regarded migration as a temporary measure yet, for some it becomes a more permanent move, including those who cannot or do not wish to return home due to the risk of violence and political instability (Brown & Connell, 2004; Hawthorne et al., 2003; Klein et al., 2009; MacKenzie & Forde, 2009; Shuval, 2000). According to the Australian Rural and Remote Workforce Agencies Group (2004), particular locations in Australia are selected by IMGs to live and work in for two main reasons: career opportunities and meeting the educational needs of children. These reasons continue to make it difficult to recruit and retain IMGs in some rural and remote areas (Durey, 2005b; Durey et al., 2008; Gilles et al., 2008; Hawthorne et al., 2003).

Incongruous placement of IMGs may also impact negatively on the doctor, their family, the medical practice and the community (Durey et al., 2008; Han, 2010; Han & Humphreys, 2005). In some cases, difficulties were experienced at the time of recruitment. This difficulty has led to an insufficient understanding of rural communities, how medicine is practised in Australia and how the Australian culture is at times vastly different to an IMGs own culture (Durey et al., 2008; Han, 2010; Han & Humphreys, 2005; Harvey & Faunce, 2005).

However, the placement experience can differ between IMGs and the communities they serve. For example, one US study demonstrated that 92% IMGs in rural Wisconsin felt integrated within their workplace and 62% of the IMG families felt they were well accepted within the community (Crouse & Munson, 2006). In a



different US study, it was demonstrated that only 30% of IMGs felt integrated within their workplace (Hagopian, Thompson, Kaltenbach, & Hart, 2003).

In addition to an incongruous placement, it has been shown that many other issues can be challenging prior to and be problematic once rural placement has occurred. These issues include the loss of status and professional identity (Atri et al., 2011; Wong & Lohfeld, 2008); professional isolation in rural practice; the need to undertake further medical examinations; the restrictions on medical practice; accessing provider numbers; and social isolation experienced in rural areas (McGrath et al., 2009; Stanley & Bennett, 2005). For example, a number of rural communities may have had very little experience with individuals from other cultures and may be less welcoming and mistrust people when cultures, customs and religious beliefs are unfamiliar (ARRWAG, 2004; Louis et al., 2010b; Maynard-Reid, 2005).

Limited experience with migrants and IMGs coupled with stigma and negative media scrutiny such as the Dr. Patel case, outlined in chapter 2.6, has further incited intolerance of migrants within the Australian public (Dunn, 2005; Forrest & Dunn, 2011; Louis et al., 2010a; Quayle & Sonn, 2009). These challenges have restricted migrant acceptance within communities, where antagonism, stigma and rejection produce poor long term acculturation, quality of life and poorer health of migrants (Berry, 1997; Crompvoets, 2010; Durey et al., 2008; Han, 2010; Han & Humphreys, 2005; Harvey & Faunce, 2005; Louis et al., 2010b; Mpofu, 2008).

This stigma can stem from the community and within the medical profession (Han, 2010; Louis et al., 2010b). However, these racial challenges are faced by many other professional migrants when seeking employment. For example, the current literature has demonstrated various migrant professionals in Canada encounter “unequal opportunity, devaluation of foreign credentials, and racism” (Zong, 2004, p. 2). Likewise, Danso (2009) reports many migrants enter countries as skilled migrants; however, are denied access to the jobs they are qualified for due to discriminatory or oppressive industries.

These practices were also observed when IMGs and other migrant health professionals were recruited and employed within the British NHS (Organisation for Economic Co-operation and Development, 2007). According to (Kyriakides & Virdee, 2003), the NHS frequently uses migrant workers, who were viewed to be a cheaper alternative to training within the country. IMGs filled positions which many locals were observed to be unwilling to fill themselves (Fellini, Ferro, & Fullin, 2007; Kyriakides & Virdee, 2003; Shuval, 2000).

Often migrant workers are underpaid compared to local workers, are employed based on the stereotyping of a particular CALD community, and are often overqualified for the positions they fill. There is evidence, particularly, within the NHS, the least prestigious and lower level medical practitioner positions were given to those migrants of colour (Fellini et al., 2007; Kyriakides & Virdee, 2003; MacKenzie & Forde, 2009; McDowell, Batnitzky, & Dyer, 2009). Nevertheless, there remains very little evidence regarding these racial challenges faced by IMGs within Australia (Han & Humphreys, 2005; Louis et al., 2010b). It has been indicated a number of IMGs are unable to gain registration as medical practitioners in Australia and Canada and are employed as taxi drivers, general labourers or in adjunct health occupations (Colic-Peisker, 2009; Hathiyani, 2007).

Conversely, high levels of unemployment among IMGs have occurred elsewhere; however, this was simply due to over-supply, stigma, institutional and individual barriers. For example, the UK had an over-supply of IMGs between 2001 and 2004 (Wawdhane et al., 2007) while Israel due to its open-door policy for Jewish immigration, had a high number of IMGs entering the country (Shuval, 2000). This over-supply has particularly led to Jewish IMGs migrating to Israel to work in allied health or complementary medicine occupations or low-status medical positions. Kielhofner (2004) and Shuval (2000) have argued human beings have a natural tendency to be 'occupational,' in that occupation or professional identity is the primary basis of identity, a sense of self and the meaning in life. Thus, "people who are denied access to occupations or are restricted in their occupations may suffer a reduction in quality of life" (Mpofu, 2008, p. 99). This issue is also one of the professional challenges IMGs are faced with as they migrate.

In addition to the potential social stigma and quality of life challenges which face IMGs, other issues such as hypermobility has been emphasised by (Hawthorne et al., 2003). When speaking of migrants, hypermobility was used to denote “the circulation of commodities, people, information, cultural goods [which] keeps increasing” (Berger, 2011, p. 147). Hawthorne, et al. (2003) in their rural Victorian study examined the hypermobility of the IMG GP population. They had noted that 66% of IMGs in Victoria had experienced high levels of hypermobility, where more than five major moves were completed by IMGs. At least 30% had moved three to four times and 5% had moved more than eight times (Hawthorne et al., 2003). This hypermobility included moving from country to country and also within Australia prior to their current position at the time of the study. (Hawthorne et al., 2003, pp. 73-74) held that

It would be rare for a random Victorian rural appointment to result in a commitment to permanent stay. For many [IMGs], Victorian country posts are inevitably no more than an additional step along the way to doctors’ goal of maximising family lifestyle, income level, and personal security.

In addition to the hypermobility challenge IMGs encounter, other Australian and international studies identified a number of specific professional factors which inhibited successful rural integration. These factors will be highlighted and discussed.

#### *3.4.1.1.1 Immigration, accreditation, registration and financial challenges*

Both temporary and permanent IMGs are confronted by many challenges, such as substantial financial pressures when arriving and relocating to a new country and within rural communities (Gilles et al., 2008; Lillis et al., 2006; Mpofu, 2008).

For example, in a submission to the inquiry into registration processes and support for overseas trained doctors, the MBA outlined the financial cost of each of the pathways that could be undertaken by IMG to gain registration (House of Representatives Standing Committee on Health and Ageing, 2012a, p. 179). Using

the Royal Australian College of General Practitioners (RACGP) as an example, the estimated costs, excluding visas and registration interview travel, were

- Competent Authority Pathway – approximately \$4 165;
- RACGP Pathway (ranging depending on the categorisation of the IMG's comparability level) – approximately \$3 615 to \$11 900; or
- Standard Pathway – approximately \$8 730.

These financial burdens IMGs are challenged with impact recruitment and retention in rural areas (ARRWAG, 2004; Stanley & Bennett, 2005). In addition, IMGs face long, complex procedures of immigration, accreditation, and costly annual renewal of provisional registration and training (Gilles et al., 2008; Louis et al., 2010b).

This complex and all-consuming process has been reported to leave many feeling alienated, angry and uncertain as they endeavour to enter the medical workforce. These processes were demonstrated to occur in Australia, Canada and New Zealand (Heal & Jacobs, 2005; Mpofu, 2008; Wong & Lohfeld, 2008). For example, many IMGs experience problems due to “the English language and cultural differences embedded in the pre-registration assessment process (particularly the clinical examination)” (Hawthorne et al., 2007, p. 11). Also, IMGs and their families, particularly temporary residents, may be unable to access Medicare benefits and private medical insurance and encounter higher tax rates and school fees (East, 2010; Heal & Jacobs, 2005; House of Representatives Standing Committee on Health and Ageing, 2012a).

#### *3.4.1.1.2 A lack of facilities, long hours and self-education issues*

In addition to the financial pressures that IMGs encounter, working in rural communities is indicated to be challenging when attempting to maintain a manageable work-life balance (Durey, 2005b; Han & Humphreys, 2005; Heal & Jacobs, 2005). Doctors working in small rural and remote communities are faced with long working hours and heavy workload, which often includes substantial on-call commitments (Durey, 2005a; Nair & Parvathy, 2012). For example, it has been shown that GPs work up to 26% longer in very isolated rural locations than those in

major cities. Specifically, 27-40% of GPs in rural areas work more than 60 hours, while 14% in major cities work more than 60 hours (Phillips, 2005, p. 21). In addition, working in rural and remote communities often means working in facilities which have unfamiliar, insufficient and inefficient clinical infrastructure and administrative practises (Durey, 2005b; Han & Humphreys, 2005; Heal & Jacobs, 2005). This additional pressure in the work-live balance impacts on families and creates a greater burden on spouses who may be caring for a family and managing their own professional obligations (Frehywot et al., 2010; Stanley & Bennett, 2005).

In addition to balancing the work and life in rural contexts, many IMGs experience frustration when preparing for and undertaking further educational study and examinations (Kearns et al., 2006; Lillis et al., 2006). As many IMGs in rural areas study in isolation while a number of IMGs have trained in disadvantaged educational situations, with marginal access to western technology (Han & Humphreys, 2005; Hawthorne et al., 2003).

Lastly, the cost of the examination is often unaffordable with some IMGs experiencing examination failure on a number of occasions (Heal & Jacobs, 2005; House of Representatives Standing Committee on Health and Ageing, 2012a; Louis et al., 2010b; Moynihan, 2010). For example, the latest Australian data indicated most IMGs (86.5%) who attempt the MCQ exam pass within the first two attempts with 66.8% passing on the first attempt while 19.7% passed on their second attempt. However, it is the remaining 13.5% who fail the first two attempts bear a large proportion of the examination costs as they seek to gain registration in Australia (AMC, 2011; House of Representatives Standing Committee on Health and Ageing, 2012a). For this reason, professional support for IMGs aims to assist examination preparation (AMC, 2012).

#### *3.4.1.1.3 Professional support*

The professional support for IMGs, although studied comprehensively remains critical, as it contributes to IMGs inevitable integration and retention in a rural community (Alexander & Fraser, 2007; Carlier et al., 2005; Durey et al., 2008; Gilles et al., 2008; Han & Humphreys, 2005; Hawthorne et al., 2003; Kilpatrick et al., 2011;

McGrath et al., 2009; Mpofu, 2008; Wright et al., 2012). Professional support also includes colleagues' clinical support and supervision which remains a precarious factor in assisting IMGs to feel integrated in the practice setting and community (Atri et al., 2011).

A lack of collegial assistance can impede professional integration (Gilles et al., 2008; Han & Humphreys, 2005; Hancock et al., 2009; Lillis et al., 2006). It has been noted a lack of assistance may stem from the medical profession itself which at times has been divided by the employment of large numbers of IMGs to abate the rural doctor shortage in Australia (Gilles et al., 2008; Han & Humphreys, 2005; Hancock et al., 2009).

For example, IMGs joining rural settings may be faced with AMGs who have animosity toward IMG recruitment which can then challenge workplace relationships and create an environment which is less conducive for both parties (Han, 2010). A number of contrasting experiences have been voiced by IMGs in Australia (Durey, 2005b; Lim, 2010). These accounts include being welcomed by colleagues and their families to discrimination and professional isolation.

It has been shown that some experiences extend from nursing staff and managers building strong and lasting professional relationships, to the provision of refurbished practices in close proximity to the hospital as a means to retain IMGs in the community (Durey, 2005b; Lim, 2010). The support provided by a practice whether positive or negative assists in the camaraderie or isolation experienced and the ultimate acculturation of IMGs (Durey, 2005b; Han & Humphreys, 2005). Nevertheless, there are additional non-professional, social barriers which impact on IMGs and their families.

#### **3.4.1.2 Social barriers**

Within the literature, a number of studies that examined the motivations for staying or leaving rural practice showed non-professional, social barriers had the greatest bearing on the decision of where to practise (Carlier et al., 2005; Durey, 2005b; Gilles et al., 2008; Han & Humphreys, 2005; Hancock et al., 2009; McGrail et al., 2010; McGrath et al., 2009). The most prominent non-professional social barriers

include employment for spouse, limited schooling and housing options, physical and social isolation and limited cultural and religious access. A number of challenges regarding community support were also identified. Each of these key barriers will be discussed in greater detail.

#### *3.4.1.2.1 Limited educational and employment options for spouses*

A significant barrier impacting IMG rural acculturation is the challenge of limited education and employment opportunities for an IMG's spouse (Carlier et al., 2005; Durey et al., 2008; Hawthorne et al., 2003; Kearns et al., 2006). One study undertaken by (Durey, 2005b, p. 49) examined the impact of living and working in rural or remote Australian communities on IMGs and spouses. It was shown that

Rural practice is a family concern and the success and retention of a doctor depends to a large extent on the adaptability of the spouse, although opportunities to work locally in their chosen profession [are] limited or non-existent, often leading to frustration. (Durey, 2005b, p. 49)

Spouses may be working in professional, well paid positions prior to rural relocation where many small rural communities may not offer equal employment opportunities (Alexander, 1998; Durey, 2005b; Kearns et al., 2006; Kilpatrick et al., 2011). This issue may lead to unemployment or long commutes to larger centres for employment. As such, it has been shown that younger female doctors are more likely to move out of rural settings due to their spouses' work commitments (Kilpatrick et al., 2011).

In addition to the employment challenges, a spouse who requires professional development or retraining to guarantee their qualifications are accepted in Australia may also have limited opportunity to achieve this in a number of rural settings. It may also be inhibitory due to the large financial cost for newly migrated families (Han & Humphreys, 2005; Heal & Jacobs, 2005). Moreover, temporary residents, who generally earn below average incomes (Iredale, 2009) are required to pay full fees for tertiary education. In this case, incentives such as "financial support for spouses who need professional development has been shown to be an

effective means of supporting families of doctors in rural and remote areas” (Stanley & Bennett, 2005, p. 2).

#### *3.4.1.2.2 Limited childcare and schooling options*

Another identified social barrier is limited childcare and schooling options, which impacts IMG integration and desire to stay in a rural area (Alexander, 1998; Alexander & Fraser, 2007; Durey, 2005b; Durey et al., 2008; Gilles et al., 2008; Hawthorne et al., 2003; Kearns et al., 2006). Childcare may be relied on by female IMGs to fulfil their work commitments; however, childcare facilities are often limited in rural communities. If employment or educational opportunities are obtained for a spouse or partner then childcare support becomes increasingly necessary. Likewise, those IMGs with school age families may desire to move from rural employment or be deterred from accepting rural employment. This move from rural areas may be due to a lack of acceptable educational opportunities, particularly for those entering secondary schooling (Alexander, 1998; Alexander & Fraser, 2007; Han, 2010; Kearns et al., 2006).

The Australian Rural and Remote Workforce Agencies Group (Stanley & Bennett, 2005) recognised the use of boarding schools was a familiar method of schooling for Australian rural populations; however, IMGs may be unfamiliar with or not see this as a viable alternative. In some instances, it may be culturally desirable to be in close proximity to children when they attend school. Also for temporary resident IMGs, this may not be a financially realistic in addition to paying full fees for a child’s education (Frehywot et al., 2010; Han & Humphreys, 2006; Heal & Jacobs, 2005; Stanley & Bennett, 2005).

#### *3.4.1.2.3 Limited housing*

An additional social barrier is affordable accommodation and it is central for IMGs retention in rural practice (Frehywot et al., 2010; Han & Humphreys, 2005; Kilpatrick et al., 2011). Lack of suitable housing and poor or unsafe living conditions remains a challenge for IMGs and their families in rural settings, where adequate housing may be limited (Frehywot et al., 2010; Han & Humphreys, 2005; Kilpatrick et al., 2011). In rural or remote communities where housing is limited or property values remain high, government initiatives such as the ‘Accommodation



Infrastructure Project,' have previously provided funds to doctors for suitable housing construction (ARRWAG, 2004; Stanley & Bennett, 2005). Conversely, in rural and remote communities, housing may be available, but home ownership is less practical for IMGs when residency status remains uncertain and poor rates of return is not observed as an attractive investment (Heal & Jacobs, 2005; Stanley & Bennett, 2005).

#### *3.4.1.2.4 Physical and social isolation*

Beyond housing, lack of infrastructure is another significant barrier in recruitment and retention. For example, shopping centres, public transport, social organisations and basic amenities to develop interests are needed to retain IMGs and their families (McGrail et al., 2010; Stanley & Bennett, 2005). A lack of infrastructure can impede the transition and retention of IMGs and families in rural communities. Stanley and Bennett (2005, p. 4) who discussed this issue, in their policy position statement on supporting doctors' families in rural and remote communities, state "In many situations, this represents a significant contributor to social and physical isolation." As such, isolation can be heightened if public transport is deficient and a spouse does not drive.

It has been reported that many IMGs and their families living and working in rural and particularly remote communities do encounter physical and social isolation (Durey, 2005b; Durey et al., 2008). Nevertheless, an IMG by the nature of their employment has interaction with community members within the work environment, more than a spouse may have opportunity (Durey, 2005b; Harding et al., 2010).

In addition, culturally and linguistically diverse (CALD) individuals may also find language barriers in the workplace and community, which can further increase social isolation. In some cases, it was demonstrated in the Western Australian study conducted by Durey (2005a) that several IMGs and their families would travel hundreds of kilometres to participate in cultural activities and visit with people from their same CALD community (Durey, 2005b; Harding et al., 2010).

Similarly, those IMGs from an Asian or Hispanic background in the US, were shown to have a greater propensity to seek employment where a greater proportion of similar CALD communities occur (Polsky et al., 2002). Thus, the availability of cultural activities and entertainment is a vital factor in IMG integration and retention (Han & Humphreys, 2005; Kearns et al., 2006; Kilpatrick et al., 2011). Increased isolation can occur if contact with cultural, social or religious background is difficult or non-existent (Han & Humphreys, 2005; Kearns et al., 2006). This isolation hampers integration of the IMG, but more so their family (Stanley & Bennett, 2005).

#### *3.4.1.2.5 Cultural and religious connectivity*

When isolation from cultural or religious background occurs, the maintenance of cultural and religious values, as well as connectivity with the respective CALD community was viewed as highly important within US, Australia and New Zealand studies (Carlier et al., 2005; Durey, 2005b; Kearns et al., 2006; McGrath et al., 2009; Polsky et al., 2002). Carlier, et al. (2005) stated providing information about how to obtain cultural foods; linking IMGs with cultural or religious background, and providing a local mentor for family support assisted IMG and family acculturation in rural South Australia. Nevertheless, in Western Australia, IMGs and their families found the move to rural life a little more challenging due to cultural, language and religious differences and a lack of extended family or friends (Durey, 2005b; McGrath et al., 2009).

In terms of access to large CALD communities, a contrast exists between Victoria, South Australia, Western Australia and areas such as Tasmania. Many IMGs from these rural communities have relative ease of access to metropolitan cities such as Melbourne, Adelaide and Perth where large CALD communities exist. These communities in large Australian cities are dense and cohesive ethnically-distinct populations and allow cultural traditions, beliefs and experiences including socio-cultural norms to continue (Bécares, Nazroo, & Stafford, 2011; Chou, 2007; Daly et al., 2002; Dang, 2010; Gray, Harding, & Reid, 2007; Stafford, Bécares, & Nazroo, 2010b). Migrant communities in Tasmania often do not exist, are much smaller and arguably less cohesive than those found in larger Australian cities (Wu, 2001).

In contrast to the large CALD communities in the large cities, a number of large CALD populations exist in rural areas. For example, Cobram in Victoria has a large Iraqi population. These communities can create a greater level of satisfaction when living and working in rural settings for IMGs and their families (Han & Humphreys, 2005; Hawthorne et al., 2003). However, the effects of sub-optimal integration on physical and social outcomes are not always positive regardless of place of residence (Hancock et al., 2009; Osypuk, Diez Roux, Hadley, & Kandula, 2009). Nevertheless, in areas where greater CALD community density occurs, there is an increased ability for new migrants to access and understand public services. These services include cultural specific social, shopping and health care services which can assist in retaining cultural identity, health beliefs, traditions and lifestyles (Chan & Quine, 1997; Gray et al., 2007; Tang & Easthope, 2000).

Living in CALD communities has been shown to facilitate successful migrant adaptation by increasing social networks, improving communication for those unfamiliar with local languages and it allows cultural goods and familiar food to be accessed (Osypuk et al., 2009). Migrant community institutions, such as local places of worship, also play a vital role in maintaining traditional cultural values and facilitating community cohesion and acculturation (Han & Humphreys, 2005). These institutions increase access to resources which support migrants adjust to life in their new country and continue to sustain many cultural aspects of their lifestyle, which does not always occur in rural settings (Chin, Neilands, Weiss, & Mantell, 2008; Chiswick, Lee, & Miller, 2008; Stanley & Bennett, 2005).

#### *3.4.1.2.6 Challenges in social support*

Social support for IMGs, their family and engaging in community participation are also essential elements to reduce social isolation and to ensure integration occurs in rural communities (Han & Humphreys, 2005; Hancock et al., 2009). The probability of and capability to integrate within rural communities has been shown to be an element of professional satisfaction irrespective of an IMGs cultural and religious background (Han & Humphreys, 2006; McGrail et al., 2010). In addition, social support facilitates the integration of IMGs and their families into the community

whereas discrimination and other obstacles can accelerate a family leaving (Han & Humphreys, 2005; Han & Humphreys, 2006).

It was demonstrated by Atri et al. (2011, p. 22), in their US study, social support aids mental health and wellbeing, which in turn assists “in successful cultural adaptation and, eventually, in the optimal integration of IMG residents into the U.S. physician workforce.” Thus, addressing prevailing barriers through community orientation and knowledge of IMGs cultures and difference can help a community’s empathy and consideration for IMGs, their spouses and children (Han & Humphreys, 2005).

Community orientation can assist integration within the community whereas indifference, cultural stigma and judgmental discourse can create lasting and profound apprehension and anxiety (Han & Humphreys, 2005). For example, it was shown in an Australian study, which looked at community integration in rural communities, that “some patients are reluctant to consult [IMGs], both in the hospital emergency room and the practice setting... [however] rural people are more cautious than their urban counterparts in what they say to doctors in general conversation” (Han & Humphreys, 2005, p. 239).

Conversely, Louis et al, (2010b), examined patient’s views regarding an IMG’s place of education and if this impacted the patient approval of IMGs. They found IMGs who had trained in developing countries were observed to be less desirable by potential patients than IMGs of the same nationality who trained in the UK or medical graduates born in Australian. Nevertheless, Harding et al. (2010) found Australian-born patients in rural general practice had high levels of satisfaction with both IMGs and AMGs GPs.

In addition to improved community orientation, positive social support for IMGs may extend from renting a car, providing housing to being provided information about the community and the available facilities (Durey, 2005b; Han & Humphreys, 2005; Hancock et al., 2009; McGrath et al., 2009). In other examples, a number of central Queensland communities had purchased practice facilities and provided generous lease-back arrangements to IMGs. Other communities built, equipped and staffed surgeries to ensure IMGs felt welcomed. A mid-northern community in

South Australia constructed a new house to support a new IMG and make them feel welcomed (Han, 2010). Those professionals, such as IMGs, which are positively supported by capacity building and innovative community ownership have been observed to be increasingly loyal with aspirations to remain longer in communities than required (Fleming, McRae, & Tegen, 2001; Han, 2010; Kilpatrick et al., 2011). However, in some cases those who are obliged to work in rural areas through compulsory schemes are less satisfied and more likely to leave a rural area (McGrail et al., 2012; Russell et al., 2013).

Despite this finding, Han and Humphreys (2005) indicated that IMGs in rural Victoria did not require much practical community support to feel welcomed. The IMGs in this state did cite a culture of being welcomed and community awareness, which embraced difference was critical to their integration and feeling accepted in the community (Han & Humphreys, 2005). Those communities that cultivated relationships with migrants assisted the formation of migrant identity within the new community. In addition, a rural community's connectivity with an IMGs family was the most significant factor to influence an IMG and their family's integration and retention (Carlier et al., 2005; Han & Humphreys, 2006).

Social and community events also have meaningfully assisted the acceptance, wellbeing and a sense of belonging for IMGs and their families (Carlier et al., 2005; Han & Humphreys, 2006). When first migrating, IMG experience a loss of personal identity, social status and a sense of belonging (Atri et al., 2011; Shuval, 2000; Wong & Lohfeld, 2008). Thus, these types of community connections assist IMGs and their families to feel a sense of belonging and support, which reduces the cultural dislocation they experience from family and friends (Durey, 2005b; Kilpatrick et al., 2011).

Those IMGs and families who actively engaged and participated in the community, through school activities, voluntary work, community events and social outings, had a greater acceptance by the community and community integration (Carlier et al., 2005; Han & Humphreys, 2006). Nevertheless, in Durey's (2005b) Western Australian study, one family maintained professional boundaries with the

community. Socialising with the community was prohibited due to past bad experiences, where they had been 'taken advantage of' by a number of community members. Ultimately this family moved away to maintain boundaries and for schooling while the IMG commuted the long distance back to the community daily to complete the compulsory service scheme. Conversely, other IMGs in the study wanted greater social connectivity with the community, but the community remained unapproachable (Durey, 2005b).

### **3.5 Overview of literature**

A review of the literature has indicated previous IMG studies have focused primarily on acculturation and retention issues within the workplace, such as IMG satisfaction and practice support (Alexander & Fraser, 2007; Carlier et al., 2005; Durey, 2005b; Han & Humphreys, 2005; Han & Humphreys, 2006; Hawthorne et al., 2003; Heal & Jacobs, 2005; RHWA, 2011a). Only a small number of these studies recognised quality of life and psychosocial needs of IMGs and their families as significant factors impacting rural acculturation and retention (Alexander, 1998; Colic-Peisker, 2009; Stanley & Bennett, 2005). Alexander and Fraser (2007) said IMGs' non-professional needs in rural contexts required further research. While Klein, et al. (2009) have said there is a need to undertake further qualitative research to understand what motivates IMGs to stay in a particular place.

In addition, within the literature, prior IMG research has focused on employment satisfaction as a measure of integration and settlement success. This research focus follows the view that obtaining "employment is universally considered – among scholars, settlement service providers and policy makers – to be the single most important aspect of migrant integration" (Colic-Peisker, 2009, p. 176). Migrants obtaining employment is viewed as a central indicator of successful settlement in Australia (Richardson et al., 2004). This focus on integration and settlement success remains detached from the additional social and psychological indicators of successful integration, settlement and life satisfaction. The social and psychological indicators include establishing social networks within communities, quality of life,

wellbeing, happiness and acculturation of migrants (Colic-Peisker, 2009; McGrail et al., 2010; Mpofu, 2008).

In addition, Kilpatrick et al. (2011, p. 183) has said the factors of successful acculturation for skilled migrants are defined by:

job opportunities for partners, perceptions of rural life, lifecycle, place identity and social networks, education and training, infrastructure, housing and health provision. Supportive partners have been identified... as a key factor in recruitment, satisfaction and retention of workers in rural areas.

Furthermore, acculturation of IMGs and their families may be achieved through a supportive community environment. This assists IMGs and their families to reside, integrate and acculturate in rural contexts. This had been observed and achieved in some degree throughout the identified IMG studies, by providing a number of key strategies that made the transition easier and less confusing for IMGs and families (Carlier et al., 2005; Durey, 2005b; Gilles et al., 2008; Han & Humphreys, 2005; Hancock et al., 2009; McGrath et al., 2009). These strategies can be divided into two groups and include:

Those carried out by IMGs

- Develop local acquaintances before arriving;
- Seek assistance from medical colleagues and their families; and
- Gain more information on the community and its facilities.

Those by the host community

- Provide transport at arrival or assisting with car hire;
- Provide information regarding spouse employment;
- Help familiarise the family to the community;
- Involve the family in community events and participation;
- Assist with temporary furnished housing and loans; and
- Meet the specific social and cultural needs of IMGs.

### **3.6 Conclusion**

An overview of both international and Australian IMG literature has highlighted the challenges encountered by IMGs as they live and work in rural communities. These challenges include employment integration, satisfaction and practice support in addition to the quality of life and psychosocial needs of IMGs and their families. A number of key findings remain unanswered; however, these questions to a certain extent will be answered in the current research as it aims to explore the experiences and challenges of IMGs living and working in rural and remote Tasmania, and how this informs the acculturation process.

A number of key theoretical concepts and frameworks are required to address the study's aims. The next chapter introduces internationalisation and globalisation of health workforce and acculturation. The chapter is then followed by a discussion regarding the theoretical standpoints which are employed as the framework and lens to guide the study. These theoretical standpoints include human and social capital of migrants in new social and workplace environments. These theories draw attention to the acculturation and identity challenges, which migrants in the health workforce, particularly IMGs, encounter in new cultural and healthcare contexts.



# **Chapter four: Theoretical framework underpinning the study**

## **4.1 Introduction**

Chapter three has provided an overview of both international and Australian IMG studies and highlighted the challenges faced by IMGs as they live and work in rural communities. These challenges include employment integration, satisfaction and practice support in addition to the quality of life and psychosocial needs of IMGs and their families. A number of key theoretical concepts and frameworks underpin this study to address the study's aims. Chapter four introduces the internationalisation and globalisation of health workforce and acculturation followed by a discussion regarding the framework to guide the study that uses a number of theoretical standpoints. These theoretical standpoints include human and social capital of migrants in new social and workplace environments. These theories draw attention to the challenges of acculturation and identity, which migrants in the health workforce, particularly IMGs, encounter in new cultural and healthcare contexts.

## **4.2 Internationalisation and globalisation of health workforce**

Internationalisation is a commonly used term within economics to denote an increased involvement of enterprises in international markets (Susman, 2007). However, it is a term and definition which has many conflicting and perplexing meanings. Internationalisation is used in many different contexts and can be confused with globalisation that is very different, yet a related and poignant process. Globalisation is defined as "the flow of technology, economy, knowledge, people, values, [and] ideas... across borders, [and] affects each country in a different way due to a nation's individual history, traditions, culture and priorities" (Knight, 2003, p. 2). Within this study's context, globalisation is about the increased mobility of the medical workforce which has a positive and negative impact within both the country of departure and the host country (Laurence, 2008).

The internationalisation of health and the health workforce is more than the globalisation or the flow of health knowledge, technology, people and human capital. Internationalisation is also about developing relationships, such as memorandums of understanding and shared learning between health care systems (Forcier, Simoens, & Giuffrida, 2004; World Organization of Family Doctors, 2002). In addition, internationalisation refers to embracing the diversity of cultures within hospitals, primary health care settings and the wider community (Knight, 2003, 2004). With the definitions of globalisation and internationalisation of health care in mind, the increased mobility of the medical workforce will be discussed.

### **4.3 The migration of doctors and other health professionals**

Migration has accelerated over in the past few decades, with the migration of doctors and other health professionals from developing countries forming a large part of the globalisation of health care (Brown & Connell, 2004; Oman et al., 2009). Intrinsically migrant labour has been observed as a means of meeting job shortages within developed countries, from low-skilled to professional occupations, such as IMGs (Lindgren & Gordon, 2011; MacKenzie & Forde, 2009). Migrant workers, including IMGs, have also been observed to be a cheaper alternative to training within the country and to fill positions which many of the local population are unwilling to fill themselves (Birrell & Hawthorne, 2004; Kyriakides & Virdee, 2003).

The motivations for IMGs to migrate are a mixed number of complex push-pull and plant factors (Durey, 2005b; Klein et al., 2009). These factors range from political instability, family welfare, frustrations with career progression, a desire to gain competitive advantage, a lack of further education opportunities and economic reasons (Brown & Connell, 2004; Oman et al., 2009). In addition, there are other factors which influence migration, such as family and community ties in the country of destination.

There are also a number of countries, such as West Africa and Lebanon, where academic institutions, health professionals and the public maintain a well-developed view and culture of medical migration. This culture of further training abroad is not discouraged, but rather endorsed and encouraged by academic

institutions and often brokered by medical school instructors (Akl et al., 2007). It is to gain better working conditions, pay, training, and research opportunities and for those who return to their country of origin it provides a competitive advantage (Akl et al., 2007; Hagopian et al., 2005). Conversely, the culture of medical migration differs in the South Pacific, Cuba, India and the Philippines where the premeditation of occupational choice made by individuals is promoted and supplemented by governments. This choice in profession and investment in the over-supply of a country's own required professional needs ensures international migration transpires. This investment guarantees a migrant's remittances are sent home. This major source of income is to support relatives and supports the long-term development of the country of origin (Ahmad, 2005; Brown & Connell, 2004, 2006; Forcier et al., 2004; Goldfarb, Havrylyshyn, & Mangum, 1984; Kangasniemi, Winters, & Commander, 2007).

For example, in the 1980s, remittances from Filipino doctors practicing overseas were considered "large enough to compensate for the economic losses associated with emigration" (Forcier et al., 2004, p. 6). More recently, 80% of Filipino medical practitioners working in the public sector had applied or planned to apply to work overseas. Many were opting to work as nurses to secure better paying work overseas. This diaspora of Filipino medical practitioners and other health workers has "become one of the country's most valuable exports, sending billions of pesos back to the Philippines as remittances and taxes" (Cheng, 2009, p. 111). This economic motivation not only encourages and engenders individuals to continue to migrate but also has created incentives for governments to perpetuate a culture of medical migration.

#### **4.4 Human capital theory**

There are a number of theories which help to understand and explain the overarching notions of medical migration culture, internationalisation and globalisation. A number of these theories stem from the central theory of capital, which is used to inform the study and guide the research processes. Bourdieu (1986) states that capital is divided into three fundamental forms, human capital,

cultural capital and social capital theory. It is important to understand capital theory prior to understanding the various categories of capital theory.

The notion of capital, a concept and theory, was first established by Marx (1867). Marx identified capital being developed through the social relations between capitalists and their labourers to create profits (Bourdieu, 1986; Lin, 2001a, 2001b, 2008; Marx, 1867). Capital is therefore “a return on an investment in the production of useful commodities in the marketplace” (Lin, 2001b, p. 6). However, capital is also the process around the investment required and the production of a commodity, the ability to gain profit from the commodity that is reinvested (Lin, 2001a, 2001b).

In addition, neo-capital theories such as human capital theory, demonstrate labourers have the ability to procure capital themselves (Becker & Tomes, 1994; Lin, 2001b, 2008; Schultz, 1961). This theory was developed by Schultz (1961) and Becker (1962) who argue capital can be in the hands of the capitalist and also the labourer. The labourer obtains surplus capital and it is available to the labourer to re-invest rather than simply to sustain life. This excess can be invested in generating more capital and accumulating wealth and reduce the boundaries of class distinction while promoting upward mobility and health (Becker, 1962; Lin, 2001b; Schultz, 1961).

Human capital is therefore an “investment in technical skills and knowledge” (Lin, 2001a, p. 5). It is gained by obtaining and furthering education, having on the job training or work experiences which develop skills. The capitalist and the labourer are both allies in the production process, which in turn motivates the labourer to gain greater knowledge and skills (Lin, 2001b, p. 12). Human capital theory is also “the product of worker’s free will or self-interest” (Lin, 2001b, p. 14). It is related to a labourer’s acquisition of and investment in human capital, which improves the economic abilities of the individual (Sweetland, 1996). It requires a labourer’s self-investment to ensure a profitable return, regardless of what commodity they are hired to produce (Lin, 2001b).

To become fully registered as a doctor in a new country, an IMG needs to produce human capital at various stages. Firstly, the initial investment of education in medicine occurred in their country of origin. Secondly, a heterogeneous movement of these medical graduates from their country of origin to Australia has occurred in most cases because of free will and self-interest. This movement to Australia can be observed to be an investment in human capital, which may improve the economic abilities of the individual (Sweetland, 1996). Thirdly, there are policy requirements which elect to recognise or invalidate an IMGs current human capital (Colic-Peisker & Walker, 2003). Also, dependant of the amount of human capital which the IMGs already possesses, additional investment in human capital may be required to generate more capital or to enhance competitive position after arrival. All elements, however, are dependent on the current supply and demand for IMG labour (Lin, 2001b).

Human capital is also about being physically healthy and moving to areas where demand for skilled labour is higher. This demand is one of the underlying motivations, within many of the IMG studies, why movement away from rural areas occurs. IMGs and their families moved to where demand for skilled labour was higher (Durey, 2005b; Han & Humphreys, 2005; Kearns et al., 2006; Kilpatrick et al., 2011). As such,

Human capital theory... explains migration using an economic model: people migrate to places where their human capital—formal education and training, as well as their other ‘value-adding’ features—will attract higher profits, that is, where they can better ‘sell themselves’ on the labour market. (Colic-Peisker & Walker, 2003, p. 339)

Becker (1962) and Schultz (1961) maintain education and skills acquisition linked to wages, are core to human capital and the labourer’s major assets. The greater the human capital, the more capacity an individual has to obtain a better paying employment or be employed by larger and successful companies and firms (Lin, 2001a, 2001b). This process also impacts on an individual’s ability to invest in other

forms of human capital such as health, nutrition, quality of life. It can enlighten people, communities, and countries (Becker, Murphy, & Tamura, 1994; Sweetland, 1996).

While the actions or behaviours of individuals to generate capital may partially explain why IMGs move from a rural area, human capital theory does recognise other factors at play. These factors include gender, cultural background and other individual characteristics to generate capital that are less considered in human capital theory, but more so in cultural capital theory (Lin, 2001b).

## **4.5 Cultural capital theory**

In contrast to human capital theory, cultural (symbolic) capital theory argues structures such as gender, race and other individual characteristics interplay with the actions of individuals to generate capital (Lin, 2001b, 2008). For example, the dominant values or culture play a role in an individual's behaviour and ability to generate capital (Kim, 2001). This theory maintains dominant cultural characteristics are conveyed or reproduced through symbolic violence by the dominant society. This reproduction is achieved through the pedagogic instruction and the misrecognition that the ritualised practices of cultural values are of the whole society (Bourdieu, 1986; Lin, 2001b). They are, therefore contributory to individual actions, which ultimately impinge on capital generation (Lin, 2001b). Bourdieu (1986) goes further to divide cultural capital, the acquisition of non-financial social assets, such as skills, aptitude or education, into three distinct forms: the embodied, the objectified, and the institutional state.

### **4.5.1 The embodied state of cultural capital**

Firstly, the embodied state of cultural capital is the accumulation of cultural capital within one's self, or simply, the development or embodiment of culture (Bourdieu, 1986). It is a process of inculcation as an individual, within the family structure or scholastically (Bourdieu & Passeron, 1990). It occurs through acculturation, where cultural changes occur prominently in the less dominant group (Berry, 1997; Hunt et al., 2004; Salant & Lauderdale, 2003; Thompson et al., 2002).

However, it also occurs through the socialisation amongst peers, such as professional socialisation which is “the process by which people selectively acquire the values and attitudes, the interests, skills and knowledge – in short, the culture – current in groups of which they are, or seek to become, a member” (Merton, Reader, & Kendall, 1957, p. 278). For example, “the profession of medicine provides its members with a shared identity through commonality in entry criteria and a long socialisation [sic.] process which includes both knowledge and practice skills that create a common culture” (Shuval, 2000, p. 192).

Similarly, Clouder (2003, p. 215), in her study of the professional socialisation of occupational therapy students, has said “the individual is enveloped by the influence of various discourses, scarcely aware of changes to their own identity. In other words, professional socialisation is a process through which individuals are socially constructed and largely shaped into conformity.” The individual process of the embodied state of cultural capital can take time and often much energy; however, the process, depending on the individual, can be an unconscious process with minimal effort (Clouder, 2003). The process can depend on how it is transmitted within a structure and the time for each individual to obtain this capital.

#### **4.5.2 The objectified state of cultural capital**

Secondly, the objectified state of cultural capital is related to the procurement of “material objects and media, such as writings, paintings, monuments, instruments” (Bourdieu, 1986, p. 50). For this procurement to occur, it requires both economic capital, the procured of money as described previously, and an association with the embodied state of cultural capital. The embodied state of cultural capital allows the individual to possess the ability to use the material objects which have been procured with capital (Bourdieu, 1986).

For example, a number of IMGs may have the economic capital to develop and obtain cultural goods and tools such as communication skills to work more effectively in the workplace. As new cultural nuances, vernacular and colloquial speech may be required to communicate with the health seeking public or within the health profession (Lillis et al., 2006). However, without embodied cultural

capital (the ability to use these cultural goods), these skills may not be used successfully. As highlighted previously, this capital may require much energy or be relatively easy for some (Bourdieu, 1986).

#### **4.5.3 The institutional state of cultural capital**

Thirdly, the institutional state of cultural capital relates to the objectification of cultural capital. It is about placing cultural capital within the framework of “academically sanctioned by legally guaranteed qualification, formally independent of the bearer” (Bourdieu, 1986, p. 50). An academic qualification (certificate of cultural capital) requires economic capital investment, yet allows the holder to create greater economic capital. However, this is dependent on the type, scarcity and value placed on the certificate of cultural capital obtained (Bourdieu, 1986).

The institutional state of cultural capital for IMGs is the possession a certificate of cultural capital, meaning their medical qualification obtained in their country of origin. These qualifications have different values placed on them when not used in the country they were obtained. For example, in Australia, the values placed upon these qualifications are dependent upon the country and education system in which they were obtained (AMC, 2009a, 2012; MBA, 2010). The more comparable or equivalent an IMGs qualification is to an Australian medical qualification, the greater the recognition and value which is placed on it (AMC, 2009a, 2012; MBA, 2010).

### **4.6 Social capital theory**

Like cultural capital, social capital theory is another neo-capital theory where interplay between structure and individual action occurs. The social capital of IMGs and their families may be used to explain why a lack of employment, the loss of status or identity may increase an IMGs or a spouse’s isolation, feelings of inadequacy and lack of self-worth (Colic-Peisker & Walker, 2003; Wright et al., 2012). It must be noted, there is no one agreed definition of social capital; however, in a review conducted by Portes (1998), concerning the origins and definitions of social capital, he provides some understanding of social capital by inferring:



Economic capital is in people's bank accounts and human capital is inside their heads, social capital inheres in the structure of their relationships. To possess social capital, a person must be related to others, and it is those others, not himself, who are the actual source of his or her advantage. (Portes, 1998, p. 7)

Furthermore, (Kilpatrick, Field, & Falk, 2003, p. 419), in their critique of McClenaghan's (2000), definition of social capital and its link with community development, further explain and outline what social capital is by asserting that:

Social capital is a resource based on relationships among people. In particular, most definitions focus on membership in networks and the norms that guide their interactions. These in turn generate secondary features such as knowledge and trust, which then facilitate reciprocity and co-operation.

Regardless of the debate, there are three schools of thought regarding social capital. Firstly, it has been defined by Putnam (1995), sociologically, as a community level resource which has "features of social organisation such as networks, norms and social trust that facilitate coordination and co-operation for mutual benefit" (Putnam, 1995, p. 67). However, another definition regards social capital, economically, as an "investment in social relations with expected returns in the marketplace" (Lin, 2001b, p. 19). It allows the "cultivation of goodwill, fellowship, sympathy and social intercourse among those that make up a social unit" (Lê & Kilpatrick, 2008, p. 4). Put simply, social relations, interactions and networks create capital in the marketplace, such as an economic or political marketplace, a community, neighbourhood or even the global society (Bourdieu, 1986; Coleman, 1988; Coleman, 1990; Esser, 2008; Lin, 2001a, 2001b, 2008; Seibert, Kraimer, & Liden, 2001).

The second school of thought has been described by Bourdieu (1986) as being on an individual level and within an individual's social networks (Baum & Ziersch, 2003). It is defined as "the aggregate of the actual potential resources which are linked to possession of a durable network of more or less institutionalised relationships of

mutual acquaintance and recognition” (Bourdieu, 1986, p. 248). Lastly, Coleman’s (1988; 1990) less used definition of social capital is used in terms of an educational process (Baum & Ziersch, 2003). In addition to the three schools of thought, of which the first two underpin the study, Baum and Zierch (2003) added, there are also structural (social networks, community and associations) and cognitive (trust, norms, reciprocity) elements to social capital.

A common feature of social capital is that it is reliant on four resources that are imbedded in social ties for it to work effectively. These resources include a flow and access of information; influence and trust being exerted on others; social credentials or trust created by social ties, and a reinforcement of identity, norms and recognition (Esser, 2008; Falk & Kilpatrick, 2000; Lin, 2001b). Furthermore, (Esser, 2008, pp. 24-25), in his discourse of social capital, argues there is an additional two resources to social capital, which are defined as;

the production of support, help and solidarity [and] the availability of social control and a certain level of attention on the fate and action of other members of an entire network... like in the family, among relatives or in the neighbourhood.

#### **4.6.1 Different types of social capital**

In addition, there are different types of social capital that are emphasised by their individual and collective distinctions (Kawachi, Kim, Coutts, & Subramanian, 2004; Lin, 2001b). Individuals can use the resources of social relationships for their own benefit; they can profit from investment in social relationships. These investments have been coined *relational capital* (Esser, 2008). A by-product of such individual social relationships can include improved health outcomes (Kawachi et al., 2004). However, social capital is also used collectively for an entire network to gather or pass on information, as a social control, morality and system of trust within a community or society, known as *system capital* (Esser, 2008). Both relational and system capital are relevant to the current study as they both provide a framework to understand those connections that are made within the workplace and also connections both within and external to a community.

#### **4.6.1.1 Relational capital**

Relational capital is an individual's own resources or income that is invested in other individuals who are willing to provide (reciprocate) those same resources when and as needed. From this perspective, relational capital is much like economic or human capital, as its main purpose is the procurement of capital (social income). Thus in a similar vein to economic capital, investments in social relationships, which prove to be less or non-profitable, are either not undertaken or are abandoned promptly (Esser, 2008).

For example, it was noted those medical professionals who did not reciprocate resources such as clinical and collegial assistance toward those IMGs who invested time in rural practice, impeded professional, practice and community integration (Gilles et al., 2008; Han & Humphreys, 2005). Conversely, those health professionals who provided resources to IMGs then experienced a greater reciprocity (Durey, 2005b; Kilpatrick et al., 2011). As outlined previously, those professionals such as IMGs who are positively supported by capacity building and innovative community ownership have been observed to be increasingly loyal with aspirations to remain longer in communities than required (Fleming et al., 2001; Han, 2010; Kilpatrick et al., 2011).

#### **4.6.1.2 System capital**

Unlike relational capital, system capital is disconnected from the individual actors and is not the product of individual investment (Coleman, 1990). System capital exists through the interaction between actors. It is the shared social norms, a collective or public good, which powerfully guides each member's behaviours within a group. "All actors in either a network or collective profit from system capital independently of whether they have invested in it" (Esser, 2008, p. 37). All are interested in its development but often there is a lack of investment by its members (Esser, 2008).

Within the hospital or community practice setting, each member of the hospital or medical network, collectively profit from the divisions of system capital. This benefit is achieved through trust within each member of the group and has an impact on collective information sharing and the inhibition of incongruous practices or

behaviours (Esser, 2008). However, system control may be problematic as racial intolerant behaviour from other local health professionals can lead to a lack of trust and a reduction in collective information and resource sharing. Durey's (2005b) rural Western Australian study is an example where system capital can also work in opposition to the collective good. Racial intolerance was maintained as the norm within a medical practitioner group and became the norm of the community and led to poor retention of IMGs (Cohen & Prusak, 2001; Coleman, 1988; Durey, 2005a; Durey, 2005b).

In addition to social capital theory where the interplay between structure and individual action occurs, bonding and bridging social capital requires discussion as intrapersonal and interpersonal relationships both play a central role in IMG adaptation and acculturation.

#### **4.6.1.3 Bonding and bridging social capital**

The late 1990s saw social capital being redefined into *bonding* and *bridging* forms of social capital (Baum & Ziersch, 2003; Kawachi et al., 2004; Pretty, 2003; Szreter & Woolcock, 2004). Bonding social capital is the trust and co-operation between members of a network who have similar social identity. This network may include those who share the same ethnicity, are part of local groups, which include guilds, societies and sporting clubs (Baum & Ziersch, 2003; Kawachi et al., 2004; Pretty, 2003; Szreter & Woolcock, 2004). In other words,

bonding capital is developed via associations within one's more core community that may include voluntary organisations, religious institutions and residential enclaves. Bonding social capital reinforces exclusive identities (i.e., race, ethnicity, gender, class) and defines the scope of societal interactions. (Manzano, 2007, p. 125)

Bridging social capital is about bridging between *structural holes*, the gaps or separation between different networks that occur between individuals and across groups, such as the separation between CALD groups and the dominant population (Burt, 1992; Lancee, 2010). These connections between gaps in networks are made amongst individuals who may be unlike, but may be equal because of their status

and power (Kawachi et al., 2004). For example, an IMG may be from a CALD background, but due to the IMGs status and power as a doctor they can make connections across gaps in networks, thus, making social connections with local doctors or other IMGs from alternate CALD backgrounds. Thus, bridging social capital is “defined by inclusive social connectedness across lines of class, ethnicity, gender, race, and broader lines of community building” (Manzano, 2007, p. 125).

When focusing on the different forms of social capital among migrants, little is known. Lancee (2010), amongst others (Portes, 2000) has focussed on economic returns of migrants, whereas Kim’s (2001) seminal work has focussed on cross-cultural adaptation through intercultural communication. Each academic has explained that bridging social capital (intercultural networks and communication) produces greater opportunity for economic capital growth, upward mobility and greater cross-cultural adaptation (Kim, 1977; Kim, 2001; Lancee, 2010; Portes, 2000). However, bonding social capital (intracultural networks and communication) through CALD community ties remains a valuable social and economic resource for a number of individuals (Lancee, 2010).

In studies, conducted by (Kuo & Tsai, 1986), Thompson et al. (2002) and Bagchi (2001), migrants with tertiary education, who desired to or had obtained professional employment, were not only required to, but wanted to be involved within the host culture. This process gradually provided a greater integration within the wider community, but more so in the professional subculture (Bagchi, 2001; Kuo & Tsai, 1986; Rogler, 1994; Thompson et al., 2002). It is noted within Bagchi’s (2001) study, immigrant professional connections with host communities were dependent upon gender, where male rather than female doctors had greater connections with host communities.

Immigrant professional connections with host communities have also been observed amongst IMG and other professional or skilled migrants in rural Australia. These migrants had a desire to contribute or be part of the community by participating in social activities such as sports and actively contribute through volunteering (Han & Humphreys, 2005; Kilpatrick et al., 2011). Lancee (2010)

maintains bridging social capital (intercultural networks and communication) creates greater opportunities, whereas bonding social capital (intracultural networks and communication) can limit opportunities (Kim, 1977; Kim, 2001; Lancee, 2010). In other words, “bonding social capital is to get by, bridging social capital is to get ahead” (Lancee, 2010, p. 2).

Nevertheless, Coleman (1988; 1990) argues that closure within bonding social capital networks can also be positive. These networks offer increased reliable communication and safeguards against exploitation. In addition, there are also opportunities within these close knit networks to gain employment and produce economic capital. However, “the relationship between social capital and labour market outcomes is stronger for bridging than for bonding social capital” (Lancee, 2010, p. 6). (Colic-Peisker & Walker, 2003, p. 351) state that, within large CALD concentrations, such as Liverpool, a suburb of Sydney, there is “a high level of community support, but also a high level of community control and pressure.”

What had been observed was as social capital from networks and connections with the wider community are reduced, a greater development of social capital in the form of familial support preserves the culture aspects from a home country (Gold, 1995; Hagan, MacMillan, & Wheaton, 1996; Portes, 1998; Valenzuela & Dornbusch, 1994). What remains less well articulated in the literature is what occurs to individuals or small family units when social capital from both community networks and greater familial support are reduced or absent? What forms of social capital are developed or used in these circumstances? If social capital is underdeveloped or absent for individuals, such as IMGs or members of their family, are these vital factors impacting rural acculturation and long term retention (Alexander, 1998; Colic-Peisker, 2009; Stanley & Bennett, 2005). These are a number of questions that the study aims to answer.

In contrast to the economic returns of migrants through bonding and bridging social capital, Kim (2001) sheds light on cross-cultural adaptation through intercultural communication. Kim (2005) explains, intercultural communication increases a migrant’s ability to adapt within a new cultural environment. As previously

highlighted, there are obscured demands and pressures through symbolic violence by the dominant society to conform. New migrants are unconsciously compelled to meet these demands, to learn and change, which leads to growth and adaptation (Bourdieu, 1986; Kim, 2001). This adaptation has been shown to predict greater mental health among IMGs in the US (Atri et al., 2011).

Nevertheless, this is dependent upon three key processes. Firstly, the preparedness a migrant is for an anticipated change. Secondly, the cultural proximity or cultural similarities between the IMGs and the dominant culture, the greater the similarities, the less the demands placed upon the individual. Thirdly, it is dependent upon the adaptive personality of both the migrant and those within the migrant's bridging social capital network (Kim, 2001; Kim, 2005; Lancee, 2010).

Intercultural communication through bridging social capital networks plays a key role in cross-cultural adaptation. The dominant language of the host community is often imposed on migrants, who then are required to instinctively conform (Kim, 2001). For example, intercultural communication challenges may occur within the doctor-doctor and the doctor-patient relationship. It is these encounters where nuances, vernacular and colloquial speech may be required to communicate effectively, yet these forms of social interactions can be achieved, but less accepted or at times not well understood by migrants (Kim, 2001; Lindström, 2008; Pilotto et al., 2007; Steinert, 2003). Through this type of dialectic process, individuals adapt and grow from the experiences they encounter. Kim's (2005) integrative communication theory of cross-cultural adaptation states this is the *stress-adaptation-growth* dynamic which leads to adaptation, health and wellbeing in the new environment.

It is through this mode of interaction with others where a migrant, such as an IMG can secure information, cultural learning and further bridging social capital (intercultural) networks (Kim, 2001; Lancee, 2010). It is the development of greater bridging social capital networks which govern and reinforce the language migrants are required to use. It is this language which conveys the implicit or explicit messages of dominant cultural values and social sanctioned norms (Kim, 2001).

When wanting to understand the bridging social capital networks of IMGs, there is a need to first look at the immediate opportunities and platforms, such as the workplace, for these networks to occur.

In the study of the personal development of core identity in medical students, Cohen, Kay, Youakim, and Balacius (2009), found “group membership in the guild of physicians is an old and strong component of physician identity. Medicine is its own culture, with its own power hierarchy, its own language, its own inside jokes” (Cohen et al., 2009, p. 45). The medical fraternity are dominant members of both the *micro* and *macro* societies (Durey, Thompson, & Wood, 2011). There are demands and pressures which are enforced through symbolic violence of the dominant hospital culture, where implicit rules and the unwritten expectations are not always positive (Kitto, Petrovic, Gruen, & Smith, 2011). Within the dominant hospital culture there are elements of institutional stigma, which impose oppressive conditions against those of different race or culture. The dominant culture is well understood in terms of patient care; however, between staff it is less well articulated (Durey et al., 2011; Henry, Houston, & Mooney, 2004).

Nevertheless, as IMGs enter this new medical fraternity, where they have been initially uprooted from supportive ties, these migrants, much like other migrants are “keenly aware of the vital role that interpersonal relationships play by offering a personal community through which they can receive informational, technical, material and emotional support for their functioning in the new environment” (Kim, 2001, p. 75). In many circumstances, support is available for IMGs through official rural workforce agencies to meet the informational, technical and at times material support (DoHA, 2011b; Organisation for Economic Co-operation and Development, 2007; RHWA, 2011a). However, it is the interpersonal relationships, developed through intercultural communication in the workplace, which plays a central role in IMG workplace adaptation and community acculturation (Kim, 2001).

#### **4.7 Acculturation: from concept to context**

Acculturation was originally defined by anthropologists as a process of interactivity between cultures (Redfield, Linton, & Herskovits, 1936). It was later redefined to



denote the process of accommodation with eventual (and irreversible) assimilation into the dominant culture group (Thomson & Hoffman-Goetz, 2009, p. 983). A more contemporary definition of acculturation is the maintenance of the original culture and the development of relationships with the new culture, where changes to an individual's social and economic contexts are often ignored (Spielberger, 2004; Thompson et al., 2002; Thomson & Hoffman-Goetz, 2009).

Acculturation was once viewed as a linear and uni-dimensional process (Hunt et al., 2004; Salant & Lauderdale, 2003; Thompson et al., 2002). However, it is now regarded as a multifaceted bi-directional process where migrants adopt aspects of the new culture, while retaining elements of their original culture. It remains a continuously redefining process, which can lead to changes in the cultural patterns of both migrant and host communities. Nevertheless, this is not always an automatic process and occurs prominently in the less dominant group (Berry, 1997; Hunt et al., 2004; Salant & Lauderdale, 2003; Thompson et al., 2002).

Berry and Sam (1997; 1997), in their seminal work, regarding the bi-dimensional model of acculturation, highlight there are many variations of cultural groups within multicultural societies. As shown in Figure 4.1, these cultural groups are dependent upon their mobility, voluntariness and permanence. For example, the acculturation experience can be quite different between immigrants when compared to sojourners who stay on a more temporary basis.

		Voluntariness of contact	
		Voluntary	Involuntary
Mobility	Sedentary	Ethno-cultural groups	Indigenous peoples
	Permanent migrant	Immigrants	Refugees
	Temporary migrant	Sojourners	Asylum seekers

**Figure 4.1: Types of acculturating groups**

Source: (Berry & Sam, 1997). Adapted with permission.

For example, Indigenous populations experience acculturation without seeking it whereas voluntary immigrants are more likely to seek acculturation where both the original and new cultures are endorsed in a bicultural manner. However, Schwartz and colleagues (2010), have argued “biculturalism” can manifest in many ways. It can occur when an amalgamation or a hybridisation of two cultures transpires, where language values and behaviours are diametrically opposed when observed within various contexts, such as work and home. Regardless of the depth and level of hybridisation or dichotomy occurring among migrants, it is argued, “the psychological processes that operate during acculturation are essentially the same for all groups” (Berry & Sam, 1997, p. 296).

Additionally, Berry (1997) highlights the acculturation strategies used by individuals and groups are achieved by addressing two factors. The first is related to the continuity of cultural maintenance while the second is related to having contact and participation with the host community. These two factors, when addressed concurrently generate four acculturation categories. These categories or strategies of acculturation are highlighted in Figure 4.2 and include

assimilation (acquires the receiving culture and discards the heritage culture), separation (rejects the receiving culture and retains the heritage culture), integration (acquires the receiving culture and retains the heritage culture), and marginalisation (rejects the receiving culture and discards the heritage culture). (Schwartz & Zamboanga, 2008, p. 276)

		Issue 1: Is it considered to be of value to maintain cultural identity and characteristics?	
		YES	NO
Issue 2: Is it considered to be of value to maintain relationships with dominant society?	YES	Integration	Assimilation
	NO	Separation	Marginalisation

**Figure 4.2: Acculturation strategies**

Source: Berry and Sam (1997). Adapted with permission.

#### 4.7.1 Framework and understanding of acculturation

Initially, earlier definitions of acculturation focused on group acculturation and did not consider individual acculturation. Individual acculturation was also coined 'psychological acculturation' which was defined as a change in the psychology of the individual (Berry, 1997; Maynard-Reid, 2005). Berry (1997) established this phenomenon when he acknowledged acculturation could occur to an individual's group, yet could be observed differently between individuals within the group. Individual acculturation that is experienced differently by each individual occurs in three complex phases. These phases include behavioural shift, culture learning, and social skills acquisition with elements of culture shedding or deculturation. This culture shedding is where the unlearning of one's previous life occurs as it is no longer required and internal transformation transpires (Kim, 2001). Nevertheless, individuals may experience culture conflict, where new behaviours are in opposition with the individual. This cultural conflict produces challenges and leads to acculturative stress also known as 'culture shock' (Berry, 1997; Muecke, Lenthall, Lindeman, & Lindeman, 2011). Thompson et al. (2002, p. 682) outlines the process of migration and resettlement by identifying

- three broad transitions that are mediated by age and gender: (i) changes in bonding and the reconstruction of social networks, (ii)

extraction from one socioeconomic system and insertion into another, and (iii) the transition from one cultural system to another.

Each of the broad transition elements of migration and settlement are discussed in detail below.

#### **4.7.1.1 Changes in bonding and the reconstruction of social networks**

Firstly, changes in bonding and the reconstruction of social networks occur as an individual migrates, as they are separated from their usual network of family, friends and neighbours. It is superseded by the development of new social networks in the host society (Kuo & Tsai, 1986; Rogler, 1994; Thompson et al., 2002). The ability to successfully re-establish social networks and relationships in the host society with low-density heterogeneous networks can protect the mental health of immigrants, such as IMGs, as outlined previously (Atri et al., 2011). Additionally, similar CALD community support also remains beneficial; however, high-density networks within a CALD group can prove to be disadvantageous as they restrict the development of social interaction of the greater heterogeneous community (Kuo & Tsai, 1986; Rogler, 1994; Thompson et al., 2002). Nevertheless, migrants at times lack the confidence to negotiate social structures that are a dominant and unfamiliar culture. They may make “a conscience choice not to negotiate a cultural structure that differs from their own due to issues of mistrust” (Maynard-Reid, 2005, p. 13).

#### **4.7.1.2 Withdrawal from one socioeconomic system into another**

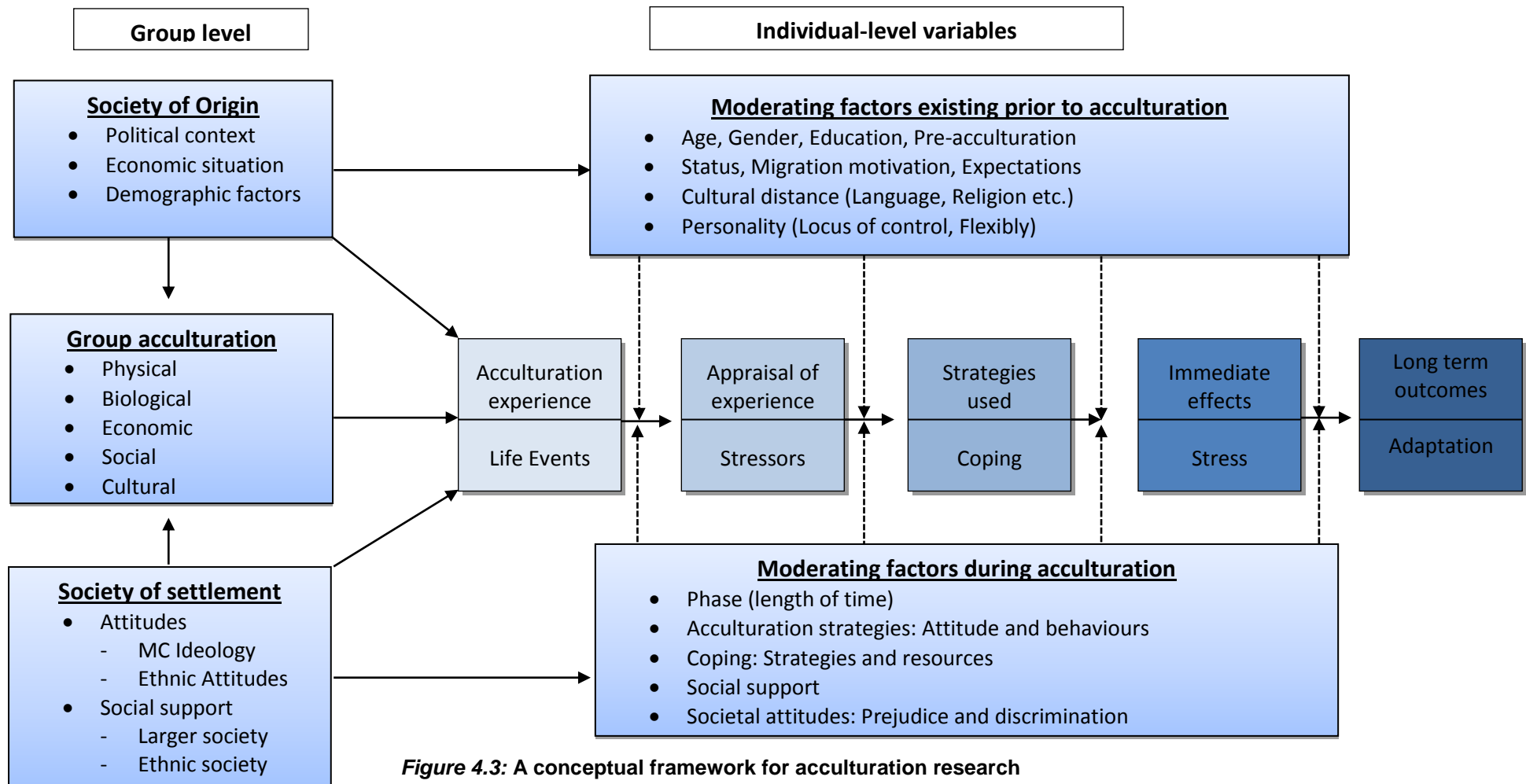
The second element of migrant transition involves the withdrawal from one socioeconomic system into another and leads to migrants ‘starting over.’ For example, as IMGs enter Australia, as migrants, sojourners or refugees, they often enter their occupation at a lower standing than previously experienced (Thompson et al., 2002; Vega & Rumbaut, 1991). In addition, limitations often occur due to discrimination and can discontinue the satisfaction of their role as a spouse, parent or provider (Thompson et al., 2002; Vega & Rumbaut, 1991).

#### **4.7.1.3 Transition from one cultural system to another**

The third and major element of the migration transition is moving into a society with different cultural beliefs and acquiring elements of the host culture. At times, this may be challenging as this transition may involve a shift in from a collectivist society. These societies are where family or community interests take priority or outweighs the interests of individuals. As such, when a migrant enters an individualist society, such as Australia, often the interests are in contrast to the familiar collectivist view (McLaughlin & Braun, 1998; Thompson et al., 2002).

#### **4.7.1.4 The conceptual framework for acculturation**

Overall, Berry and Sam (1997), provide a framework that also highlights group and individual acculturation. Their framework demonstrates the features which existed prior to acculturation and also the features that occur during the acculturative process. Initially, a collective group can undergo changes such as political, economic changes and even social structures of the group can change. In addition, these changes can also occur at the individual level. These changes occur under the guise of behavioural shifts, acculturative stress and psychopathology (problems, crises and mental health issues) which lead to ultimate adaptation of the individual, as shown in Figure 4.3.



Source: Berry (1997). Adapted with permission.

There is an understandable flow within the framework; however, the nature of the flow is decidedly variable between individuals. It is dependent upon many factors within the group, individual factors pre-acculturation and during the acculturative process. For example, sub-groups within the specific CALD may face differing degrees or levels of challenges throughout the acculturation process. Another example may be younger migrants experience fewer acculturation challenges, when compared to older migrants from the same CALD (Schwartz et al., 2010). These overarching factors and the numerous variables impact the acculturation process. It is not a 'one size fits all' process (Schwartz et al., 2010). The factors and variables cannot be ignored when researching and understanding the acculturation of individuals or groups (Berry, 1997; Berry & Sam, 1997).

#### **4.7.2 Cultural and professional acculturation and identity**

As discussed, acculturation occurs when an individual migrates, is separated from a familiar social network and the development of new social networks and identity in the host society occurs (Kuo & Tsai, 1986; Rogler, 1994; Thompson et al., 2002). The ability to successfully establish social networks in the host society with heterogeneous networks as well as CALD community support is beneficial. However, a plethora of social factors are involved in the acculturation process and identity reconstruction.

While researching refugee migrants in Australia, Colic-Peisker and Walker (2003), argued there were three essential elements of human capital which aide acculturation and forms social identity. The three elements include skills, language, and an individual's sense of place within a given environment. An individual's sense of place is a profound symbolic centre of meaning and experience. Place is fundamental to human existence, individual identity and psychological wellbeing. It is more than an individual's experience, but has collective social meaning, which also brings about the perception of belonging and collective identity (Godkin, 1980, pp. 73-74). Intrinsically, these elements are determined by the nature of the interface within a new social context, where the process of acculturation and identity re-building occurs (Colic-Peisker & Walker, 2003; Kim, 2001).

In addition to migrant characteristics, acculturation and identity re-building are also determined by the reception of the community in which an individual lives (Berry, 1997; Hunt et al., 2004; Salant & Lauderdale, 2003; Thompson et al., 2002). For example,

visibility, cultural distance from the host society, human and social capital represented in the group—and the host society with its specific treatment of immigrants, through official policies and informal encounters, create a series of cumulative, compounded and mutually reinforcing actions and reactions that determine the shape and direction of the processes of acculturation and identity re-building. (Colic-Peisker & Walker, 2003, p. 339)

Lastly, as outlined in section five of chapter three, for most migrants, employment is the crux of one's identity (Kielhofner, 2004; Mpofu, 2008; Shuval, 2000), which is achieved through their human capital or the formal recognition of their human capital (Colic-Peisker & Walker, 2003; Robinson & Coleman, 2000). In turn, this can improve social identity and successful acculturation within a community or society (Colic-Peisker & Walker, 2003; Robinson & Coleman, 2000). As such,

The most urgent and profoundly felt need of an immigrant is to re-establish a meaningful sense of identity of which the professional component is a major element. Professions provide such a sense of identity and belonging to a community which has a common set of norms and values; these set boundaries which define those who are on the 'inside' and those who are not. (Shuval, 2000, p. 192)

However, if the human capital of norms and values is not recognised, such as one's medical qualifications, a migrant's sense of identity is also invalidated (Colic-Peisker & Walker, 2003). For example, the absence of acknowledgment of an IMGs' identity in the host country may be remedied through the investment of human capital, such as undertaking AMC examinations and further medical training.



In addition to human capital, acculturation, although a complex process, is firstly determined by social capital, as discussed previously, which is the investment in social relations and networks which create a return for individuals (Bourdieu, 1986; Coleman, 1988; Coleman, 1990; Esser, 2008; Lin, 2001a, 2001b, 2008; Seibert et al., 2001). Secondly, acculturation is determined by the new country's capacity to recognise a migrant's human capital and lastly, the capacity to provide access to re-invest in congruent human capital. This re-investment may take many forms, such as developing language proficiency and obtaining formal education and qualifications. It also requires an improved reception of the community where a migrant is living (Colic-Peisker & Walker, 2003).

International Medical Graduates, as they enter and live in a new society, acculturate, but this also occurs as they enter the Australian medical system. For example, IMGs may be required to shed ethnomedical systems and retrain as their known biomedical training or therapies may be dissimilar (Fiscella & Frankel, 2000; Han & Humphreys, 2005; Inhorn, 2003; Inhorn & Buss, 1994; Pilotto et al., 2007). In addition, IMGs may need to acculturate and develop new medical practitioner identities, particularly when an IMG is faced with a new 'colloquial' language, new or challenging types hierarchy and perplexing doctor-patient relationships (Atri et al., 2011; Han & Humphreys, 2005; Lillis et al., 2006; Pilotto et al., 2007). These changes in role behaviours and conforming to required social interactions are achievable yet are not always well understood or accepted (Kim, 2001). However, there are a number of identified factors which aid IMGs to successfully acculturate as they live and work in a new country, particularly in rural contexts.

#### **4.7.3 Factors identified as part of successful acculturation**

To comprehend successful acculturation, an understanding of the types of IMGs who work in rural contexts is required. One formative study, conducted by Han and Humphreys (2006), examined the integration and retention of IMGs in rural Australian communities. The study revealed four 'types' of IMGs. Coined by Han and Humphreys (2006), they included IMGs who lived in the city, but worked in rural areas, 'satellite operators'; IMGs who affiliated with city fringe areas, 'fence sitters'; IMGs uncertain about their future settlement place, 'the ambivalent'; and IMGs

who were integrated into the community, ‘The integrated’ (Han & Humphreys, 2006; Klein et al., 2009), as shown in Figure 4.4.

Urban ↑	<b>Satellite Operators:</b> Families settle in the city; the doctors commute to work until they are allowed to practise in the city	<b>The Ambivalent:</b> Appreciates rural life and practice, but unsure about long term rural settlement; may settle either rural or urban
	<b>Fence Sitters:</b> Enjoy the advantages of both rural and urban life and practice, unable to live away from the city	<b>The Integrated:</b> Appreciates rural life and practice; able to live as a minority; pragmatic about the limits of rural communities
		Rural →

**Figure 4.4: Typology of IMGs**

Source: Han and Humphreys (2006). Adapted with permission.

To understand the types of IMGs who live and work in rural Australia, the literature reveals there are a number of factors that contribute to successful acculturation. As such, successful acculturation occurs when an individual “acquires the receiving culture and retains the heritage culture” (Schwartz & Zamboanga, 2008, p. 276). However, as outlined previously, acculturation of an individual is mediated by the society of origin, cultural background, gender and age (Berry, 1997; Berry & Sam, 1997; Kilpatrick et al., 2011). It is also determined by the cultural distance to, social support of and acceptance from the community including the individuals own capacity to acculturate, as observed previously in Figure 4.3, on page 99 (Berry, 1997; Berry & Sam, 1997; Han & Humphreys, 2006; Kilpatrick et al., 2011).

With these factors in mind, Han and Humphrey’s (2005) study of community integration of IMGs in rural Victoria had identified a number of key factors that aided successful acculturation of IMGs in rural communities. This study clearly identified migrants who were better-educated were able to adapt better in new communities and integrated swiftly in smaller rather than larger communities (Han & Humphreys, 2005; 2006). However, within another Victorian study, it was also noted

[International Medical Graduates] from Commonwealth Asian nations characterised by strong exposure to English and British-based education systems (such as India, Singapore and Malaysia)... typically encounter[ed] fewer post-migration barriers than doctors derived from a broad range of non-Commonwealth nations. (Hawthorne et al., 2007, p. 28)

Moreover, those IMGs who were more cognizant regarding the requirements of the 10-year moratorium were more predisposed to being more integrated with the communities in which they were placed. This integration was regardless of their cultural, religious and rural or urban background (Han & Humphreys, 2006).

In addition to an IMGs background, Han and Humphreys (2005), found the length of stay in rural Australia positively related to an IMGs ability to cope with life as a migrant particularly in rural settings. Moreover, doctors with an Australian spouse or who practised rural medicine prior to migration were more familiar with the benefits of rural life as a sense of place (Han & Humphreys, 2005; Hancock et al., 2009). This finding is clearly demonstrated from a number of other Australian studies where Asian migrants married to locals had shorter trajectories to acculturation. (Kelaher, Williams, & Manderson, 2001; Thompson et al., 2002). The social networks developed in these relationships may be vital in adapting to Australian life (Kelaher et al., 2001; Thompson et al., 2002).

## **4.8 Conclusion**

This chapter introduced the theoretical standpoints of human, social and cultural capital as the framework and lens to guide the study. These theories were used to highlight internationalisation and globalisation of health workforce, which included a discussion surrounding the human and social capital of migrants in new social and workplace environments. These theories help to develop an understanding of the acculturation and identity challenges IMGs encounter in new cultural and healthcare contexts.

In addition, social capital was further delineated into bridging and bonding social capital. Bonding social capital, intracultural communication and networks, allow an IMG to access their respective CALD, which is vital for IMGs and migrants alike. However, it was highlighted increasing bridging social capital, intercultural communication and networks provide access to the wider community and have been demonstrated to play a key role in cross-cultural adaptation and ultimately acculturation of IMGs. Nevertheless, this is dependent upon each individual's ability or personality to make a large number of reciprocal acquaintances. Those who have this ability or personality, adapt quickly and more easily, when compared to other individuals.

The overview of both international and Australian IMG literature has highlighted a number of key findings, which remains unanswered. These key findings include what key characteristics enable IMGs to acculturate and, therefore experience improved retention rates within rural practice and community. These questions will be answered in the current research as it aims to explore the experiences and challenges of IMGs living and working in rural and remote areas of Tasmania, and how this informs the acculturation process. Intrinsically, the next chapter outlines the methods used to collect the data and the analytical framework of the study.

# **Chapter five: The study design**

## **5.1 Introduction**

The preceding chapter has provided the theoretical concepts and framework underpinning the study of IMGs in the Tasmanian context. This chapter describes the research framework and mixed method design of the study to address the research questions. It also discusses the rationale and the methodologies used for data collection. In employing a mixed method design, the study involved data collection from both IMGs and key informants. Data collection was achieved by conducting a questionnaire with IMGs. In addition, semi-structured interviews were conducted with both key informants and IMGs. The chapter concludes with a discussion regarding the analytical frameworks which guided the analysis of the data including thematic analysis and Critical Discourse Analysis (CDA).

## **5.2 Methodological framework of the study**

The methodological framework aids to inform and guide the research approach. A review of the literature indicated many commensurate IMG studies were framed by many theories. These included hypothesis testing, ethnography, phenomenology, social critical theory, critical realist theories and socio-cultural educational theory with the most common frameworks being human, social and cultural capital theories. The remaining studies were relatively 'silent' regarding their theoretical framework. Many did not specify or articulate their theoretical standpoint at all. However, these studies were clearer regarding their analytical framework.

This study draws on phenomenology and human, social and cultural capital theories while also being informed by acculturation. These theories allow a more developed understanding of the complexities concerning the discourse of IMGs in Tasmania. Phenomenology is a philosophy where reality is viewed to be constructed from our own experiences and beliefs (Carpenter, 2010; Creswell, 1998; McConnell-Henry et al., 2009). It is also a research approach in which phenomena are explored (Carpenter, 2010, p. 72). Phenomenology is the study of the everyday subjective

experiences of an individual's lived world – the life-world (*Lebenswelt*), where meaning is shaped and produced continuously (Bowling, 2005; Greenhalgh, 2007; Liamputtong & Ezzy, 2005).

However, this life-world is different for each individual and the actions of an individual can be best understood by placing them within the context of their own life-world. This is where an individual's own life-world, according to Liamputtong and Ezzy (2005, p. 18), includes:

taken-for-granted assumptions about everyday life, such as what clothes should be worn, what the weather will be like, the way you should greet a friend, where to write from left to right or right to left and how to deal with embarrassing events.

Thus, phenomenology's strengths are in its ability to provide a "rich, in-depth understandings about social phenomena in their natural settings, which cannot be captured by quantitative methodologies" (Wong & Lohfeld, 2008, p. 54). Its purpose is to allow a researcher to borrow "people's lived experiences so that the researcher can better understand the meaning or the significance of the event" (McConnell-Henry et al., 2009, p. 2).

Phenomenology has become a popular and widespread theory in many disciplines concerned with human experience such as nursing, sociology, social work, psychology, education and health (McConnell-Henry et al., 2009). While the use of phenomenology in IMG studies is somewhat limited, phenomenology is well established as a significant theory in other areas within the health sciences. For example, phenomenology has been used to explore the lived experience of childhood cancer survivors (Karian, Jankowski, & Beal, 1998); what it means to be HIV positive in pregnancy and motherhood (Sanders, 2008); or the lived experience of migrants in an acute health care settings (Vydelingum, 2000).

Phenomenology will be used primarily to guide the qualitative aspects of this study concerning IMGs, whereas an interpretive research approach will be used for key informants. Phenomenology will help to understand the world of lived experience

of IMGs living and working in Tasmania and how this may impact the acculturation process of IMGs as they migrate (Berry, 1997; Berry & Sam, 1997; Schwartz & Zamboanga, 2008; Van Manen, 1990). Conversely, the interpretive research approach is used among key informants as it is through their perceptions, observations and interactions with IMGs that additional key data is gained. This approach is used as the lived experience of an IMG is unable to be provided through a key informant, no more than the lived experience of a cancer survivor can be provided through their medical practitioner. Phenomenology theory is a fundamental source of research understanding and is not attainable through other research methodologies, particularly those of a quantitative nature (Campbell, 2011; Van Manen, 1990; Wong & Lohfeld, 2008). As such, it will generate a depth of understanding relating to IMGs acculturation, health and wellbeing.

Within the literature, only two IMG studies employed phenomenology. The first is a Canadian study conducted by Wong and Lohfeld (2008), which aimed to gain an in-depth understanding about the social phenomena of the recertification training experiences of IMGs. They aimed to improve the integration of IMGs into the medical community. The second study conducted by Gilles, et al. (2008), examined IMGs working in rural and remote Australian Aboriginal health settings. They observed the everyday subjective experiences of the lived world from the perspective of both the IMGs and those with whom they had contact. This observation included spouses, co-workers and members of the Aboriginal and Torres Strait Islander community (Bowling, 2005; Gilles et al., 2008; Greenhalgh, 2007; Liamputtong & Ezzy, 2005).

Although IMGs in remote Aboriginal settings had been studied previously (Arkles, Hill, & Pulver, 2007), the study provided the perspectives not only of the IMGs, but also those of Aboriginal Community Controlled Health Service (ACCHS) staff and community members. The study endeavoured to highlight a number of distressing and challenging situations these doctors and their families encountered. These experiences of the lived world were not only concerning the world of remote areas of Australia, but also the complexities and the cross-cultural challenges of working within the ACCHS and Aboriginal communities (Gilles et al., 2008). The study,

although poignant, was left wanting in terms of gaining greater understanding and insight into the deeper issues faced by IMGs and the communities they were servicing.

### **5.2.1 The key mixed methods approach**

In addition to methodological frameworks, previous IMG studies have utilised a various number of quantitative and qualitative methods. These methods included questionnaires (Alexander & Fraser, 2007; Carlier et al., 2005; Laven et al., 2003), in-depth interviews (Han & Humphreys, 2006) and the most commonly used method, semi-structured interviews (Durey, 2005b; Durey et al., 2008; Gilles et al., 2008; Han & Humphreys, 2005; Lê & Kilpatrick, 2008; McGrath et al., 2009). Only two of the identified studies had used a mixed method approach in their study (Hawthorne et al., 2003; Laurence, 2008).

This project utilises a mixed method design, which is “a procedure for collecting, analysing, and ‘mixing’ or integrating both quantitative and qualitative data at some stage of the research process within a single study for the purpose of gaining a better understanding of the research problem” (Ivankova et al., 2006, p. 3). The rationale for using mixed methods in the current study is to better understand the lived experience, the challenges they face and gain greater insight into IMGs as they migrate, work and live in rural Tasmania. This study employed the use of both questionnaires and semi-structured interviews and each will be discussed in detail later in this chapter.

#### **5.2.1.1 Pragmatism and mixed method design**

It must be noted, the overarching mixed method paradigms used by health researchers are increasingly “pragmatic” in their approach to research, where the most fitting methods are used to answer research questions. Pragmatists focus less on reality and focus on what works in terms of ascertaining the truth behind the research question (Broom & Willis, 2007; Teddle & Tashakkori, 2003). Pragmatists play a significant role in the selection of the research topic and the interpretation of results (Broom & Willis, 2007; Tashakkori & Creswell, 2007). Nevertheless, my standpoint, perspectives and assumptions are from an interpretivist or



constructivist position, from which the tradition of phenomenology stems (Broom & Willis, 2007). However, Creswell and Tashakkori (2007), when highlighting what constitutes mixed methods research, have stated mixed methods approach has no one single paradigm which is fixed. Many “paradigms might be used in mixed methods research; researchers have a responsibility to honour the different worldviews and the contradictions, tensions, and oppositions they reflect” (Creswell & Tashakkori, 2007, p. 305).

The views and approaches used in mixed methods by health researchers can significantly vary between individuals as it is dependent on their own ontological and epistemological perspective (Broom & Willis, 2007). The ontological perspective or how the “world” is viewed by the researcher impacts the shaping of research questions, the interpretation of data and how it is analysed. How the world is observed is dependent upon what the observer has previously observed and experienced (Bowling, 2005; Kuhn, 1996).

Individuals enter the realms of research bringing with them their own view of reality, how they “view” the world, with each individual not observing reality exactly the same (Kuhn, 1996). An individual’s view of the world is often value-laden with their past experiences, personal ideas with undertones of the cultural and socio-political context of the day (Bowling, 2005; Creswell & Tashakkori, 2007; Kuhn, 1996). Therefore, it is vital “for the investigator to be aware of his or her theoretical perspectives and assumptions about the research topic... when designing research and analysing the data” (Bowling, 2005, p. 119).

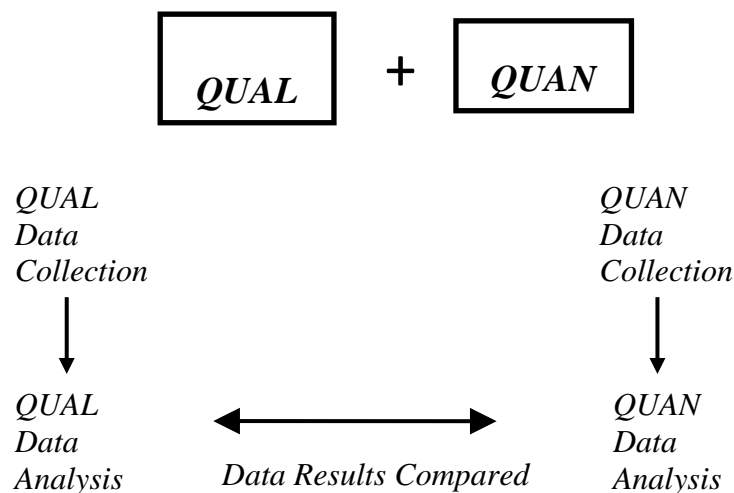
Thus, my own acute awareness of this fact, that my own theoretical perspectives and assumptions must be taken into account are explicitly required to ensure the research is conducted as “objectively as possible” (Bowling, 2005, p. 120).

Objectivity is required from inception to the interpretation of research results; however, this value freedom is the ideal, yet social and natural science research remains innately value-laden.

### 5.2.1.2 The concurrent triangulation design

In addition to being aware of personal perspectives and assumptions, the research design must be selected to fit the particular research situation (Creswell et al., 2003). Creswell et al. (2003) identified several types of mixed methods approaches, such as the sequential explanatory, sequential exploratory, concurrent triangulation, concurrent nested and concurrent transformative approach. Each of these approaches is focussed on a particular method of data collection and when the data is 'integrated' or mixed within the process. For example, the sequential approaches facilitate data collection 'sequentially,' collecting one group of data before another whereas concurrent approaches collect data at the same time. The data from the various approaches may then be integrated at the interpretive or analysis phase as determined by the theoretical perspectives used within the process.

The mixed method approach for this research is framed by the *concurrent triangulation design* (Creswell et al., 2003). The concurrent triangulation design is one of the more simple mixed method designs where priority (dominance) is neither given to the qualitative or quantitative methods (Creswell et al., 2003), as demonstrated in Figure 5.1



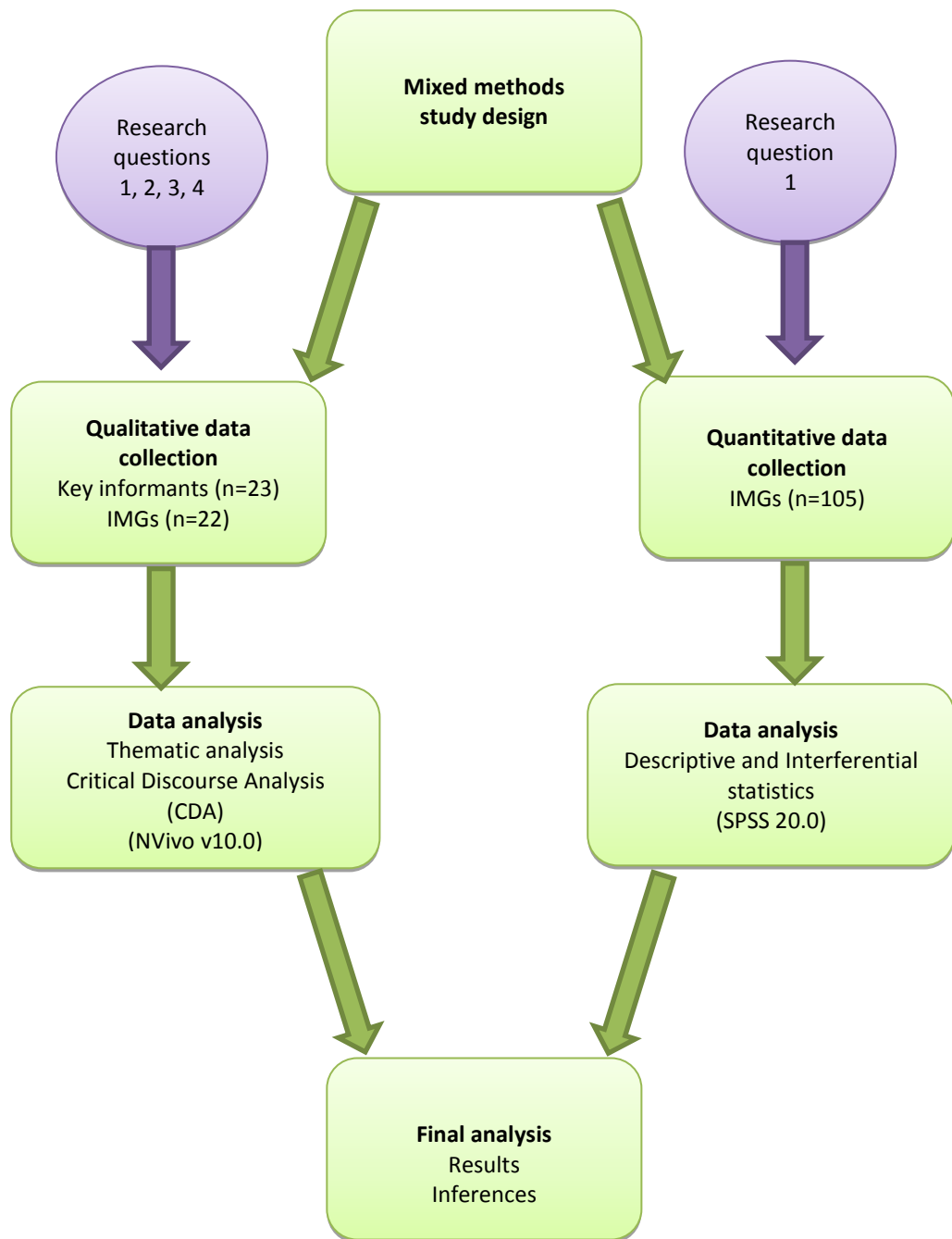
**Figure 5.1: Concurrent triangulated design**

Source: Creswell, et al. (2003). Adapted with permission.

The rationale for selecting the concurrent triangulation design was to “confirm, cross-validate, or corroborated findings within a single study” (Creswell et al., 2003, p. 229). Sequential designs initially collect and analyse one set of data which ‘assists’ to focus the collection and interpretation of the second set of data. Within concurrent designs, all qualitative and quantitative data are collected separately, yet concurrently. In the concurrent triangulation design, the qualitative or quantitative data are then combined at the interpretation stage of the study (Creswell, 2009; Creswell et al., 2003; Creswell & Tashakkori, 2007; Morse, 2005; Tritter, 2007). This mixed method design is used to “offset the weaknesses inherent within one method with the strengths of the other method” (Creswell et al., 2003, p. 229). By so doing, the study design places less emphasis on the priority (dominance) of one group of data over another. This synergistic approach has equal value and when combined the “the sum of quantitative and qualitative is greater than either approach alone” (Creswell, 2009, p. 104).

Although widely used, the concurrent triangulation mixed method design does possess a number of limitations. These include the challenges of comparing the results of the two different forms of data and resolving discrepancies within the results (Creswell et al., 2003). However, within this study each form of data were analysed individually and then as a whole, discussed later in the chapter. Any discrepancies in the results will create discussion as to why or how it may have occurred, such as differences observed between questionnaire and interview data.

The data collection in a concurrent triangulation design occurs in one stage, yet “these designs are not complex enough to mirror actual practice” (Creswell, 2009, p. 102). There are three stages of data collection. As shown in Figure: 5.2, the initial qualitative data were collected from key informants, through semi-structured interviews. A questionnaire was then administered to IMGs that was subsequently followed by semi-structured interviews with IMGs. Each of these data collection methods will be discussed in the following section.



**Figure: 5.2 Study design schematic**

### 5.2.1.3 Qualitative method trustworthiness

Prior to the development of the interview questions and data collection, the trustworthiness of the qualitative research method needed to be realised.

Trustworthiness of qualitative research is recognised to be achieved differently to quantitative research. It is determined by principles that include rigour, validity,

reliability, generalisability and reflexivity that produce high-quality data (Patton, 1999). How each of these principles was achieved in this study is discussed below.

#### *5.2.1.3.1 Rigour*

Rigour refers to the systematic approach to the research study and follows a defined process while addressing issues such as selective interpretation and presentation of findings (Grbich, 1999). In this study, rigour was addressed through the use of preliminary data, the use of snowball sampling, being familiar with many of the cultural and social issues of the subjects and being assisted by key informants. In this manner, the study allowed a sense of ownership is transferred to the IMGs, especially among the key informants. This sense of ownership ensured a greater access to more IMGs, and more in-depth information being provided throughout the interviews.

Rigour in terms of the research method's dependability is also concerned with reducing the risk of inconsistency which can be caused by the variability from the phenomena itself, changes induced by the research design or the researcher. Graneheim and Lundman (2004, p. 110), stated in their commentary on gaining trustworthiness within research that

It is important to question the same areas for all the participants, [however], interviewing and observing is an evolving process during which interviewers and observers acquire new insights into the phenomenon of study that can subsequently influence follow-up questions or narrow the focus for observation.

#### *5.2.1.3.2 Validity*

Validity is established by how appropriate and meaningful the inferences are in terms of the quality and assertions made from the data (McDermott & Sarvela, 1999). In this case, validity refers to whether the study investigates what it is meant to study (Malterud, 2001). Validity in qualitative research also lies in the reader being convinced that the researcher has accessed and accurately represented the social world under study (Grbich, 1999).

Access to the lived world of IMGs was achieved by building rapport with key informants, who not only accepted the research being conducted but the researcher who was conducting the research. It led to greater insights concerning IMG experiences and contact with IMGs. Access to the IMGs' social world was also realised by developing trust with the IMG participants that led to a greater level of openness and truth being provided. In some cases, experiences that were shared which IMGs had not been shared with anyone else.

Validity is also accomplished by presenting multiple quotes, reflexive notes and addressing complex questions within the data analysis phase by seeking further clarification from IMG and key informant participants.

#### *5.2.1.3.3 Reliability*

Reliability is concerned with using research methods that provide consistent, dependable and stable information and occurs when the participant's views and meanings have been meaningfully accessed (Grbich, 1999; McDermott & Sarvela, 1999). It is the capacity to provide representations of good quality research which are believable from the point of view of the research subjects rather than the researcher (Graneheim & Lundman, 2004). Ensuring credibility occurs; the participant's views and voices become a more powerful vehicle within the research rather than just a researcher's values, assumptions and suppositions which have been put forward (Denzin & Lincoln, 2000). To achieve this, greater authenticity of the qualitative data, tangible accounts of the participant's perspectives within the research need to be provided. By so doing, the reader can analyse and judge for themselves the quality and authenticity of the data put forward. This process is where direct quotations are highlighted in the study and are included in the thesis, so as to illustrate and support the accounts emerging from the research (Liamputtong & Ezzy, 2005).

#### *5.2.1.3.4 Transferability*

There are other measures of trustworthiness within qualitative research and they include transferability (Graneheim & Lundman, 2004). Transferability is "the extent to which the findings can be transferred to other settings or groups" (Hungler & Polit, 1999, p. 717). In most cases, qualitative research is unable to be generalised

to other populations; however it has been argued that qualitative research may be in part transferable to other populations that are in similar situations, or at least illuminative in the sense that it helps to better understand similar cases (Malterud, 2001). In this sense, in this study qualitative research provides thorough and descriptive findings to the needs, desires and challenges encountered by IMGs locally that can be transferred to other situations nationally and internationally (Malterud, 2001).

#### *5.2.1.3.5 Reflexivity*

The trustworthiness of the research methods also requires reflexivity and personal note taking throughout the research process. Liangputtong and Ezzy (2005, p. 43), highlighted the significance reflexivity plays in the rigor and validity of qualitative research when they state, “reflexive research acknowledges that the researcher is part and parcel of the setting, context and culture they are trying to understand and analyse. That is to say, the researcher is the instrument of the research.”

In addition, reflexivity is a process where the researcher needs to self-assess and recognise their own subjectivity, preconceptions, motivation and theoretical foundations within the research process (Liangputtong & Ezzy, 2005; Malterud, 2001). In this sense, reflexivity is a method which

requires the researcher to be critically conscious through personal accounting of how the researcher’s self-location (across for example, gender, race, class, sexuality, ethnicity, nationality), position, and interests influence all stages of the research process... to produce research that questions its own interpretations and is reflexive about its own knowledge production towards the goal of producing better, less distorted research accounts. (Pillow, 2003, p. 178)

As part of this process, the researcher then needs to review and analyse the data in such a way that it avoids any previous notion or anticipation of findings and eliminate portraying personal opinions as the finding concerning IMGs emerged.

### **5.3 Data collection methods**

This cross-sectional study, a type of observational study employed to determine the incidence of a phenomenon or condition within a population (Bonita, Beaglehole, & Kjellström, 2006), uses two key methods to collect data. Semi-structured interviews were used to gather qualitative data from both key informants and IMGs.

Moreover, the key method of gathering quantitative data from IMGs was through a questionnaire. Both of these methods are highlighted and discussed, including their strengths, weaknesses and how these were rectified or acknowledged within the study.

#### **5.3.1 Semi-structured interviews**

The initial method was semi-structured interviews. This method aims to focus on the richness and depth rather than the breadth of information (Bernard, 2000).

Semi-structured interviews stem from the family of 'in-depth' interviews, where there are a number of taxonomies and variations. These include unstructured interviews; non-directive and active interviews amongst many others, yet these terms are often synonymous with in-depth interviews (Liamputtong & Ezzy, 2005; Wengraf, 2001).

In-depth interviews differ from structured interviews. Structured interviews, as the name suggests, are highly structured, where the interviewer's sole purpose is to be the collector of the data on the schedule. In contrast, in-depth interviewers evoke responses through highlighting concepts, ideas and create discussion (Bowling, 2005; Liamputtong & Ezzy, 2005; Minichiello, 2008). Semi-structured interviews have fixed questions with negligible or no response codes and allow flexibility within the interview, which can ensure probing of further data which may not have been on the interview schedule (Bowling, 2005). This flexibility also allows no specific ordering of the questions to occur, which may be required (Bowling, 2005).

The use of semi-structured interviews enabled qualitative data to be constructed in collaboration between the interviewer, key informants and IMGs. Qualitative methods, such as interviews, focus groups and participant observation also assist to provide greater and in-depth understanding of the issues raised from quantitative



data. It is achieved by “establish[ing] an understanding of people’s lives, experiences and the subjective meanings” (Broom & Willis, 2007, p. 24). It is a means to provide further insights to consolidate the quantitative analysis and to enrich the findings with intricate meanings (Bernard, 2000; Broom & Willis, 2007; Calnan, 2007; Davis & Scott, 2007). Semi-structured interviews generated data to ‘shed light’ on the issues and problems faced by IMGs and their immediate families in rural Tasmania who are experiencing employment and social challenges.

### **5.3.2 International Medical Graduate questionnaire**

In addition to in-depth interviews, other survey methods such as questionnaires are commonly used in a number of disciplines, including health, the health care field and social research (Calnan, 2007; Dawson & Trapp, 2004; Neuman, 2000). Questionnaires are well tested methods for obtaining data from a selected population, which provide statistically based evidence to make inferences and generalisations about a population (Calnan, 2007; Neuman, 2000).

A questionnaire was used in the study as this method takes a ‘snapshot’ of IMGs in Tasmania to explore issues, commonalities and questions which are both descriptive and analytical. However, a number of weaknesses are apparent with questionnaires, such as their ability or capacity to gather depth of meaning and the insights of social beings. In addition, there can be low response rates from participants or there may be problems of questions being not answered, which create difficulties when analysing data (Calnan, 2007; Minichiello, 2004; Neuman, 2000).

These weaknesses inherent in quantitative methods, such as questionnaires, can be overcome with the use of qualitative methods. For example, in-depth interviews address some of these weaknesses, by addressing particular research questions, which are narratives embedded with themes, sensitivities and concepts (Calnan, 2007; Minichiello, 2004). Conversely, the weaknesses in qualitative methods can be offset by the strengths in quantitative methods. For example, questionnaires facilitate greater objectivity and less bias than semi-structured interviews. Thus, a

mixed methods approach has the capacity to strengthen research outcomes of a study (Bernard, 2000; Calnan, 2007; Dixon-Woods, Fitzpatrick, & Roberts, 2001).

## **5.4 Data collection**

As outlined, the mixed methods approach used in this study was through semi-structured interviews and a questionnaire while the collection of data occurred in three different stages within the data collection timeframe (see Appendix E) and as indicated in Figure 5.2.

- Stage one of the data collection commenced with semi-structured interviews with informants to generate a depth understanding of the challenges and issues from the perspective of informants. This initial contact with key informants also ensured an opportunity for greater responsiveness to the remaining stages of the study. This contact enabled the establishment of meaningful connections with key individuals to further assist the future distribution of information to IMGs (Gaglio et al., 2006).
- Stage two, the administration of the questionnaire was followed by the initial contact.
- Stage three was the interviews with IMGs, which highlighting their perspective of the issues and challenges and completed the data collection process. The data collection stages are outlined in detail below including the how the sampling, recruitment, interview and questionnaire schedules were developed.

### **5.4.1 Semi-structured interviews**

Stage one of the qualitative data collections occurred between September and December 2011 and involved initial interviews with a purposive snowball sample of 23 key informants. These informants were identified as key individuals who recruit, support and act as educators and advisors to IMGs in the Tasmanian public and private health workforce (Hawthorne et al., 2007). The informants included those with clinical and non-clinical backgrounds who worked full or part time in various capacities such as medical educators, directors of clinical training, program officers, organisational heads and recruitment management and staff. In two cases, the informants who were identified and interviewed were also IMGs.

The key informants were initially recruited from third party organisations that assist IMGs in either the acute care sector or general practice sectors of Tasmania. The organisations included the University of Tasmania, DHHS; General Practice Tasmania (now Tasmanian Medical Local); General Practice Training Tasmania (GPTT); Health recruit plus (HR+); and PMCT. These organisations are both public and private and cover the whole of Tasmania with centres in Hobart to Launceston, Burnie, Latrobe and Ulverstone.

Initially contact was made via phone call, letter or email with the various organisations to introduce the researcher and the research that was to be conducted. At first, the recruitment of key informants was slow, however by developing trust and rapport with the key informants, within a few weeks there was greater acceptance and recognition of the research that was being conducted. Due to the nature of the snowball sampling, new informants were identified as original informants were being interviewed. Many newly identified informants were contacted and subsequently interviewed. A number of informants were identified toward the end of the data collection timeframe.

Stage three of the data collection occurred between March and August 2012 and consisted of follow-up interviews with a 'call for volunteers' style of convenience sample of 22 IMGs. As qualitative data focusses on the insights, meaning and experience of the research, the sample size was determined by saturation, when new themes were no longer being highlighted or additional information was not generating any further understanding (Bernard, 2000; Davis & Scott, 2007; Liangputtong & Ezzy, 2005). Participants were asked to indicate on the returned questionnaire, if they are willing to be contacted for a 30-45 minute interview. When affirmatively indicated each IMG was contacted regarding a time and location for an interview.

The IMGs involved in the study included all doctors who had obtained their primary medical qualification in a country other than Australia and there were no additional exclusions. Thus, a heterogeneous cohort of IMGs, who represent many and varied

cultures, from both English speaking and non-English speaking backgrounds were included in the study.

#### **5.4.1.1 Development of interview questions**

As part of this trustworthiness within the qualitative research, both key informant and IMG interview questions used in this study were based on interview questions used in 'The Retention of Overseas Trained Doctors in General Practice in Regional Victoria,' a study conducted by Hawthorne, et al. (2003). This Victorian study, interviewed key informants to understand the perceived factors likely to influence IMG retention in general practice, in rural Victoria. Both the IMGs and informant interviews were focused on rural retention issues, including professional and social support issues. Many questions were incorporated into the final version of the current study's interview questions and were revised to suit the Tasmanian study's context. For example, the Tasmanian study focussed on understanding IMGs across all types of medical practice, rather than general practice alone (see Appendix F).

The interview questions specifically for IMGs were developed in response to the Victorian study by Hawthorne, et al. (2003) and the work of Han and Humphreys (2005), which examined the community integration of IMGs and their intention to stay in rural communities. The interview questions were also developed and based on a number of previous studies, which explored the acculturation, community integration and community support of IMGs (Carlier et al., 2005; Colic-Peisker, 2009; Laven et al., 2003). These studies included other those which explored the acculturation, health risk and the health and wellbeing of Asian migrants in rural Tasmania. As each of the interviews was conducted, clarification and probing questions, not on the interview schedule were used (Bowling, 2005). These probing questions were used to seek clarification; gain greater insight into an issue or themes that was highlighted; and to provide an opportunity to revisit remarks that were said in passing that were felt to be poignant. These probing questions were also incorporated when required as it allowed the researcher remain open to changes within the interview.

In addition to the flexibility of the interview questions, reflexivity and refinement of both informant and IMG interview schedules also occurred as interviews were conducted. At the conclusion of each interview, a reflexive research journal entry was made in addition to reflective thoughts, comments and questions which arose throughout the research process. A reflexive journal allowed me to write the views, feelings and impression gained from the participants, their data and their own views (Finlay, 2002). The journal and its entries were revisited throughout the analysis process to assist the understanding of the discussion, contexts or the feelings gleaned from the interview at the time.

The research journal enabled me to reflect on the interviews and the things that worked or did not work. For example, after the very first IMG informant interview I stated

*This was the first attempt at using the questions for the interview; however having conducted semi-structured interviews was something I was not unfamiliar with. I knew by the time the professional and personal type questions came up, there was going to be future issues. I realised I could actually ask the questions more concisely, without being too long winded. I would stick with the same format, but combine these questions rather than have many separate questions on their own. This is the format and process I will endeavour to follow. The interviewee was very articulate and insightful and was a pleasant person to be interviewing first; she knew what she wanted to say and highlighted a couple of things which I might have missed at this initial interview. I have since adapted the interview schedule (Researcher's reflexive journal entry 1).*

Ultimately this reflexive process led to me being able to refine the interview schedule, which occurred more markedly at the beginning of data collection stages.

Greater flexibility was required when interviewing IMGs, as they each had a story to tell and often would answer questions along the journey. For example, when interviewing a particular IMG, I later wrote

*I was unsure how it would go as there was limited time and the IMG didn't seem too interested... He was a bit reserved at first and ... I started with question one, but the interview became more about "tell me your story"... It was good to see that half way through the interview the doctor's clinical façade was lowered and he began to speak more relaxed and candidly. To him it probably felt like a consult as that is how I initially felt... I guess the interview being similar to a professional encounter, there was a sense that he needed to lead the discussion... His story was fascinating and I wanted more time to talk to him. I got the impression, as he opened up and as those barriers were broken down, he wanted to talk more as well... The IMGs have had these experiences and want to talk about it, regardless of the questions. At times I felt as though these interviews are almost debriefing sessions and in this interview the subliminal message was 'I have never been able to talk about this outside my close circle of friends and so I want to keep sharing' (Researcher's reflexive journal entry 23).*

To this end, I required a flexibility that allowed me to return to points and elements of the IMG's story to seek clarification and have the IMG expound upon issues that were related to the interview schedule. In addition, a number of questions were altered slightly to suit a number of IMGs, who were from a non-English speaking background. One example was question four, "what are some positive or negative factors associated with your current position?" This question, as with a number of others was often asked to be repeated by IMGs. Subsequently, the question was altered to incorporate a restatement of the question. Ultimately the question became "what are some positive or negative factors associated with your current position – what are the good and bad things about your job."

#### **5.4.1.2 Interview sampling method of key informants**

The main sampling technique employed in the study when recruiting interview participants was purposive snowball. This method is where certain individuals or groups of interest are identified through other sampled individuals and networks

that have contact with many other individuals. The sample may not be representative of the population; however, when individuals or groups are hard to access, this may be the only practicable sampling method (Abramson & Abramson, 1999). This method was used to identify other key informants. The newly identified informants provided new and meaningful data within the study and were able to identify more key informants and IMGs within Tasmania (Kermode & Roberts, 2006; Silverman, 2001). This sampling method was selected as there is a large network of informants, who through linkages had a vast network with each other and with potentially all IMGs within the state (Liamputtong & Ezzy, 2005).

Tapping into the informants network was vital due to the wealth of knowledge represented by key informant's regarding IMGs (Hawthorne et al., 2007). As these informants were professionally in close contact with IMGs, they potentially had insight and greater contextual information regarding the key issues and challenges faced by IMGs who enter, work and live in the Tasmanian rural context. The contact with key informants also allowed me to gauge the contextual and political frameworks which operate in Tasmania, and to explore how informants see and perceive IMGs, including the key factors which impact on their roles and responsibilities. It was initially anticipated that these participants would also provide information regarding the policy challenges which IMGs and the informants encounter. Their input was sought to provide direction for improving future IMG policy both locally and nationally. This method of sampling also allowed greater access to recruiting IMGs to participate in the IMG questionnaire.

Due the nature of the snowball sampling, new informants were identified as original informants were being interviewed. Many newly identified informants were contacted and subsequently interviewed. At times, this was problematic as a number of informants were identified much later in the data collection process. However, many of these later identified informants were working in the same organisations as those already interviewed and it was felt they were unlikely to provide any additional data. Nevertheless, in one case, a previously unknown key informant approached me five months after interviews were completed. This

particular informant was not brought to my attention when interviewing his/her colleague's months earlier.

In total, 23 of the 29 identified informants agreed to be interviewed, representing a response rate of 82%. Of the six who elected not to be interviewed, three did not accept the invitation to participate while the remaining three cited work schedules that inhibited their participation.

Interviews lasted between 20 and 75 minutes each, were audio recorded and conducted face-to-face. Audio-recording permitted a greater freedom to interact, listen and concentrate on the participant and the opportunity for a detailed and accurate record of the interview. It increased validity "by the preservation of authentic data" (Minichiello, 2008, p. 117). The face-to-face interaction allowed greater probing, clarification and more in-depth data to be gathered from the participants (Bowling, 2005; Liamputtong & Ezzy, 2005; Minichiello, 2008). However, two key informants' interviews were conducted over the telephone. These telephone interviews occurred because making interview appointments was problematic due to work schedules and unforeseen circumstances of the informants.

#### **5.4.1.3 Interview sampling method of IMGs**

To gain access to IMGs for the study without using snowball sampling would have been challenging. Currently, the Federal *Privacy Act 1988* and Tasmania's *Personal Information and Protection Act 2004*, protects the personal information of the general public including those working in the public and private sector. In this case, key informants were observed as the principal means to ethically distribute information regarding the study to IMGs. It was the contribution of many of the informants, which made it possible to connect with a wider number of IMGs. Their contribution allowed many IMGs to provide data to achieve the study's aims and objectives. Without the assistance from key informants, the study would not have gathered sufficient data from IMGs within Tasmania.

Interviews with IMGs lasted between 15 to 90 minutes with an average length of 34 minutes and were conducted either face-to-face in a place that was most



convenient for the participant. In five cases, interviews were conducted over the telephone. These telephone interviews occurred due to the complexities of making interview appointments within IMGs work schedules or due to unforeseen circumstances. A list of open-ended questions, an information sheet, and a consent form were provided to all research participants prior to the interview. Each interview was audio recorded with the participant's oral and written consent.

#### **5.4.2 IMG questionnaire**

Stage two of the study, the 'Tasmanian International Medical Graduate questionnaire,' was administered both on-line and in hardcopy format between March and July 2012 via third party recruitment (key informants). There were 105 respondents to the questionnaire. The study included all doctors who had obtained their primary medical qualification in a country other than Australia. A heterogeneous cohort of IMGs, who represent many and varied cultures, from both English speaking and non-English speaking backgrounds participated in the questionnaire.

Initially, hard copies of the questionnaire were mailed to key informants IMGs between March and July 2012 for distribution to IMGs. Secondly, each informant received an email with an electronic version of the information sheet and a web link to the on-line questionnaire in March 2012. The informants were requested to forward the information, via email, to all IMGs in their contact list. A reminder email was sent to each informant on the fourth, eighth and fourteenth week of the questionnaire administration.

Finally, questionnaire distribution was conducted via direct mail to known IMGs, which may not have had on-going or direct contact with informants at the time of the study. These IMGs included private specialist and GPs which were identified through the Tasmanian eHealth Directory (TeHD) (General Practice Tasmania, 2012). IMGs were requested to either fill in the questionnaire on-line or return a completed hardcopy questionnaire using the prepaid envelope provided.

#### **5.4.2.1 Questionnaire design and development**

The anonymous self-administered questionnaire used in the study was based on the 'Victorian IMG Rural General Practice questionnaire' used by Hawthorne, et al. (2003), in their Victorian study. Permission to use sections and elements of the questionnaire was received on the 31st August 2011 via email with the principal researcher, Professor Lesleyanne Hawthorne. The Victorian IMG Rural General Practice questionnaire had undergone face and content validation by way of scrutiny of the questionnaire from members of the Victorian project's steering committee which had been organised by RWA, Australia. The questionnaire was subsequently piloted with five IMGs and final adjustments were made prior to the implementation of the questionnaire in full. Within the Tasmanian context, minor adjustments were made to the questionnaire, to ensure relevance and to improve clarity.

For example, in the questionnaire used by Hawthorne et al. (2003), there were nine items that explored and measured the level of satisfaction in current position. However, this study used thirteen items to explore the different aspects of IMGs satisfaction of their professional work. The additional items included questions which asked about friendliness of patients, friendliness of the local community, access to public transport and access to private transport. These questions, in the Likert-scale format, were professional and non-professional challenges highlighted within the literature and from the interviews conducted with key informants.

The final version of the Tasmanian questionnaire had forty-two questions, which were across six sections. The questions covered areas such as IMG demographics and background, including specific data such as age, gender, marital status, number of children and religion. More specific data were requested from each of the participants that were related to current employment and location; motivation for migration and experience; qualifications and Australian registration; medical employment history; and questions relating to current professional and non-professional lifestyle. The questionnaire included nine questions which required a written response, such as qualification or where the IMG had worked previously. The remaining questions were check boxes (✓) to allow ease of use and simplicity. In

addition, three Likert-scale questions focusing on an IMGs' satisfaction with the aspects of their current professional position and non-professional lifestyle were included in the study (see Appendix G).

#### **5.4.2.2 Questionnaire validation**

The Tasmanian IMG questionnaire had undergone face and construct validation between August 2011 and February 2012. Face validity was assessed in terms of the presentation and relevance of the questionnaire by myself and three academic staff members from various academic backgrounds. Construct validity was also assessed, to ensure the questionnaire measured what it set out to measure. There was some debate and concern about the use and wording of the original four point 'forced choice' Likert-scale format used by Hawthorne et al. (2003). It was felt the scales needed to reflect a five point Likert-scale, so as to allow neutrality or undecided choice to any posed question. However, the four point Likert-scale has been developed and is used at times to prevent the acquiescent response effect, where respondents answer the middle question at each question (Polgar, 1995).

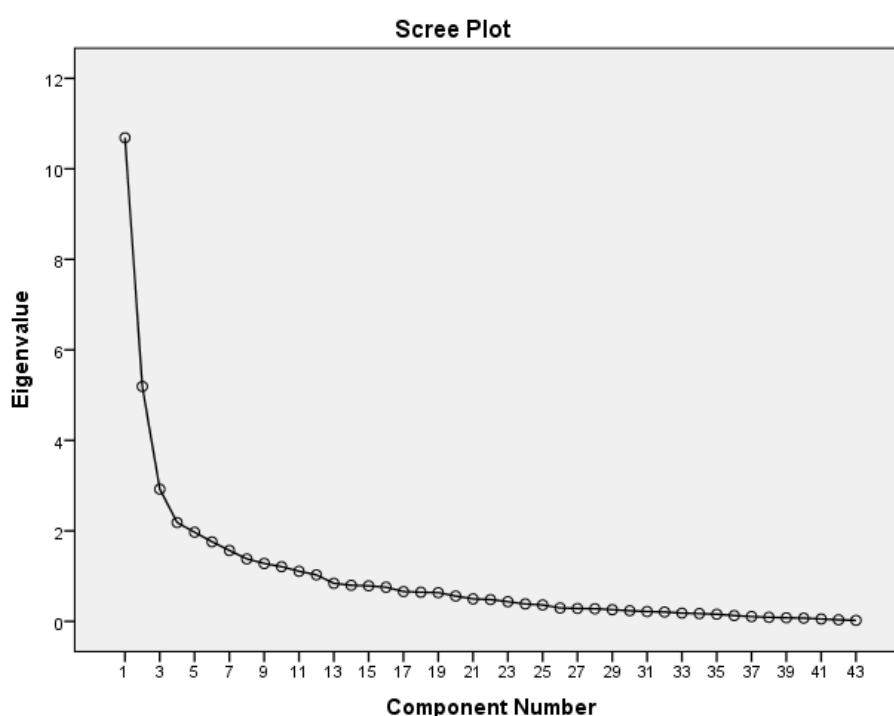
Moreover, the wording used to determine the professional and non-professional satisfaction levels of IMGs in the original Likert-scales, was 'very satisfactory'; 'satisfactory'; 'fair'; and 'very unsatisfactory.' Similarly, the wording used when determining the level of importance for certain aspects of residential location was 'very important'; 'important'; 'not very important' and 'unimportant.' It was felt the wording needed to be rectified to allow greater clarity of the rating scale currently used (Polgar, 1995). After much debate and discussion, the Likert-scales remain unchanged, so as to make more accurate parallel comparison between the Victorian and Tasmanian study results. Despite this concern being addressed, there were still a number of concerns regarding the four point Likert-scale and wording of the scales from the academic staff and myself. These concerns became more apparent as the results of the questionnaire were analysed.

In addition to these initial concerns, other psychometric properties of the three principal Likert-scales in the questionnaire were evaluated before the data were analysed. These Likert-scales focused on an IMG's satisfaction with the aspects of

their current professional position and non-professional lifestyle. The 43 items from the three Likert-scales were subjected to Principal Components Analysis (PCA) with a Varimax rotation using SPSS 20.0. This analysis was conducted to extract the maximum amount of variance across each of the three Likert-scales (Pallant, 2011).

Data suitability was assessed prior to performing PCA where items were excluded if loading of coefficients were less than 0.5 (Pallant, 2011). In addition, the Kaiser-Meyer-Olkin measure of sampling adequacy was shown to be .666, which is above the recommended value of .6 and Bartlett's Test of Sphericity was .000, which is statistically significance, and supports the factorability of the correlation matrix (Pallant, 2011).

To identify and label each component, an additional exploration of the highest loaded items was undertaken. PCA revealed 12 components were shown to have Eigen values above 1, as shown in Figure: 5.3.



**Figure: 5.3 Principal Components Analysis scree plot**

However, when parallel analysis was conducted using Monte Carlo PCA for Parallel Analysis (Watkins, 2000), the results showed only four components with a total of

32 questions were suitable to be retained. These four components explained 24.85%, 12.07%, 6.79% and 5.08% of the variance respectively as presented in Table 5.1. The four components were identified and labelled 'the importance of satisfaction with employment and community'; 'the perceived socio-cultural factors influencing future employment'; 'the factors which improve satisfaction of the quality of life'; and 'the perceived workplace factors influencing future employment.'

**Table 5.1: *Principal Components Analysis results for Likert-scale questions***

	Varimax rotation			
	Component			
	1	2	3	4
Q37a. Level of satisfaction with type of work	.777			
Q38c. Non-professional aspects of friendliness of people	.768			
Q37k. Level of satisfaction with friendliness of the local community	.755			
Q37d. Level of satisfaction with good/ supportive colleagues	.706			
Q37j. Level of satisfaction with friendliness of your patients	.682			
Q38a. Non-professional aspects of appeal of location	.679			
Q37f. Level of satisfaction with level of professional support	.653			
Q37h. Level of satisfaction with medical facilities/resources	.632			
Q37e. Level of satisfaction with salary level	.626			
Q38i. Non-professional aspects of access to cultural community and resources	.617			
Q37b. Level of satisfaction with medical location	.615			
Q37c. Level of satisfaction with relevance to your skills/past experience	.614			
Q38m. Non-professional aspects of access to private transport (own car)	.580			
Q37g. Level of satisfaction with access to training/ supervision	.569			
Q38b. Non-professional aspects of size of city/town	.534			
Q38j. Non-professional aspects of access to social activities	.532			
	1	2	3	4
Q39m. Influence future work: Access to cultural community and resources		.760		
Q39o. Influence future work: Access cultural or religious foods or goods		.738		
Q39n. Influence future work: Access to social activities		.681		
Q39k. Influence future work: Access to religious facilities		.644		
Q39b. Influence future work: Improved medical facilities/resources		.643		
Q39p. Influence future work: Access to public transport		.643		
Q39l. Influence future work: Access to friends/ family members		.599		
Q39h. Influence future work: Settlement near cultural community		.598		
Q38l. Non-professional aspects of access to public transport			.859	
Q37l. Level of satisfaction with access to public transport			.747	
Q38k. Non-professional aspects of access cultural or religious foods or goods			.670	
Q38e. Non-professional aspects of access to employment for partner/ spouse			.647	
Q38d. Non-professional aspects of quality of facilities (transport, shops etc.)			.644	
Q38f. Non-professional aspects of access to good schools			.540	
Q39d. Influence future work: Shorter working hours				.781
Q39e. Influence future work: Less on-call responsibility				.664
Percentage (%) of variance explained	24.85	12.07	6.79	5.08

In addition to factor analysis, internal consistency was used to assess reliability of each of the components prior to any subsequent analysis. Cronbach Alpha is the most commonly used method of assessing reliability. Thus, Cronbach Alpha coefficient of a scale above 0.7 demonstrates an acceptable level of internal reliability, while scores lower than 0.7 indicates an unacceptable level of internal reliability (Munro, 2005; Pallant, 2011). The results of the internal reliability of the four components indicate a high degree of reliability as presented in Table 5.2.

**Table 5.2: Cronbach's Alpha reliability coefficients of factors**

<b>Components</b>	<b>Cronbach Alpha</b>	<b>Number of items</b>	<b>Number of cases</b>
Satisfaction with employment and community	.925	16	84
Perceived socio-cultural factors influencing future employment	.841	8	89
The factors which improve satisfaction of the quality of life	.858	6	68
Perceived workplace factors influencing future employment	.785	2	92

#### **5.4.2.3 IMG questionnaire sample size**

At the time of the study, the actual number of IMGs in Tasmania was unknown and this was reinforced by informants in both informal discussion and formal interviews. Nevertheless, as discussed in chapter 2, section 13; approximately 350 IMGs are working in Tasmania. Thus to identify a suitable sample size, the sampling design was well considered. A simple random sample of the IMG population would have been optimal for the study. However, due to the complexities of making contact with IMGs, contact to distribute the questionnaire was made possible through key informants. As such, the study used snowball sampling to “draw a representative sample from the population, so that the results of studying the sample can then be generalised back to the population” (Marshall, 1996, p. 522).

On the other hand, with this in mind, other considerations were also taken into account such as the sample size required for the data analysis. For example, any sample size may be suitable for descriptive statistics; however, a sample of 200 - 500 is needed for multiple regression, analysis of covariance, or log linear analysis

(Israel, 1992, p. 4). However, specific populations such as doctors, have a history of being more difficult to collect questionnaire data because of a number of matters, which includes a busy work schedule (Berry & Kanouse, 1987). On average, questionnaire response rates for doctors have been recorded to be 13% lower than general public response rates (Field et al., 2002).

Data from previous IMGs research in Australia and New Zealand which utilised questionnaires was also considered. For example, the study conducted by Hawthorne, et al. (2003) had a response rate of 38% (sample size 245) while Alexander and Fraser (2007) who examined the education, training and support needs of both AMGs and IMGs in rural Australia had a response rate of 53.0% (sample size 215). Similarly, Laven, et al. (2003) who examined AMG GPs in rural practice had a response rate of 53.4% (sample size 4513).

Based on the approximate 350 IMGs who have migrated temporarily or permanently to Tasmania, the required sample size was calculated to be 183 (95% Confidence Level) (Creative Research Systems, 2011). Despite the calculated sample size of 183, Israel (1992), in his commentary on sampling, encourages the sample size to be increasing by at least 30% (or 55) to compensate for participant nonresponse. Thus, a sample of at least 238 participants was needed to be recruited for this study to ensure the response rate would reach 183. This sample size would then be large enough to guarantee a level of accuracy at 5% (AIHW, 2010; DoHA, 2011a; Israel, 1992; Munro, 2005; Peat, Mellis, & Williams, 2002).

#### **5.4.2.4 Recruitment, consent and confidentiality**

Given the limitations produced by the Federal *Privacy Act 1988* and Tasmania's *Personal Information and Protection Act 2004*, outlined previously, IMG questionnaire distribution was made through the permission and support from key informants acting as third parties. The questionnaire was made available using a mixed-mode strategy, where the questionnaire was made accessible through mail and on the World Wide Web (Web) (Groves, Fowler, Couper, Lepkowski, & Singer, 2009; Kaplowitz, Hadlock, & Levine, 2004).



As mentioned above, the questionnaire was made available on-line with a web link which was sent to informants to forward to IMGs via email. The questionnaire was also provided in hard copy to IMGs who worked with or were known by the key informants directly. For example, this included questionnaires being placed by informants in reception areas of relevant services or the pigeon holes of IMGs. Reply-paid envelopes were provided for the return of completed questionnaire. In addition, each of the hard copy questionnaires also had a link and instructions for IMGs who wished to complete the questionnaire on-line.

The on-line version of the questionnaire was designed through and collected by SurveyMonkey®, an on-line questionnaire development and data collection tool (SurveyMonkey, 2013). It was also anticipated early in the research that participants in the research would be recruited using multiple media strategies, including social networking (e.g., Facebook, Twitter). However, only one informant responded regarding participation in the study in October 2011 and, therefore, this approach was abandoned.

It was anticipated using web questionnaires may significantly reduce the per case cost involved in data collection and also reduced cost and time of data entry (Groves et al., 2009; Kaplowitz et al., 2004). In addition, it was felt it may be useful to improve response rates of IMG participants, due to busy schedules. However, there is a wealth of evidence which demonstrates web questionnaires have not been shown to improve response rates, but are either comparable to or yield lower response rates than other questionnaire modes (Groves et al., 2009; Kaplowitz et al., 2004; Lozar Manfreda, Bosnjak, Berzelak, Haas, & Vehovar, 2008). The on-line questionnaire amongst the Tasmanian IMG cohort proved to be the more popular option of completing the questionnaire, with 73 (69.5%) completing the on-line version of the questionnaire and 32 (30.5%) completing and returning the paper-based version.

#### **5.4.2.5 Incentives**

Questionnaire participants were offered the opportunity to be eligible for a participation prize. There were a total of three prizes available (A\$100, \$50 and \$25

gift/store vouchers). These prizes were used as an incentive to encourage a rapid response and to increase the return rate of questionnaires (Church, 1993). Although it has been shown not to increase response rates significantly (Dillman, 2007; Field et al., 2002), it was used to demonstrate a small token of thanks to each respondent for being part of the study. In addition to the incentives, additional measures were taken into account to increase response rates such as, making special contact with potential participants and personalisation with mailed questionnaires (Berry & Kanouse, 1987; Dillman, 2007; Field et al., 2002; VanGeest, Johnson, & Welch, 2007).

## **5.5 Data management**

Once all data were collected it underwent preparation for analysis by undertaking a number of steps, which included coding, entry, cleaning and managing the missing data as outlined below.

### **5.5.1 Quantitative data**

#### **5.5.1.1 Data coding**

Data were coded using a coding frame while a code book was developed prior to and refined after data were collected. Coding is a process where data is classified into meaningful and relevant categories by consistently and comprehensively using codes to create greater ease in statistical analysis (Bowling, 2005). For example, males were given a numerical code of 0 while females were given a numerical code of 1. New codes were given when new variables were created (Bowling, 2005). In addition, codes such as 99 or 999 were used for missing, skipped or inadequate responses.

#### **5.5.1.2 Data entry**

Data entry was conducted by importing data gathered from SurveyMonkey into Microsoft Excel, while paper-based questionnaires were manually entered into Microsoft Excel afterwards. The entered data were then imported from Microsoft Excel into the SPSS 20.0 for data analysis.

#### **5.5.1.3 Data cleaning**

Prior to and after importation of the data into SPSS 20.0, the data were checked for any discrepancies. This process was to remove any errors which occurred during the data collection, coding and input stages. Initial visual checks of the data against the original data were undertaken once entry into Microsoft Excel was completed. After being imported into SPSS 20.0, a standardised procedure for data cleaning was undertaken by checking for outliers and error codes by inspecting frequency distributions (Bowling, 2005). An additional cleaning procedure involved range and consistency checks, where questions were checked for unrealistic and inconsistent values (Bowling, 2005). No outliers were noted within the data; however, there were three instances where error codes occurred; but, this was due to human error when hardcopy questionnaire data were entered into SPSS 20.0.

#### **5.5.2 Qualitative data**

##### **5.5.2.1 Transcription of interview data**

The semi-structured interviews were transcribed verbatim into Microsoft Word. All transcriptions were checked for accuracy against the audio recordings and entered into NVivo v10.0. The data were then analysed for emerging themes, patterns of living and behaviour. NVivo v10.0 software (QRS International, 2012) was used to aid data collation and coding as “software for qualitative data analysis can benefit the researcher in terms of speed, consistency, rigor, and access to analytic methods not available by hand” (Weitzman, 1999, p. 1241).

##### **5.5.2.2 Data coding**

Each interview participant was coded based on information such as being a key informant or an IMG and then assigned a numerical code based on the order in which they were interviewed. For example, a key informant participant would be presented as “Key informant 17” and IMG would be presented as “IMG 20.” Using the auto-coding function of NVivo v10.0, data were then collated based on question headings.

Those participants who provided written responses in the Tasmanian IMG questionnaire were similarly assigned a numerical code, such as “IMG questionnaire

respondent 55,” to ensure anonymity and assist collation of data. Once identified these responses were copied into the qualitative database using NVivo v10.0 (QRS International, 2012).

### **5.5.2.3 Collection of secondary data**

As part of the CDA data analysis, a secondary literature search was conducted to obtain reports, policy documents and academic literature. The literature review helped to provide context to the study and determine the areas where social power, dominance, and inequality were enacted and reproduced through the text and talk of key informants (Blommaert & Bulcaen, 2000; Fairclough, 1992).

## **5.6 Data analysis**

### **5.6.1 Quantitative data**

The questionnaire data were analysed using SPSS 20.0 (IBM, 2012) to ascertain and present findings from the various quantitative responses within the questionnaire (Calnan, 2007). Descriptive statistics were used to organise, summarise, analyse and present respondent data in a convenient and informative way (Munro, 2005). The descriptive data is presented where “N” is the total number of respondents and “n” is the subset number of the respondents. Descriptive statistics are used to present such things as frequency and proportion for categorical or ordinal data.

Inferential statistical techniques were employed to determine the significance of the results. The chosen statistical tests reflected the type of data gathered from the questionnaire, which includes categorical data and ordinal scales. The Kolmogorov-Smirnov test is used to examine the normality of data distribution in this study. If the p-value is significant ( $p \text{ values} \leq 0.05$ ), data scores are significantly away from normal distribution. As a result, non-parametric tests such as Spearman’s correlation tests, Chi-square ( $\chi^2$ ) tests and ordinal logistic regression should be used to examine if there are any associations between variables.

As outlined in chapter one, Chi-square ( $\chi^2$ ) tests were performed between gender, age group, region of origin and current employment in Tasmania (independent variables) and each Likert-scale outcome variable relating to the future

employment, professional and non-professional satisfaction of IMGs (dependent or outcome variables). If Chi-square assumptions are violated (i.e., more than 20% of expected cells less than 5), a Fisher's exact test should be used. P-values are used to estimate the relationships prior to undertaking ordinal logistic regression using the GENLIN procedure. Overall, test of significance between variables, odds ratios (OR) and 95% confidence intervals are calculated. Results are considered statistically significant at  $p \leq 0.05$  (Munro, 2005). All assumptions are tested prior to performing ordinal logistic regression analysis including testing for multicollinearity – where two or more independent variables are highly correlated with each other.

It must be noted that only those factors that are indicated to be significant in Chi-Square tests underwent further analysis using ordinal logistic regression. In most cases an IMG's region of origin was the factor that was indicated to be most significant. Spearman's correlation test was used to measure statistical correlation between dependent variables.

### **5.6.2 Qualitative data**

Analysing qualitative data, such as interviews and field notes can be achieved through any number of methods available (Aronson, 1994; Pope, Ziebland, & Mays, 2000). For the purposes of this study, two analytical approaches were used. These included thematic analysis and CDA. The strengths of each of these approaches were used identify known themes while CDA was used to highlight the relationship between discourse and power within the data.

#### **5.6.2.1 Thematic analysis**

Thematic analysis is a method used to systematically identify recurring themes, patterns of living, behaviour and experience which then become a description of the phenomenon (Aronson, 1994; Braun & Clarke, 2006; Fereday & Muir-Cochrane, 2008). In addition, these themes are viewed in the context in which themes were developed, which allows the identification of new or emerging themes (Aronson, 1994; Boyatzis, 1998; Fereday & Muir-Cochrane, 2008; Pope et al., 2000).

The process of thematic analysis is to assemble the singular, small and at times meaningless ideas or experiences from individuals (Boyatzis, 1998). When combined

with similar ideas and experiences other from many other individuals it forms a “comprehensive picture of their collective experience” (Aronson, 1994, p. 2). Once thematic analysis was completed, a valid argument was made regarding the themes selected and identified. Inferences were made from the rich data, identified themes and phenomena and how these relate to the literature to form a tapestry of findings, interpretations and conclusions (Aronson, 1994; Fereday & Muir-Cochrane, 2008; Pope et al., 2000).

Braun and Clarke (2006) and Boyatziz (1998) state thematic analysis is very versatile as it is less theoretically bounded as other analytical methods. Therefore, researchers need to ensure the theoretical position of thematic analysis is made clear at the outset. As such, the thematic analysis used in the study followed the theoretical position of the essentialist or realist paradigm “which reports experiences, meanings and the reality of participants” whereas, a constructionist perspective views “events, realities, meanings, experiences and so on are the effects of a range of discourses operating within society” (Braun & Clarke, 2006, p. 81). An essentialist or realist method of thematic analysis was selected for data analysis to report the “experiences, meanings and the reality of participants... in a straightforward way, because a simple, largely unidirectional relationship is assumed between meaning and experience and language” (Braun & Clarke, 2006, p. 81).

In addition, the thematic analysis used within the study draws on a hybrid approach where both an inductive and a theoretical (deductive) approach were used.

Inductive thematic analysis is where themes identified are linked to the data.

In this approach, if the data have been collected specifically for the research, the themes identified may bear little relation to the specific questions that were asked of the participants. They would also not be driven by the researcher’s theoretical interest in the area or topic. Inductive analysis is, therefore a process of coding the data without trying to fit it into a pre-existing coding frame, or the researcher’s

analytic preconceptions. In this sense, this form of thematic analysis is data-driven. (Braun & Clarke, 2006, p. 83)

This approach resembles grounded theory, however, lacks the development of theory whereas theoretical thematic analysis identifies themes and codes them according to previous research and pre-existing coding frames. In the study conducted by Fereday and Muir-Cochrane (2008), which examined performance feedback in the self-assessment of nursing practice, their approach was a hybridisation of both inductive and deductive. The themes were both driven by the data and identified according to a priori (pre-existing) coding frames.

The essentialist or realist paradigm and the hybrid approach were selected to be used in the study to allow a simple method of identifying key patterns regarding the realities of IMGs living in rural Tasmania. As information emerges from the data, it is placed into the corresponding pre-classified or newly identified themes (Aronson, 1994). They can be patterns of “conversation topics, vocabulary, recurring activities, meanings, feelings, or folk sayings and proverbs” (Taylor & Bogdan, 1984, p. 131).

Following this initial step of gathering the data into large groups or “clusters” of similar data, the next step in the process is to break these clusters of data into smaller groups of data or “sub-themes” and then overarching themes (Boyatzis, 1998; Braun & Clarke, 2006). A summary of the themes and sub-themes within this study are provided in chapter seven.

#### **5.6.2.2 Critical Discourse Analysis**

The second element of qualitative data analysis used in the study was CDA, which is a branch of discourse analysis; however, CDA is a means of criticising or critiquing the social order of power and inequality in language (Blommaert & Bulcaen, 2000; Van Dijk, 2001). In other words, it is critical because it is rooted in a thorough critique of social relations (Billig, 2003). CDA “primarily studies the way social power abuse, dominance, and inequality are enacted, reproduced, and resisted by text and talk in the social and political context” (Van Dijk, 2001, p. 352). Thus, the use of CDA within the study was to observe and determine the areas where social power,

dominance, and inequality were enacted, reproduced, and resisted through the text and talk of colleagues and informants of IMGs.

#### *5.6.2.2.1 Background*

Critical Discourse Analysis is not defined by one specific theory or methodology; however, it is informed by a wide range of approaches, which draws on linguistics, psychology and sociology (Wodak, 2002; Wodak & Meyer, 2009). Those who have used CDA are from diverse disciplines and are informed by varied data and methodologies. Therefore, there are many various approaches to CDA that at times can be theoretically and analytically diverse. For example, a CDA approach may be quite different when analysing personal conversation, political discourse or even media discourse (Van Dijk, 2001). This heterogeneous paradigm and methodology allows innovation, flexibility and improvement, when compared to other theories (Blommaert & Bulcaen, 2000; Wodak, 2002; Wodak & Meyer, 2009).

Critical Discourse Analysis is unlike thematic analysis, which identifies patterns of living, behaviour and experience which is then described as a phenomenon (Aronson, 1994; Braun & Clarke, 2006; Fereday & Muir-Cochrane, 2008). CDA has moved beyond simply describing discursive practices to illustrating how discourse is fashioned and developed by its relationship with power and ideologies (Billig, 2003; Blommaert & Bulcaen, 2000). CDA due to its diversity of methodologies incorporates viewpoints such as ideology, hegemony and discourse to explore language and power relationships within societies (Dunmire, 2011; Van Dijk, 2001; Wodak, 2002; Wodak & Meyer, 2009).

Critical Discourse Analysis aims to bring this power out of obscurity and make it more discernible. Blommaert and Bulcaen (2000, p. 449) when discussing CDA, state it “should have effects in society: empowering the powerless, giving voices to the voiceless, exposing power abuse, and mobilizing people to remedy social wrongs.”

As outlined, CDA considers language is a social practice where a relationship exists between an event and the situation in which it occurs (Wodak, 2002; Wodak & Meyer, 2009). In addition, the context of where the language being used occurs is seen as being vital. As such, discourse establishes



situations, objects of knowledge, and the social identities of and relationships between people and groups of people. It... helps to sustain and reproduce the social status quo [and] can help produce and reproduce unequal power relations between... social classes, women and men, and ethnic/cultural majorities and minorities. (Fairclough & Wodak, 1997, p. 258)

To achieve this, CDA occurs at three levels, the micro, meso and the macro. At the micro level, discourse needs to be systematically analysed with the view of 'discourse-as-text.' This approach requires discourse to be analysed in terms of the linguistic patterns used and the organisation of the text, including vocabulary, grammar and how the text is structured (Blommaert & Bulcaen, 2000; Fairclough, 1992).

At the meso level, 'discourse-as-discursive-practice,' discourse is analysed as being text that has been produced, circulated, distributed, and consumed within a community or society. The analysis focuses on speech acts, coherence and intertextuality, which all link text to its context (Blommaert & Bulcaen, 2000; Fairclough, 1992).

Finally, discourse at the macro level, 'discourse-as-social-practice' is where CDA is concerned with hegemony and changing hegemony (Blommaert & Bulcaen, 2000; Fairclough, 1992). This level of exploration analyses "the way in which discourse is represented, re-spoken, or rewritten. [It] sheds light on the emergence of new orders of discourse, struggles over normativity, attempts at control, and resistance against regimes of power" (Blommaert & Bulcaen, 2000, p. 449).

Nevertheless, Blommaert and Bulcaen (2000), highlight those who use CDA have a preponderance to analyse discourse with a view which is biased by their own political views and prejudices of the discourse (Blommaert & Bulcaen, 2000; Schegloff, 1997). However, Van Dijk (2001, p. 352) argues those researchers who engage in CDA must assume an unambiguous position as their aim is to "understand, expose, and ultimately resist social inequality."

In addition to the levels of analysis, there are also a number of social domains of analysis such as power inequity, inequalities and exploitation, where various topics are analysed. These may include, but are not limited to political discourse, ideology, racism, ethnocentrism and immigration, gender, economic discourse, media discourse, advertising discourse, institutional discourse and education (Blommaert & Bulcaen, 2000; Van Dijk, 2001).

#### *5.6.2.2.2 Method of approach within the study*

For the purposes of the study, the method used was a 'systematic and focused framework' to explore the language and power relationships between and among those who have contact with IMGs in the Tasmanian context. CDA was undertaken to examine informant discourse in terms of the linguistic patterns used and how the discourse was used by informants who were interviewed. This analysis included the use of vocabulary, grammar and how the discourse was structured (Blommaert & Bulcaen, 2000; Fairclough, 1992). In addition, the central focus was on the social domains of intolerance, ethnocentrism, and immigration with regard to power and dominance of specific social groups such as institutional, professional or group discourse which is highlighted through the analysis of informant data (Van Dijk, 2001).

Initially, to critically analyse the data, a similar approach to thematic analysis outlined earlier was used. An initial examination of the vocabulary, grammar and linguistic patterns, including how the discourse was spoken by informants was conducted. Throughout this process key phrases and words were identified from the data, which were then placed into corresponding pre-classified or newly identified themes. This analysis was then followed by breaking these data groups into smaller groups of data. The discourse was then analysed in terms of how it is produced within the context of the views of migrants and different cultures in Australia including the social hegemony within the workplace. Similar to thematic analysis, the process was to assemble singular, small, meaningless words or phrases, which allowed a more comprehensive picture of the power and hegemony within the informant cohort (Aronson, 1994; Boyatzis, 1998) (see Appendix I).

Once this initial analysis was completed, an analysis of the contemporary political, media, and nationwide discourse was conducted. It highlighted and outlined the discourse which contributes to current ethnocentrism and immigration discourse within Australia. The literature then assisted the critical analysis of key informant discourse in Tasmania. Inferences were made from the rich data collected, identifying micro, meso, and macro level discourse which was being used by informants and workplace colleagues when discussing IMGs. The literature provided unique insights into the underlying ideology and hegemony between informants, IMGs, within the workplace and among the associated professional bodies.

Critical Discourse Analysis has been briefly outlined above, yet is a complex framework which is informed a large number of approaches to critically analyse discourse (Van Dijk, 2001; Wodak, 2002; Wodak & Meyer, 2009). CDA is about understanding the relationship between discourse and power within text and speech. However, it moves beyond understanding, to acts as a means to “make proposals for change and suggest corrections to particular discourses. CDA thus openly professes strong commitments to change, empowerment, and practice-orientedness” (Blommaert & Bulcaen, 2000, p. 449).

## **5.7 Conclusion**

The research aim and objectives guide the research questions in the current study. However, the mixed method techniques, using a double stage sequential explorative design, are used to collect data for the study. The analytical framework of the study to examine the acculturation of IMGs is ambitious; however, to answer the research questions, this multifaceted structure is used to enable the identification and comparison of known themes with similar studies of IMGs. This method also provides the ability to uncover and develop new theories that emulate from the textual information from the questionnaire and interviews. Finally, this method of analysis provides the capacity to evaluate the social order of power and inequality in language, regarding IMGs who live and work in Tasmania.

The study findings are presented in the following two chapters, which highlight, compare and generate discussion concerning the experiences and challenges of

IMGs living and working in rural and remote Tasmania, and how this informs their acculturation. The findings are discussed both visually and thematically using a number of noteworthy quotations and graphics within in the thesis. The following chapter presents the analysis of quantitative data from the Tasmanian International Medical Graduate questionnaire conducted across Tasmania.

# **Chapter six: Quantitative data analysis and results**

## **6.1 Introduction**

The preceding chapter introduced and described the research framework and design of the study. This chapter is the first of two results chapters in this thesis. It highlights results of the data collected from 105 IMG respondents to the Tasmanian International Medical Graduate questionnaire. These IMG respondents included interns, RMOs, registrars, specialists and GPs working full or part time across Tasmania. This cross-sectional questionnaire was used to respond to the research question one (RQ1) “What are the enablers and barriers which IMGs encounter as they live and work in Tasmanian communities?”

The questionnaire explores the issues, commonalities and questions which were both descriptive and analytical, using a number of statistical methods. The findings presented in this chapter include a discussion regarding the characteristics of IMG respondents including issues such as mobility, patterns of migration and the motivations for moving to Australia and Tasmania. In addition, results relating to satisfaction within the workplace and non-professional aspects of living in Tasmania are reported. The chapter concludes by using inferential statistics to highlight which factors contribute to the integration of IMGs, their retention and length of stay in Tasmania.

## **6.2 Questionnaire administration**

As outlined in section four of chapter five, the Tasmanian International Medical Graduate questionnaire was sent to IMGs across Tasmania using three methods. In order to recruit a sample of 180 IMGs with a 60% anticipated response rate, 581 questionnaires were distributed: 229 electronically and 352 paper-based. IMGs were requested to either fill in the questionnaire on-line or return a completed hardcopy questionnaire.

The greatest response was through the electronic version of the questionnaire and at the time of the first reminder being sent out at week four weeks 48 (45.7%) electronic questionnaires were completed, while only nine (8.5%) hard copy questionnaires were returned within the same period of time. Reminders were sent out in week eight at which time an additional 19 (18.1%) electronic questionnaires were completed and the remaining three (2.8%) hardcopy questionnaires were returned. Finally, in week 8 direct hard copy questionnaires were mailed directly to known IMGs with 20 (19.0%) being returned within the first four weeks. In total, 105 questionnaires were returned representing an overall response rate of 18.0%, and represents 30.0% of the IMG population in Tasmania, as indicated in Table 6.1.

**Table 6.1: Questionnaire response rate**

Distribution method	Number sent	Number returned	Percentage returned (%)	Percentage of total returned (%)
Hard copy				
- Third party	291	12	4.1%	11.4%
- Direct	61	20	32.8%	19.0%
Email				
- Third party	229	73	31.9%	69.5%
Total	581	105	18.0%	100%

There was the possibility of more than one survey being distributed to a single IMG. In order to address this issue, clear instructions were outlined on the questionnaire. Participants were instructed to complete either the on-line or hardcopy version, not both. Of those who were 39 years or younger, 58% completed the on-line questionnaire while only 42% of those who were 39 years or younger completed the hardcopy questionnaire.

### 6.3 Analysis techniques

As discussed in Chapter four, the questionnaire data were analysed using SPSS 20.0 (IBM, 2012). Descriptive statistics were used to organise, summarise, analyse and

present respondent data including proportions and frequencies of collected data (Munro, 2005).

Inferential statistics was used to analyse the data and to draw conclusions from the sample populations (Munro, 2005; Pallant, 2011). Therefore, the collected data from target participants allow inferences to be made regarding the overall population. The Kolmogorov-Smirnov test of normality was conducted to examine the normality of collected data distribution. The analysis showed that data were non-normally distributed as their scores were significantly away from the normal bell curve ( $p$  values  $< 0.05$ ). Therefore, non-parametric tests, such as, Spearman's correlation tests, Chi-square ( $\chi^2$ ) tests and ordinal logistic regression were appropriate to analyse the collected dataset.

### **6.3.1 Spearman's correlation tests**

Correlation is used when need to explore strength and direction of the linear relationship between two dependent variables. For example, a positive correlation indicates that, as one variable increases, the other will also. As the data were non-normally distributed the non-parametric Spearman's correlation test was used to measure statistical correlation between variables. Results were considered statistically significant at  $p \leq 0.05$  and the strength of the relationship was considered to be small when  $r$  values = .10 to .29, medium  $r$  values = .30 to .49, large  $r$  values = .50 to 1.0 (Munro, 2005; Pallant, 2011).

### **6.3.2 Chi-square ( $\chi^2$ ) tests**

Chi-square ( $\chi^2$ ) tests are used to determine if a correlation or association exists between two variables. The basis of a Chi-square test is a comparison of the observed frequencies in each cell and the expected frequencies or numbers of subjects expected (Munro, 2005).

As outlined in Chapter five, Chi-square ( $\chi^2$ ) tests were performed between gender, age group, region of origin and current employment in Tasmania (independent variables) and each Likert-scale outcome variables. The Likert-scales related to the professional and non-professional satisfaction of IMGs and the factors that would

determine their future employment (dependent or outcome variables). If Chi-square assumptions were violated (i.e., more than 20% of expected cells less than 5), a Fisher's exact test was used. All Chi-square ( $\chi^2$ ) tests were performed and are shown in Table J1, Table J2 and Table J3 (see Appendix J).

Chi-square ( $\chi^2$ ) tests only indicate an association, they do not give a measure of the strength of the association between the variables nor does it give any information about what the nature of the differences between the groups are (Munro, 2005; Pallant, 2011). Those factors that were indicated to be significant ( $p$  values= $<0.05$ ) underwent ordinal logistic regression.

### **6.3.3 Ordinal logistic regression**

Ordinal regression is used to determine which independent variables, as discussed above, have a significant effect on the dependent variables. In addition, the OR provides insight into which of the groups within the independent variable had a higher or lower value compared to other groups. For example, ordinal regression may show that female IMGs may have higher odds of being more satisfied with the friendliness of their patients than male IMGs.

Ordinal logistic regression was conducted using the GENLIN procedure within SPSS version 20.0 to determine the significance between variables, also odds ratios (OR) and 95% confidence intervals were calculated (IBM, 2012). Results were considered statistically significant at  $p < 0.05$  (Munro, 2005). Prior to performing ordinal logistic regression analysis all assumptions were tested including testing for multicollinearity. The results indicated that no assumptions were violated.

## **6.4 Profile of the participants**

The questionnaire participants provided basic information regarding their characteristics and background which is highlighted in detail.

### **6.4.1 Characteristics of participants**

The questionnaire data, as shown in Table 6.2 comprises of 57.2% male respondents and 42.8% female respondents. The respondents were aged 20 years of age and higher. Those aged between 30 and 49 accounted for 69.5% IMGs, while



18.1% IMGs were over the age of 50. Those who were married or in de facto relationship accounted for 75.0% of the respondents and 65.4% had children. Religion was observed to be reported by 83.3% IMGs, of whom 28.4% were Christian, 21.6% Hindu, and 15.2% of the Islamic faith. The high proportion of Hindu IMGs reflects the main country of origin within the cohort.

**Table 6.2: *Characteristic of participant study sample***

Variables	Number (n/N)	Percentage (%)
Gender		
- Male	60/105	57.2
- Female	45/105	42.8
Age		
- 20-29	13/105	12.4
- 30-39	38/105	36.2
- 40-49	35/105	33.3
- 50-59	11/105	10.5
- 60+	8/105	7.6
Marital status		
- Married/De facto	78/104	75.0
- Separated/Divorced	16/104	15.3
- Never married	9/104	8.7
- Widowed	1/104	1.0
Total with children	68/104	65.4
Religion		
- Christian	29/105	28.4
- Hindu	22/105	21.6
- No religion	17/105	16.7
- Islam	16/105	15.7
- Buddhist	12/105	11.8
- Sikh	5/105	4.9
- Jewish	1/105	1.0

#### **6.4.2 Country of birth**

The respondents had originated from 30 different countries, which were grouped into six 'regions' of origin. The grouping of IMG respondents included 59.2% from Asia, 10.4% from Africa, 9.5% from Middle East, 5.7% from the Americas, 5.7% from Europe, 5.7% from UK and 4.7% Oceania, as observed in Table 6.3. It is noted that

over half of all respondents were from the Asian region with the highest number of respondents within this group originating from India.

**Table 6.3: Country of birth**

Origin (N=105)	Country	Number (n/N)	Percentage (%)
Asia (n=61)	India	33/105	31.4
	Sri Lanka	9/105	8.6
	Myanmar	7/105	6.7
	Malaysia	4/105	3.8
	Pakistan	3/105	2.9
	Indonesia	2/105	1.9
	Bangladesh	1/105	1.0
	Philippines	1/105	1.0
	Vietnam	1/105	1.0
Africa (n=11)	South Africa	5/105	4.8
	Nigeria	2/105	1.9
	Egypt	1/105	1.0
	Libya	1/105	1.0
	Mauritius	1/105	1.0
	Zimbabwe	1/105	1.0
Middle East (n=10)	Iran	8/105	7.6
	Lebanon	1/105	1.0
	United Arab Emirates	1/105	1.0
Americas (n=6)	USA	3/105	2.9
	Brazil	1/105	1.0
	Colombia	1/105	1.0
	Mexico	1/105	1.0
Europe (n=6)	Germany	3/105	2.9
	Russia	2/105	1.9
	Spain	1/105	1.0
UK (n=6)	United Kingdom	6/105	5.7
Oceania (n=5)	Australia	4/105	3.8
	New Zealand	1/105	1.0

### 6.4.3 Languages spoken

In addition to the country of birth, 34 languages were listed as being spoken by the respondents other than English. There were 24.8% IMGs spoke two or more languages other than English with 12.4% speaking up to three different languages other than English. The most common language other than English among the

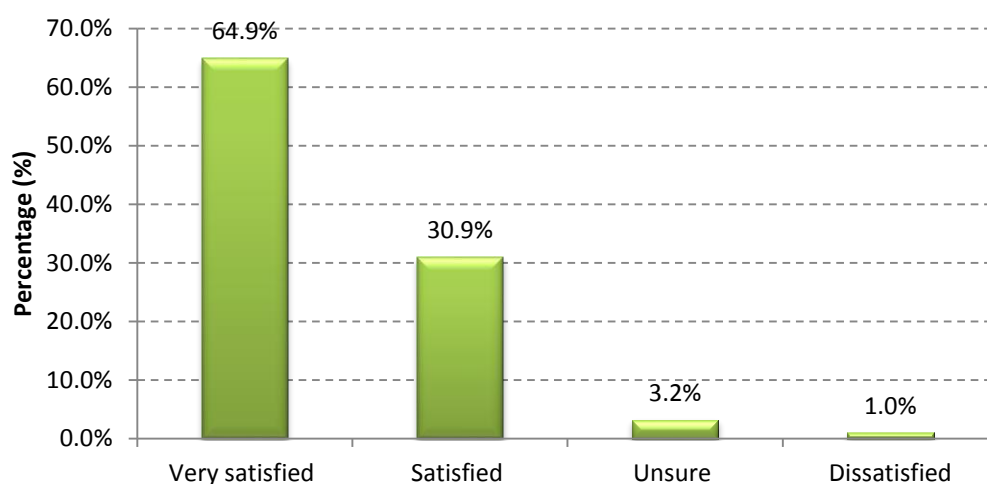
cohort was Hindi (17.3%), followed by Tamil (10.5%) and Telugu (6.7%). English was reported to be a first language among 14.5% IMGs, with 49.5% reporting their English skills at the time of migration was very good, 30.9% stating their English was good, and 1.0% stating their English at the time of migration was poor, as shown in Figure 6.1.



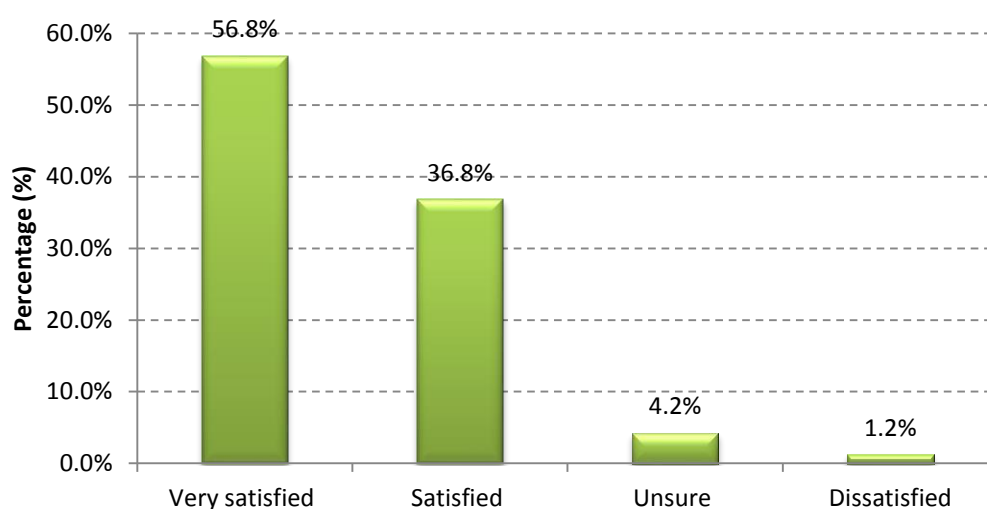
**Figure 6.1: Self-reported English proficiency at time of migration**

#### **6.4.4 Communication skills**

The respondents were also asked to self-report their communication skills within the workplace and the community. In response to this question, 64.9% IMGs stated they were very satisfied with their communication skills within the workplace, while 56.8% stated they were very satisfied with their communication skills within the community as outlined in Figure 6.2 and 6.3 below.



**Figure 6.2: Self-reported satisfaction communication skills professionally**



**Figure 6.3: Self-reported satisfaction communication skills socially**

## 6.5 The migration profile of respondents

The participants provided basic information regarding the aspects concerning migration and migrating to Australia, which are discussed in detail below.

### 6.5.1 Immigrant entry

The data showed that 83.5% of the IMG respondents arrived in the past 10 years with the remaining 16.5% arriving before the year 2000. There were 51.0% IMGs reported their immigration category when first arriving was under the temporary subclass 422 or 457 visas, whereas 9.0%, 7.0% and 6.0% had arrived on family visas, independent skilled and employer nominated scheme visa categories respectively,

as shown in Figure 6.4. It is noted that the 23.0% IMGs who entered under the ‘other’ category were on dependant spouse visas, student visas (PhD), student dependant visas, tourist and visitor visas or as New Zealand citizens.

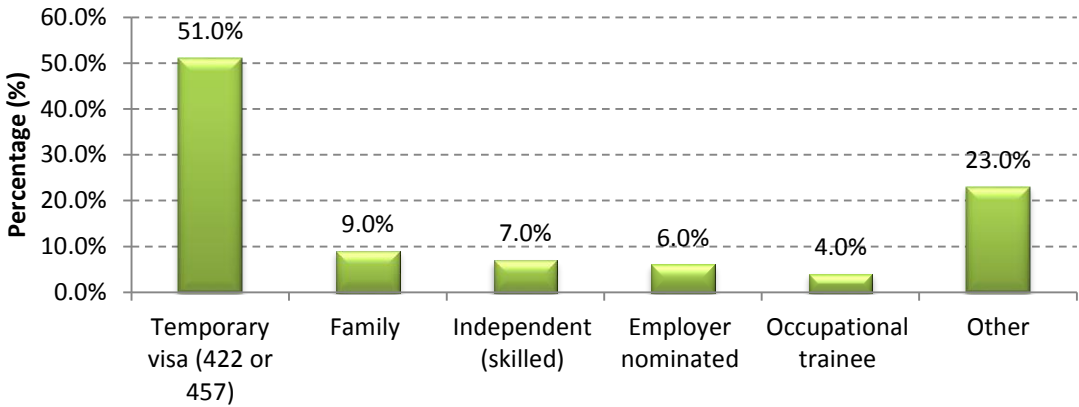


Figure 6.4: Immigration category entry

6.5.2 Current residency status

In addition to each respondent’s immigration category, their current residential status was also provided. It was found that 37.1% of the respondents were temporary residents while the remainder had specified their residency status as either permanent residents or Australian citizens, as indicated in Figure 6.5.

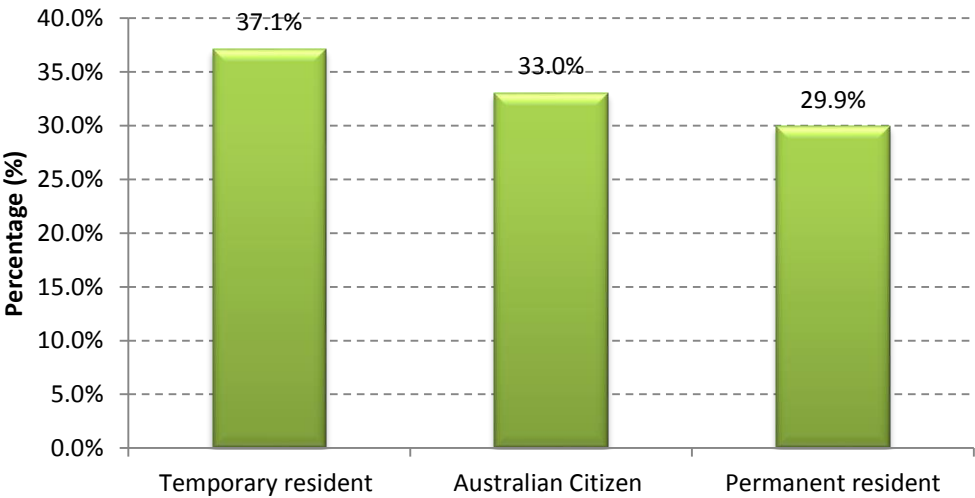
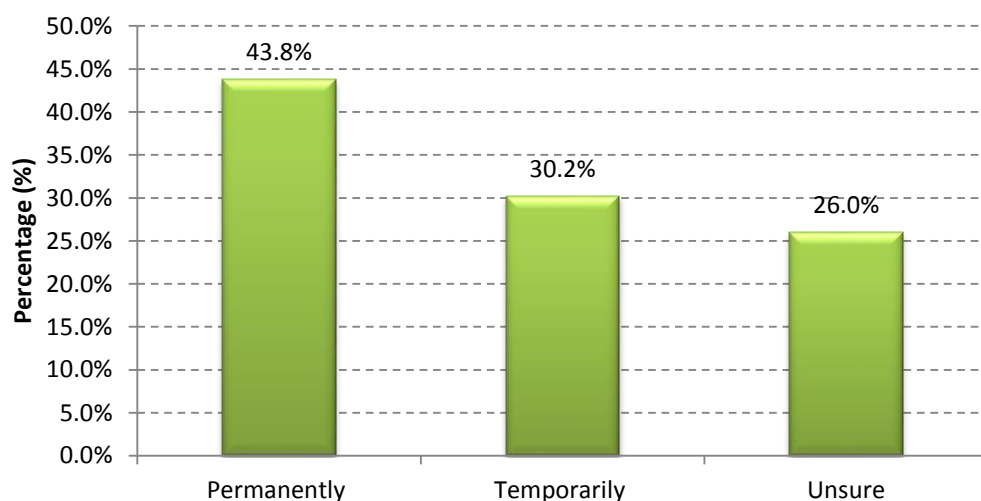


Figure 6.5: Immigration category entry

### 6.5.3 The intention of IMGs to live in Australia

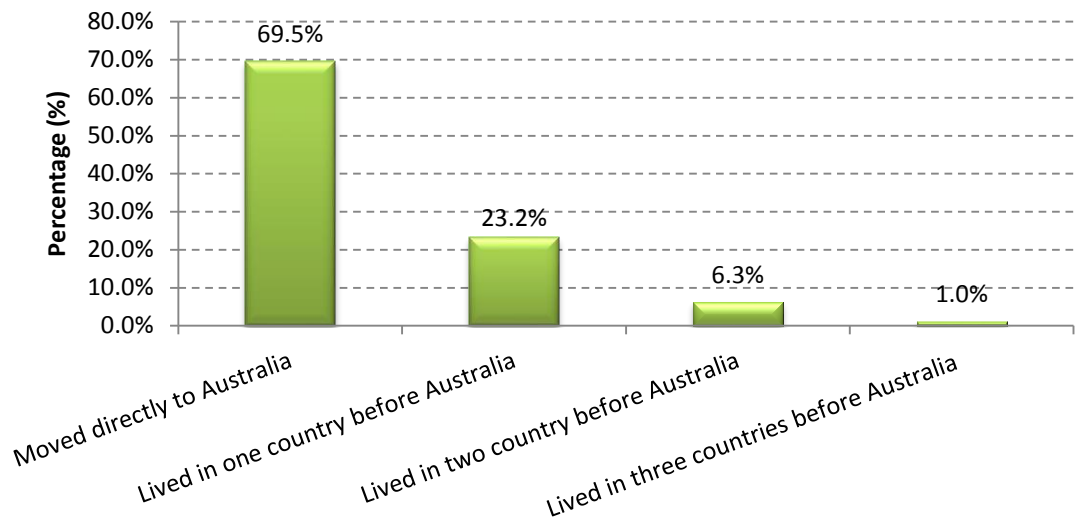
Each respondent was also asked what intentions they had and in what capacity they had intended to live in Australia when they first arrived. Nearly half of the respondents (43.8%) indicated that they had moved to Australia with the intention to live here permanently; however, 26.0% of them indicated that they were unsure at the time of migration, as shown in Figure 6.6.



*Figure 6.6: Intention to stay at time of migration*

### 6.5.4 Number of moves prior to migration to Australia

In addition to indicating the intention to stay in Australia, the respondents were asked as to their movements prior to migrating to Australia. Overall, 29.5% respondent had experienced migration to other countries and this cohort had migrated to a total of 36 countries before migrating to Australia. Among them, 23.2% had worked in at least one country and 6.3% had worked in two or more countries prior to migration to Australia, as shown in Figure 6.7.

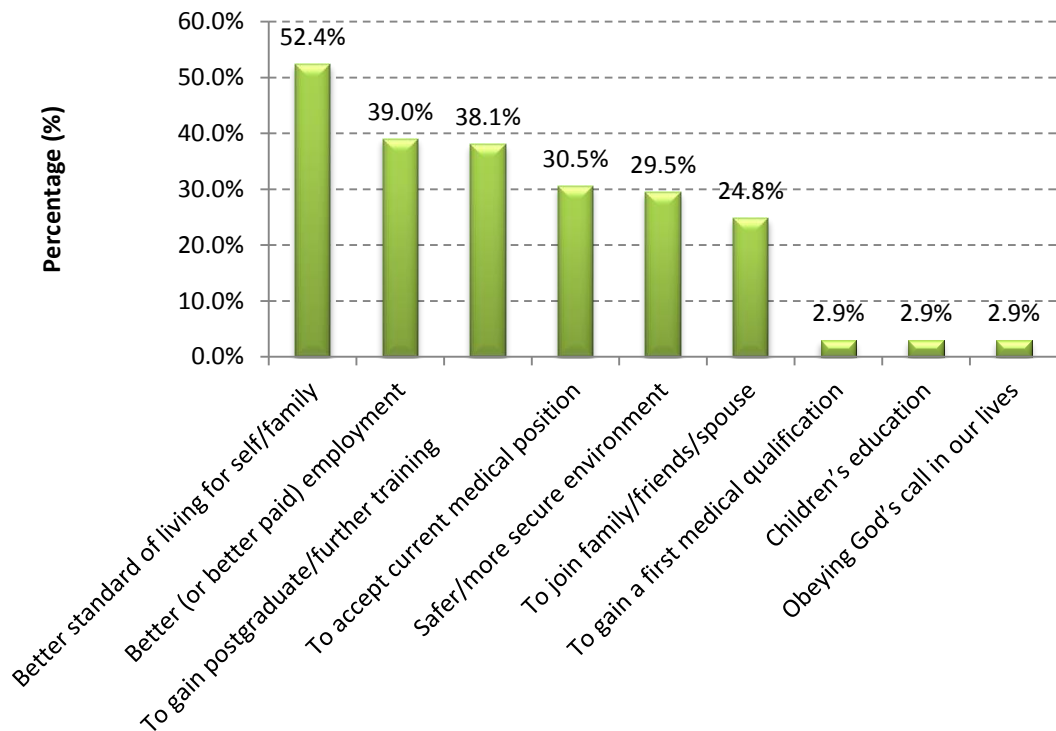


**Figure 6.7: International movement of IMGs prior to migrating to Australia**

It was observed that those respondents who were from Asian and Middle Eastern countries had a propensity to move directly from their country of origin to Australia than those who were from other countries.

#### **6.5.5 Reasons for migrating to Australia**

After indicating their movement prior to coming to Australia, the respondents were further asked to indicate the three most important reasons for migrating to Australia. The findings indicated that 52.4% of the respondents migrated to Australia ‘for a better standard living’ which was the most common reason to seek work in Australia, as shown in Figure 6.8. ‘To gain a better employment or better paid employment’ was the second most common reason, chosen by 39.0% of the respondents. A slightly smaller percentage of 38.1% were motivated by ‘the desire to undertake post-graduate training’ while 29.5% migrated ‘to obtain a safer and more secure environment for family.’

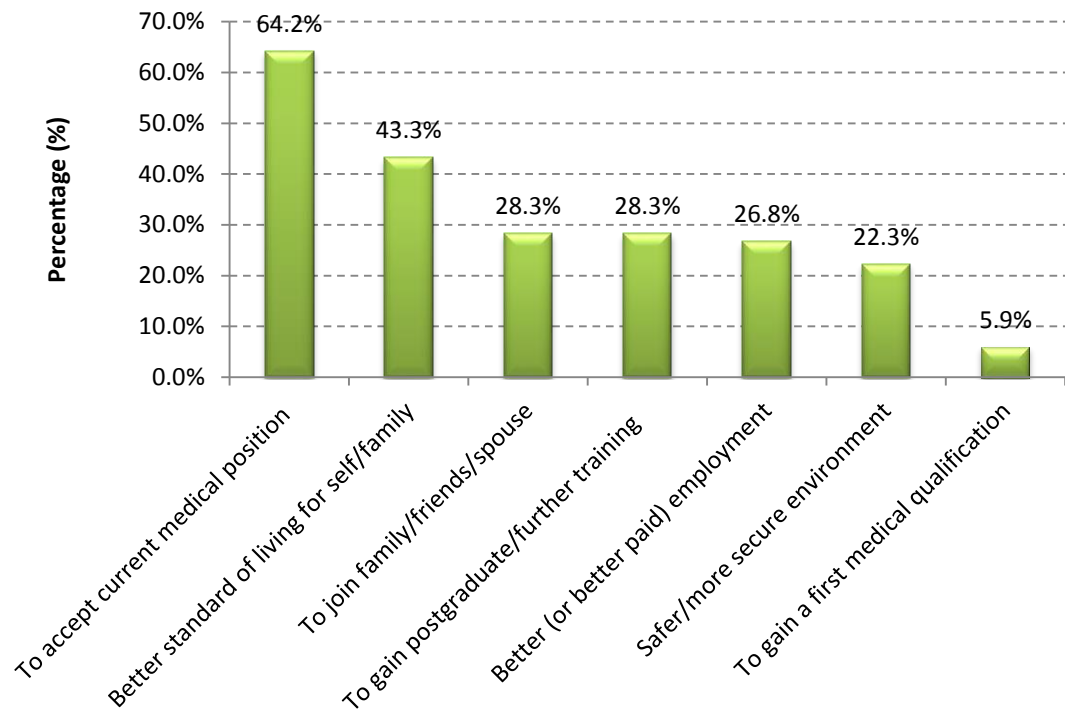


**Figure 6.8: The most important reasons for coming to Australia**

#### **6.5.6 Reasons for migrating directly to Tasmania**

The most common reasons for migrating directly to Tasmania were specified by 64.2% of the respondents to be 'to accept current medical position'; 43.3% indicated it was 'to gain a better standard of living'; 28.3% of the respondents identified migration to Tasmania was motivated by 'the desire to join family or friends' while 28.3% said it was 'for post-graduate or further training', as shown in Figure 6.9.

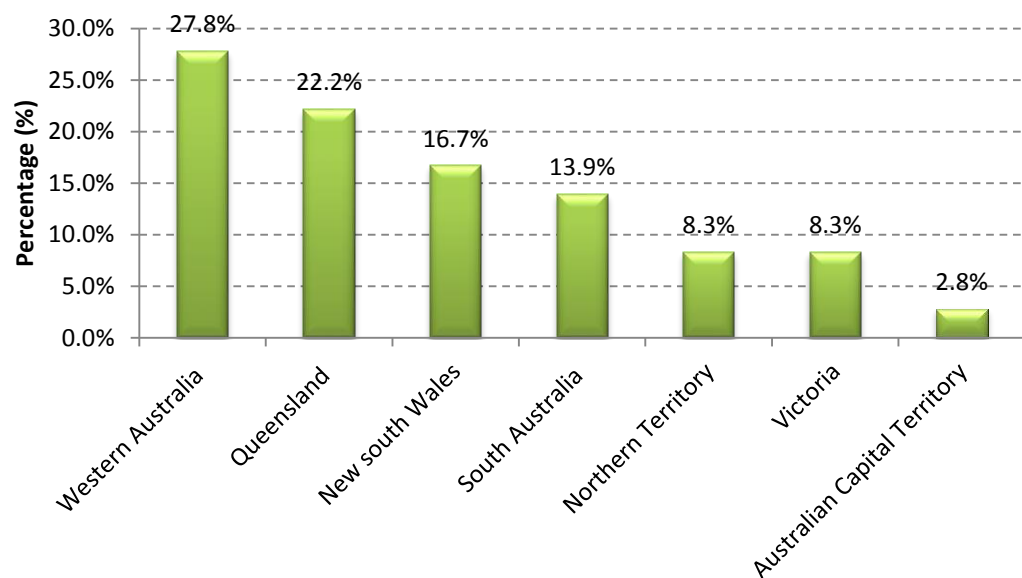




**Figure 6.9: The most important reasons for coming directly Tasmania**

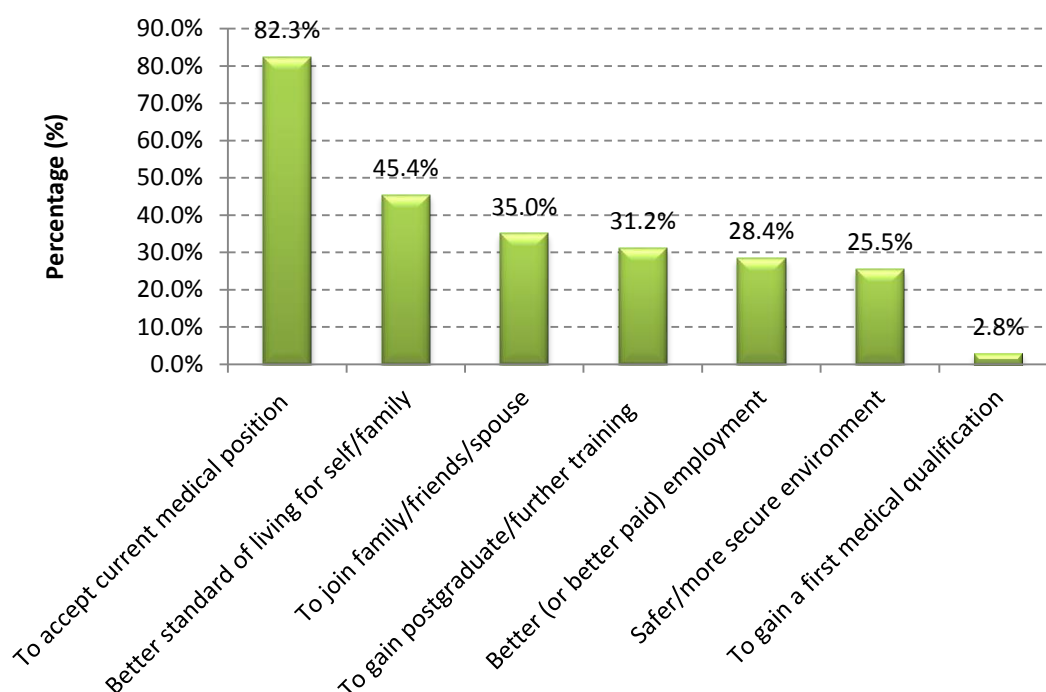
#### **6.5.7 Reasons for relocating from elsewhere in Australia**

At the time of the questionnaire, 26.6% IMG respondents stated they had worked elsewhere in Australia. The most common states the respondents had worked in were Western Australia, Queensland, and New South Wales, as shown in Figure 6.10. However, 21.4% had worked in two states, while 3.6% respondents worked in three states.



**Figure 6.10: State where IMGs have worked**

Those who had worked or lived elsewhere in Australia before migrating to Tasmania indicated the three most important reasons for moving to Tasmania. There were 82.3% of the respondents stated that it was 'to accept current medical position'; 45.4% specified it was 'to gain a better standard of living'; 35.0% of the respondents said moving to Tasmania was motivated by 'the desire to join family or friends' while 31.2% of the respondents stated it was also for a 'safer or more secure environment', as shown in Figure 6.11.



**Figure 6.11: The most important reasons for coming to Tasmania**

In addition to these factors, written responses for moving to Tasmania after living elsewhere in Australia was for the climate (2.8%), to see and discover Tasmania (2.8%), to gain further experience as a GP (2.8%) and lastly, to settle down in Tasmania (2.8%).

## **6.6 Respondents qualifications and registration profile**

The participants were asked to provide information regarding their qualifications and registration background. This included country of highest overseas qualification and their current medical registration in Australia. Each of these aspects of the participant's qualifications and registration profile is discussed below in detail.

### **6.6.1 Country of highest overseas medical qualification**

The highest medical qualifications gained overseas within the IMG cohort ranged from MBBS, MD, MBChB to physician, specialist in anaesthetist, plastic surgery and obstetrics and gynaecology. Overall, there were 54 variations of overseas qualifications which were obtained in 26 countries. Most of these qualifications were gained in countries such as India, Iran, Sri Lanka, United Kingdom and

Germany, as outlined in Table 6.4. However, it is noted 17.1% IMGs did not respond to this question.

**Table 6.4: Country overseas medical qualification obtained**

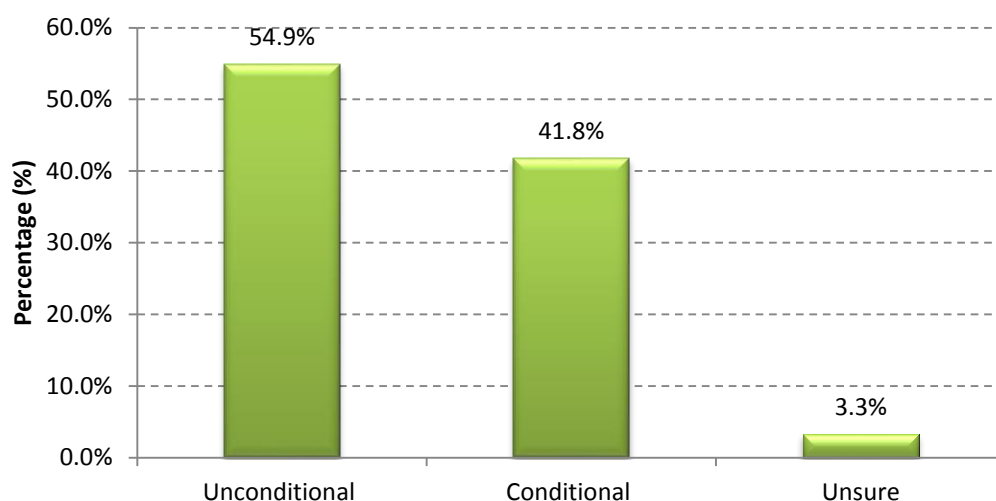
Country received (N=87)	Number (n/N)	Percentage (%)
India	29/87	33.3
Iran	8/87	9.2
Sri Lanka	7/87	8.0
United Kingdom	7/87	8.0
Germany	5/87	5.7
South Africa	4/87	4.6
Myanmar	3/87	3.4
Pakistan	3/87	3.4
Ireland	2/87	2.3
Lebanon	2/87	2.3
New Zealand	2/87	2.3
Nigeria	2/87	2.3
Malaysia	2/87	2.3
USA	2/87	2.3
Bangladesh	1/87	1.1
Indonesia	1/87	1.1
Mexico	1/87	1.1
Russia	1/87	1.1
Spain	1/87	1.1
Thailand	1/87	1.1
Trinidad	1/87	1.1
Uzbekistan	1/87	1.1
Zimbabwe	1/87	1.1

In addition to overseas qualifications, IMGs outlined the qualifications they had obtained in Australia. Only 39% had completed this question with 16.2% of the respondents indicating their Australian qualification was the AMC certificate. The

remaining IMGs had reportedly received a fellowship in General Practice, Surgery, Anaesthetics, Rural Remote Medicine, Public Health and Physician. Conversely, others stated they had received adjunct higher education, such as a Diploma of Community Welfare, Master of Medical Imaging Science, Master of Medical Health, while another had completed a Doctor of Philosophy.

### 6.6.2 Current medical registration in Australia

The data showed that 54.9% of the IMG respondents specified their current medical registration was unconditional while 41.8% had conditional registration as shown in Figure 6.12.



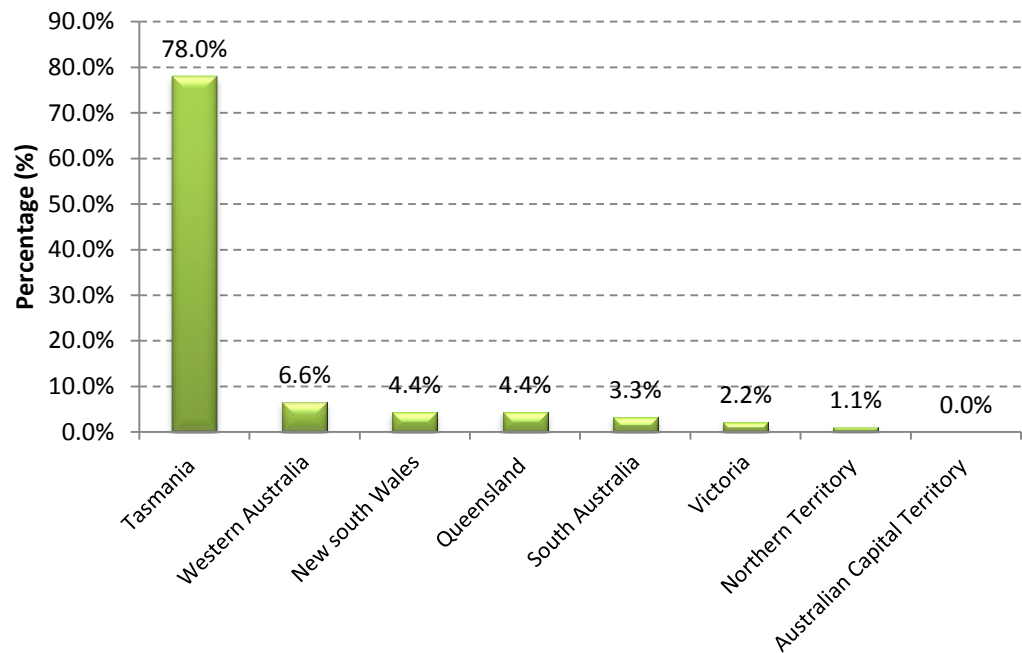
**Figure 6.12: Current registration in Australia**

In addition, it was shown that 82.1% of the IMG respondents had first become registered in the past 10 years and of those, 50.4% were registered in the past five years. The greatest number of registrations occurred between 2009 and 2010 as shown in Table 6.5. Again, it is noted 17.1% IMGs did not respond to this question.

**Table 6.5: Year of registration**

<b>Year of registration (N=87)</b>	<b>Number (n/N)</b>	<b>Percentage (%)</b>
2012	3/87	3.4
2011	3/87	3.4
2010	17/87	19.5
2009	16/87	18.4
2008	5/87	5.7
2007	6/87	6.9
2006	11/87	12.6
2005	6/87	6.9
2004	4/87	4.6
2002	1/87	1.1
2001	1/87	1.1
2000	3/87	3.4
1999	1/87	1.1
1998	3/87	3.4
1996	2/87	2.3
1993	2/87	2.3
1990	1/87	1.1
1984	1/87	1.1
1982	1/87	1.1

It was also shown that 78.0% of the IMG respondents were first registered in Tasmania while, the remaining IMGs first became registered in Western Australia, New South Wales, Queensland, South Australia, Victoria and the Northern Territory, as indicated in Figure 6.13.



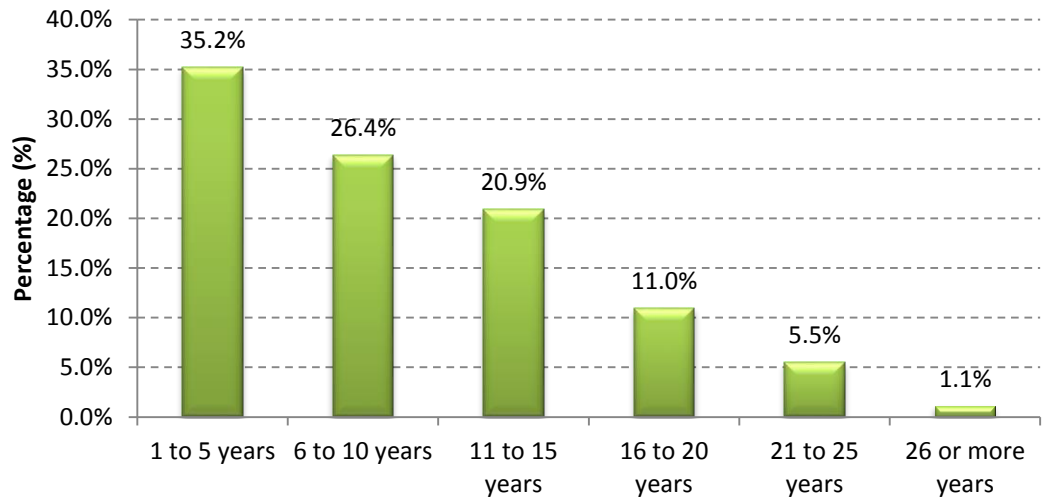
**Figure 6.13: Australian state where IMGs first registered**

## 6.7 Current and past employment profile

Each respondent provided information regarding their past and current medical employment. This included years of medical experience and previous rural experience and the time when the respondents were able to secure medical employment once in Australia. More specific data regarding the participants' current position, contract length and working hours per week were collected. Each of these aspects of the participants' profile is discussed in detail.

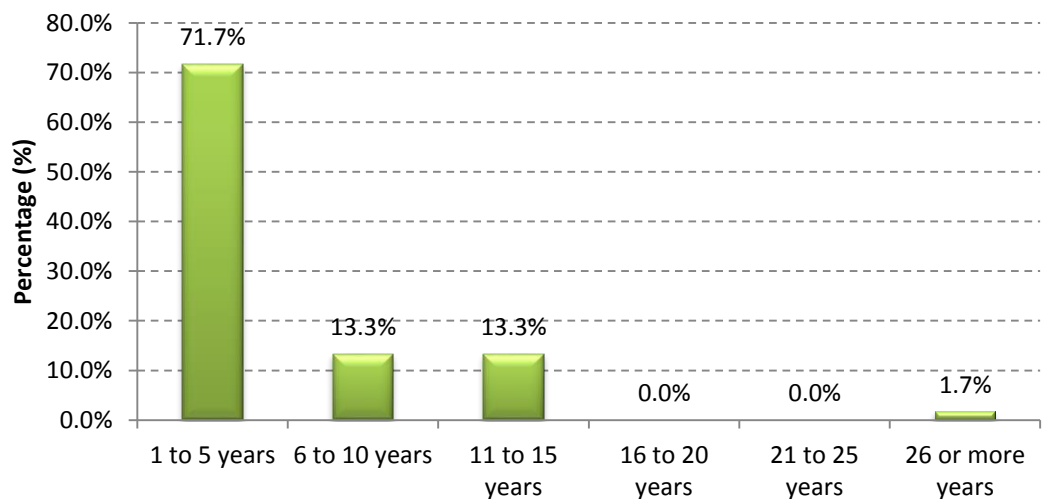
### 6.7.1 Medical employment prior to migration

The data demonstrated that the mean length of time an IMG had worked prior to arriving in Australia was  $9.37 \pm 6.7$  years, with 61.6% of the respondents working for 10 years or less, as shown in Figure 6.14. It is noted that 13.3% IMGs did not respond to this question.



**Figure 6.14: Years of experience prior to migration**

The analysis showed that 53.3% IMGs indicated they had worked in rural areas before migrating to Australia for a mean length of time of  $5.10 \pm 4.8$  years, with 71.7% of the respondents working in rural areas for 5 years or less, as shown in Figure 6.15.



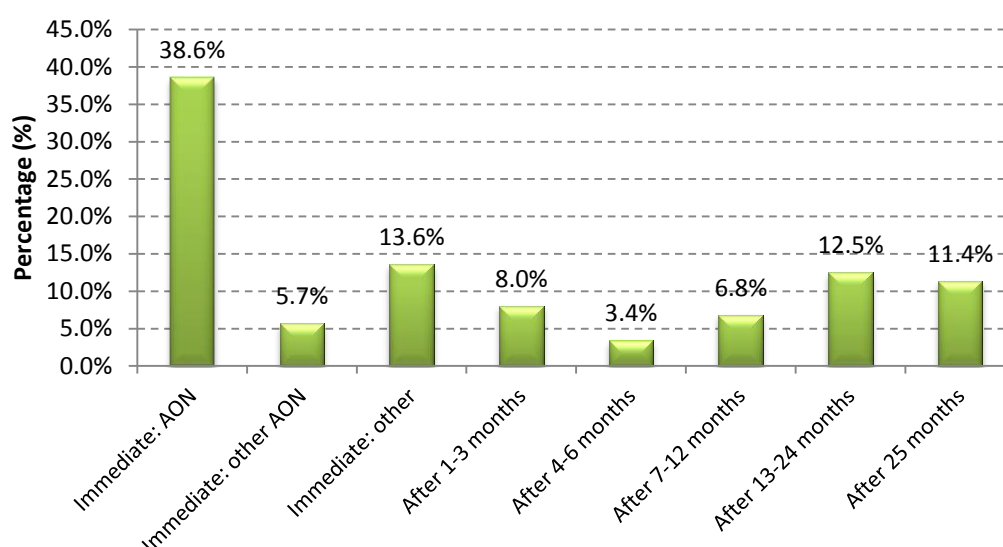
**Figure 6.15: Years of rural experience prior to migration**

### 6.7.2 Time medical employment gained after arrival

The IMG respondents also specified how quickly they had gained medical employment after arriving in Australia. There were 57.9% of the respondents indicated that they had immediately gained employment through AoN or other similar medical position. It is shown that 11.4% gained employment more than 25



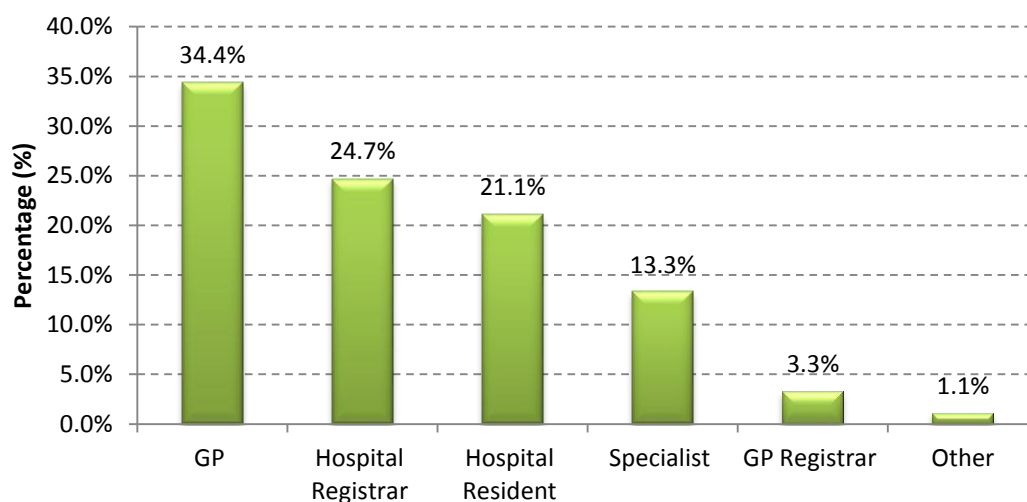
months after arrival in Australia as demonstrated in Figure 6.16. Again, 16.2% IMGs did not respond to this question.



**Figure 6.16: The timeframe IMGs gained medical employment after arrival**

### 6.7.3 Current medical position

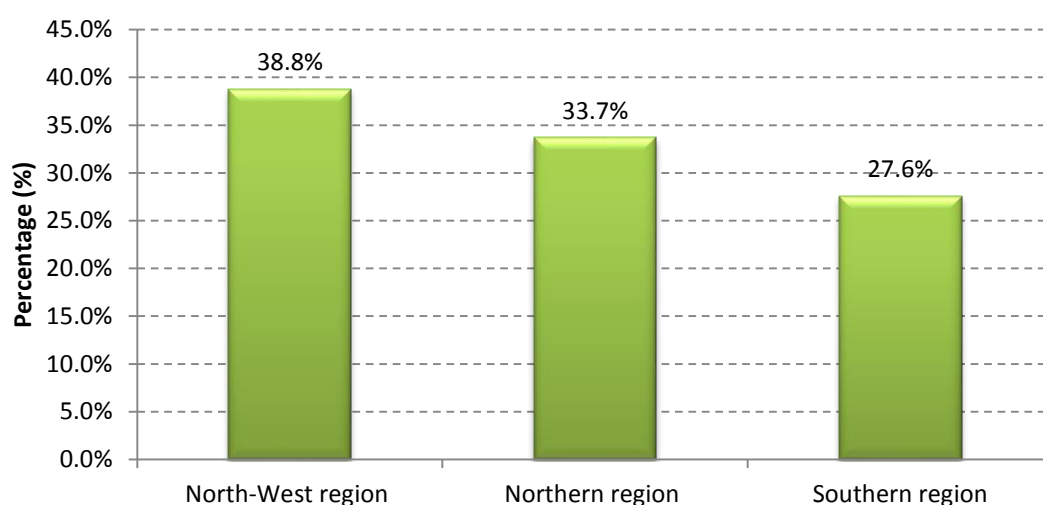
The current medical positions held by the IMG respondents varied and encompassed many positions within medicine. At the time the questionnaire was administered, 34.4% of the respondents were working in General Practice while the remaining 65.6% were working in acute care sector positions such as hospital registrars (26.7%), hospital residents (including interns) (21.1%) and specialists (13.3%) as shown in Figure 6.17.



**Figure 6.17: Current position held by IMG respondents**

#### 6.7.4 Current medical employment location

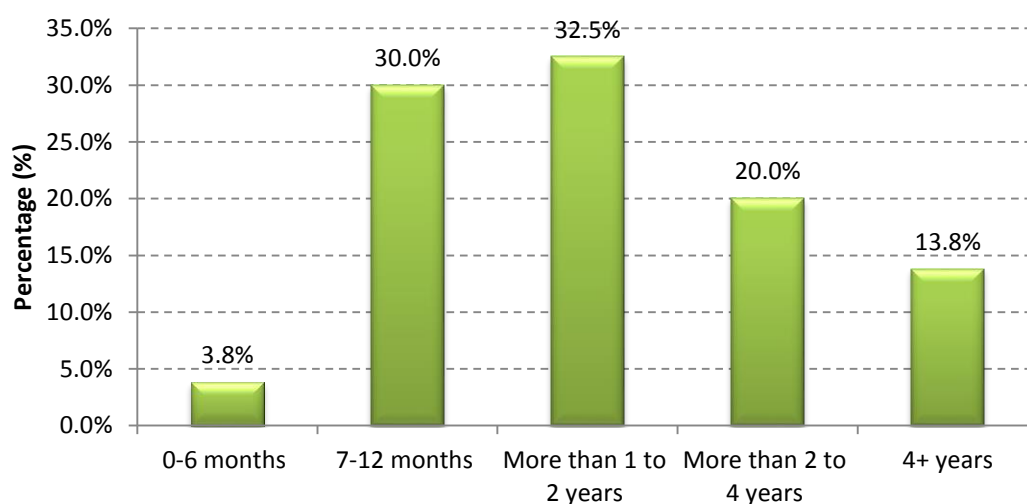
The participants were each asked to provide information regarding their current location. As shown in Figure 6.18, the respondents indicate they were working in a wide variety of areas across Tasmania, with 38.8% working in the North-west region, 33.7% in the Northern region and 27.6% in the Southern region. A high proportion of the IMGs were working in and around the three major population centres of Hobart, Launceston and Burnie. There were seven respondents who did not report where they were working.



**Figure 6.18: Current employment location**

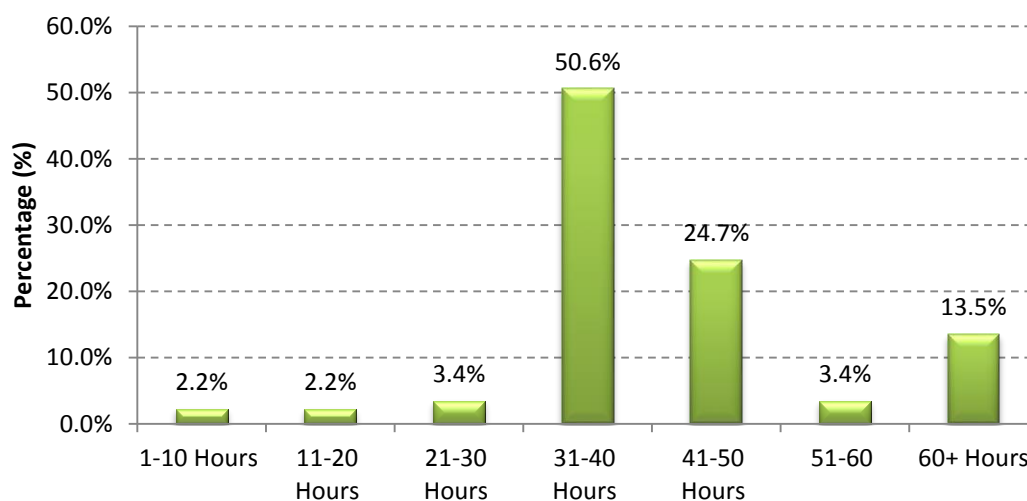
### 6.7.5 Contract length and hours working in current position

In addition to current employment, 82.5% of the IMG respondents reported that their current contracts were between 7-24 months. However, the overall contract length was a mean length of 3.1±1.1 years, as outlined in Figure 6.19. Again there was a low response rate, with 23.8% IMGs not completing this question.



**Figure 6.19: Contract length of current position**

In addition, it was observed 50.6% of the respondents were working between 31 to 40 hours a week at the time the questionnaire was being administered. In addition, 13.5% of the respondents were working more than 60 hours a week as outlined in Figure 6.20.

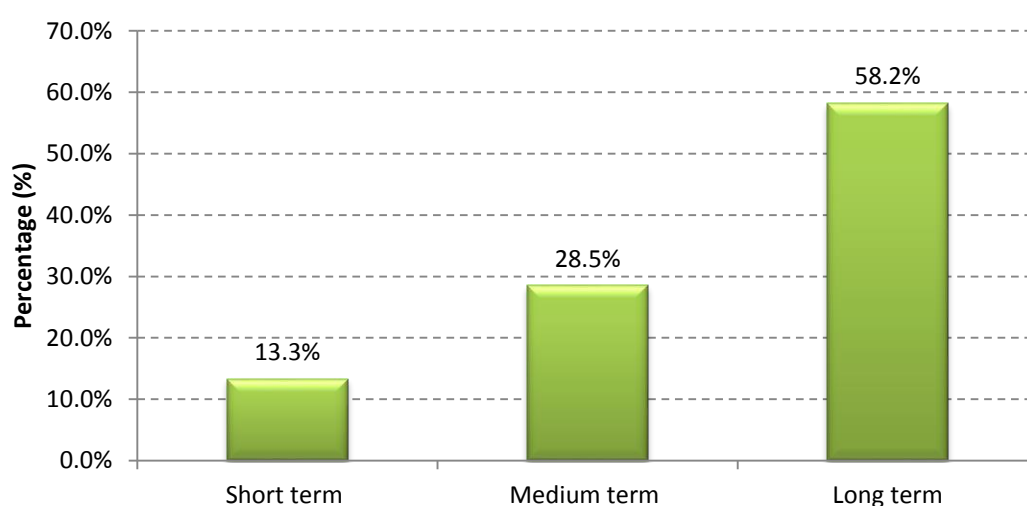


**Figure 6.20: Number of hours worked per week**

Lastly, 3.4% of the respondents indicated they were self-employed and working in their own practice, while 1.1% were working as a locum and 2.2% were currently looking for work in Tasmania.

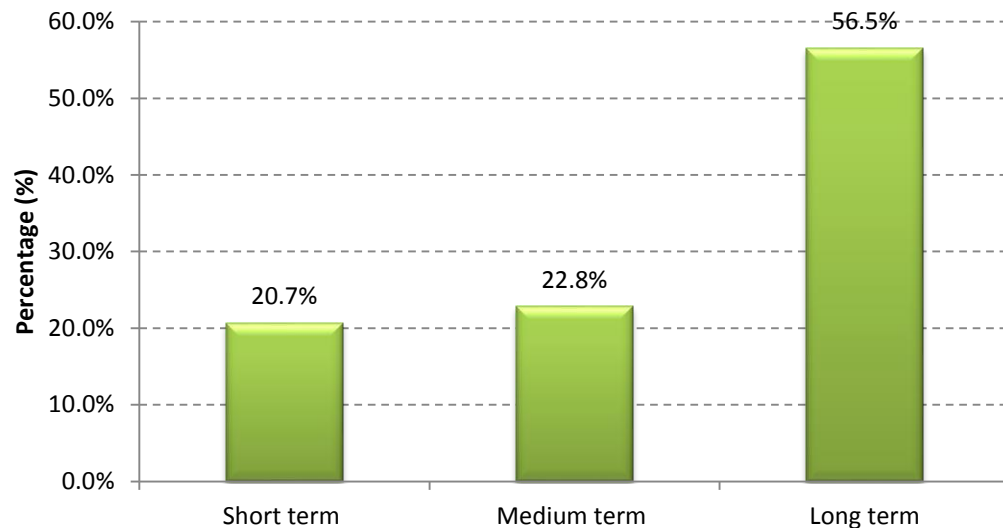
#### **6.7.6 Current time and intention to stay in location**

The respondents were asked about the length of time they had stayed in Tasmania and it was indicated that they had been living in the state between one month and 30 years. More than half (59.0%) of the respondents indicated they had lived in Tasmania for two years or less; however, the median length of time was 1.67 years. The respondents were further asked to specify how much longer they would like to stay in Tasmania. The finding showed that 58.2% of the respondents indicated that they would like to stay long term, as shown in Figure 6.21. However, when they were asked to indicate how much longer they were aiming to working in Tasmania, 60.0% of them said they were aiming to work in their current location for a further one to two years with a median of 2 years being indicated.



**Figure 6.21: How much longer an IMG would like to stay in Tasmania**

This same question was asked again with respect to how much longer the respondent's family would like to stay in Tasmania. The results showed that 56.5% of the families would like stay in Tasmania long term, as shown in Figure 6.22.



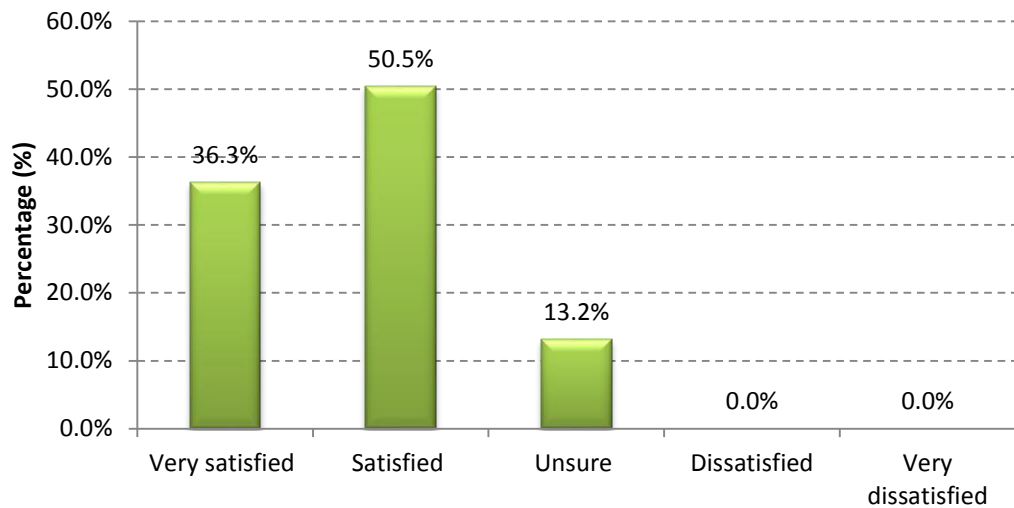
**Figure 6.22: How much longer an IMG's family would like to stay in Tasmania**

## 6.8 Satisfaction with employment and current lifestyle

Lastly, the participants were asked a number of questions relating to satisfaction with employment and lifestyle. In addition they were asked to complete two Likert-scale questions about their level of satisfaction relating to both their current employment position and lifestyle. This included medical location, salary level, and other things such as access to employment for spouse or partner and the friendliness of the local people. The participants were then asked to rate the level of importance regarding certain aspect of their current location that may influence future employment. The aspects included job satisfaction, shorter working hours, less on-call responsibility, access to good schools, cultural community and religious facilities. Finally, each IMG was asked to indicate what their immediate plans were for employment and the reason behind the decision. The data gathered from these questions is outlined below.

### 6.8.1 Satisfaction within current employment

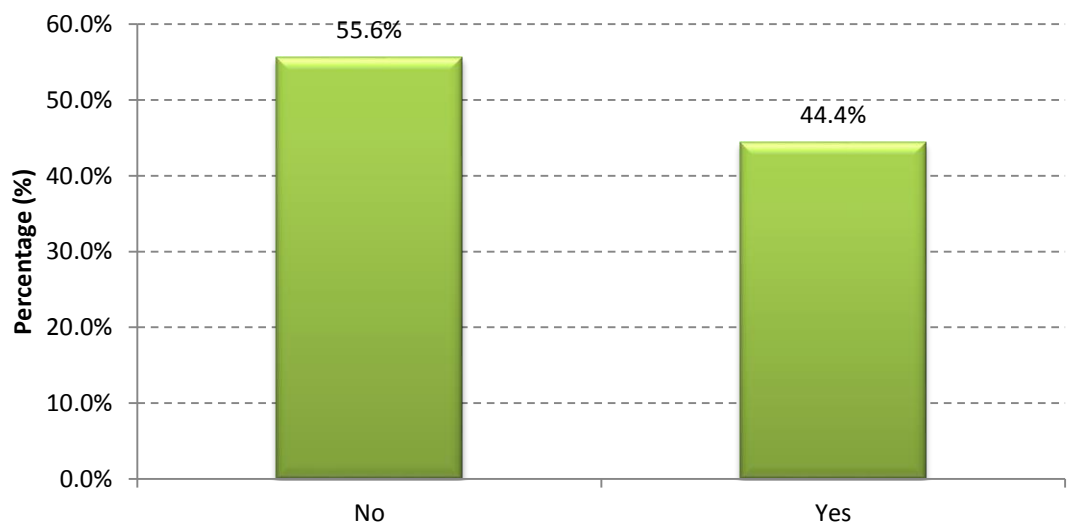
In terms of satisfaction with current employment, Figure 6.23 shows that 36.3% of the respondents reported they were very satisfied in their current position, 50.5% being satisfied whereas 13.2% being unsure. It is noted that no IMGs indicated that they were dissatisfied or very dissatisfied in their current position; however, 13.3% respondents did not complete this question.



**Figure 6.23: Satisfaction with current position**

### 6.8.2 Barriers when practicing medicine in current position

The respondents were also asked if they had experienced any barriers or disadvantages in their current position as a result of being an IMG. This may have included problems such as stigma or challenges navigating a new medical system when practicing medicine. It is shown in Figure 6.24, that 44.4% of the respondents indicated, because of being an IMG, they felt that their practice was hindered in some way while 55.6% reported they had not had experienced these concerns.



**Figure 6.24: Practice hindered due to being an IMG in current position**

### 6.8.3 Satisfaction with current position

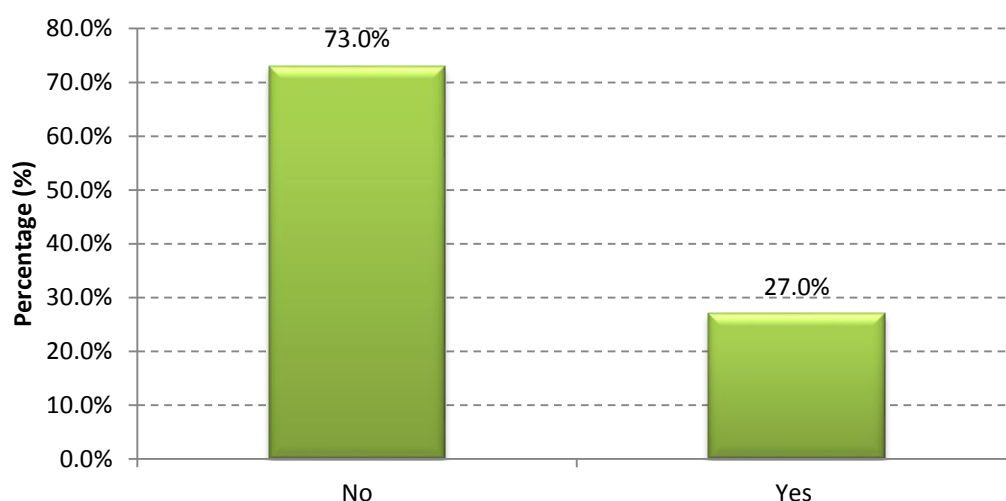
The IMGs were also asked to rate their level of satisfaction in terms of specific aspects of their current position in Tasmania. For example, they were asked to rate their satisfaction with the medical location, if their employment was relevant to their level of skill or experience and the friendliness of patients. As shown in Table 6.6, there were a high percentage of IMG respondents who indicated that they were 'very satisfied' or 'satisfied' with many of the professional aspects of their current position. For example, 46.2% of the respondents indicated that they were very satisfied with good supportive colleagues while an additional 39.6% were satisfied. In addition, 41.3% and 46.7% of the IMG respondents were very satisfied and satisfied with the friendliness of their patients respectively. It is noted that 29.9% were very unsatisfied with access to public transport in relation to their current position.

**Table 6.6: Professional satisfaction**

Professional satisfaction	Very satisfied			Satisfied		Unsatisfied		Very unsatisfied	
	N	n	%	n	%	n	%	n	%
Type of work	92	34	37.0	44	47.8	13	14.1	1	1.1
Medical location	92	34	37.0	47	51.1	11	12.0	0	0.0
Relevance to your skills / experience	92	40	43.5	39	42.4	10	10.9	3	3.3
Good or supportive colleagues	91	42	46.2	36	39.6	11	12.1	2	2.2
Salary level	91	19	20.9	42	46.2	29	31.9	1	1.1
Level of professional support	92	33	35.9	38	41.3	19	20.7	2	2.2
Access to training/supervision	92	31	33.7	35	38.0	21	22.8	5	5.4
Medical facilities or resources	92	28	30.4	47	51.1	14	15.2	3	3.3
Access to specialist services	92	11	12.0	41	44.6	33	35.9	7	7.6
Friendliness of patients	92	38	41.3	43	46.7	11	12.0	0	0.0
Friendliness of community	92	41	44.6	38	41.3	12	13.0	1	1.1
Access to public transport	87	8	9.2	23	26.4	30	34.5	26	29.9
Access to private transport	89	50	56.2	35	39.3	2	2.2%	2	2.2

#### 6.8.4 Disadvantages of living in current location

In addition to the level of satisfaction with specific aspects of their current position, the respondents were asked if they or their family had experienced any disadvantages as a result of being a migrant and living in their current community. As shown in Figure 6.25, 73.0% of the respondents reported not having any form of disadvantage in their current location due to being a migrant. However, 27.0% of the respondents indicated they had experienced such disadvantages.



**Figure 6.25: Disadvantages experienced in current community**

#### 6.8.5 Non-professional satisfaction

Beyond experiencing any disadvantages, the respondents were asked to rate their level of satisfaction in terms of specific aspects of their lives outside of the workplace. For example, they were asked to rate their satisfaction with the appeal of location, the size of city or town they were living in and such things as their satisfaction with the access which they have to their cultural community. The respondents were relatively satisfied with their location, with 41.9% and 43.0% highlighting they were very satisfied or satisfied with their current location respectively, as shown in Table 6.7. Moreover, 46.2% were very satisfied with the friendliness of the local people. Nevertheless, the data also showed 32.9% of the respondents were very unsatisfied with being able to access religious facilities while 40.0% were very unsatisfied with being able to access cultural or religious foods or goods.



**Table 6.7: Non-professional satisfaction**

Non-professional satisfaction	N	Very satisfied		Satisfied		Unsatisfied		Very unsatisfied	
		n	%	n	%	n	%	n	%
Appeal of location	93	39	41.9	40	43.0	13	14.0	1	1.1
Size of city/town	93	23	24.7	41	44.1	26	28.0	3	3.2
Friendliness of people	93	43	46.2	31	33.3	17	18.3	2	2.2
Quality of facilities	93	15	16.1	33	35.5	39	41.9	6	6.5
Employment for partner/spouse	85	20	23.5	30	35.3	17	20.0	18	21.2
Access to good schools	80	19	23.8	33	41.3	21	26.3	7	8.8
Access to religious facilities	82	11	13.4	29	35.4	15	18.3	27	32.9
Access to friends/ family members	92	13	14.1	28	30.4	32	34.8	19	20.7
Access to cultural community	90	15	16.7	21	23.3	38	42.2	16	17.8
Access to social activities	93	15	16.1	30	32.3	38	40.9	10	10.8
Access cultural/religious foods	85	11	12.9	19	22.4	21	24.7	34	40.0
Access to public transport	89	7	7.9	25	28.1	29	32.6	28	31.5
Access to private transport	91	52	57.1	31	34.1	6	6.6	2	2.2

#### **6.8.6 Aspects of residential location that are likely to influence the future working location**

Each IMG was asked to rate the level of importance of 17 aspects of a residential location which were likely to influence their choice of workplace in the future.

76.1% of the respondents rated job satisfaction as a very important aspect of future employment, followed by access to private transport (65.9%), improved medical facilities and resources (51.1%), access to good schools (48.9%) and employment for a partner or spouse (48.4%), as indicated in Table 6.8. In addition, 77.0% of the IMG respondents rated settlement near a CALD community as unimportant while 59.8% indicated access to cultural community was important and 55.0% indicated access to cultural or religious foods and goods was also important.

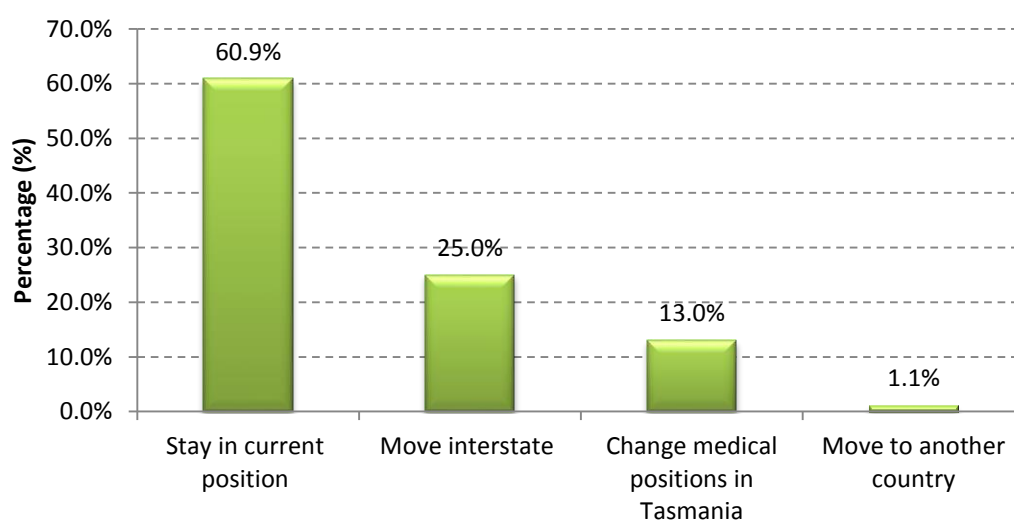
**Table 6.8: Importance of factors for future work**

Non-professional satisfaction	N	Very important		Important		Not very important		Unimportant	
		n	%	n	%	n	%	n	%
Job satisfaction	92	70	76.1	21	22.8	1	1.1	0	0.0
Improved medical facilities	92	47	51.1	41	44.6	3	3.3	1	1.1
Higher salary	91	34	37.4	48	52.7	7	7.7	2	2.2
Shorter working hours	92	18	19.6	41	44.6	29	31.5	4	4.3
Less on-call responsibility	92	21	22.8	35	38.0	33	35.9	3	3.3
Improved support colleagues	89	39	43.8	47	52.8	2	2.2	1	1.1
Access to metropolitan location	92	19	20.7	35	38.0	35	38.0	3	3.3
Settlement near ethnic community	91	4	4.4	17	18.7	43	47.3	27	29.7
Access to employment for partner	91	44	48.4	34	37.4	8	8.8	5	5.5
Access to good schools	90	44	48.9	20	22.2	11	12.2	15	16.7
Access to religious facilities	91	9	9.9	29	31.9	21	23.1	32	35.2
Access to friends/family members	92	26	28.3	54	58.7	8	8.7	4	4.3
Access to cultural community	92	14	15.2	41	44.6	24	26.1	13	14.1
Access to social activities	91	24	26.4	53	58.2	11	12.1	3	3.3
Access to cultural or religious foods	91	12	13.2	38	41.8	19	20.9	22	24.2
Access to public transport	91	20	22.0	35	38.5	27	29.7	9	9.9
Access to private transport	91	60	65.9	27	29.7	3	3.3	1	1.1

### 6.8.7 Future plans of respondents

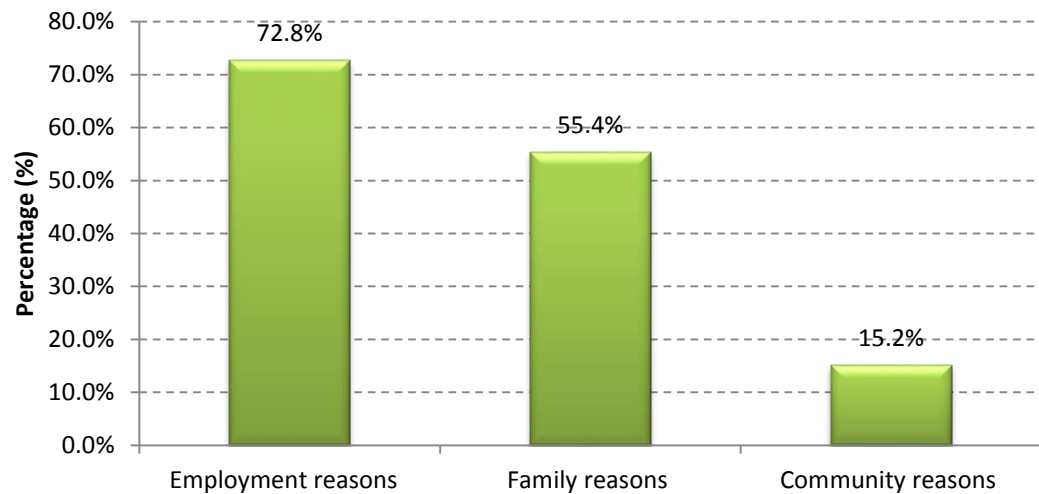
At the conclusion of the questionnaire, the participants were asked concerning their future plans. Figure 6.26 shows that 60.9% of the respondents reported that they

would like to stay in their current position for the foreseeable future whereas 13.0% of the respondents wanted to stay in Tasmania, but change or move into an alternative position. The results show that 25.0% of the respondents wanted to move interstate while 1.1% were planning to move overseas. The interstate locations to which the IMGs stated they were intending to move were diverse; however, most wanted to move to Queensland while another IMG stated he wanted to move to “a warmer climate” (IMG questionnaire response 88).



**Figure 6.26: Future plans of IMG respondents**

The respondents were then asked to indicate which reasons, if applicable, their future plans were based on. The majority (72.8%) of the respondents’ future plans were based on employment, while 55.4% on family reasons and 15.2% on community reasons, as shown in Figure 6.27. Particularly, one respondent stated that it was so their partner could obtain suitable work which was unavailable in Tasmania.



**Figure 6.27: Future plans of IMG respondents**

## 6.9 Factors determining IMGs satisfaction and desire to stay

The descriptive statistics section has demonstrated and highlighted the IMG respondents' characteristics including their employment profile and satisfaction. This section explores the data, using Chi-square ( $\chi^2$ ) tests and ordinal regression. These tests were to determine if a correlation exists between an IMG respondent's gender, age group, region of origin and current employment region (independent variable) and the factors such as professional satisfaction, non-professional satisfaction and those factors influencing the future employment of IMGs in Tasmania (dependent variable).

Each respondent was grouped into one of the three different employment regions of Tasmania, which includes the North, North-west and South regions. In addition, IMGs were grouped into five regions of origin, which were labelled Europe (including UK), Asia (including Middle East), America Africa and Oceania. The respondents from Oceania were excluded as only one of the five had completed the Likert-scale questions and SPSS was unable to calculate this specific data using less than two cases.

It must be noted that only those factors that were indicated to be significant underwent further analysis using ordinal logistic regression. In most cases an IMG's

region of origin was the factor that was indicated to be most significant, while there was no statistical significance between other independent variables. The findings are discussed in detail below.

### 6.9.1 Non-professional satisfaction of IMGs

#### 6.9.1.1 Satisfaction with lifestyle and access to religious facilities

An IMG's region of origin was shown to have a statistically significant effect on the satisfaction encountered in relation to access to religious facilities (Wald  $\chi^2(3) = 13.697$ ,  $p=.003 < 0.05$ ). Those IMG respondents from the Americas were shown to be 10.879 times more satisfied with being able to access religious facilities and resources than IMG respondents from Africa as demonstrated in Table 6.9, while there was no statistical significance between other countries.

**Table 6.9: Ordinal logistic regression of region of origin and satisfaction with lifestyle and access to religious facilities**

Region of origin	OR	95%CI	Wald $\chi^2$	df	p-value
America	10.879	1.109 to 106.724	4.197	1	.040

#### 6.9.1.2 Satisfaction with current lifestyle and access to public transport

The data analysis shows 63.6% of IMG respondents were unsatisfied to very unsatisfied with access to public transport. A respondent's region of employment was significantly associated with the level of satisfaction with the access to public transport in their current lifestyle (Wald  $\chi^2(2) = 7.260$ ,  $p=.027 < 0.05$ ). Table 6.10 demonstrates IMGs working in the Southern region of Tasmania were 4.356 times more satisfied with access to public transport than those IMGs in the North-west region of Tasmania, while there was no statistical significance other regions.

**Table 6.10: Ordinal logistic regression of workplace region and satisfaction with lifestyle and access to public transport**

Region workplace	OR	95%CI	Wald $\chi^2$	df	p-value
Southern	4.356	1.489 to 12.746	7.217	1	.007

### 6.9.1.3 Satisfaction with current lifestyle and size of town

The level of satisfaction with current lifestyle and the size of town IMGs were living in were shown to be among 67.7% of respondents. An IMG's region of origin was shown to have statistically significant effect on satisfaction with size of town (Wald  $\chi^2(3) = 9.306$ ,  $p=.025 < 0.05$ ). Those IMG respondents from Europe, Asia and the Americas were more satisfied with size of town than IMG respondents from Africa as outlined in Table 6.11.

**Table 6.11: Ordinal logistic regression of region of origin and satisfaction with size of town**

Region of origin	OR	95%CI	Wald $\chi^2$	df	p-value
Europe	12.597	2.200 to 72.114	8.099	1	.004
Asia	6.821	1.615 to 28.805	6.825	1	.009
America	12.008	1.417 to 101.752	5.197	1	.023

## 6.9.2 Factors influencing future employment of IMGs

### 6.9.2.1 Future employment and improved medical facilities

The data analysis demonstrated 95.5% of IMG respondents rated improved medical facilities and resources as important to very important, however an IMG's region of origin and their view on the importance of having improved medical facilities was highlighted to influence the future employment (Wald  $\chi^2(3) = 11.716$ ,  $p=.008 < 0.05$ ). Table 6.12 demonstrates that IMGs from Asia viewed improved medical facilities were more important to impact future employment than IMGs from America, while there was no statistical significance between other countries.

**Table 6.12: Ordinal logistic regression of region of origin and improved medical facilities influencing future employment**

Region of origin	OR	95%CI	Wald $\chi^2$	df	p-value
Asia	43.238	4.907 to 381.025	11.509	1	.001

### 6.9.2.2 Future employment and access to religious facilities

An IMGs' country of origin and access to religious facilities was also highlighted to influence the future employment (Wald  $\chi^2(3) = 13.226$ ,  $p=.004 < 0.05$ ). The data

analysis demonstrates that 40.9% of IMG respondents rated access to religious facilities as important to very important. However, IMG respondents from Asia, the America and Africa indicated access to religious facilities was more likely to influence future employment when compared to IMGs from Europe, as demonstrated in Table 6.13.

**Table 6.13: Ordinal logistic regression of region of origin and access to religious facilities influencing future employment**

Region of origin	OR	95%CI	Wald $\chi^2$	df	p-value
Asia	37.206	4.833 to 286.446	12.060	1	.001
America	18.943	3.363 to 106.691	11.124	1	.001
Africa	16.470	1.670 to 162.381	5.757	1	.016

#### 6.9.2.3 Future employment and access cultural or religious foods

It was shown that an IMGs' region of origin and their level of importance of access to cultural or religious foods or goods was also highlighted to influence the future employment (Wald  $\chi^2(3) = 14.110$ ,  $p=.003 < 0.05$ ). It was shown that, 54.5% of IMG respondents rated access to cultural or religious foods or goods as important to very important. However, IMGs from Asia and Africa indicated access to cultural or religious foods or goods was more important to influence future employment when compared to those IMG respondents from Europe as indicated in Table 6.14. There was no statistical significance between any other regions.

**Table 6.14: Ordinal logistic regression of region of origin and access to cultural or religious foods influencing future employment**

Region of origin	OR	95%CI	Wald $\chi^2$	df	p-value
Asia	13.888	3.432 to 56.200	13.608	1	.000
Africa	6.585	1.174 to 36.946	44.588	1	.032

#### 6.9.2.4 Future employment and access to metropolitan location

The data analysis demonstrated that 57.3% of IMG respondents rated access to metropolitan locations as important to very important and was highlighted to influence the future employment (Wald  $\chi^2(3) = 9.533$ ,  $p=.023 < 0.05$ ). IMGs from

Asia and Africa viewed access to metropolitan location was more important to impact future work than IMGs from both America and Europe as indicated in Table 6.15.

**Table 6.15: Ordinal logistic regression of region of origin and access to metropolitan location influencing future employment**

Region of origin	OR	95%CI	Wald $\chi^2$	df	p-value
<b>America</b>					
Africa	6.842	1.247 to 37.545	4.902	1	.027
Asia	4.728	1.276 to 17.510	5.407	1	.020
<b>Europe</b>					
Africa	10.274	1.165 to 90.951	4.400	1	.036
Asia	7.098	1.137 to 44.308	4.400	1	.036

#### 6.9.2.5 Future employment and settlement near cultural community

The data analysis showed that 78.4% of IMG respondents rated settlement near cultural community as not very important to unimportant; however, an IMG's region was highlighted to influence the future employment (Wald  $\chi^2(3) = 14.769$ ,  $p=.002 < 0.05$ ). As shown in Table 6.16, IMGs from Europe viewed settlement near cultural community was significantly less important to future employment than IMGs from Africa. There was no statistical significance between other countries.

**Table 6.16: Ordinal logistic regression of region of origin and a settlement near cultural community influencing future employment**

Region of origin	OR	95%CI	Wald $\chi^2$	df	p-value
Europe	23.431	3.029 to 181.251	9.131	1	.003

#### 6.9.3 Relationship between an IMGs desire and the family's desire to stay in Tasmania

A final examination of the association or relationship between an IMG respondent's desire to stay in Tasmania and their family's desire to stay in Tasmania was undertaken. The results showed there was a strong positive correlation between an IMG respondent's and their family's desire to stay in Tasmania,  $r=.784$ ,  $n=92$ ,  $p-$



value = 0.01 < 0.05, as shown in Table 6.17. It was evident those IMGs who desired to stay long term (60.87%) also had families who desired to also stay long term (54.35%).

**Table 6.17: Spearman's correlation test of the relationship between IMG and family desire to stay in Tasmania**

Spearman's correlation		IMGs' desire to stay	Family's desire to stay
IMGs' desire to stay	Correlation coefficient		.784*
	Sig.		.000
	N		92
Family's desire to stay	Correlation coefficient	.784*	
	Sig.	.000	
	N	92	

\*Correlation is significant at the 0.01 level (2-tailed).

## 6.10 Conclusion

This chapter has discussed the findings of the IMG questionnaire data, including the IMG respondents' demographics, mobility, patterns of migration and their motivations for moving to Australia and Tasmania. In addition, a number of statistical insights were provided with respect to satisfaction with the non-professional aspects of living in Tasmania and the factors influencing future employment. The following chapter will highlight the findings and analysis of the interviews conducted with key informants and IMGs which includes the written responses from the IMG questionnaire data. It will provide insight into the lived experience of IMGs, which help to answer the research questions regarding the enablers and barriers which IMGs encounter as they live and work in Tasmanian communities. The chapter will also offer a number of comparisons between the views and insights of informants and those of IMGs. This comparison will then lead onto a discussion regarding all the data and will provide an overarching understanding of the acculturation and retention of IMGs in rural Tasmania.

# **Chapter seven: Qualitative data analysis and results**

## **7.1 Introduction**

The preceding chapter has highlighted and outlined the results of the Tasmanian International Medical Graduate questionnaire data analysis. This chapter highlights the analysis of the qualitative data collected from interviews conducted with twenty-two IMG respondents, twenty-three key informants and 39 written comments from the Tasmanian International Medical Graduate questionnaire.

The interviews and written comments were used to respond to each of the research questions. These included:

1. What are the enablers and barriers which IMGs encounter as they live and work in Tasmanian communities?
2. What are the acculturation process and strategies which facilitate trust, co-operation and connections between IMGs, other health care professionals and the community?
3. What are the strategies used by IMGs to improve community engagement and integration? and
4. What acculturation strategies and barriers are observed by key informants who support IMGs in Tasmania?

The data from the interviews, particularly from each of the IMGs, were provided as a narrative of their experience migrating to, living and working in Tasmania. The data were analysed and presented in terms of the emerging themes. Many of the themes that emerged from the IMG and key informant data were parallel and it was felt combining these two sources of data in one results chapter would be less repetitive and would highlight and give strength to the themes identified.

Initially, the characteristics of the participants are presented, which is followed by the presentation of the central theme of transition with six major themes being identified and stemming from the data analysis. These themes are: professional transition challenges; social transition challenges; isolation; stigma; support provided to and by IMGs; and factors influencing retention. In addition to each major theme, additional sub-themes and sub-sub themes were developed and are presented in this chapter.

An addition section of the chapter focuses on CDA where the nature of key informant discourse, rather than themes is presented. This analysis highlights informant discourse in terms of the linguistic patterns and how discourse was used within the informant interviews.

## **7.2 Data analysis**

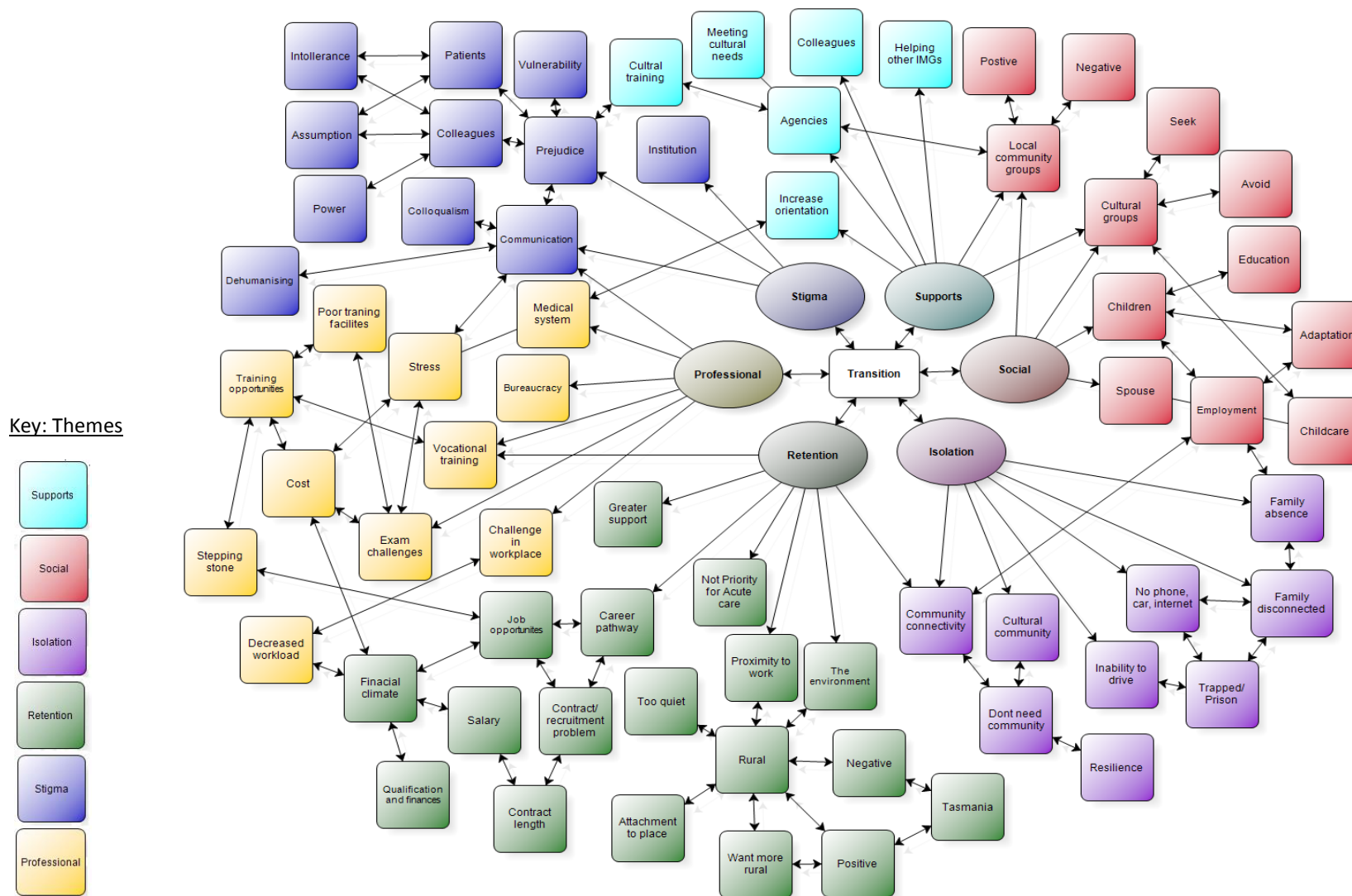
The qualitative data collected from the interviews and open questionnaire responses was organised and analysed using NVivo v10.0, a software package for qualitative research (QRS International, 2012). As part of the analysis, the data were coded and organised by being placed into 'nodes.' Within thematic analysis, the results were presented in terms of themes, including positive and negative attitudes and views of the interviewees as outlined in Table 7.1 and Table 7.2 (see also Appendix H). As observed in Figure 7.1, a mud map was developed to demonstrate the data analysis results more clearly. The mud map illustrates the emerging major themes, sub-themes, sub-sub themes and their interconnectedness.

**Table 7.1: Coding used within thematic analysis of key informant interviews**

Themes	Sub-themes	Clusters
<b>Professional challenges</b>	<ul style="list-style-type: none"> <li>– Medical systems</li> <li>– Workplace challenges</li> <li>– Current professional support</li> <li>– Meeting future professional challenges</li> <li>– Meeting the cultural needs within the workplace</li> </ul>	<ul style="list-style-type: none"> <li>– Vulnerability</li> <li>– Discrimination</li> <li>– Workplace isolation</li> <li>– Hierarchy and power</li> <li>– Communication</li> <li>– Meeting needs</li> <li>– Consistency across hospitals</li> <li>– Resource challenges</li> </ul>
<b>Social challenges</b>	<ul style="list-style-type: none"> <li>– Spouse employment</li> <li>– Education for children</li> <li>– Cultural and religious connectivity/identity</li> <li>– Isolation</li> <li>– Access</li> <li>– Available social support</li> </ul>	<ul style="list-style-type: none"> <li>– Physical isolation</li> <li>– Psychological isolation</li> <li>– Social support</li> <li>– Cultural understanding/ tolerance</li> </ul>
<b>Retention</b>	<ul style="list-style-type: none"> <li>– Job opportunities</li> <li>– Job security</li> <li>– Vocational training</li> <li>– Greater support for IMGs</li> </ul>	<ul style="list-style-type: none"> <li>– The changing workplace</li> <li>– Achieving timely fellowship</li> <li>– Increase training opportunities</li> <li>– Career pathways</li> <li>– Support</li> <li>– Orientation</li> <li>– Increased contracts</li> </ul>

**Table 7.2: Coding used within thematic analysis of key IMG interviews**

Themes	Sub-themes	Clusters
<b>Professional supports</b>	<ul style="list-style-type: none"> <li>– Meeting specific needs of IMGs within hospital context</li> <li>– Has a desire to help new IMGs</li> <li>– Supportive agencies</li> <li>– Supportive colleagues and peers</li> </ul>	
<b>Professional challenges</b>	<ul style="list-style-type: none"> <li>– Workplace</li> <li>– Medical system</li> <li>– Exams - monetary, psychological, and process</li> </ul>	<ul style="list-style-type: none"> <li>– Training required elsewhere Lack of accreditation</li> <li>– Health system challenges</li> <li>– Communication challenges</li> <li>– Lack of challenge in workplace</li> <li>– Lack of support</li> <li>– Prejudice/abuse by staff</li> <li>– Poor exam preparation</li> <li>– Exam fairness</li> </ul>
<b>Social supports</b>	<ul style="list-style-type: none"> <li>– Connection through groups</li> <li>– Local community support</li> <li>– Colleague support</li> <li>– Friends, family and cultural community</li> </ul>	<ul style="list-style-type: none"> <li>– Spousal employment</li> <li>– IMG to adjust or adapt</li> <li>– Positive/negative</li> <li>– Community support</li> <li>– Making own effort</li> <li>– Agency support</li> <li>– Family concerns and matters</li> <li>– Avoid own cultural group</li> </ul>
<b>Social challenges</b>	<ul style="list-style-type: none"> <li>– Prejudice/Isolation</li> <li>– Family challenges</li> </ul>	<ul style="list-style-type: none"> <li>– Communication with family</li> <li>– Family support/disconnection</li> <li>– Cultural community and foods Poor cultural connectivity</li> <li>– Inability to drive</li> <li>– Adaptation of children</li> <li>– Education/Jobs for children</li> <li>– Work impacting families</li> </ul>
<b>Motivation for Tasmania</b>	<ul style="list-style-type: none"> <li>– Job offer</li> <li>– Training</li> <li>– Family, rural life and work</li> <li>– Political reasons</li> <li>– Long term goals</li> <li>– Positives/negatives</li> </ul>	<ul style="list-style-type: none"> <li>– Tasmania not too remote</li> <li>– Proximity to work</li> <li>– No traffic issues</li> <li>– Enjoys rural work and life</li> <li>– It is quiet not much to do</li> </ul>
<b>The way forward</b>	<ul style="list-style-type: none"> <li>– Improve work orientation</li> <li>– More migration information</li> <li>– Family assistance</li> </ul>	<ul style="list-style-type: none"> <li>– Improved training</li> <li>– Increased rotations</li> <li>– Immigration assistance</li> <li>– Registration support</li> </ul>



**Figure 7.1: Mud mapping of thematic coding process**

## **7.3 Context of the results**

Once analysed, it was noted that a clear division existed within the IMG and key informant interview data. IMGs were delineated into two distinct groups which were demonstrated by experiences, need, concerns and support. The first group included the IMGs from the acute care setting, who were closer to major centres of Tasmania with a greater concentration of early career or junior doctors. The second group consisted of those IMGs within general practice, who were less concentrated in number, were away from major centres and were further along their career pathways.

Therefore, IMGs need to be placed into the two distinct contexts to understand the issues relating to each of these groups. Nevertheless, throughout the discussion both IMG groups will be mostly discussed as one entity. When the discussion pertains to only a specific group each group will be identified as either acute care IMGs or general practice IMGs. In most cases, there were very similar themes emerging across the data, regardless of where IMGs were working and living; however, as a group, they were in no way homogenous. Specifically, the IMGs interviewed were quite different from each other as to their cultural or religious beliefs and medical training. As such, the discussion of the diverging experiences and perspectives is highlighted when specific issues or challenges were encountered by various IMGs.

## **7.4 Profile of participants**

### **7.4.1 Characteristics of key informants**

The key informants included those with clinical and non-clinical backgrounds who worked full or part time in various capacities such as medical educators, directors of clinical training, program officers, organisational heads and recruitment management and staff. Table 7.3 illustrates 56.5% of the key informants were from the acute care sector while 47.8% had more than five years' experience working with IMGs.

**Table 7.3: Characteristics of informant interview participants**

Characteristics	Number of participants (n/N)	Percentage (%)
Key informant profession		
- Clinicians	11/23	47.8
- Non-clinicians	12/23	52.2
Organisation		
- Informants from acute sector	13/23	56.5
- Informants from primary care	10/23	43.5
Years of experience with IMGs		
- Less than 2 years	2/23	8.7
- 2 to 5 years	10/23	43.5
- More than 5 years	11/23	47.8

#### 7.4.2 Characteristics of IMGs

Among the twenty-two IMGs who participated in the semi-structured interviews, 63.6% were male and 36.4% were female. As previously outlined, the IMGs included interns, RMOs, registrars, specialists and GPs who worked full or part time in various capacities within the acute or primary health care sectors. Data, such as years of medical experience, country of origin and marital status was also obtained within the interview and is illustrated in Table 7.4.

**Table 7.4: Characteristics of IMG interview participants**

Characteristics	Number of participants (n/N)	Percentage (%)
Gender		
- Male	14/22	63.6
- Female	8/22	36.4
IMGs working in acute care		
- Specialists	5/22	22.7
- Registrars	4/22	18.2
- RMOs	1/22	4.5
- Interns	2/22	9.1
IMGs working in primary care		
- General Practitioners	9/22	40.9
IMGs not currently working	1/22	4.5
Marital status (N=104)		
- Married/De facto	18/22	81.8
- Single	4/22	18.2



Years of medical experience		
- Less than 5 years	4/22	18.2
- 5 to 10 years	10/22	45.5
- More than 10 years	8/22	36.4
Country or origin		
- India	7/22	31.8
- Iran	3/22	13.6
- Germany	2/22	9.1
- South Africa	2/22	9.1
- Egypt	1/22	4.5
- Indonesia	1/22	4.5
- Libya	1/22	4.5
- Malaysia	1/22	4.5
- New Zealand	1/22	4.5
- Pacific Islands	1/22	4.5
- Sri Lanka	1/22	4.5
- Vietnam	1/22	4.5

It was highlighted by 12 IMGs that they had migrated directly from their country of origin to Tasmania. Three (13.6%) IMGs had experienced two moves and seven (31.8%) had experienced three or more moves before arriving Tasmania, as illustrated in Table 7.5. However, it was indicated by those IMGs who had moved more than five times, they had been in Tasmania for more than six years. For example, one IMG had lived and worked in six different countries, yet had been living in Tasmania for 29 years at the time of the interview.

**Table 7.5: *Hypermobility of Interview participants***

Number of moves	Number of IMGs (n/N)	Percentage (%)	Average years in Tasmania
1	12/22	54.5%	3.0
2	3/22	13.6%	12.3
3	4/22	18.2%	4.7
4	-	-	-
5	1/22	4.5%	6.0
6	2/22	9.1%	18.0

## **7.5 Motivation for migrating to Tasmania**

Amid the data analysis of IMGs living and working in Tasmania, the principal motivations of moving to Tasmania were highlighted. Many IMGs said they had a desire to migrate to Australia, yet a specific desire to live in Tasmania was uncommon. Only two of the twenty-two IMGs interviewed said they specifically had chosen to live in Tasmania. Their particular choice had occurred only after visiting the state to complete further University study or to do a locum at one of the community hospitals. In most other cases, moving specifically to Tasmania was not out of choice, but rather it was serendipitous. A list of motivations (in order of frequency) included:

- Tasmania was the first place in Australia to offer a position (n=6);
- a desire to be with family already in Australia (n=5);
- a better life and better education for children (n=4);
- government sponsorship (n=2);
- for adventure (n=2);
- approached by a hospital (n=1);
- accredited training position was available (n=1); and
- motivated by political reasons (n=1).

## **7.6 Professional transition challenges**

Amid the motivations for migrating to Australia and specifically Tasmania, there were many professional transition challenges or barriers which were highlighted by both IMGs and key informants. These challenges followed a number of broad, yet common themes. These included challenges that IMGs have had with college examinations and registration; working in a new and unfamiliar medical system; communication challenges; professional transition challenges in the workplace. Each theme is discussed in greater detail as follows.

### **7.6.1 Examination challenges**

The disadvantages of examination preparation and training in Tasmania were discussed by participants and included the availability and accessibility of training;

the time elapsed between examinations; the purpose of the exam; and the direct and indirect costs that were involved. One IMG stated “I think the doctors get recruited here and they don’t realise how difficult it might be to sit the examination when they are isolated from all the other candidates” (IMG 19). However, many IMGs revealed there was much assistance in Tasmania, yet those IMGs who had friends or colleagues elsewhere in Australia, said they were aware of the discrepancies and financial disparity between states. For example, one IMG stated the availability and accessibility of training and education sessions for IMGs in Tasmania and Victoria was very dissimilar.

To address this, two of the more recent IMGs who had arrived in Tasmania revealed that they had travelled interstate to undertake further training as they felt it would be advantageous when passing examinations in Tasmania. One travelled interstate and attended training sessions in three different states. Both of these IMGs indicated that the information and training on mainland Australia were more intensive and up to date, which they felt had assisted them in their examination preparation. Conversely, one IMG who came to Tasmania much earlier in the 1990s had undertaken a training program on mainland Australia and felt it “was a waste of money and time because it didn’t really prepare me for the exam... it wasn’t really tailored to passing the exam, I think it was a money making venture” (IMG 1).

Another concern raised as a challenge was the large amount of time which elapsed between examinations. It was indicated that some IMGs were waiting five to eighteen months before being able to undertake the AMC examination. These timeframes were particularly a concern as at least half had not passed their first examination and were anxious to re-sit. In some cases, IMGs stated they had taken up to four times to pass their examinations while other IMGs knew colleagues who repeated the process five to six times.

It was felt the inability of IMGs to pass the examination in the first instance was motivated by the examination bodies needing to make money. One IMG said “Don’t try and make money out of the IMGs. That is what they are doing at the moment and they call it examination” (IMG 16). In addition, there was agreement concerning

the large number of direct and indirect costs associated with the examination, which made the process even more challenging.

The three main concerns were related to the impact the examination process had personally, on the family and within the workplace and community. Each of these is highlighted below.

#### **7.6.1.1 Personal impact**

The direct and indirect costs which are incurred were highlighted by most of the participants. This was particularly apparent when one IMG relayed a colleague's experience who

*sat the exam five or six times and... spent \$50,000 on exam fees, hotels fees, flights, courses, and psychologists... [If you don't pass] the recommendation is you see a psychologist... [so] you have a bill for the psychologist. (IMG 4)*

Another IMG emphasised the psychological impact failing the examination had on him when he said "we had years of hardship you know, mainly psychological, it was hard to fail exams" (IMG 1). In addition to the financial and psychological burdens of the examination, another IMG was concerned with the physical impact preparing for the examination on his health. Preparing for the examination meant regular exercise was not being achieved, as the pressure of passing was so great that studying had become their sole focus.

#### **7.6.1.2 Family impact**

The challenges of examination were also having an impact on the family and were highlighted by four IMGs. Each said there was a huge responsibility to pass the exam not only to continue working in the country, but also for personal relationships within the family and the family's long term wellbeing. One IMG was very fearful of this fact when he stated

*The existence of the whole family depends on me passing the exam in this timeframe as we could potentially be expelled from the country... It is a big*

*responsibly if you do it with kids... If we now should have to leave [here] or Australia this will be a major psychological disaster for the kids. (IMG 4)<sup>3</sup>*

While failing the examination was a very real fear, other IMGs stated they were contemplating leaving their family behind in Tasmania to work at larger hospitals on the Australian mainland. This interstate employment would provide greater exposure to training and patient procedures and would ensure the IMG would pass the examination. These motivations were based upon the very real prospect of deportation.

#### **7.6.1.3 Workplace and community impact**

It was also reported that the pressure of the examination “impacts the rest of the department, to find that one of your colleagues is under so much stress from the exams” (IMG 19). In addition, failing the examination was also highlighted to have a far reaching impact on the wider community. After failing the examination more than once and eventually losing registration in Tasmania, one IMG said

*It was hard to be told, you can't work here and actually pack your suitcase and leave... We had to close the surgery and with it, 2,000 people who came to it didn't have a doctor overnight, so there was an impact of course in that community. (IMG 1)*

It is noted this IMG, after several years, later returned to work again in Tasmania.

#### **7.6.2 New medical system challenges**

There were additional challenges faced by IMGs as they entered the medical system in Tasmania. It was noted that the clinical element of a position was similar to positions held in home countries, and some differences were recognised. This included exposure in Australia to a greater number of chronic medical conditions; sexually transmissible infections (STI); mental health; palliation of a dying patient; and unfamiliar diagnosis such as ‘acopia.’ Four key informants also highlighted that IMGs, particularly Middle Eastern men, were unfamiliar with women’s health. While

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<sup>3</sup> This IMG contacted me later in the year to inform me that the IMG had passed the exam on the first attempt.

some IMGs were reported to have difficulty diagnosing conditions such as chicken pox due to its presentation being unfamiliar on the local population who have a fairer skin colour.

Nevertheless, the clinical elements of employment were easier to comprehend and develop when compared to navigating the medical system. One IMG commented “Medicine wasn’t a problem; it was just the health system being different, that was the problem” (IMG 6). While another IMG stated “[we] know the disease and what you need to do with it, but [we] don’t know the protocol over here and how to do it” (IMG 3).

A number of other examples were highlighted by both IMGs and informants to demonstrate these professional transition challenges. These challenges included understanding and using patient-centred care in clinical encounters; working in multidisciplinary teams; the absence of procedural work in general practice; understanding the Medicare system; prescribing medications; knowing what the Department of Veteran Affairs does; what an occupational therapist is; and dealing with a loss of status.

To address a number of these challenges, understanding the medical ‘system’ was indicated to be vital and extended right down to knowing how to review pathology results and using general practice computer programs such as Medical Director®. This challenge was highlighted by two IMGs who had not used computers in their practise before. One of these IMGs relayed their experience when they first arrived and was unsure what or where anything was. They said

*[I] had orientation, but it was for two weeks... On the second week [of orientation] even the first day I was given patients and I hadn’t tried the Medical Director computer... So the first day we were pushed to see patients... that is unfair... we are dealing with life. (IMG 13)*

Stress was a major outcome of being unable to navigate the medical system effectively, with many IMGs stating they felt they were just ‘thrown in’ without adequate orientation. In one case, an IMG said “the system itself is difficult... and

it's something that we have to get used to first before you really have to get comfortable" (IMG 8). Although many IMGs could not pinpoint a timeframe, three IMGs said it was at least 12 months to two years before they felt comfortable enough to navigate the medical system effectively. One IMG specifically stated

*Clinical knowledge is completely different from the [medical] system knowledge... that is the gap, once you bridge it, over a period of time you get to understand it... [If] someone had showed it to me it would have made it less stress[ful]. (IMG 7)*

### **7.6.3 Communication challenges**

Beyond navigating a new medical system, communication was an additional workplace challenge as highlighted by both IMGs and key informants.

Communication was voiced to be one of the greatest challenges faced by IMGs. This challenge extended from communication between colleagues to both patient and IMG doctors understanding each other. It was detailed that patients and colleagues often did not understand the doctor when speaking to them. In addition, it was reported some IMGs were having difficulty understanding others, but "will not give any indication that they have misunderstood, or do not want to admit they have misunderstood, saving face. That issue has been quite a big misunderstanding [as] some doctors are perceived as rude or uncooperative" (IMG 4).

Nevertheless, it had been observed it was often the subtleties of how to interact with patients which was essential to be developed and refined further. These subtleties included understanding colloquialisms, nuances and vernacular. For example, an informant reported

*We had one IMG who came in here just distraught and shaking because he had been told off in Department of Emergency Medicine. A woman had yelled at him, said he was a pervert and to get out. It was a misunderstanding of phrases and nuances. Instead of saying is it okay if I examine you, he said is it okay if I touch you up? (Key informant 4)*

This was further summarised by another informant who said

*Communication really matters and often patients have... certain things they want to be told or hear and if they don't get that, that means that they are unhappy with their professional encounter and so I think you are more likely to miss the mark if you don't understand the cultural nuances. (Key informant 8)*

Communication skills workshops to assist with such things as colloquialisms, vernacular and cultural nuances were recognised as a high priority throughout the various key informant organisations. It had been reported many IMGs communication skills were relatively good, yet some IMGs were still hard to be understood. There were also further challenges for clinical educators who were providing these additional and supplementary communication skills workshops. It had been reported

*Unless we force them in some way shape or form to have additional communication training they don't voluntarily take it up... I think there is a degree of defensiveness... and there are so many competing things for their time. (Key informant 17)*

It was felt a good command of English decreased the amount of prejudice IMGs would anticipate from certain patient encounters. One IMG relayed poignantly the importance of effective communication.

*If communication is a bit of a problem then I guess [patients] get frustrated and I don't think it is to do with a person being from an overseas place, but just frustration with being able to communicate or understand what the doctor is saying. (IMG 10)*

Regardless of effective communication, one IMG relayed in an open questionnaire response, that communication was not actually the problem; the biggest problem within a doctor-patient encounter “is more about not being able to relate to patients as good as my Aussie colleagues” (IMG questionnaire respondent 5).



Other IMGs stated most patients and colleagues were very empathetic when language was felt to be a barrier. In most cases, it was elderly patients who were more challenging in a clinical encounter. However, IMGs who were in more rural areas specified that they would try “not to use medical jargon, [but] to use simple terms” (IMG 20). In this case, patient education books were being used by this IMG to help with patient encounters in her general practice.

Lastly, it was said that many IMGs were academically brilliant. However, due to the disadvantage of communication skills and the increasing competition occurring from recent increases in domestic Commonwealth-supported medical students, IMGs would find obtaining specific training and employment more challenging. This disadvantage was felt to be due to a potential poorer interview performance because of communication.

#### **7.6.4 Financial climate and professional transition challenges**

In addition to the primary professional transition challenges, further challenges were highlighted within the context of the current financial climate and its impact on workplace morale. These challenges included a lack of training opportunities, the impact on future recruitment and an absence of skills development for IMGs in the workplace, which are discussed below.

##### **7.6.4.1 The financial climate impacting surgical placements**

Four IMGs felt there was no opportunity for skills development in their current position. In most cases, this was attributed to the impact the current financial climate was having on the significant decrease in the current number of surgeries and procedures. In two cases there was a reduction from 24 to four operations a month. This reduction in surgeries was impacting on the skills development in the workplace and IMGs “skills [were] being eroded by the lack of cases to do” (IMG 19). One IMG was fearful his contract would not be renewed within the state if the number of cases being seen a month did not increase. Despite these current challenges and the reduction in surgery cases, it was felt this allowed greater time to study and pass the required upcoming examinations.

#### **7.6.4.2 Other financial concerns**

There were a number of minor concerns that were raised by one or two individuals and often only in passing conversation. These minor concerns related to employment and its impact or benefit to lifestyle and how the current financial challenge faced by the state health system was also impacting not only the IMGs but also others in the health system.

The working conditions within the Tasmanian context were seen as generally positive although the wages were a concern. It was recognised that although the wages were lower in Tasmania when compared to other Australian states, the benefits of staying in Tasmania outweighed a lower income from elsewhere in the country. In one instance, one IMG had been offered a better paying job elsewhere on mainland Australia, yet did not take up the offer as he said “the cost [in Tasmania] is less than anywhere else” (IMG 3). Another IMG stated that money was a large motivator to leave the state as those with specialities have greater potential for increased earning capacity elsewhere in Australia.

In addition to earning capacity, there was a concern regarding the opportunity to obtain more permanent positions, especially for those who completed training and wanted to stay in Tasmania. One IMG had recently left the state with his wife who was also a doctor. This move was not desired, but was undertaken so as to obtain more permanent employment. Other IMGs faced the similar situations, but for different reasons. Most, who were contemplating leaving, revealed they were motivated purely by the need to complete training and further their careers.

There were additional minor concerns regarding the financial climate and its impact on the health system, available jobs, training positions, on-going employment and the impact of patient waiting times. It was felt patient waiting times in acute care was increasing the level of stress being felt by GPs. This IMG later stated this greater reliance on GPs within the community due to budget constraints had the potential to influence the retention of current and future IMG GPs in Tasmania.

Lastly, a key informant quantified the main professional transition challenges faced by IMGs were greater than clinical knowledge when stating

*[Professional] transition... isn't around their clinical knowledge which is what gets bandied about all the time... The more I work with them the more I think the professional transition is really is made more challenging by any degree of what I would call post-traumatic stress or the result of the trauma of having to move away from home and country and through a process of such great uncertainty... Some are definitely are very fragile at the end of that process. In my mind probably this is the biggest barrier. (Key informant 15)*

This comment highlighted that a number of professional challenges were more associated with the social and psychological transition challenges that IMGs encounter.

## **7.7 Social transition challenges**

International Medical Graduates saw Tasmania as “one of the most ideal places to bring up a family” (IMG 7) as “it is... very safe [and] very good for children” (IMG 20). However, a number of challenges were raised by IMGs and key informants which followed three broad themes. These included employment for a spouse or partner; education for children; and cultural and religious connectivity.

### **7.7.1 Spouse employment**

It was indicated by key informants that employment for a spouse was a concern for many IMGs and was an essential element for transition and settlement success.

*The biggest indicator is making sure the spouse is happy and employed, if you can get that, it is fantastic. I mean just making sure they are happy and feeling comfortable in the community. Time and time again it was the spouse saying it was too cold here, the kids aren't happy, I have got nothing to do and I have got no one to talk to, [which] is a big stress... So employment is really good, it is one of the biggest indicators. (Key informant 20)*

It was felt that spousal employment was often dependent upon where in the state the IMG and their family were residing, the skills which the spouse possessed and the current economic climate.

The challenge of spouse employment was reported to occur more on the North-west and West coast of Tasmania. In one case a spouse, who “was a nurse had to get a job in Launceston while her husband worked in Roseberry [200km away]” (Key informant 20). Those spouses, who had not found work, took longer to settle into the community as “work gives you self-esteem, you feel valued [and] it gives you social outlet” (Key informant 22). Alternatively, it was found if a husband, who was the spouse, did not find work “then they become the house husband and in many cultures that is a real no-no, so that is generally the reason that they move on” (Key informant 19).

### **7.7.2 Education for children**

In addition to meaningful employment for a spouse, the provision of good education for children was also highlighted. One IMG stated, she had moved to Tasmania just for her “daughter’s education... [specifically] secondary school and University” (IMG 13). It was noted that children, from ‘IMG families’, were known to be reasonably resilient when attending school and making friends. However, one informant stated she knew one family, who moved interstate due to the children having racial issues at school. Another informant revealed “I haven’t heard many people say oh my kids are so depressed or aren’t coping...[however] high school is a big challenge and it is more about getting their kids the best academic access” (Key informant 20).

Access to high school had been voiced by IMGs and key informants alike as a future concern in rural areas of Tasmania. Primary school attendance was, on the most part, reported to be suitable for children. When high school attendance was required, this was a major motivator for being in close proximity to larger centres such as Launceston and Hobart. To this, one IMG living in a rural area stated “I am not so sure what is in the future when my son is a teenager” (IMG 19).

Another IMG was concerned with the lack of education and job opportunities for teenage and adult children in Tasmania. Nevertheless, informants argued AMG are faced with similar concerns and issues. They felt obtaining the best education was a major concern for all doctors in the rural areas of Tasmania. An informant stated “most Australian doctors don’t last long in these communities either because of the education. Their kids need to get to high school and they want to bring them into the city” (Key informant 20).

To address some of the education challenges many IMG parents sought assistance from informants as to know which schools were best for their children and where to access the appropriate information. Many informants, although not part of their core responsibilities, often assisted IMGs, when requested, with information about schools; where to access information; or connecting IMGs with AMGs who had children at similar ages. An additional concern for a number of IMGs and their spouse was ensuring the children were fitting in. In many instances this came right down to simple things such as making sure school lunches were packed in similar way to local children.

### **7.7.3 Cultural and religious connectivity**

Another social transition challenge for IMGs was cultural and religious connectivity and was often determined by an IMG’s nationality. Most key informants identified there were a number of communities, which IMGs tap into within the larger population centres of Tasmania.

Despite these ‘larger’ cultural communities there are a number of IMGs and their families who still continue to move to the mainland. It was reported that, it was the spouse and family members who lacked this connectivity with the larger community. For example, it was reported that a South American spouse of an IMG “had very limited English and found it hard to meet people and transition into the community” (Key informant 7). There is a desire to be in a larger city or closer to family or friends and leads to moving to much larger and more supportive communities. It was also argued AMGs did not fare so well in the more rural communities either. It was stated the work in rural areas

*is fairly stressful [and] you are just lacking that peer or cultural interest. You do have sports, but not so much of the arts and movies, so Australian doctors go out there for five years... and then come back. (Key informant 20)*

In addition to cultural community connectivity, at times meeting religious needs can also be challenging.

*If you are a Muslim and you are the doctor in Queenstown and you cannot go to the mosque, you miss your colleagues and this can be a real issue... [also]... it is much easier to keep Ramadan when you have got some friends. (Key informant 4)*

Very few key informants were aware of local mosques or temples, but were more aware of food requirements and special events such as 'Diwali' and 'Ramadan.' They also recognised the challenges of being alone when these events were occurring. For example, it was reported a number of IMGs who are Hindu could become quite low and unhappy the days leading up to Diwali. While IMGs of the Muslim faith have specific needs within the workplace over Ramadan, informants were aware that IMGs from the same countries gathered together across the state on a regular basis to meet and shop for specific foods. Despite this, many IMGs remain physically, psychologically and culturally isolated.

## **7.8 Isolation**

Although related to both social and professional transition challenges physical, psychological and cultural isolation was identified as a major theme within the data. It is a theme which is interwoven among many challenges throughout the interview data of IMGs and key informants. As such, the complexities of physical, psychological and cultural isolation of one IMG and their family are outlined in greater detail.

### **7.8.1 Physical isolation**

There were many forms of physical isolations which were identified by each of the key informants as problematic for IMGs. This included simple isolation due to

proximity from a major centre, an inability to access a cultural group, a lack of collegial support within work or a lack of locum support to allow time away from work. In addition to these forms of isolation, IMGs who develop connections and friendships in the workplace, find these same friendships and network quite isolating when interacting outside the workplace. This was demonstrated by an informant who stated IMGs

*feel quite diffident about joining in a social situation where there are Australian doctors because of some of the religious taboos, such as alcohol... so they don't go to social events... Sometimes the IMGs do not engage in that sort of socialisation because they do not drink they think they will be either pressured into it or judged, as a result they often do not go to social things. (Key informant 1)*

Isolation also occurs for many IMGs, particularly those in general practise when compared to the acute setting, as public transport may be problematic. To add to this, it was reported many IMGs are unable to or lack the confidence to drive in Tasmania. A small number of IMGs were reported, by an informant, as being in serious accidents when returning home from training in one of the larger centres.

One IMG reported she initially could not drive when arriving in Tasmania and this impacted on her wanting to stay. She said “at one point I didn't [drive] and I wanted to leave, and believe it or not the minute I learned how to drive, it changed. [It] opened the world” (IMG 18). This IMG still knew many other female IMGs in Tasmania who were unable to drive. She reported this was due to the fact that some cultures did not allow women to drive in their home country.

To add to the inability to drive, recruitment issues were occurring as IMG GP registrars who could not drive remained reluctant to take up rural or satellite postings. If they did these IMGs became isolated and there was an anticipation they “are going to leave, or plan to leave” (Key informant 21). In addition to these challenges, those GP registrars, who can drive, become frustrated due to the inequity in placements, as those who do not drive are often placed in more urban areas.

Despite these challenges, an informant stated many IMGs in general practice became settled and really appreciate how good the lifestyle is in Tasmania, but they remained resolute not to be too isolated. So they do not hesitate to live in satellite areas around major centres, such as Longford, which is near Launceston and Brighton, which is near Hobart. However, living and working in places such as Queenstown and Ouse, which are remote towns is observed to be too isolating.

### **7.8.2 Psychological isolation**

A common observation by both informants and IMGs was there are both husband and wife IMGs who are on alternate training trajectories. This would mean there may be a difference between AMC preparation, training years or a difference between specialities. It was stated isolation could potentially occur when a husband or wife needed to leave Tasmania for further training and this could impact many things. An informant specified

*sometimes a couple are separated for work purposes, one is working here and one is working interstate and this can cause... loneliness, depression, child care issues... They are really unhappy and don't perform well [and] their unhappiness interferes with their performance. (Key informant 8)*

In several circumstances the family had become so settled in Tasmania that IMGs who desired speciality training in a mainland capital city or were offered employment elsewhere ceased, so as not to break the family up and cause isolation. In these circumstances alternate employment or training pathways in Tasmania are selected to accommodate the family's needs.

Other issues were raised when an informant expressed her concern for the psychological welfare of a number of IMGs she had worked with. In particular, she shared one experience she had witnessed where she felt hospital policy regarding the social challenges faced by IMGs could be improved.

*A [IMG] told me this year that he felt so lonely, isolated and felt as if nobody cared. When he came here and went to the temporary*



*housing he said he felt like he was an alien... This doctor had post-traumatic stress disorder from how upset, fearful and anxious he felt when he first came here because he came without his family... [It] was a real eye opener to talk to him 18 months down the track and find out he was an absolute wreck... I had to do a lot of counselling work with him. (Key informant 4)*

It was observed that access played a contributing factor to isolation, as many IMGs required a number of essential services. Internet and phone access and transport were the only two barriers which were highlighted as issues for IMGs within the Tasmanian context. For example, one IMG had come to Tasmania without his family. He was unable to obtain a landline phone connection and internet access at his residence in rural Tasmania. This had created anxiety and isolation and this challenge was made more difficult when a lack of assistance was forthcoming from his employer or the community.

Other experiences shared by informants were regarding IMGs who have come from very close knit or “collectivist cultures where the extended community and family are important” (Key informant 11). Who then migrate to work and train in an individualist society where isolation occurs. It was reported that many IMGs go home after work and they sat by themselves in their units until their next shift. Alternatively, it was stated

*[They will stay] well beyond their shift is finished, poking around, doing work, discharge summaries, finding things to do because there is nothing else for them to do. This is a real problem... they are probably not developing social networks, they are not getting out finding walks to do, getting out going to the cinema and then they risk burn out and getting overtired. (Key informant 22)*

In some instances, it was reported that IMGs arrive in Tasmania alone while leaving family at home until they were more settled. This at times was initially isolating as IMGs were unable to call home or did not have internet connection to make connection with family in their home country. There was also a concern regarding

the isolation experienced by the partner or spouse of an IMG. It was noted, spouses with school aged children, who were employed, who were in education and other regular social and cultural activities, experienced a greater ability to adapt and felt being part of their new community. However, one IMG shared that in the first few weeks of arriving in Tasmania, their initial experience was isolating and described by his wife “as an open jail, like you are in a prison” (IMG 6).

In another case, the IMG’s husband was working in a completely different country from the country of origin while the IMG and her children were in Tasmania. She had migrated specifically to meet the needs of her children’s education. She found the experience overwhelmingly isolating. She was unsure how long the situation would last. Most IMGs without extended families close by stated life would have been made a little easier if family were closer.

### **7.8.3 Cultural isolation and adoption**

It had been reported by informants, there is not always a large cultural community, in Tasmania, for IMGs to connect with, which may cause isolation. It was also stated that isolation may still occur even if similar cultures are in close proximity. This was made clear when an informant stated

*One of the IMGs has said to me ‘I am a single girl, and in our culture we don’t go out except with other girls or sisters, we don’t go out with other couples as they are a couple and you are not.’ Unless there are other single females available to go out with them they find [themselves isolated]. (Key informant 22)*

On the other hand, one IMG reported she was the only one in the town from her cultural background, but she found this was not in any way isolating. Other IMGs stated they would not forget their cultural background and heritage, yet, were happy to embrace the change in culture and lifestyle. In one instance one IMG said “I am not worried about my community. I can survive without [my culture]... so I am not very particular about my own community and culture” (IMG 13). When discussing culture and fitting into a rural community another IMG said

*If you come into a country you really have to fit into that country and that lifestyle and... rural communities are really the best way to come in for IMGs, provided they come in with an open mind and try and adjust into the community. I try and to teach the new [IMGs], not to look for people from their country because they may as well have stayed back. Then why are they here... They should absorb the two cultures – that makes the country richer as that is what Australia is about. (IMG 14)*

Throughout the data, there was quite a diverse range of views and perspectives on maintaining connection with one's cultural community. In most cases, there was a greater desire by many IMGs to have increased access to familiar cultural foods rather than their actual cultural communities. Despite the desire to 'fit in' and become part of the larger community, in some cases, IMGs have experienced stigma as they have lived and worked in Tasmania.

## **7.9 Stigma**

Again stigma is related to both social and professional transition challenges and is highlighted as a major theme within the data. It is a theme which, like isolation, is interwoven among the many challenges throughout the interview data of IMGs and particularly key informants. Within this context, the occurrence and complexities of stigma within the workplace and community are highlighted.

### **7.9.1 Workplace stigma**

#### **7.9.1.1 International Medical Graduate questionnaire participant perspective**

The responses regarding stigma within the workplace from the IMGs interviewed were overall positive. However, in the 'open' written responses from the Tasmanian IMG questionnaire data analysis, IMGs indicated that "IMGs are currently being treated as 'illiterate' imports and this poses a major risk to their mental and physical health. Most IMGs would like to leave Tasmania if they could (IMG questionnaire response 28). Another IMG said "discrimination is rampant [in] the workplace and otherwise and is based on skin colour however it manifests very subtly" (IMG questionnaire response 22). In four of the ten responses regarding workplace

stigma, it was stated to occur more when preferential treatment was given to those who were not IMGs. For example, it was said to occur when referrals were preferentially sent to local doctors rather than IMGs.

Similarly, an IMG questionnaire respondent stated “mistakes done by IMGs are very much highlighted while same mistakes done by local graduates are ignored and the situation diffused to protect them” (IMG questionnaire response 11). While another said “differential treatment is meted out to IMGs, as compared to [AMGs] by nursing, allied health and medical staff” (IMG questionnaire response 22). Another IMG specifically stated “there is some discrimination - more chances [are given] to local graduates, IMGs are left out, given last priority, even if they take proper specialist pathway” (IMG questionnaire response 45). Lastly, it was noted only one of the ten open questionnaire responses, regarding stigma, discussed issues regarding patients not wanting to see one IMG due to being ‘foreign.’

#### **7.9.1.2 Key informants’ perspective**

Key informants highlighted IMGs were a vulnerable group, who were at times being used unfairly. One informant commented “IMGs in the past have been seen as a dependable and hostage workforce that you could give the shittiest jobs to” (Key informant 13). While it was reported by another informant that “there is a, I won’t say discrimination, but a preferential process whereby there is automatic decision to employ local doctors” (Key informant 12). From this perspective, an IMG’s vulnerability was observed to be caused by fear of job insecurity. This fear was at the centre of the reported stress they were experiencing, which was leading to tiredness and burn out. According to one informant, many IMGs, particularly interns and RMOs, were being asked to work extra shifts, do extra hours and being overloaded.

Another key informant stated a loss of status was another cause of IMG vulnerability.

*Many of them were specialist in their own field back home with a high degree of authority and competence and now they are here in Australia. They have to be fairly junior and work as a generalist,*

*[which] is a very big professional change. They are less respected by peers and other doctors as they are seen as being just an IMG out in the rural areas, [where] no one else wants to go. (Key informant 20)*

This vulnerability is not only led by less confidence within oneself but also fuelled by peers, where it was stated, may have less respect for and observe IMGs as a “hostage workforce” (Key informant 13).

IMGs being observed as a hostage workforce can impact upon how they are further viewed among colleagues, other health professionals and the public. Over half of the key informants stated there were elements of stigmatisation, which often occurred in small pockets and made IMGs uncomfortable and stressed. To this, two informants stated they were aware of at least one IMG who left Tasmania and moved hospitals due to prejudice within the workplace.

It was stated that prejudice had occurred among peers, which extended to nursing staff. This has occurred when IMGs with strong accents speak too fast and health professionals are unable to understand. In other circumstances, IMGs in remote areas would be ridiculed and dismissed by peers across sites. For example, an informant shared an experience where one IMG was “ridiculed because... the doctors in [a hospital], hearing a Nigerian doctor [on the phone] who they couldn’t really understand very well, was almost racist, like dismissive” (Key informant 20).

This culture of intolerance has also been reportedly experienced by IMGs, when dealing with and seeking assistance from people in organisations who sit in position of great power and who are extremely overbearing and insolent. This has caused high stress and “doctors [to] burst into tears saying ‘have I done something wrong’, as the officious rudeness is unbelievable” (Key informant 4). An informant reported greater tolerance and understanding was occurring when compared to how many IMGs were being treated a decade ago when hospital culture of intolerance was observed to be abysmal. Still, there is an attitude among peers and supervisors that IMGs are here and therefore should “assimilate” (Key informant 1).

Conversely, an informant argued there was not a culture of discrimination, but rather a culture of indifference. He said

*There are individuals within the Tasmanian system as there are in any system that makes it hard for IMGs... While I don't think there is a culture of bullying, a cultural of racism or a culture of discrimination in Tasmania's hospitals I think that sometimes there is a culture of tolerating it and so those individuals who display that behaviour aren't effectively censured. (Key informant 13)*

A culture of stigma or intolerance from the community was also highlighted within the informant data. It was noted that it was the exception and often occurred more within the Department of Emergency Medicine (DEM), where IMGs were leaving due to racial intolerance from the community.

*We have lost [IMGs] who mainly worked in the DEM and found that it got them down. (Key informant 22)*

Another informant reported it was the nature of DEM, as it was the 'coal face' where building a rapport was less able to be achieved. However, it was reported to be something which was not tolerated within the hospital and especially DEM. Another informant added the greatest amount of intolerance occurred among people who were younger, less educated or those who were under the influence of drugs or alcohol, while others revealed it was older people who had expressed concerns and issues relating to IMGs.

This was reiterated by IMGs who felt it was the situations in which IMGs were working, such as DEM, which led to challenging situations and could be viewed as intolerance. One IMG said

*Only a certain percentage of the population gets really sick, you don't meet the regular people, particularly in the department, so your view can be biased as it is based on when people come not in their normal state of mind most times. (IMG 7)*

One key informant openly said that some patients were racist and not very pleasant. “Tasmania is very parochial and we have a lot of patients like all places that are still very racist and quite frankly can be very rude and very offensive to some of our doctors” (Key informant 22). Yet, the majority of key informants stated it was less common, but occasionally a patient would refuse to be treated by an IMG.

These issues were less common within general practice, particularly in more rural areas. It had been stated rural patients were now quite “accepting [of IMGs]... and finding them intriguing and interesting. They are quite welcoming and they see that IMGs are trying to help, so I think that transition is quite positive” (Key informant 21). These communities recognise the contribution they make to the community. For example, an informant stated

*The Brighton community, lost their IMG GP recently, they were very up in arms about losing this guy who they had come to trust... they understand they are struggling to get doctors in those areas. (Key informant 17)*

Those IMGs who are GPs stated they had many positive encounters with patients, but there was still what many IMGs stated as “the odd [patient] out, who was difficult” (IMG 9). In one case, an IMG said “we have very good patients and sometimes we don’t feel like that they belong to another culture, [they are] very friendly” (IMG 13). In addition, other IMGs stated that although stigma was evident, they recognised that it was only a small part of the medical and health community which were making life difficult. There were a lot of positive colleagues and staff that were very helpful and kind, which made a difference; however, it was felt a lot of good work could be undone and offset by a few bad experiences.

### **7.9.2 Social stigma**

The topic of one’s cultural background and stigma within the community was discussed with each of the IMG participants who were interviewed. Again there was a similar response to the findings regarding workplace stigma, where interview

responses differed from open questionnaire responses. Only a quarter of IMGs interviewed discussed stigma in any detail, whereas the response rate was slightly higher in the questionnaire and had more detailed negative discussion of prejudicial actions and feelings regarding the community. Of those IMGs who discussed social prejudice in their interviews, two were Caucasian.

These Caucasian IMGs said they did not experience any prejudice, but expressed concerns for those who were non-Caucasians in the smaller Tasmanian communities which lacked cultural diversity. One stated “I think certainly moving into a small community and being non-white would be very difficult” (IMG 1). Nevertheless, a non-Caucasian IMG stated that working in the rural communities, he found people to be more tolerant, and people in the larger cities like Hobart were more problematic. He stated

*Hobart is, I think, racist... but I have never had problems with Launceston, Burnie, Devonport or Ulverstone, no problem with them, but Hobart I couldn't believe it as Hobart is more cosmopolitan. (IMG 16)*

In addition three IMGs had children who were being bullied at school due to their colour, accent or ethnicity with one IMG contemplating moving schools. It was one of these same IMGs who found it was the elderly community members and neighbours who were more culturally tolerant than younger people. He stated “I found that it is easier to adjust with people who are elderly and I think they are a bit more mild... they are more adjusting and willing of your existence in Australia, rather than the younger population” (IMG 6).

The overall feeling expressed by most IMGs was mixed, with comments such as “I have not come across any overt sort of discrimination” (IMG 9); to “multiculturalism has not been accepted in Tasmania” (IMG 17); “we have a lot of patients... who are still very racist and quite frankly can be very rude and very offensive” (Key informant 22); and “I think that Australians are bloody xenophobic and by and large are a little bit racist” (IMG 2). Many IMGs stated this stigma and intolerance was due to colour or race; however, one IMG delineated the issue when he said



*I am not talking about a coloured problem, I am talking about Asian people, people from the UK, even people from out of the country having problems here, there is not a coloured or religious thing; it is just that you are not Australian. (IMG 16)*

Within the open questionnaire responses, many of the IMGs stated they had experienced overt and covert forms of prejudice which occurred in supermarkets, outdoor markets, other shops and from passers-by on the street who “yell at us” (IMG questionnaire response 11). One IMG stated it was occurring less as “people are getting used to foreigners living here” (IMG questionnaire response 25). Nevertheless, another questionnaire respondent stated “most rural dwellers in Tasmania should wise up to life outside Tassie in order to be more accommodating rather than rigid in their dealings [with migrants]” (IMG questionnaire response 51).

## **7.10 Professional and social support**

To meet many of the professional and social transition challenges, interview participants highlighted the support, both professionally and socially which was currently available to IMGs and their families. This support included both formal and informal support, which encompassed assistance from colleagues, peers and the particular recruitment, hospitals and training agencies. In addition, IMGs highlighted some of the current inadequacies, including the formal and informal ways in which they accessed support for themselves. Also, it was highlighted many IMGs, because of their experiences, were acting as a source of formal and informal support for newer IMGs. Each of the sub-themes, professional, social and future support is discussed in greater detail below.

### **7.10.1 Professional supports**

Due to the nature of most key informants’ employment, much of their discussion was centred on the current professional support, within their particular organisation, provided to IMGs in Tasmania. The level and amount of support was also dependent upon four factors.

- The organisation in which the IMGs were working;

- The level at which the IMGs are employed;
- The rate at which IMG turn-over occurs; and
- The need for IMGs to meet AMC registration requirements.

For those IMGs yet with full registration, professional support and training were viewed to be the highest priority. This support is provided through external organisations such as PMCT who aim to assist and prepare IMGs to complete their AMC clinical examination. Adjunct training is also provided by PMCT, GPTT, HR+ and other professional bodies on a regular basis as needed or as part of post-graduate studies. Additionally, within the general practice settings, professional support is also provided by HR+ to practise settings and key managerial staff within those settings who employ IMGs.

Within the hospital setting, interns and RMOs worked in the hospital for a set period, which was from 12 months to two years and received a large amount of official in-house professional support. Registrars rotate on a three, six or 12 monthly basis depending upon the position and the training they require. However, many registrars and specialists have been known to stay for years. The in-house or collegial support for specialists and registrars, due the nature of registrar training, is provided more informally through a “buddy” or “apprentice” system of senior registrars and specialists. Within the general practise setting, IMGs are supported by their employer and either GPTT or HR+ depending on the pathway of employment. Thus, professional support was said to be usually provided on an individual basis to both IMGs and other managerial staff when specific needs arose.

These specific needs are dependent upon the setting in which one IMG is working and includes but not limited to communication skills, cultural understanding and interprofessional training. The methods used to aid both IMGs and other employees was through direct discussion, group workshops, posters throughout settings reminding of cultural tolerance, from information booklets for newly arrived IMGs and employees to web-based resources.

In addition, it was stated, IMGs within the public setting were able to access the Employment Assistance Program (EAP) and confidential telephone counselling services within and outside of Tasmania for any issues, including work related, personal or even financial issues. Another informant indicated that the EAP was successful in the area of she was working and was being used quite frequently for a myriad of reasons. She said “a number of our IMGs have been referred them this year for counselling, so we have used the psychologists this year, we have used legal advisors, relationship and marriage counselling” (Key informant 22). Nevertheless, this informant found that many of the IMGs were still not accessing the assistance available. The reasons for this were due to the stigma associated with these services. For example, poor mental health has been shown to be a stigmatised health issue among various migrant communities with many less likely to seek assistance.

#### **7.10.1.1 Support provided by colleagues, peers and professional bodies**

Despite highlighting the support that was felt to be lacking, 18 of the 22 IMGs interviewed had commented or gave an experience of support which was provided by colleagues, peers and professional bodies. Many of the comments were brief and highlighted the supportive nature of most avenues of support within their profession. However, a number of the IMGs provided some insightful reasons why there was a high level of support, particularly from colleagues. One IMG working in acute care, when speaking of why support was good in Tasmania, said “everybody is just like family in Tassie... they know you more and they are willing to help you more. In terms of support I think the support here is much better compared to other states such as [Victoria]” (IMG 11). Whereas one IMG working in primary health stated

*With training, they know who you are and the way you practice medicine, [and] all the registrars know each other and also know all the medical educators and vice versa, so we get a lot of tailor made care, when you just pick up the phone and say your name, they know everything about you, so it makes training a lot easier. (IMG 18)*

The assistance and support provided was in most cases was attributed to the proximity and closeness of colleagues and other staff within the acute and primary care settings. However, it must be noted within the primary setting, it was those IMGs who were closer to larger population centres and worked in larger general practice settings were those who reported greater support from colleagues. Those IMGs in more rural and isolated general practices had support; however, it was more intermittent or indirect.

In addition to support provided by peers and colleagues, support from professional bodies was also highlighted. This help made individual IMGs feel as though they were fully supported in their first few months after arriving in Tasmania. This assistance was observed as a positive for coming to and gaining registration in Tasmania. One IMG said he would advocate others coming to Tasmania due to the support that was provided, even stating the director of clinical training was more of a friend than a work colleague. He stated

*I really appreciate my experience here and I would probably be recommending it for someone who is coming new as well, as they don't get this feeling that they are completely stranded because you get so much support from the hospital and from the PMCT. (IMG 3)*

In addition to the support from professional bodies within the acute sector, the support within the primary setting was also appreciated. As such, it was said there was a seamless transition between the recruitment agency, Health Recruitment Plus and the regional arm of the general practice professional body, Tasmanian Medicare Local. However, the limitations within the primary care settings for IMGs to access professional bodies at all times were highlighted. These limitations were particularly evident when colleagues were unable or less willing to provide support. Professional organisations were seen as providing support and training as a means to connect with or have contact with other IMGs across the state, which then contributed to supportive relationships between IMGs.

#### **7.10.1.2 Supporting cultural needs within the workplace**

Informants made reference to the need to meet the cultural needs of IMGs within the workplace. They argued that making IMGs out rightly 'assimilate' was not the solution. It was felt that a greater cultural awareness must be used within the healthcare profession. They stated it was about being more inclusive, by recognising differences and that some cultural needs were required to be met for a greater harmonious medical community.

The views shared by a number of informants, particularly those who had very close contact with IMGs understood integration was a 'give and take' process and not one sided. For example, the provision of acceptable and non-offensive prayer space for IMGs was indicated as one way to improve integration. Also, assisting IMGs to ensure religious or culturally acceptable food was made available in the hospital cafeteria was another way. This change in the availability of food was noted to have occurred with the initiation of a number of informants.

#### **7.10.1.3 Support from within and a desire to help new IMGs**

Finally, those IMGs who experienced hardship, difficulties and problems when first arriving in Tasmania, are those who became staunch advocates and key individuals for new IMGs when they were employed. They provide and continue to provide informal and formal advice to new IMGs. In some cases these IMGs became examiners, participated in IMG mentorship or supported the development of programs aimed at assisting new IMGs entering the Tasmanian workforce. One IMG who was affected by his experience said, "you understand what you have gone through and you don't want others going through that, it was terrible" (IMG 6). At times, the support provided was giving information; however, in some cases IMGs would make a concerted effort to provide care and even physical support when new IMGs first arrive. For example, one IMG stated he bought phone cards for newly arrived IMGs so they could have access to calling family at home.

#### **7.10.2 Social supports**

The interviewed IMGs discussed the professional needs of new IMG, but also stated the social needs of new IMGs were just as important because there were many perplexing social challenges faced by new IMGs to Tasmania. As such, all informants

were asked what official social support services were available. The responses were mixed, extending from no official support to quite extensive support such as EAP for psychological counselling and even legal advice. In some cases, support had occurred well before the IMG and their family arrived in Australia. Social support included short term to long term housing, which was either a single room within the hospital, temporary hotel accommodation to fully furnished housing for families. The level of support was dependent on the doctor's training, employment award and particularly for those in the acute setting was determined by the rurality of the acute care setting. For example, a greater amount of housing support was evident for interns who were in more rural acute care settings.

Much of the other social support encompasses information sharing through newsletters; websites and Facebook groups; health and wellbeing booklets; orientation workshops; IMGs and their families being collected from the airport; and involving IMGs with social outings to help them settle in. An informant within the acute care sector stated

*I used to give them a pack about schools, banks, housing. I don't need to do that anymore, I find people tend to Google and find things out themselves. Certainly people will come and ask me about accommodation and things like that and I point them to the best sources. (Key informant 4)*

Regardless of what was available, it was felt much more could be done; however, there were not specific examples provided, just the recognition that it would require greater funding.

Conversely, support for IMG GPs in the community is provided by case managers, to aid in the transition of IMGs and their families. This support included bringing many spouses and families together to make social connections, which were observed to be, absent within the acute setting, but were rather doctor initiated. However, an informant felt social support and integration also had to do with community engagement and more than what the acute setting could provide.

*I think another part around assimilation, is it has to do with how the community engages and embraces and it has to do with the whole family, I don't think it is about the IMG, I think more importantly it is about the family... so I think every effort should be made. (Key informant 14)*

Informants recognised themselves as acting as formal and informal ties, which connect IMGs to many different networks to access information, such as banks, schools, child care and how to organise a house cleaner. An informant shared an experienced where she was asked many social support questions rather than clinical questions by a number of IMGs when clinical education actually was occurring.

A rapport had been established and one IMG felt they could ask unrelated questions. This situation does however become difficult as it was stated by a different informant “it is quite hard to wear the pastoral hat and look after assessments as well, without confusing [IMGs]” (Key informant 15). Other informants stated IMGs were often referred to the multicultural officer. However, at the RHH and LGH, multicultural officers were used less, or no longer able to provide assistance to IMGs whereas the multicultural officer at the NWRH was used extensively for IMG social needs and issues.

Within the general practice setting, support was said to be much more individualistic and dependent upon the needs of the IMG and family. For instance, one family needed assistance with shopping; others have needed transport; driving lessons; English tuition for a spouse; to swimming lessons for one IMG's children as they lived next to a river. At times the information regarding filling many social needs is passed through the practice, in an informal way, such as a formal morning tea. This informal process is to ensure the needs are met and also greater social connections are formed and not forced upon the IMG and their family.

In contrast, IMGs indicated they sought support in a hierarchical manner. Support was first obtained from extended families, friends or cultural communities; from workplaces; and then local communities. Also it is noted many IMGs, their spouse or

partner built associations with and gained support through connections with local community groups, clubs and associations, as outlined in detail below.

#### **7.10.2.1 Support within families, friends and cultural communities**

International medical graduates sought and obtained support from a variety of means; however, of particular importance was the support provided by family, friends and cultural communities. IMGs had either joined family or later had extended family join them in Tasmania. In one case, an IMG had made contact with a cousin whom she had never met until moving to Tasmania. The support that IMGs sought from family to establish themselves included housing, gaining local information, care of children or providing post-natal care of a spouse.

Those IMGs, who were single, left family in their country of origin, or had no extended family locally had a propensity to connect with the local cultural community or seek and befriend those with a similar cultural background within the workplace. However, this was not always the case as three IMGs stated they made a conscience effort to avoid anyone from their cultural background. It was also noted, if support and connection with family was absent locally, there was a tendency for IMGs and their families to move where extended families were residing elsewhere in Australia. For example, two IMGs stated they anticipated leaving the state to be with other family members who lived on the mainland.

Nevertheless, one IMG said because she had no family in Australia, it was her friends she had made locally that had made living in Tasmania a large motivation to stay. However, another IMG who had no family, friends or cultural community said he was focussed on his work and training. He said “Well people here are very friendly but my motivation... [is] for a better course and a better hospital in the mainland” (IMG 11). Although he was joining in workplace social activities, he was aiming to move to the mainland in the near future to continue his career.

#### **7.10.2.2 Support from workplace colleagues and agencies**

It is within the workplace, through recruitment and support agencies, which many of IMGs were also utilising to gain social support. However, two IMGs stated it was the recruitment and support agencies which were at times inadequately informed



or lacked the specific cultural needs of the IMG. In one case, the IMGs was informing the agency of what social supports were available as the agency was unable to address the IMGs initial social support concerns. The IMG did state this particular agency had improved since he first came to Tasmania seven years earlier. Regardless of the initial concerns after arriving, this IMG stated “if it was not for [the agency] I would have left after two to three months” (IMG 16). Moreover, two other IMGs stated it was the social support which the key agencies provided which made the greatest impact when initially arriving in the state.

In addition to the initial support provided by the key agencies, many of the more junior IMGs or those who were single within the acute care sector were tapping into social groups that were formed within a number of the hospitals. The social groups were to access the support and social life which they desired. A newly married IMG said before he was married, it was the social club of the hospital that helped him integrate.

*We have a social club where the junior doctors meet together; most of the junior doctors know each other and some of the seniors as well were part of the social club, so we had activities together because there is no big community outside, so you had to get inside to find your social life. (IMG 3)*

These connections and relationship building social activities, where many of the IMGs were able to develop personal relationships with a number of the specialists, were a huge advantage in both social and workplace relations. For example, the social connections were reported to open dialogue in a non-threatening way to discuss and explore a challenge one IMG was facing within the workplace. These social activities also created an avenue to explore and discuss a number of social needs which were of concern to an IMG or a spouse.

Connections within the workplace also led to social connections and assistance socially as well. For example, one IMG who had no extended family or cultural community locally, stated, his department colleagues were of most help and understanding. He stated

*I have a nice department, very nice colleagues. They are very helpful, not only from a professional point of view but also as a whole. If there are any family issues they are always willing to give a hand and are prepared to jump in to take over a list or whatever. (IMG 4)*

As discussed previously, the experienced IMGs were those who supported newer IMGs both professionally and socially. This help was provided through sharing a kind word; providing advice or even being available and approachable when social advice was needed by new IMGs. One IMG stated after a five hour shift being the clinical educator with a new IMG, it was the social needs which the new IMG wanted to discuss rather than any clinical matters.

Another IMG shared an experience where a tragedy had occurred in her life and she was without any family support, so it was kindness and care and support of her colleagues that aided her at the time. She later added

*The staff members really became my family, I bought my house and they came in with food and a rose bush. When I was taking my exams they organised a party for me quietly after. I came from my exam the next morning, they were all here with food and guitars and so that is where I got my social support. (IMG 14)*

It was later and after the purchase of her house that this IMG made a greater connection with neighbours and the local community, who now form part of her social network and support.

#### **7.10.2.3 Support from local community**

The local community was observed by most IMGs as being supportive; however, other IMGs recognised this was due to the fact IMGs were providing an essential service to the community and, therefore a sense of reciprocity from the community was felt. Nevertheless, it was reported this type of reciprocity at times can be quite volatile. One IMG gave the example of the precariousness IMGs are placed in, when he said

*There is a reasonable standard that is expected in communities... in that you will get [one IMG], who goes to an area and if he stuffs up, the local population shout and scream and say why the hell do we get IMGs [without] adequate training. This same group if they have one IMG who they like... and who gets taken away because of the bureaucratic process they are fickle enough to say it is bullshit. (IMG 2)*

In general, each community the IMGs had or were living in had been inquisitive, receptive and supportive of the IMGs in many capacities. This support extended from neighbours having the family over for afternoon tea; the community helping with the care of lawns and rubbish bins while one IMG was overseas; and parents of school aged children assisting with transport or after school care. Another instance of community support is where classmates defended the spouse of one IMG who was being harassed by another student while attending a polytechnic lecture. It is these types of support from the community that is what created for one IMG “a sense of belonging” (IMG 14).

Other IMGs felt the smaller communities often were over inquisitive and too involved in wanting to know all of the IMGs personal business and was disconcerting for at least one IMG. Nevertheless, another IMG saw this as a positive aspect of support which living in rural communities provided. He said

*I am sure that if you are part of a supportive community and your health goes cockeye, it helps to be in a caring community, who may know you a little bit, who may know too much about you, but they know too much about you because they care for you. (IMG 2)*

Similarly, one IMG who had worked in two remote towns of Tasmania reported on each occasion, he initially felt like an outsider, but was quickly accepted by the community, particularly as he was the only doctor in the town.

Lastly, one IMG who had been living in Tasmania for more than six years stated there were not many facilities or entertainment in Tasmania that big cities

possessed. She felt this difference provided a motivation for greater connectedness with the community or rather was the force behind IMGs connecting with the larger community. She said “I find this one of the big positives, you actually get to build closer bonds, and you get some of the best friends basically... and therefore more support, more social support in these areas” (IMG 18).

#### **7.10.2.4 Connection through community participation**

As outline previously eighteen IMGs were married or in a de facto relationship, of which only four who had partners who were not working or retired at the time of the interview. It was observed both IMGs and their spouse or partner in many cases were involved with the community through some form of community group, sport or common interest. These social groups included social groups initiated at work; participating in charity fundraising groups; and being a member of the local dancing, mountain bike, cricket, tennis, soccer or golf club. Other activities included participating in church or other religious activities; parents and friends association and other school activities; interacting with local councils; and being a member of the local fire brigade.

Many key informants commented on the positive benefits of belonging to a club, church or a group of individuals and how this ‘common interest’ had a propensity to develop greater community connectivity. For example a key informant said

*Those who settled in well were those IMGs who joined sporting clubs... We had a couple who were really good cricketers in [rural community] and they fitted in really well and their family then fitted in really well too, [when] they were brought into the sporting club community... so if you can actually get into some club, they have common interest that tends to help everyone. (Key informant 20)*

IMGs stated integrating with the community meant more than just community participation, and making connections in the community. One IMG specifically stated

*I think a lot of the response from the community depends on the amount you put into getting involved in the community... I think that there needs to be an understanding that by and large Australians will accept you if you make an effort to integrate... we found it was really easy to [integrate] because we did what all the locals did, whether that was fighting local fires or going to the local school fair. (IMG 2)*

It was also noted that integration also had to do with specifically adapting to and being willing to adjust to the new environment.

*If you are coming to a different country you have to adapt to the culture... and that a person should be ready to change. You cannot expect the population to change for you; you have come from elsewhere, so you probably need to adapt a bit. (IMG 10)*

Overall, connection to the community through participation was observed to help with adaptation and integration within the community, yet was said to be an individual choice. It must be noted five IMGs stated work and study schedules were at times prohibitive to make and create new connections within local neighbourhoods, communities. However, it was in most cases, these same individuals who also had the greatest connection with their local cultural community. These cultural communities were often made up of a small to medium number of people or consisted solely of IMGs and their families.

### **7.10.3 Perceived lack of support and meeting future needs**

Despite IMGs and key informants highlighting what professional and social supports are available, inadequate support was the most often discussed professional challenge highlighted by IMGs. The inadequate support ranged from insufficient orientation from formal support mechanisms when first arriving in the acute setting to less than desirable support through informal mechanisms and from colleagues within a primary health care setting.

Thirteen informants noted if greater supports were available, this would play a large part in the longevity of IMGs staying in place. "I think there are factors outside of

the IMG population that causes high turn-over and this can... be where there is appropriate, local, cultural and infrastructural support for them” (Key informant 13). An informant commented, IMG retention rates had increased since improved support for IMGs was developed. However, another informant stated greater consistency was required across the various acute setting. She added

*I am not sure what that could be, but at the moment it is a bit of an ad-hoc support system. I suppose if there was a bit more organisation or someone at least, because at the moment it is nobody’s responsibility. (Key informant 11)*

Nevertheless, one IMG said there was a lot more formal support available now, in the acute setting, when compared to when he first arrived six years earlier. At the time of his arrival, he stated the support was “ad-hoc” (IMG 8).

#### **7.10.3.1 Difference between practice settings**

In addition to the challenges, in the acute setting, it was reported each primary health setting was very different from each other. Some IMGs in general practice were very well supported, while others were eager to leave their practice as they felt the support provided was inadequate or absent. For example, one IMG discussed a colleague’s experience who had just left the practice two weeks earlier.

*We had a [IMG] here in the clinic, he moved last week to Brisbane with his family ... he wasn’t happy here... the working environment is not up to expectation. That is all I could say... I think we are not given enough support that we were promised. (IMG 13)*

In addition to this comment, an informant said to improve IMG retention in general practice, more face-to-face contact was needed. In addition, greater provision of skills training with emphasis on information technology (IT) was needed to build education or clinical support networks. To this another informant stated IMGs required appropriate clinical support. She said

*If jurisdictions are going to take [IMGs] on, they need to have commensurate support that is valid. At the moment the personnel are*

*just not there and it is not 'mickey mouse' support, it is not social workers, it is not 'do-gooders', it is actually clinicians and that is the resource that is light on. (Key informant 16)*

Two informants felt this was only half the solution, as there needed to be support provided to the family through greater and improved community engagement. Still, all stated these two improvements would require a substantial amount of money.

#### **7.10.3.2 The impact of inadequate support**

In addition to highlighting inadequate support, one IMG stated the situation IMGs are at times left in was not safe for themselves and their patients. This view was shared by another IMG who relayed the experience of working in a rural area alone, with intermittent and often no supervision, for the first two months of working in Tasmania. She said “I didn’t have the supervision, so... I called the medical board” (IMG 20). Subsequently, once her situation was made known to the medical board, she was transferred elsewhere.

Support, at times, was stated to be inadequate and disappointing and that IMGs needed to be viewed more than just a means of making money and just getting the job done for some of the practices. One IMG stated

*They just leave us on our own. I asked the other colleagues for some help and some don't help... We are getting a lot of IMGs here because nobody else comes so they should give more support getting to know the system and every patient. (IMG 13)*

This IMG latter added there was no point recruiting IMGs to come and work if the quality of support to assist IMGs was not improved. These comments and views were also shared by other IMGs who were concerned with the disadvantage of working in a number of Tasmania practices. The general practitioner training and support were felt to be adequate and in some cases reported to be very good; however, orientation with and training to navigate the medical system was reported to be the most challenging.

### 7.10.3.3 Orientation

At times, orientation was reported to be inadequate, for example one IMG stated “I didn’t understand this legal stuff and all this red tape at all and I made many mistakes, and I paid for them” (IMG 1). While another said he initially struggled to understand what a speech pathologist or occupational therapist was. In addition to these challenges, informants also recognised IMGs required a greater transition timeframe of orientation to the Australian health system that should be revisited over a six month period. Although, another informant argued both IMGs and non-Tasmanian trained AMGs face similar challenges, such as acclimatising to a new health system when moving to Tasmanian. This informant stated what is needed is

*The same nature of support in place for everybody, which is then scalable depending on their identified need. What that requires is the infrastructure to provide it, the capacity to adequately identify and quantify the need, the wherefore to provide the assistance and the capacity to assess how effectively it has been. (Key informant 13)*

Over half of the IMGs said the current orientation to the health system was good; though it needed to be improved. Often this reflected the pathway in which the IMG entered the country and the medical systems they had practiced in previously. For example, two IMGs interviewed did not come through the ‘normal’ recruitment process and found there was a lack of support due to their unorthodox entry to Tasmania. In addition, those IMGs who were from a similar medical system, tended to have fewer challenges understanding and developing the required skills to navigate the Australian medical system.

Lastly, there was consensus between interview participants and the open questionnaire responses. IMGs who provided written responses in the questionnaire also said there was not enough support and what was available was deficient. Some of the comments included “it would be good if the IMGs were provided with better supervision support” (IMG questionnaire respondent 16); “IMGs should be provided with more support than putting them alone in the remote areas” (IMG questionnaire respondent 36); and “there should be some kind



of peer support for new arrivals to understand... the system. In Tasmania, this kind of support is very little" (IMG questionnaire respondent 82).

#### **7.10.3.4 Financial support**

In addition to professional support, relieving a number of financial pressures was highlighted to be a support that would aid IMGs to become accredited. It was felt assisting to meet a number of financial obligations to gain accreditation would be an incentive to bring and keep IMGs within Tasmania. It was noted the Royal Australian college of General Practitioners (RACGP) is now providing greater funding, to assist in preparing for fellowship exams. Nevertheless, another informant stated not providing financial assistance motivated IMGs to obtain their permanent residency and to gain a timely fellowship. This informant stated

*One part of me says yes, you shouldn't subsidise medical practitioners... it does cause some grief for some of them and I don't know how or what we do about that, but I always think it's an incentive to get your fellowship so you can get you permanent residency. (Key informant 2)*

#### **7.10.3.5 The impact of increased local graduates on IMG support**

Lastly, one key professional challenge was highlighted within the discussion by many key informants, which was the impact of the increase in domestic Commonwealth-supported medical students. At the time of the interview, many informants were speculating this increase in AMG's was anticipated to change the 'playing field' dramatically for many new and future IMGs. It was anticipated to mean fewer positions for IMGs, increased competition and greater disadvantage. In addition, other informants stated due to budget restraints and the future potentiality of fewer IMGs, this would mean less incentive to improve or provide greater professional assistance and support required by current IMGs. An informant stated employers had a duty of care to meet these challenges. As such the informant said

*We have raped and pillaged [IMGs] contribution in the past and we now are going to have a surfeit of our own doctors. We are likely to*

*throw the baby out with the bath water and that is very offensive. The real challenge is making sure that we exercise a duty of care to those people that we have taken on. (Key informant 16)*

#### **7.10.3.6 Recommendations for future IMG support**

Beyond much of the current support and needs of IMGs observed within the data, many participants provided recommendations and suggested how the initial transition of new IMGs could be improved. These recommendations included how to fulfil any on-going professional needs. Also proposed was how to make the transition for the whole family a better experience. Many suggestions were also provided by IMGs through written responses from the IMG questionnaire which gave greater richness to the interview data.

One of the first recommendations from IMG participants was to provide greater information about the migration process, assistance with visa and permanent residence applications, with added information about the processes of medical registration. These recommendations included what is needed to meet the requirements of working in Australia. One participant stated

*People come here and they don't exactly know what they are in for so they need all that information at their fingertips. Don't tell them to look at 'Doctor connect.' There are a lot of things there which are valuable if you know what you are looking for, but until you are here it means nothing to you... It needs to be a step by step process of what you will need to know. (IMG 16)*

In addition, a longer orientation process when first arriving was a significant recommendation made by almost all IMG participants. Most felt they were significantly under prepared and lacked the appropriate information, even with the current orientation, to make informed choices both within the community and workplace. To address these challenges, it was felt the orientation process needed to occur in the first year of being in Australia at regular intervals. In addition, the orientation process needed to specifically address the different requirements of IMGs.

To improve the current orientation, IMGs stated more simple and tailored processes were required to be addressed. Suggestions included greater supervision in remote areas, the ability to rotate between the three major hospitals as part of their training and improving access to salary, by providing it in a timely manner after arriving. For example, one IMG stated “I went to [my employer] and said ‘look I need my salary’ and they gave me an envelope with \$100 in it. I got pissed off... I got my salary six weeks [after starting work]” (IMG 6).

Another participant stated to improve IMGs support, it was not about receiving incentives, he stated it was more about being feeling welcomed. He said “they must make their IMGs feel welcome, they don’t have to give us a car and a house when we come, we don’t need that, just the feeling that you are welcome and you are not being exploited” (IMG 16).

In addition to the IMGs feeling welcomed, many IMGs stated it was also about making the family feel welcomed as well and to ensure they were also well supported. However, there were not a lot of specific suggestions regarding the support that was needed for families. Nevertheless, two specific suggestions for supporting families related to being able to access Medicare and Centrelink benefits for children.

## **7.11 Expectations of living, working and staying in Tasmania**

Throughout the interviews, IMGs shared a number of positives and negatives of living and working in Tasmania, specifically rural areas and included their long term goals and aspirations for a Tasmanian lifestyle. In addition, key informants perceived staying in Tasmania was determined more by training and employment rather than lifestyle reasons. Each of the identified themes is highlighted.

### **7.11.1 Positives of living and working in Tasmania**

Most IMGs felt Tasmania was not truly a rural or remote setting. Tasmania’s ruralness was often compared to an IMG’s country of origin or to other states within Australia. One IMG stated “to me Tasmania is a big city, if you come from Western Australia, it is not that remote” (IMG 1). It was argued Tasmania had all the modern

conveniences, yet retained a small town, country feel. At least five IMGs had migrated from very large cities with more than one million people, yet they preferred the smaller more rural towns. Other IMGs stated when they first arrived they initially struggled to be in a small town, but now love rural life. “My life has been enriched by the change from an urban to a rural existence” (IMG 2).

Two IMGs had applied several times to work in bigger cities elsewhere in Australia; however, have stated they loved Tasmania so much that they decided not to leave.

*I quite like Tasmania, it was hard for me initially, but surprisingly that has gone. I have not thought about moving out of Tasmania, I did at one point, certainly, I wanted to go more metropolitan, to bigger cities, but I have lived here for six years and this is home. Now I can't leave this place, if anything I will probably get a bit more rural within Tasmania. (IMG 18)*

One IMG said “I have had no desire to move, I have made no attempt to look anywhere, I like [Tasmania], I have settled into my practice and am content” (IMG 12).

Those IMGs who are married with younger children showed a greater tendency to want to stay in Tasmania and recognise the positives of bringing up a family in a place where the people were friendlier and IMGs feel safer. “It is a huge lifestyle improvement for my family” (IMG 19). Many felt these positives may also be available in other rural areas of Australia, not just Tasmania. Three IMGs enjoyed Tasmania so much they had expressed a desire to work in more rural and isolated areas of Tasmania.

As such, one of the unique benefits of Tasmania was outlined by two individuals who lived in the heart of the capital city, Hobart. They said they could live in the capital city, yet could still fulfil the 10-year moratorium by working in rural practice, which was less than 30 minutes' drive time from their home. One of these IMGs stated they were happy to travel 30 minutes to work while their friend who was living on the mainland had to travel 400km to the nearest Capital city.

Again, proximity to the workplace was seen as a great advantage in Tasmania. Eleven IMG specifically commented on how happy they were that their workplace was within minutes of their home and they did not have to commute long hours to get to work. One IMG added “I love the fact that I can drive everywhere without a traffic jam... [it is not] a concrete jungle with pollution” (IMG 18). These positives were felt to improve their lifestyle as they were less stressed and had more time to be home with the family.

In addition to the positive lifestyle Tasmania affords IMGs, a number of positives were highlighted, including the ability to adjust quickly to the new health system within a smaller acute setting. These smaller acute settings allow direct contact with supervisors and directors of clinical training, who may know the IMGs on a more personal level and provide tailored support. From a teaching point of view, the smaller acute settings and rural primary health care settings were felt to provide doctors with a diversity of patients presenting with a multiplicity of pathologies

*You get to see a lot of... variety of patients... you get a lot of varieties and we see a lot of varieties and a lot of pathologies here for a rural hospital, it is not just a say a concentrated on the trauma, you see paediatrics, all sorts of things. (IMG 8)*

Lastly, it was highlighted that due to the small medical community across Tasmania there was a greater knowledge of and awareness of doctors in the region that benefited patient care and outcomes. For example, one IMG said “because...the medical community is small, you sort of know everyone and if I pick up the phone to get a specialist’s help, most likely he knows me...it makes is easier to practice medicine” (IMG 18).

### **7.11.2 Factors influencing retention**

When key informants were asked about what could be implemented to improve retention in Tasmania, the responses were varied. Many felt there was not a lot that could be done to retain IMGs in Tasmania. It was felt IMGs saw Tasmania as a temporary place of residence. The view was many IMGs were coming to Tasmania

to pass the AMC examination, obtain registration with the objective of leaving. An informant stated IMGs were viewed as using

*Tasmania as a stepping stone to somewhere else... We get people here who just getting a foot in the door and they basically arrive here looking for greener pastures. That is a really big problem for us because they are expensive to recruit, they don't really want to be here, they tend not to perform particularly well... and they tend to milk the system. (Key informant 8)*

Two informants stated, for IMGs, Tasmania was an alternative post to Victoria. If unsuccessful in gaining employment in Victoria, Tasmania was the closest alternative to be where family and friends are living. An informant stated

*I wonder if you are coming from another country and if you are looking to work for a place in Australia, that Tasmania would be your first choice. I don't think doctors from overseas are much different from within Australia, I don't think Tasmania is... the first choice in Australia; it is usually not. (Key informant 13)*

Regardless of the perceived motivations for coming to Tasmania, both informants and IMGs identified two factors, which they felt determined the retention of IMGs. These included job opportunities and vocational training opportunities.

#### **7.11.2.1 Job opportunities**

The consensus among both informants and IMGs was if local job opportunities or training schemes were available after AMC examination, IMGs would take them. Many junior appointments were reported to be only for a period of 12 months or for two years "once we know someone is committed" (Key informant 1). It was reported by both informants and IMGs, after receiving registration, IMGs wish to stay in Tasmania, with some indicating they have purchased houses and are settled. However, due to a lack of available employment or specialist training requirements they have to leave the state.

Nevertheless, it was stated by an informant that many IMGs including AMGs saw greater movement within Australia as part of their experience and training. As such, registrars were reported to rotate across states on three, six or 12 monthly basis depending upon the position and the training they require. However, it was reported specialists were less likely to move once they were in Tasmania. An informant said, “we don’t lose a lot; we only loose those who have to go for their training” (Key informant 6).

#### **7.11.2.2 Vocational training opportunities**

Again, it was reported it is the training requirements and opportunities which dictate where registrars could seek employment and the length of time that they could reside in any one particular place. An informant explained the predicament many IMGs faced in Tasmania.

*Tasmania is good for offering GP training because we have a lot, we have the rotation available for GP training, we have a shortage for GPs... There are places for the registrars in the practices and so forth, so it is pretty good on that front. In terms of other specialty training, as the hospitals get bigger there are greater opportunities, so in a [Tasmanian hospital] you can start some specialty training in some areas, but you will always have to move to tertiary areas to complete your training... so we can keep them to a point... small places are always going to find it difficult to retain. (Key informant 22)*

However, there were reports of a number IMGs who have left Tasmania for further training and had returned “because this is their home and this is where they want to be” (Key informant 6). However, this phenomenon was also reported to occur among the AMGs originally from Tasmania.

Moreover, it was reported training positions were becoming increasingly competitive due to increased domestic production of AMGs. In addition, elements of vocational training were not available in Tasmania or were being lost. This loss was due to the inability to retain college accreditation, a result of the diminished service delivery currently occurring in Tasmanian hospitals. “Specialists are leaving, wards are

getting smaller, we don't have the patient load, they are not seeing the cases that they are meant to see for their curriculum, so [positions] are getting derecognised" (Key informant 21). As such, this informant went on to report a number of significant positions were at risk of being 'lost.' Which she perceived would force IMGs to return home, move interstate or change career pathways. She stated

*For some, it is the realisation that do they want to live and raise their families in Australia and have to change to a different career within medicine. Maybe not be a surgeon, as they have been in their own country, maybe look at a different area such as general practise, or do they go back to their county. That is a very tough decision for a lot of them. (Key informant 22)*

Changing career pathways was reported to sometimes be difficult, as many training programs, such a general practise, require IMGs to be permanent residents before being accepted into the program. This requirement was reported to be inhibitory, whereas other training programs, such as emergency medicine, did not require permanent residence status. As such, it was reported those IMGs with families who would like to stay in Tasmania and commence general practise training are moving. This move allows the opportunity to commence training in another discipline while waiting for permanent residency.

## **7.12 The discourses of IMGs: A CDA perspective**

Beyond the recurring themes, patterns of living, behaviour and experience of IMGs which have been identified, within the informant data a number of unique insights were highlighted. These relate to the underlying ideology and hegemony of the power relationship between informants, IMGs, the institutions in which they work and associated professional bodies. Much of the discourse is centred on the workplace and the relationships which exist within the various institutions. This may be through institutional, professional, community or group discourse (Van Dijk, 2001). In addition, other domains such as political and media discourse which also contribute to ethnocentrism and immigration discourse are also included as a backdrop to the analysis.



As outlined in section eight of chapter five, the focus of CDA is on the social domains of prejudice, ethnocentrism, and immigration with regard to power and dominance of specific social groups. CDA is principally concerned with illustrating how discourse is fashioned and developed by its relationship with power and ideologies. Its process empowers, gives voice and exposes social inequality in an attempt to right social wrongs and propose change within discourses. As such, CDA has propensity to be critical on discourse while overlooking the positive aspects of the discourse that is used. Thus, by its methodological 'nature' CDA focuses on and highlights negative discourse to bring about change within discourse. So too, it is not the intention of this study to ignore positive discourse, but rather to focus on bringing to light negative aspects of discourse to influence positive change.

To aid the discussion of results, the three levels of analysis, the micro, meso and macro are outline below.

#### **7.12.1 Micro level – informant discourse as text**

Informant discourse was diverse and wide-ranging. Much of the discourse was positive in its delivery and expression; however, within certain texts, colloquialism and turns of phrase were used, which demonstrated an underlying chasm between the expressions used by informants and the work they were doing with IMGs. It must be noted, similar colloquialism and turns of phrase were also used when speaking of the elderly, such as "old codgers" and individuals from a lower socioeconomic backgrounds. Other examples of text that were used by informants when talking about IMGs included "Muslim doctors," "boat person," "these particular people," "some of them we have had," "for them, it is an important part of...."

Informants reported similar colloquialism and turns of phrase were also used by some patients and other healthcare staff when speaking of, to and about IMGs. For example, an informant shared "there is that sort of attitude that 'they live here they should assimilate'" (Key informant 1). Nevertheless, when speaking about other colleagues or health professionals within the hospital context other more positive

texts such as “the hospital is becoming more accepting of the Muslim faith” (Key informant 5) were used within the discourse.

Also within the text, subtleties of discourse were structured in such a way that demonstrated a lack of awareness of other individual cultures and the “Australianess” of the views held by both informants and other healthcare professionals. Individuals were denoted by religious background and skin colour, rather than their particular cultural group. For example, an informant said, “it was [a town’s] first doctor with dark coloured skin” (Key informant 3) rather than indicating nationality or cultural background. In one example, skin colour was used to indicate Australian citizenship. While another informant stated when visiting the mainland “you go to Melbourne and Sydney and you go ‘spot the Aussie,’ even though the people who weren’t the same colour skin like us were Aussies” (Key informant 2).

Conversely, three informants spoke of IMGs, who were from a refugee background, with one making a statement, within the text, which ‘assumed’ IMGs were similar to refugees. Another informant expressed that similar assumption have been made by other health professionals. In addition, IMGs were in most cases discussed as a heterogeneous group; however, on three occasions, text was used, which denoted IMGs homogeneity. Also, when speaking of IMGs, informants often discussed differences and challenges among those from different CALD backgrounds while often omitting those IMGs from the US, England and New Zealand. In two cases, surprise was expressed by informants when IMGs from more western countries were also having professional and psychosocial challenges as they migrated and worked in Tasmania.

In addition to these assumptions within the wording of the text, many other subliminal texts were used to describe IMGs when discussing their practice and a number of social issues. It must be noted; at times it was informants reporting what other colleagues had said. The texts that were used in these descriptions were “they are almost useless to us,” “poor clinical knowledge,” “a dangerous group,” “they tend to milk the system” and “there is always a family crisis.” Regardless of

these instances, it must be noted, many informants were extremely positive and respectful in their vocalisation of IMGs and the great work and contribution which IMG make to the Tasmanian health system and community. For example, one informant said, “IMGs have been one of my favourite groups, they are probably the most satisfying to work with, they do appreciate the training and you get such success out of them” (Key informant 20). While another said

*[IMGs] are remarkable people and you know they are sort of in advance of where the world is going because the world is global... and they give us the opportunity to look to the future a bit and practice... they are a wonderful contributors, they have got great humour and you learn heaps. (Key informant 16)*

Nevertheless, it was noted there were a small number of individuals, who through their discourse and subtlety of language were inconsistent with the message they provided and the manner in which the information was disclosed.

#### **7.12.2 Meso level – informant discourse as discursive practice**

In addition to discourse-as-text, the discourse was also analysed in terms of how it has been developed and produced within the context of Australia’s mainstream views regarding migrants and different cultures. As such, this has been clearly demonstrated through what both a number of informants have said and what other health professionals have discussed with key informants. For example, an informant relayed her experience with the discursive practice of others, when she said

*When I first came here... somebody very wise, a senior consultant, said... this is Australia and we have people from everywhere here, we can’t fit in with all that, they have to learn to fit in with us, they can keep their cultural beliefs and behaviour at home and everything else. (Key informant 4)*

It is these ethnocentric views voiced which were the underlying messages expressed by a number of informants. IMGs were here and no matter where they were from, it was a requisite to “fit in” both at home and within the community. In addition,

there was the assumption around the ease of fitting into Australia and how it could be achieved. For example, an informant was surprised to find the great challenges faced by IMGs from commensurate cultural backgrounds to fit into Australia. It was said “we can have British doctor come across and you think it would be an easy transition, but it is not always” (Key informant 3).

Conversely, another informant felt IMGs eating similar foods to their Australian counterparts in the workplace would bring about greater connection within the medical community. As such, it was said “instead of them bringing their own food they can partake of what is here and feel more a part of the doctor community” (Key informant 5). Within the discourse, it was not outlined how these actions would bring about a greater connection with or make IMGs feel any more a part of the medical community.

There were other instances where informants felt a number of the challenges IMGs were facing were unrelated to cultural differences. The discourse used at times was dismissive of cultural background, stating the challenges faced by IMGs and AMGs were not different and that there are factors outside of the IMG population which would cause high turn-over. In some instances, it was felt cultural background was irrelevant in when discussing issues of retention, high turn-over and fitting into a community. This is highlighted when an informant said

*I am not sure if it is any more difficult for any other new people who come or whether it is because [of] the effect of the foreigner and whether that is why they find it difficult to get accommodation or schooling or whether it is the fact that it is difficult for everyone. (Key informant 10)*

In addition, there were also assumptions about the financial challenges faced by IMGs as they migrate to Australia. Many informants recognised the high financial cost it was to be an IMG which included the educating children, health care cost, meeting training requirements and remittance being sent home, to support relatives of one IMG. An informant even broke the costing down to demonstrate

the great burden it was for each IMG and their family. However, there were general assumptions made in two instances, where it was viewed that many IMGs did not face any financial challenges as they were from wealthy backgrounds. To this one informant said “[IMGs] go back home, once a year for long periods of time, they seem to be able to afford child care and good schools... [and] they get paid well here too” (IMG 5).

In contrast, there was a larger amount of discourse which viewed IMGs as “poor doctors,” deserving pity. This at times was the motivation for informants providing assistance outside their normal work activities. The positive outcome of this perception was the social needs of IMGs, when first arriving, were being met informally. For example, an informant stated “I mean, I did that off my own back because I thought ‘oh poor thing’ coming to a whole new country with family and children” (Key informant 6).

### **7.12.3 Macro level – discourse as social practice**

In addition to discourse-as-discursive-practice, the data were also analysed in terms of how discourse is used to inform social practices. For example, an informant relayed an experience she was involved with when assumptions and the discourse at the time lead to less than desirable social practices. She said

*I remember there was a patient in the emergency department, a Kayin patient, an ethnic group from Burma. So the nurse thought she was being really useful and said ‘there is a Burmese doctor here let me go and grab the doctor.’ The doctor went in and the woman just froze, she wouldn’t talk and didn’t engage... [We later found out] this woman was shot by the Burmese military... I think that is an issue for some of the overseas trained staff, sometimes other staff will pressure them to interpret for patients. (Key informant 11)*

In addition, another informant said there were other practices in place where

*there is, I won’t say discrimination, but a preferential process whereby there is automatic decision to employ local doctors and*

*again there are certain regulatory reasons for that in terms of employing Australian citizen and permanent residents versus employing temporary residents. (Key informant 13)*

In addition to these current processes, this informant highlighted other practices which he had observed when he stated

*There are individuals within the Tasmanian system as there are in any system who make it hard for IMGs they make it hard, and it is not just a matter of not recognising the particular cultural, linguistic, social isolation issues, it is actually a matter of making it particularly hard on them because they don't like them... On the mainland, you can move away from those types of individuals... Even if it means moving hospitals because you can move hospitals within in the city and within the state and that is fine... While I don't think there is a culture of bullying or cultural of racism, a culture of discrimination in Tasmania's hospitals I think there is a culture of tolerating it. (Key informant 13)*

Within this discursive text it was shown there is an underlying preferential process of employing local doctors; bias is reported to occur in mainland and Tasmanian hospitals; and there is an underlying tolerance or inability to censure prejudice.

Conversely, there was discourse regarding the power regulatory bodies had, where it was felt individuals within regulatory bodies had a sense of hegemony over IMGs. It was reported not to be among all individuals within an organisation, only a selected few individuals

*who just treat these doctors as objects and not like people and I mean there is obviously some people who don't do that but there is some people in position of great power that I find them so unprofessional the way they deal with some of the IMGs. (Key informant 4)*

Also within the text, there was discourse regarding the hegemony that government bodies had over the regulatory bodies. The example of the Patel case, in Queensland, was provided to demonstrate the government's hegemony over regulatory bodies. Within this scenario, it was presented as 'blame' toward government, with the discourse removing responsibility from regulatory bodies involved. As such, it was said

*The profession is infinitely more mindful of regulation and professional behaviours than jurisdiction are. Jurisdictions will rape and pillage to suit their own ends without any cognizant of the quality. (Key informant 16)*

## **7.13 Conclusion**

This chapter has discussed the findings of both the IMG and informant interview data including written responses from the Tasmanian International Medical Graduate questionnaire. A number of key themes were identified, which demonstrated the lived experience of IMGs. These were related to the central theme of transition, with six major themes being identified and stemming from the data. These themes include: professional transition challenges; social transition challenges; isolation; stigma; supports provided to and by IMGs; and factors influencing retention.

In addition, the key informant data highlighted a number of unique insights into the underlying ideology and hegemony of the power relationship between key informants, IMGs, the institutions in which they work and associated professional bodies. It was shown most informants were positive about IMGs and their contributions to Tasmania's health system. However, it was noted unintentional assumptions, oversights and inconsistencies within the discourse from a small minority of informants may marginalise IMGs.

The next chapter will discuss the findings from chapter six and seven and will provide a number of comparisons between the views and insights of informants, of IMGs and the quantitative data analysis from the IMG survey. This discussion will

provide an overarching understanding to answer the research questions which relate to determining the enablers and barriers which IMGs encounter as they live and work in Tasmanian communities. In addition, the chapter will provide an understanding of the acculturation process of IMGs and how IMGs are engaged in the community to improve their and their family's integration in rural Tasmania.



# Chapter Eight: Discussion

## 8.1 Introduction

This chapter discusses the results of the quantitative and qualitative data analysis from chapters six and seven and provides insight into the experiences and challenges of IMGs living and working in rural areas of Tasmania, and how this informs their acculturation process. To achieve this, the chapter will address the following four research questions:

1. What are the enablers and barriers which IMGs encounter as they live and work in Tasmanian communities?
2. What are the acculturation process and strategies, which facilitate trust, co-operation and connections between IMGs, other health care professionals and the community?
3. What are the strategies used by IMGs to improve community engagement and integration? and
4. What acculturation strategies and barriers are observed by key informants who support IMGs in Tasmania?

The chapter discusses the aim of the study and the research questions by initially presenting the concept of the *local push-pull effect*. This concept demonstrates there are a number of underlying factors which influenced IMG acculturation and whether to stay or leave a particular place. This concept also provides further insight into answering the remaining research questions, which are discussed with reference to the wider research context and implications in the following sections.

## 8.2 Results in relation to research question one

**Research question one:** *What are the enablers and barriers which IMGs encounter as they live and work in Tasmanian communities?*

The findings that address the research question enabled a better understanding of the positives and challenges IMGs encounter within the workplace and community environments. The most general finding for the survey was that the majority of IMGs were 'very satisfied' to 'satisfied' with their current employment and residential location, which is dissimilar to other recent studies in Australia (McGrail et al., 2012). Despite the high level of satisfaction, nearly half (44.4%) of the questionnaire respondents indicated that they specifically felt that their practice was hindered in some way because of being an IMG. As such, seven central and underlying factors from the IMG questionnaire and interview data were identified, which impact the experience of migrating to, living and working in rural Tasmania. The many themes concerning transition and integration that were outlined in chapters six and seven provide a comprehensive foundation regarding the seven factors which impact the satisfaction and acculturation that IMGs experience. These key factors include four barriers and three enablers and are discussed in detail.

## **8.2.1 Barriers IMGs encountered**

### **8.2.1.1 Employment barriers**

The findings indicated that 58.2% of the IMGs would like to stay long term in Tasmania; however, it was poor employment, career pathway and training opportunities that dictated the length of time an IMG would stay. Previous IMG research has focused on employment support and satisfaction as a measure of IMG integration and settlement success (Alexander & Fraser, 2007; Carlier et al., 2005; Durey, 2005b; Han & Humphreys, 2005; Han & Humphreys, 2006; Hawthorne et al., 2003; Heal & Jacobs, 2005; RHWA, 2011a). However, beyond a high level of employment satisfaction as indicated in the questionnaire, employment itself coupled with career pathway and training opportunities were highlighted by IMGs and informants as contributory factors for leaving Tasmania. The more junior IMGs, who were completing their AMC examination requirements, as outlined in section four of chapter seven, it was clearly stated that their intention was to move to larger hospitals interstate, to continue their training. In many cases, this movement

interstate was due to certain positions in Tasmanian hospitals being only accredited for 12 -24 months of training within certain specialties.

As a result, there was a continual drive or desire to fulfil the accreditation and training process above all other desires such as connection with the community. It is the need for IMGs to invest in skills and knowledge not only to complete their AMC examination but also further training that motivates the need to move. Many of the training structures which are in place preclude on-going commitment to stay within a certain place for both IMGs and AMGs. As outlined in section four of chapter four, IMGs, particularly those in more junior positions, need to further acquire and invest in human capital by undertaking training, to improve the economic abilities of the individual (Lin, 2001b; Sweetland, 1996). Consequently, IMGs need to move to areas where accredited positions are available to invest in human capital.

Once the required cultural capital or human capital has been obtained, positions need to be available for the medical practitioner and this is dependent on the current supply and demand of labour (Lin, 2001b). This challenge is further exacerbated by the need to move to areas where the demand for skilled labour is higher. It was identified that limited career options, specific employment and the current financial uncertainty for future employment within the state were large contributors for leaving Tasmania. Many IMGs within the interview and survey data indicated that they liked Tasmania, and were happy to settle here; however, they recognised unless employment in their specific speciality, including general practice was available, it was inevitable that they would move elsewhere. Employment was also one of the underlying motives within many other IMG studies, why a movement away from rural areas had been occurring (Durey, 2005b; Han & Humphreys, 2005; Kearns et al., 2006; Kilpatrick et al., 2011).

#### **8.2.1.2 Professional and social barriers**

The second barrier encountered by IMGs was unmet needs in the workplace and the community. However, it did not occur among all IMGs or across all sites, as there were interview and questionnaire participants who indicated they had positive experiences or felt their needs were being met. For those who had unmet

needs, it was highlighted by both IMGs and informants to contribute to the desire to move interstate. These unmet needs included a lack of professional and peer support within the workplace, the challenges of AMC examination preparation which encompassed registration bureaucracy, and the communication skills to adequately function within the workplace or community. In addition, navigating a new medical system and the limited timeframe to receive orientation both in the acute and primary care settings was one of the major unmet needs voiced by IMGs. The finding reflects other recent research and inquires (Health Workforce Australia, 2013; Nair & Parvathy, 2012; RHWA, 2011a).

It was also felt mental health issues, depressions and poor practice can potentially go undetected in the more isolated areas of the state, which can impact health and wellbeing (Wallace, Lemaire, & Ghali, 2009). In addition, the barriers of spouse employment, education for children and cultural connectivity became further evident in more isolated areas, particularly in the North-west of Tasmania. These issues were also highlighted within the literature as major barriers for IMGs and their families (Carlier et al., 2005; Durey et al., 2008; Hawthorne et al., 2003; Kearns et al., 2006). Nevertheless, greater funding was being provided to address a number of these issues; however 'throwing money' at the problem was felt to be inadequate.

Other minor concerns as highlighted within the interviews and questionnaire were not major motivating factors for IMGs to leave, but had an impact on the desire to stay. These concerns were related to the physical isolation from major centres, the physical and psychological proximity to family and cultural communities which allowed greater opportunity to socialise and access cultural specific foods. These concerns were also experienced by other IMGs and their families living and working in other Australian rural and remote communities, who encountered physical and social isolation (Durey, 2005b; Durey et al., 2008). Nevertheless, this isolation was less pronounced within the Tasmanian setting. For example, two IMGs lived in Hobart, the capital city and worked in a rural practice, which was less than 30-minute drive from their home. Thus, the rurality of Tasmania was substantially dissimilar to mainland Australia. However, if an IMG was unable to drive in a more

rural area of Tasmania where access to public transport was limited, this fostered poor satisfaction and a similar level of isolation as observed elsewhere in Australia (Stanley & Bennett, 2005).

The isolation of IMGs and other skilled workers from CALD communities have been shown to impact on the ability to acculturate, seek employment and be retained in a community (Han & Humphreys, 2005; Kearns et al., 2006; Kilpatrick et al., 2011; Polsky et al., 2002). Within these studies, it was demonstrated that the availability of cultural activities and entertainment was a vital factor in IMG and family integration and retention (Han & Humphreys, 2005; Kearns et al., 2006; Kilpatrick et al., 2011). However, the majority of interview and questionnaire participants within this study highlighted that their greatest desire was to have better access to familiar cultural foods and religious facilities rather than actual cultural communities.

Despite wanting better access cultural foods, a lack of social capital at these times of change and vulnerability helps to understand why the loss of status or identity may increase feelings of isolation, inadequacy and lack of self-worth (Atri et al., 2011; Colic-Peisker & Walker, 2003; Nair & Parvathy, 2012; Wong & Lohfeld, 2008; Wright et al., 2012). It is the inability of IMGs and their families to access information, support and develop trust through social ties to reinforce identity, norms and recognition. These factors impact on the desire to move to be where those elements of social capital can be cultivated and nurtured, such as near family or CALD communities (Esser, 2008; Falk & Kilpatrick, 2000; Lin, 2001b).

### **8.2.1.3 Cultural understanding barriers**

Another factor highlighted in the data analysis was ethnocentrism and cultural intolerance. As outlined in chapter seven, inconsistencies were present within vocabulary being used by informants. Informants were making unintentional assumptions regarding IMGs and oversights within their discourse. For example, this is where text such as “Muslim doctors” and “boat person” were used within the discourse. This discourse demonstrates a separation and distinction between the binary of “Us” and “Them” or “whiteness” and “otherness” that fundamentally is being vocalised when speaking of IMGs, or those who may be less “us” (Caldas-

Coulthard, 2003; McLeod & Yates, 2003). However, these subtleties may not be the individual views of the informants themselves. It may reflect the everyday commonplace language used within Australia (Dunn, 2005; Dunn et al., 2007; Jones, 2000), which is continually “constructed discursively through the social practices and processes of everyday life” (Quayle & Sonn, 2009, p. 8).

Since the abolition of the *Immigration Restriction Act 1901* (White Australia policy) in 1974, Australia has increasingly become a multicultural society (Louis et al., 2010a; McLeod & Yates, 2003). However, the historical and dominant Anglo-Celtic construction of national identity and citizenship continues to inform the informal and formal use of language which individuals, society, media and governments use. This in turn continues to reproduce and authenticate dominant discourses of power (Forrest & Dunn, 2011; Lo Bianco, 1987; Quayle & Sonn, 2009). It is, therefore, within the context of this Anglo-Celtic construction and maintenance of national identity, informant discourse was produced, circulated and distributed (Blommaert & Bulcaen, 2000; Fairclough, 1992).

In addition to linguistic patterns and use of vocabulary, there were also other forms of discourse highlighted which may impact on IMGs integration and the longevity of staying in place. It was reported, by an informant once the increase in domestic production of medical graduates had occurred, IMGs could fill the positions where AMGs are less willing to work. Within the questionnaire and interview data it was revealed there were preferential processes in place to employ AMGs. Similarly, there was the perception that AMGs were afforded greater opportunities, provided with more referrals and were more protected if mistakes were made. This preferential treatment may underlie the reason IMGs from certain countries have a higher likelihood of attracting complaints to medical boards with adverse disciplinary findings non-IMGs in practice (Elkin et al., 2012). Although dissimilar to the challenges encountered by IMGs in the UK (Kyriakides & Virdee, 2003; McDowell et al., 2009), these studies highlight IMGs encounter similar partisan challenges to IMGs in Australia (Han & Humphreys, 2005; Louis et al., 2010b).

Although these challenges have been illuminated, it must be noted that informants were extremely positive and respectful in their vocalisation of IMGs and the great work and contribution which IMGs were making to the Tasmanian health system and community. The positive views further demonstrates “cross-cultural contact can inspire positive attitudes and perceptions under certain conditions: where the groups have equal status, common goals, intergroup co-operation and where there is official support [and] opportunities to become friends” (Forrest & Dunn, 2011, p. 438).

Irrespective of the recognition, acceptance and support of IMGs being overall positive, informants did highlight there were rare occasions where elements of stigma within the workplace and community occurred. Stigma was more common among work colleagues and other health care professionals in the acute care setting. However, the intolerance of colleagues and healthcare staff was at times masked by ethnocentric comments. These comments made by colleagues to informants were often the venting of frustrations and were loaded with suggestions for the informant to fix or resolve the problem. It was reported that once colleagues and other health care professionals were better informed or provided with a means to uncover their own ethnocentricity, they were in the most part more understanding of IMGs.

Despite this, cultural intolerance and stigma had been reported to occur from those in great power which permeated down to staff and organisations. It was among particular individuals of a number of organisations who IMGs were required to affiliate with on a regular basis, which caused the highest anxiety. Another source of anxiety was the intolerance amongst patients. Anxiety again was reported more by acute care informants in the North-west of the state rather than within general practice. It was revealed that these experiences were what inhibited a number of IMGs to feel part of the community and increased their desire to leave.

As demonstrated through previous research, cultural intolerance and stigma both in the workplace and community, may restrict migrant acceptance and impede long term acculturation (Berry, 1997; Crompvoets, 2010; Han & Humphreys, 2005; Han &

Humphreys, 2006; Louis et al., 2010b). What is also evident among those IMGs who participated in the interview and questionnaire was they were individuals who demonstrated the capacity of perseverance and determination to continue living in Tasmania. As such, as people selectively acquire the values, interests, attitudes, skills and knowledge of the dominant culture, the embodied state of cultural capital, it provides the ability to generate capital (Bourdieu, 1986; Lin, 2001b, 2008; Shuval, 2000).

#### **8.2.1.4 Financial barriers**

The funding challenges were less of a focus within the acute care and general practice IMGs discussion. Much of the focus was on the current economic climate and the impact the reduction in the state health budget had on current practice within the acute sector. The concerns included the erosion of acute care skills due to a reduction in patient load. As outline previously, an IMG was concerned regarding his contract being renewed or not and how this might impact the family. Meanwhile, for others they were concerned regarding the employment prospects within the state being severely diminished after the completion of their training.

Beyond state health budget concerns, both acute care and general practice informants stated greater funding was required to ensure the Tasmania's training opportunities remained competitive and to meet the professional needs of IMGs. It was said a greater amount of funding is available than there once was, yet these funds were still felt to be limited. In one case, the funds were so limited, that one informant had relinquished their own paid hours to ensure appropriate funding was available so training opportunities for IMGs were made available.

In addition to the financial pressures within Tasmanian health system, many IMGs were also undergoing great personal financial pressures. The pressure related to not only to training and employment, but also the cost of maintaining a family. This fact was also highlighted in the literature where meeting childcare, children's education needs and also health insurance costs are non-subsidised and remain a challenge (East, 2010; Heal & Jacobs, 2005; House of Representatives Standing Committee on Health and Ageing, 2012a). These added costs may inhibit retention



and encourage IMGs to opt for careers interstate where higher incomes are more available rather than in regional areas and rural general practice. In terms of human capital theory, using an economic model, this demonstrates if greater profits are able to be procured elsewhere, then people are more likely to move (Colic-Peisker & Walker, 2003).

Despite these factors, it was shown that the financial cost of the examination process was not a motivator to move elsewhere as the examination costs are used to meet AMC registration requirements, which is the acquisition of a certificate of cultural capital (Bourdieu, 1986). The cost of an examination is this investment in capital, which is seen to improve the future economic abilities of the individual and is an investment in future potential income (Becker, 1962; Schultz, 1961; Sweetland, 1996).

## **8.2.2 Enablers IMGs encountered**

Apart from the four main barriers identified, there were three enabling factors which influenced IMG acculturation and their desire to stay. These included their specific needs being met, individual characteristics, and the connection that IMGs and their families had to a particular place. These are discussed below.

### **8.2.2.1 Professional and social enablers**

The first of the three enablers which IMGs encountered as they live and work in Tasmanian related to having their and their family's specific needs met. Informants endorsed educating IMGs and their families before, during and after arrival, while educating and making other health professionals more aware of IMGs needs and experiences. Pre- arrival education ensured IMG's professional and social needs were met and at the same time making others more cognizant of different cultural backgrounds. Most IMGs were having their professional and social needs met and were particularly evident within the acute care sector interviews and questionnaire responses. Within this group of IMGs social clubs and informal gatherings were frequently held between colleagues and senior medical practitioners. It is the relationship among people where social capital is developed and knowledge, trust, reciprocity and co-operation is cultivated (Kilpatrick et al., 2003).

However, this may be detrimental when IMGs only participate in small intracultural social networks within the hospital. Within such groups, bonding social capital (intracultural networks) provides the benefits of trust and co-operation between members of a similar social identity (Baum & Ziersch, 2003; Kawachi et al., 2004; Pretty, 2003; Szreter & Woolcock, 2004). These relationships can restrict the development of social interaction within the greater community (Kuo & Tsai, 1986; Rogler, 1994; Thompson et al., 2002). As such, bridging social capital (intercultural networks) can secure information, upward mobility, cultural learning and greater cross-cultural adaptation with the host community (Durey, 2005b; Harding et al., 2010; Kim, 1977; Kim, 2001; Lancee, 2010; Portes, 2000).

Socially or professionally, it was about IMGs having a connection with someone to discuss issues, challenges or their experiences. If individual needs and desires were being met or perceived as being met in Tasmania, this increased the likelihood of retention. For example, in the questionnaire and interview data analyses, MGs indicated they were accepted and well received by the communities in which they lived and worked. This acceptance was felt to be associated with the Tasmanian lifestyle which was less stressful and more palatable. It is this relational capital, the reciprocity of the IMGs toward supportive individuals or communities, which has impacted on IMGs to desire to remain longer in a community than required (Fleming et al., 2001; Han, 2010; Kilpatrick et al., 2011).

Meeting the social needs of IMGs was also highlighted by many informants from the primary care sector. They said a great deal of preliminary effort goes into the matching of a community to an IMG and their family and then educating the community. These strategies were said to be just as important as matching an IMG to their workplace. This matching, although governed by the 10-year moratorium, was recognised as a way of ensuring families and IMGs were able to make social connections within a community. Many informants and IMGs commented on the positive benefits of belonging to a club, church or a group of individuals. They highlighted how this 'common interest' had a propensity to help greater community connectivity, which was observed to occur among other IMG in Australia (Carlier et al., 2005; Han & Humphreys, 2006).

As outlined in section six of chapter four, social capital is developed by individuals participating with each other in an organisation (Leonard & Onyx, 2003). Onyx & Bullen (2000) further demonstrate that the membership within community organisations is a catalyst that paves the way for the development of extensive social and support networks (Leonard & Onyx, 2003). These networks are not always a calculated investment but are often the product of other activities (Esser, 2008). Thus, social capital is developed as a by-product of participating within an organisation or due to a shared common interest.

Despite these many challenges, informants and IMGs alike indicated, beyond poor employment, career pathway and training opportunities, it was access to religious facilities, cultural foods and goods, social activities and other social challenges which had the greatest impact and determined the longevity of staying in place. As the social challenges and the supports available were discussed, delineation between IMGs in the acute setting and primary care sector became increasingly manifest. Within the interview data, IMGs from the acute setting had a greater number of social challenges, less official social support, however, had greater collegial support and networks to help the social challenges they were experiencing.

Collegial support was often dependent upon the acute setting and the IMGs position or stage of training. For example, interns and RMOs received a greater amount of official pastoral support, whereas registrars and specialist were provided with greater collegial support. These differences reflect the training structures in place for interns, RMOs and registrars as discussed in chapter seven. In contrast, IMGs within the primary care setting had similar, yet less number of social challenges, greater official support and less collegial support in comparison to their acute care counterparts. In addition, it was observed those IMGs within the primary care setting had a greater connectivity to the community in which they lived and served than what was observed among IMGs within the acute setting.

As previously discussed, bonding social capital between members of a similar social identity, which may more readily occur in an acute care setting, can restrict the development of social interaction of the greater community (Baum & Ziersch, 2003;

Kawachi et al., 2004; Pretty, 2003; Szreter & Woolcock, 2004). Conversely, having contact with those from a similar social identity, such a CALD background was not always possible in a primary care setting or small community. This inability has the propensity for increased bridging social capital to occur, which influences greater cross-cultural adaptation with the host community (Kim, 1977; Kim, 2001; Lancee, 2010; Portes, 2000).

#### **8.2.2.2 Individual social skills enabling acculturation**

Another enabling factor is an individual IMG and their family's social skills and characteristics, such as resilience, perseverance and adaptation. For example, an IMG may be very shy and despondent or they may be outgoing, resilient, adaptable and possess a high level of perseverance. Almost all informants discussed the individuality and heterogeneity of both individual IMGs and their families. Within the interviews, it was indicated that two IMGs may come from the same country and similar cultural background, yet they were both unique individuals and their specific needs were to be assessed and met.

This fact was clearly demonstrated by an IMG who compared his own and his sibling's experience of living and working in Tasmania. He and his brother are both IMGs, who worked and trained in the same hospital and lived in the same home, yet adapted differently. The observation relates to the acculturation strategies, of maintaining cultural preservation and having contact with and participating in the host community. As highlighted by Berry and Sam (1997) in section seven of chapter four regarding the acculturation strategies of migrants, the IMG had observed he had become 'integrated', while his sibling was experiencing 'separation' from the host community.

#### **8.2.2.3 Connection to place and people**

The third enabling factor to help IMGs and their families to adjust was briefly touched upon by informants, yet became more apparent throughout the IMG interview and questionnaire data. This factor was the connection IMGs and their families had to particular places and people. As such, six IMGs interviewed and one IMG in their questionnaire responses expressed they were staying or had a desire

not to leave Tasmania. In these cases, alternate career pathways, such general practice, were followed to achieve this goal.

Three IMGs had purchased homes and did not foresee leaving the state in the near future. Two IMGs who expressed their desire to not to leave, said they would be happy to work and live in more rural areas of Tasmania if the opportunity arose. Another IMG said he had come to Tasmania for two years, but was still living and working in the state after four. This IMG was aiming to leave within three years, however, enjoyed the lifestyle and the people that he felt he could see himself settle down, which he said was very uncharacteristic.

Other motivations for staying in Tasmania related to being welcomed and accepted by the community and these factors were reported to be more important than receiving incentives. This finding was similar for IMGs in Victoria, where being welcomed, embraced and accepted by the community were more crucial to integration than incentives (Han & Humphreys, 2005). Nevertheless, this was in contrast to many other studies, where incentives were provided to attract and retain IMGs in other Australian communities (Durey, 2005b; Han, 2010; Han & Humphreys, 2005; Hancock et al., 2009; McGrath et al., 2009).

Lastly, connection to place and people is important and also related to IMGs being settled and attached to the place where they live. Godkin (1980, pp. 73-74) explains, an individual's sense of place is a profound symbolic centre of meaning, experience and is fundamental to human existence, individual identity, which brings about collective identity and perception of belonging. As discussed in section seven of chapter four, an individual's sense of place within a given environment aids the development of social identity and the acculturation process (Colic-Peisker & Walker, 2003).

Overall seven enablers and barriers were identified which IMGs encounter as they live and work in Tasmanian communities. These enablers and barriers are wide-ranging and complex; impacting IMGs differently. It is these factors, events, resources or needs within the acculturation process that shape an individual's experiences and when combined with personal attitudes, behaviours and coping

abilities that lead to integration (Berry & Sam, 1997). However, this will be further examined and discussed in relation to the second research question.

### **8.3 Results in relation to research question two**

**Research question two:** *What are the acculturation process and strategies which facilitate trust, co-operation and connections between IMGs, other health care professionals and the community?*

The complexity and dynamics of the acculturation process for IMGs and their families within the rural context of Tasmania were revealed within the data of this investigation. As a whole, the data in the study provided satisfactory answers to the research questions, resulting in better understanding concerning the acculturation processes of IMGs with other health care professionals and the community.

As outlined in section seven of chapter four, the acculturation process, which facilitates trust, co-operation and connections between IMGs, other health care professionals and the community, is centred on the characteristics and needs of the individual. It is also centred on other aspects such as mobility, voluntariness and permanence, the level of cultural preservation, and the development of new social networks in the host society (Berry & Sam, 1997; Kuo & Tsai, 1986; Rogler, 1994; Thompson et al., 2002).

This acculturation process is also dependent upon the experiences which an individual encounters in the host community, their shift in behaviour, the acculturative stress and psychopathology they experience which leads to ultimate adaptation (Berry & Sam, 1997). As such, it is the barriers and enablers, discussed previously, which IMGs experience as they migrate, which leads to adaptation and facilitates to their ultimate retention (Han & Humphreys, 2005; Han & Humphreys, 2006; Kilpatrick et al., 2011).

The integration or the acculturation process of an individual can be vastly different between migrants who stay in their new country permanently when compared to those who stay on a more temporary basis (Berry, 1997; Schwartz & Zamboanga, 2008). It is not a 'one size fits all' process as there are many factors and variables

impacting on this process that cannot be ignored when understanding the acculturation of individuals or groups. Acculturation is achieved when certain conditions are met and when a number of other factors are at play which specifically impact upon the acculturation process (Berry, 1997).

For IMGs, integration and retention is a complex phenomenon, which remains challenging to be predicted, as there is a large number of push-pull factors occurring both before, during and after arriving at a place (Durey, 2005b; Klein et al., 2009). Colic-Peisker and Walker (2003) state human capital theory explains migration, as individuals migrate to areas where higher levels of income are available. However, this migration may not have occurred due to economic reasons alone. There are other elements, such as *push-pull* and *plant* factors encountered by IMGs as they migrate to and stay in a particular country, which was introduced in section three of chapter four (Durey, 2005b; Klein et al., 2009). These 'global' push-pull factors, identified within the IMG questionnaire, include such things as a better standard of living, more secure and safe environment and obtaining education for children (Durey, 2005b; Han & Humphreys, 2005; Klein et al., 2009).

However, within this study additional elements were highlighted, which were built upon the concept of 'plant' and which encouraged IMGs to stay in a particular place, identified by Klein, et al (2009). As such, the term *local push-pull* was coined to demonstrate the factors that both influence IMGs to either stay or leave a particular place. For example, IMGs may experience a 'push' to leave when compelled to meet training requirements or when encounter workplace or community barriers. Conversely, they may also experience a 'pull' to stay in place, such as family who are settled and do not wish to move, thus enticing the IMG to stay. It is these elements of pushing and pulling which determine if an IMG stays or leaves a certain place.

These local push-pull factors are further delineated by workplace or community barriers and enablers. For example, poor employment, career pathway or training opportunities is specifically a barrier experienced within the workplace. The remaining three push factors overlap across the workplace and community. These

include poor cultural understanding; professional and social barriers; and the financial barriers encountered in the workplace, community and by individuals. The three remaining areas which enable integration and retention were identified as pull factors. These pull factors include professional and social enablers that impact an IMG and their family; the individual characteristics which enable acculturation; and the connection IMGs and their families have to a particular place and people.

In addition to the workplace and community factors which impact upon the integration and acculturation process, hypermobility was also identified.

Hypermobility is moving from country to country and also within a country (Hawthorne, et al., 2003). It was shown that hypermobility may also have some impact on the integration and acculturation process. Hawthorne et al. (2003, p. 73) suggested that hypermobility was a contributing factor in which there was an element of predictability that a 'random' rural placement would not result in a 'permanent stay,' as it was not the end point of an IMGs' journey. However, in this study, it was not always the case; the hypermobility of IMGs within this small sample did not follow this trend and in some cases the opposite results were observed.

In the questionnaire data analysis, it was shown that 69.5% of respondents had moved directly from their country of origin to Australia while an additional 23.2% had lived in one country prior to migrating to Australia. In addition, 73.9% stated that they wanted to stay in Tasmania for the foreseeable future. In the interview data analysis, it was shown that hypermobility may have had some impact on the integration and acculturation process. The interview data analysis also showed that 13.6% of IMGs had experienced two moves, while 31.8% had experienced three or more moves before migrating to Tasmania. Those IMGs who had demonstrated the greatest level of hypermobility had been living in Tasmania for more than 15 years, whereas the remaining IMGs had moved directly from their country of origin to Tasmania, which is in contrast to other IMG studies (Hawthorne et al., 2003; McGrail et al., 2012; Russell et al., 2013).



Beyond hypermobility and fundamental to the identified local push-pull factors, it was revealed that the process of acculturation is highly individualised, inhibited or enhanced by the experiences that the IMGs encounter and dependent upon the support each IMG was given. Acculturation and retention were not dependent on the type of support, but rather the level of support. In terms of social support, it was demonstrated that this was obtained in a hierarchical manner where it was first obtained from extended families, friends or cultural communities, then from workplaces and finally local communities. The support required was determined by the resilience and ability of an IMG to socially navigate their new community.

Within this study, both bonding or bridging social capital was shown to have initial benefits to each IMG (Lancee, 2010). However, while bonding social capital facilitated initial trust, co-operation and connections upon migration, it did not have the same level of impact on integration as bridging social capital which facilitated wider trust, co-operation and cross-cultural adaptation (Kim, 1977; Kim, 2001; Lancee, 2010; Portes, 2000). Overall, it was determined that as long as strategies such as support was accessible and amenable to an IMGs needs, it was at the heart of retaining IMGs and their families in the state. In addition, there were strategies facilitated by IMGs, beyond receiving support that improved integration, which will be examined and discussed in relation to the third research question.

## **8.4 Results in relation to research question three**

**Research question three:** *What are the strategies used by IMGs to improve community engagement and integration?*

In addition to the acculturation process and strategies, this investigation examined the strategies which IMGs use to improve community engagement. The data provided solutions to this research question and resulted in a clearer understanding about the intentional and unintentional strategies that IMGs used to improve workplace and community engagement and integration. These findings provide insight regarding how to address workplace and community engagement challenges which impact IMG integration.

#### **8.4.1 Cultivating common interests**

As outlined previously, the connection to people through community participation or a common interest was also highlighted as a means to adapt and become integrated within the community. Furthermore, participants, from diverse CALD backgrounds, said that the connections and friendship with local people and colleagues were the main motivations to stay in Tasmania. Similarly, there were other IMGs from CALD backgrounds who stated there needed to be a willingness to adapt, absorb and be part of the local culture that would aid integration. In one case an IMG was supporting and teaching new IMGs not to seek their own CALD communities only, but to join in with, adapt and adjust to the local community.

Other IMGs indicated that their participation with individuals and in the community through sport and volunteerism were the strategies that impacted their and their whole family's integration. In one case, it was the husband's common interest in fishing, another had a common interest in rotary and lions club, while another discussed long term friends were made with other parents when children commenced school.

These common interests were factors that promote the connection with other people and communities. It was a familiar theme among other IMGs who had detailed they were staying or had a desire to stay in Tasmania. Through a common interest, the social capital of IMGs was developed which allowed a greater connection with people and the community and impact upon retention and integration of IMGs and their families (Kawachi et al., 2004; Pretty, 2003; Szreter & Woolcock, 2004). It also promoted greater cross-cultural adaptation and also reduced stigma while increasing positive cultural attitudes. This phenomenon was observed by other IMG studies which highlighted how common interests had a propensity to aid greater community connectivity (Carlier et al., 2005; Han & Humphreys, 2006).

Conversely, there were a number of IMGs who stated they did not have connections through a common interest with the local community. They often remained connected to their cultural community or found other social outlets through

hospital social clubs. This inability or disinterest to make local connections may be mediated by an individual's characteristics or the dissimilar common interests which they share with the local community. For example, the IMGs from Iran, Libya and Indonesia, who were interviewed, had a greater connection with the hospital social club and their cultural community, which included other IMGs working in primary care settings. However, it was time constraints caused by work and study schedules which made it prohibitive to create new connections within neighbourhoods and communities.

#### **8.4.2 Advancing effective communication**

Besides community participation, communication was shown to have a propensity to impact the behaviour of others, and improve community engagement and integration. The questionnaire results showed that a higher proportion of IMGs were very satisfied with their communication skills within the workplace than within the community. Within the workplace, a good command of English decreased the amount of prejudice IMGs would experience from certain patient encounters. However, those who came seeking care were not inherently intolerant, but rather it was their inability to communicate or understand what the doctor was saying which was the principal cause.

Meeting patient expectations within a health encounter, effective communication, and the challenges of understanding vernacular and nuances used in Australia were also observed within other studies (Hawthorne et al., 2003). However it was shown within this context that most patients and colleagues were empathetic when language was felt to be a barrier and they were willing to work with the IMGs. In other situations, communicating with patients was not the issue, but being able to relate to and how to interact with patients on a local cultural level was more challenging and desired to be developed further.

Communication skills workshops were recognised as a high priority throughout the various key informant organisations and among those IMGs from non-English speaking backgrounds, yet there was diversity in terms of overall IMG attendance. The challenge was to ensure IMGs recognise their limitations and see the benefits of

developing communication skills further within the workplace, which was recognised to improve community engagement and integration.

As previously discussed, selectively acquiring the skills and knowledge of the dominant culture, provides the ability to generate capital (Bourdieu, 1986; Lin, 2001b, 2008; Shuval, 2000). For example, the process of generating capital occurs when communication skills are developed to ensure IMGs understand and are understood by patients and reduces frustration and intolerance. In addition to creating greater capital, it can also provide increased social mobility for the individual (Bourdieu, 1986). However, a process, such as improving communication or understanding cultural nuances may take a lot of effort for some people while it can be an unconscious process for others (Clouder, 2003).

The two principal strategies, intentionally or unintentionally, exercised by IMGs to increase community engagement and integration are by making connections with the local community through common interests and improving communication skills. It is through these strategies that influence acceptance, co-operation and reciprocity between the individual, the patient and community (Kilpatrick et al., 2003). As indicated previously, it is the cultural maintenance and development of human, cultural and social capital, which enhances the connection and participation between migrants and the host community. It is this process that has the greatest influence upon acculturation and retention (Berry, 1997; Kawachi et al., 2004; Pretty, 2003; Szreter & Woolcock, 2004).

## **8.5 Results in relation to research question four**

**Research question four:** *What acculturation strategies and barriers are observed by key informants who support IMGs in Tasmania?*

Key informants within this investigation provided a number of contrasting views of barriers and enablers which impacted on the acculturation process. These data resulted in a better understanding regarding a mismatch between what key informants perceive to be the challenges to IMGs in the acculturation process and what challenges are being experienced by IMGs.

In terms of the strategies and barriers, there were contrasting views between what IMGs and informants were discussing. For example, working in unfamiliar medical systems was highlighted as a challenge by both IMGs and informants. Nevertheless, there was the view by informants that IMGs who were educated and had been working in developing countries had greater difficulty in adjusting in the new medical system. It was said this was due to not receiving much training, experience or not being familiar with western health conditions.

However, IMGs acknowledged that there were concerns about the health system itself, rather than practicing medicine. The IMGs ability to navigate the medical system was the problem, rather than the practice of medicine itself. Despite the differences between what IMGs and informants were observing, there were some shared similarities recognised as challenges. These differences included such things as patient-centred care and the need for a greater orientation timeframe to grasp and work within the Australian health system more effectively (Nair & Parvathy, 2012).

Other contrasts that existed between informants and IMGs were related to informants being concerned with meeting the cultural and future needs of IMGs. Whereas, IMGs had greater concerns regarding the immediate challenges of navigating bureaucracy and meeting the preparation requirements of the AMC examination process. Despite these differences, there was also consensus regarding communication, particularly with patients and how this was essential to ensure the doctor-patient encounter was successful.

In addition to the contrasts concerning the professional challenges, there were also contrasting views about what the main social challenges were for IMGs. Informants said there were social challenges that extended from spousal employment, education for children and the ability for IMGs to connect with and have access their respective CALD group. There was a mixed response regarding the social challenges within the IMG questionnaire. However, those IMGs who were interviewed highlighted the challenges for individual families were dependent upon each IMG and the needs of the family, rather than simply their culture alone.

The needs of the IMG and their family were in some cases related to higher education for children, a spouse not gaining employment, while, for others stigma was the major concern. These challenges occurred on an individualised basis and there was no singular theme occurring among all participants. Despite the contrast between informants and IMGs, isolation was the only challenge which was most commonly discussed by both IMGs and informants. IMGs were isolated from family, friends, and cultural community while some were isolated by the inability to drive or by poor phone and internet access.

Similarly, other studies within Australia, IMGs and their families living and working in rural and particularly remote communities also encountered physical and social isolation (Durey, 2005b; Durey et al., 2008). Nevertheless, this isolation was less observed within the Tasmanian setting. The isolation of IMGs and other skilled workers from CALD communities has been shown to impact on the ability to acculturate, be retained and seek employment within a community (Han & Humphreys, 2005; Kearns et al., 2006; Kilpatrick et al., 2011; Polsky et al., 2002).

Within these studies, it was demonstrated that the availability of cultural activities and entertainment was a vital factor in IMG and family integration and retention (Han & Humphreys, 2005; Kearns et al., 2006; Kilpatrick et al., 2011). However, the majority of IMG questionnaire and interview participants within this study highlighted the greatest desire was to have better access to familiar cultural foods rather than their actual cultural communities. This finding again was in contrast with the key informant perception regarding being isolated from cultural community.

Beyond isolation, a commonly discussed theme of informants was the potential impact the recent increase in domestic Commonwealth-supported medical students would have on IMGs. The consensus was the future for IMGs remained unclear, but many speculated it was just about to dramatically change the 'playing field' for many IMGs. A contrasting view held by other informants was AMGs are less willing to work in the more rural areas and IMGs would always have employment in these areas. This view resonated with current reports, which anticipated an on-going need

for IMGs in Australia, particularly in the short to medium term (House of Representatives Standing Committee on Health and Ageing, 2012a, p. 31).

Lastly, there was also a contrast regarding what social supports were available for IMGs. Informants discussed the more formal supports which were available or absent. However, IMGs themselves highlighted the many avenues and methods which they sought social support, which was discussed previously. Despite this contrast of views between IMGs and informants, it was established the support required was determined by the resilience and ability of an IMG to socially navigate their new community.

The research has shown at times there is a disconnect or mismatch between what key informants perceive to be the challenges to IMGs and what the actual challenges are being experienced by IMGs as they migrate, work and live in rural and remote Tasmania. In addition, although key informants are acutely aware of the many of the challenges that IMGs and their families encounter, there was less awareness regarding the connection IMGs and their families have to a particular place and people. Although touched upon briefly by informants, fewer acknowledgements were given to the importance of IMGs and their families actively participating within the community, such as participating in social, charity or sporting groups.

In relation to the research aim, seven broad and complex enablers and barriers were identified which IMGs encounter as they live and work in Tasmanian communities. However, it was shown that these factors, events, resources or needs influence the acculturation process and shape an individual's experiences. When combined with personal attitudes, behaviours and coping abilities it leads to a shift in behaviour and facilitates adaptation, integration and retention. The two main strategies consciously or unconsciously used by IMGs to improve community engagement and integration are improving communication skills and participating in common interests. These strategies had a critical impact on the acculturation process, cross-cultural acceptance, co-operation and reciprocity between IMGs, the hospital and wider communities.

## **8.6 Conclusion**

The chapter has discussed the results from chapters six and seven in relation to the lived experience of IMGs in Tasmania, research questions and relevant research discourse. It has highlighted the principal findings and provided explanations where applicable. It has also compared these findings with those of previous research and theories within the relevant literature. In addition, the chapter has presented the concept of local push-pull effect. This concept demonstrates there are seven factors that affect the acculturation process and contribute to IMGs' retention. The following chapter is the conclusion of the thesis. It will provide a summary of the research findings and highlight the significance of the study in terms of its contributions and implications to research, IMG recruitment and future policy directions. It will also detail the personal experiences and development of the researcher associated with the study. Lastly, it will discuss the future directions for research.



# **Chapter nine: Summary and conclusion**

## **9.1 Introduction**

Previous chapters of the thesis have addressed the background, processes, results and discussion relating to the aims and objectives of the study. This chapter marks the end of the thesis and the end of the Ph.D. research journey. Thus, in reflective writing style, it provides an overview of the research findings, their significance and how the research findings have been disseminated. There is also a brief discussion which focusses on the personal development and achievements of the researcher. In addition, the chapter discusses the strengths, limitations and future directions for research concerning IMGs. Lastly, the chapter concludes by providing a number of recommendations to support the acculturation and retention of IMGs in rural contexts.

## **9.2 Research achievements**

The achievements of the current research are fourfold and are centred on the research findings, their significance, the dissemination of new knowledge and my own personal development throughout the research process. Each of these achievements is discussed in further detail below.

### **9.2.1 The research findings**

The aim of the study was to examine the experiences and challenges of IMGs living and working in rural and remote Tasmania, and how this informs the acculturation process. As outlined in chapters six to eight, the factors which impact on the integration and retention of IMGs are based on the concept of local push-pull effect, which is a highly individualised process for each IMG and their family. A number of factors had been identified by previous research; however there were additional factors identified within this study that also influence IMGs' integration and retention. A synopsis is provided regarding each of these factors.

#### **9.2.1.1 Poor employment, career pathway and training opportunities**

One of the initial push factors identified from the study was poor employment, career pathway and training opportunities. It was identified as a substantial impending factor in the integration and retention of IMGs, particularly among the more junior IMGs. In many cases, their desire to move interstate was due to the drive to continually fulfil the accreditation and training processes and it was above many other desires of IMGs. Similarly, career progression rather than connection with community was highlighted, as the main motivator to leave. In addition, many of the training structures which are in place preclude on-going commitment to stay within place.

As such, limited career options, specific employment and the current financial uncertainty for future work within the state were highlighted as large contributors for IMGs to leave Tasmania. Many IMGs said they liked Tasmania, were happy to settle here; however, they recognised unless employment in their particular speciality was obtained it was very likely that they would move elsewhere. It was also feared this great uncertainty and lack of choice would also deter others from coming to Tasmania. In some cases, long-term job opportunities were unable to be offered to IMGs; however, were not due to budget constraints.

#### **9.2.1.2 Unmet needs in the workplace and community**

Unmet needs in the workplace and the community was also a push factor. This factor was not across all IMGs or sites, as there were IMGs who had positive experiences or felt their needs were being met. Nevertheless, for those who had unmet needs, it was highlighted to contribute to the desire to move interstate. These unmet needs included such things as a lack of professional, peer and pastoral support within the workplace and assistance for AMC examination preparation. The primary concerns which frustrated IMGs were the limited timeframe in which to receive orientation both in the acute and primary care settings.

For those IMGs working in more isolated sites across Tasmania, concerns were raised about being placed in rural and remote areas where minimal support, backup and clinical training are available. It was highlighted that in these areas mental health issues, depressions, isolation and poor practice can potentially go

undetected. In times of change and vulnerability for IMGs and their families, the loss of status or identity may increase the feelings of isolation and inadequacy which impacts on the desire to leave. From the informant's point of view, isolation from family and culture was observed to be even more compelling for IMGs to move away from the state. However, there were IMGs from various CALD backgrounds who felt this cultural connectivity and access to familiar food was less important.

#### **9.2.1.3 Ethnocentrism and cultural intolerance**

Another push factor highlighted was stigma, cultural intolerance and ethnocentrism in terms of what was being said and the inconsistencies within vocabulary being used by informants. This factor, at times, was in contrast to the extremely positive and respectful nature of the way they spoke about IMGs in terms of their contributions to the Tasmanian health system and community.

Additionally, the informants highlighted there were rare occasions where elements of stigma within the workplace and community occurred, which inhibited IMGs to feel part of the community and increased their desire to leave. However, it was evident among IMGs that they had the capacity to persevere and a determination to continue living in Tasmania.

#### **9.2.1.4 Funding challenges of workplace, community and individual**

The current economic climate and the state health budgets impact on the current practice within the acute sector was a major focus. This focus included the erosion of acute care skills due to the reduction of cases being seen or surgeries being undertaken. These factors concerned some IMGs in terms of their on-going employment and subsequent registration.

Moreover, IMGs were having greater personal financial pressures related to training, examination and family challenges. These added costs may inhibit retention by encouraging IMGs to opt for careers in medicine interstate where opportunity for higher incomes are more available than careers in rural general practice. If incomes in Tasmania were increased slightly, this would increase IMG retention and the competitiveness of the state.

#### **9.2.1.5 Meeting the specific needs of an IMG and their family**

In addition to the four push factors, there were three pull factors identified which were observed to impact the retention of IMGs. These pull factors included meeting the professional and social needs of IMGs and their families and making others more cognizant of others cultural backgrounds.

In most cases, if an IMG needs were being met or perceived as being met, this would increase the likelihood of retention. For example, several IMGs stated that they were accepted and well received by the communities in which they lived and worked. These perceptions were attributed to the Tasmanian lifestyle which was less stressful and more palatable. As such, it is the reciprocity of the IMGs toward supportive individuals or communities, which was shown to impact on the desire to remain longer in a community than required.

Meeting the social needs of IMGs was about matching a community to an IMG and their family and educating the community. These strategies were said to be just as important as matching an IMG to their workplace. This matching was observed as a way of ensuring families and IMGs were able to make social connections within a community. These were social connections through community participation that impacted the integration and retention of IMGs and greatly increased their desire to stay.

#### **9.2.1.6 IMGs and their family's individual characteristics**

Moreover, pull factors are also mediated by the individual IMG and family characteristics, which include resilience, perseverance and adaptation. It was felt that an IMGs capacity to acculturate, by maintaining cultural identity and having contact with and participating within the host community was observed to come down to the capacity of the individual. As such, some IMGs were assisting newer IMGs in that transition from recently arrived IMGs to being well integrated into their new community.

In addition, flexibility is required when working with and addressing the needs of IMGs and their families. It remains a complex process which is further compounded by the characteristics of each individual. Where an IMG may be very shy and

despondent to the complete opposite, they maybe gregarious, resilient, adaptable and possess a high level of perseverance.

#### **9.2.1.7 Connection to place and people**

Lastly, integration and retention was related to the connection IMGs and their families had to certain places and people. Those IMGs who expressed they were staying or had no desire to leave Tasmania were those who were successful in obtaining alternate career pathways or gaining employment in their chosen medical specialty. They also spoke of Tasmania's beauty and the ease of access to place of employment and the absence of a large population, which made the state a more appealing place to live.

In addition, it was the connection IMGs and families had with the local people which made Tasmania a more attractive place. Those who desired to stay all shared similar experiences of making and having connections with local people through sport, social clubs or community activities, which promoted greater connections with other people and communities. Even when their initial experiences were challenging, it was the sense of belonging to the community that they had developed which increased their desire to stay.

#### **9.2.1.8 Hypermobility**

Apart from these local push-pull factors which impact upon the integration and acculturation process, hypermobility was also identified as an adjunct factor. This process of moving from country to country and within a country may also have some impact on the integration and retention of IMGs. As such, half of the IMGs within this study had experienced some level of hypermobility before migrating to Tasmania. Nevertheless, two of those who moved more than five times had had lived in Tasmania for more than 15 years. This finding was in contrast to other studies, as hypermobility within this study did not always predict an IMG would leave a rural community.

### **9.2.2 Significance of the research**

Beyond the research findings, the significance of the research is its contribution to the current body of knowledge concerning IMGs both contextually and

theoretically. It provides insight into what and how IMG's needs may be met and how their recruitment and transition may be augmented to improve IMG integration and retention. In addition, it also provides insight into the IMGs themselves, and each of these contributions will be discussed in detail.

#### **9.2.2.1 Contextual significance**

The study contributes to the current knowledge and understanding of IMGs who live and work in Tasmania. Firstly, the study has demonstrated that it is unclear as to the exact number of IMGs who are working in the state at any one time; however, General Practice Tasmania (Tasmania Medicare Local), due to its annual census, is aware of the number of IMGs in its speciality.

In addition, the research has shown that there is a disconnect or mismatch between what key informants perceive to be the challenges for IMGs and what the actual challenges are being experienced by IMGs. The research also provides insight into the complexities and main motivators why IMGs are leaving the state and offers an understanding for policy augmentation to help the recruitment and greater retention of IMGs.

The research also provides an improved awareness of the underlying relationship hegemony between informants, IMGs, the institutions in which they work and associated professional bodies. For example, there were instances of unintentional assumptions and oversights within the positive discourse concerning IMGs that was used by informants. In addition, there were reports of sporadic ethnocentrism and stigma within the workplace or from patients, which may have impacted IMGs integration and the longevity of staying in place.

Conversely, the research has also highlighted those IMGs who stayed longer in communities demonstrate the capacity of perseverance and determination despite elements of stigma and ethnocentrism. It was revealed that those IMGs who communicate effectively reduce the frustration and intolerant behaviours of others.

The study results are generalisable among IMGs across Tasmania. Despite being less generalisable among IMGs working and living in other rural communities, in

Australia, the study provides a greater insight into the needs, desires and challenges encountered by IMGs both across Australia and internationally.

#### **9.2.2.2 Theoretical significance**

Within the literature, many commensurate IMG studies were framed by various theories with very little consensus concerning specific theoretical frameworks pertaining to unearthing the acculturation and lived experiences of IMGs. However, within this study acculturation theory and human, social and cultural capital theories were shown to be vital in to understand the complex processes, interactions and experiences IMGs navigate as they move, live and work within new cultural environments, such as rural areas. These theories also allowed a more developed understanding of the complexities that IMGs encounter as a 'global commodity' and once they have migrated, how and by what means they acculturate into rural communities.

In addition to the various theoretical standpoints, the study also drew on phenomenology as the vehicle to understand the everyday subjective experiences of the lived world of IMGs. In many instances, phenomenology was less used within other studies. However, in this study, it was used to better understand the meaning of the events which IMGs experienced and how this impacted on the acculturation process of IMGs as they migrate, lived and worked in rural areas (Berry, 1997; Bowling, 2005; Greenhalgh, 2007; Liangputtong & Ezzy, 2005; McConnell-Henry et al., 2009).

As outlined previously, IMGs within the study were delineated into two distinct groups which were demonstrated by experiences, need, concerns and support. IMGs from the acute care setting, were in larger numbers, were closer to major centres of Tasmania and had a higher concentration of early career or junior doctors. The more junior doctors received a large amount of official in-house support, while specialists and registrars received collegial in-house or support. IMGs in general practice were less concentrated in number, away from major centres and further along their career pathways. GPs were supported by their employer and external agencies. Regardless of the setting, the focus of support included, but was

not limited to communication skills, cultural understanding and interprofessional training.

The new insights and knowledge concerning the theoretical frameworks used, due to the result of the study have emerged. The study of IMGs that may be further expanded to other economic migrants is a complex milieu of various theories that are simultaneously at play. For example, within the research findings and at first glance, economic capital, the procured of money, may be viewed as the underlying factor impacting to recruitment and retention among IMGs. However, this was not always the case. Beyond economic capital, it was noted that the principal motivator for moving was institutional state of cultural capital – the need to gain registration or further training, a certificate of cultural capital. (Bourdieu, 1986; Kim, 2001; Lin, 2001b)

In addition to the desire of gaining Australian medical registration, many IMGs are influenced by embodied state of cultural capital, meaning the dominant values or cultures within the workplaces and communities where they were working and living (Bourdieu, 1986; Kim, 2001; Lin, 2001b). In this sense, professional socialisation and community socialising was occurring where an individual's identity was being socially constructed and largely shaped into conformity through the workplaces and communities where IMGs were working and living. This included the types and breadth of professional and social support that was being provided or intentionally or unintentionally acquired.

However, it was shown that there is a potential conflict between cultural and social capital. Although an individual's identity is acted upon and socially constructed by and within the workplace, their identity is also be shaped and constructed by the social relations, interactions and networks outside the workplace. However, these social relations are not all equal, as some create greater acculturative outcomes for individuals than others (Lancee, 2010). It is noted that those who experienced professional socialisation and developed their identity within the workplace and maintained social networks with workplace colleagues outside the workplace were less inclined to fully acculturate within the communities where they were living and



were more inclined and had a greater propensity to leave. Whereas, those who developed their identity within the workplace and further developed their identity outside the workplace had a propensity to better acculturate within their communities they were living and were less inclined to leave.

Although cultural capital, the need to gain Australian medical registration, plays a contributory role in socialisation and identity development, social capital plays a greater and more extensive role in the development of self-identity, sense of place, ownership and belonging (Godkin, 1980; Kuo & Tsai, 1986; Rogler, 1994; Thompson et al., 2002). This study highlights there is a bond between the professionally based strategies and culturally based strategies to meet IMG needs that facilitate greater socialisation, acculturation and retention within rural communities. The study provides a comprehensive, yet a contrasting view of the current understanding of the social and psychological indicators of successful integration, settlement and life satisfaction among IMGs, particularly in rural areas (McGrail et al., 2012; McGrail et al., 2010).

Beyond these finding, other new insights and knowledge emerged, particularly as they apply to the conceptual frameworks used among IMG, other migrant and acculturative studies. These new insights have provided an added and layer of complexity to the view of social capital and its role in the development of self-identity, sense of place, and belonging. For example, the current research highlights an emerging concept, 'social ties through common interests.' This concept is where an individual is initially drawn to participate in a group due to an interest which is in common with other members of that group, rather than being drawn to the group by any one individual within the group.

This concept is concerned with an individual's connectivity to a common interest or entity, a constructed social meaning, rather than any one individual within the group. Rather than placing energy and effort into any one individual of the common interest group, effort is initially placed into the common interest itself. The connections and social ties made within the common interest and among other common interests are secondary to the initial motivation, yet are vital in

establishing extensive social and support networks and the development of greater social capital.

There are a number of conditions to be met for common interest to occur, which include, the shared common interest itself, an investment of resources (energy, time, practice or monetary) into the common interest, and an investment of resources between individuals. In addition, it must be noted there are many ties or connections with individuals among group member and there is a predisposition for these connections to be unequal, highly individualistic, with connections being in a perpetual state of development and change (Scott, 2000). As these connections change and develop, sociability, friendships, support and ultimately social capital between individuals is developed.

### **9.2.3 Personal development**

As this part deals with personal reflection on the research journey, the first person pronoun 'I' is purposely used. There has been great personal development throughout the research journey. It has been said the research journey is not like climbing a mountain, but a series of steps which need to be met one at a time (Creedy, 2008). I argue it is both climbing a mountain and a series of steps. In some cases, post-graduate research has been paralleled to many familiar, but daunting activities including negotiating a maze or even eating an elephant. The common elements between these metaphors are the difficulty of the task and the reward at its conclusion. As such, it is the skills development which has been one of the challenging highlights throughout the process. As a researcher,

- My communication, negotiation and functional plasticity skills in terms of working within a team environment and being guided by supervisors throughout the journey have improved. I have also observed the advancement of my skills such as networking, data analysis, analytical writing, document preparation and understanding the issues in relation to intellectual property, and authorship. These skills were cultured through supervisors and participating in the Graduate Certificate in Research run through the Graduate Research Office, University of

Tasmania. In addition, I participated in many Graduate Research Student support program workshops held by the CRH, University of Tasmania.

- I have gained the skills required to competently and confidently prepare and deliver oral presentations to specialists and general audiences; develop strategies to manage critical questions and have the aptitude to defend methods, outcome and interpretation of the research. These skills were established by observing, participating and presenting in seminars and conferences and attending skills workshops both locally and internationally.
- I have also had the opportunity to use and transfer the skills gained throughout the post-graduate research study period to other projects and achievements. To achieve this I have been involved in seven CRH research projects. These projects included a review of the community needs in North-west Tasmania, health literacy, healthy communities, and teenage pregnancy. I was an integral participant in the seventh project which was an evaluation of the Workplace Based Assessment process used to assess International Medical Graduate clinical competence at the LGH. This project led to recommendations for improving the Workplace Based Assessment program for IMGs and an additional scholarly publication.
- I have participated in and developed a research proposal for the Health Workforce Australia Strategic Research Program in 2012-2013 and 2013-2014. The research proposals were entitled “The rural experience of international medical and other health professional graduates” and “Evaluating and improving the quality and effectiveness of clinical supervision for interns.” The process and experience was enlightening; however, both the proposals were unsuccessful.
- I also participated in and develop a research proposal for the Department of Foreign Affairs and Trade (DFAT), Government Partnerships for Development (GPDFD) program. The research project is entitled “Capacity building for public health sector professionals in primary trauma care in rural Vietnam.
- I was able to develop additional research proposals, which resulted in securing two research grants totalling \$35,780.

- I also established my oral presentation skills when I successfully developed and trained post-graduate students and academic staff in 2012 and 2013. The training session included “Using SPSS for Understanding and Analysing Data – Part I and II.” These lectures were part of the Graduate Research Activities which are annually held to ensure post-graduate students have the skills to navigate and use SPSS, statistical software, in an effective manner. I was subsequently invited to provide these trainings and an additional session to staff and students at the School of Nursing and Midwifery, UTas, Darlinghurst campus, New South Wales.
- I further develop my oral presentation skills by presenting a paper entitled “Asian migrants’ lived experience and acculturation to western health care in rural Tasmania” at the 2011 Primary Health Care Research, Evaluation and Development (PHCRED) Symposium presentation, University of Tasmania, Hobart. In addition, I also presented “Climbing the Western health care mountain: Asian migrants’ challenges in rural areas of Tasmania” at The Fifth International Asian & Ethnic Minority Health and Wellbeing Conference in 2012, Auckland, New Zealand. I also presented a “Rural community nurses: Insights into health workforce and health service needs in Tasmania” at the Health and Wellness Conference in 2014, Vancouver, Canada.
- I undertook two book reviews for “The Internet Journal of Language, Culture and Society.” In addition, I was a reviewer for six journal articles for the International Journal of Psychology, International Nursing Review and the Universal Journal of Public Health, Journal of International Migration and Integration, BMC Medical Education and the Health Sociology Review within the post-graduate study timeframe.
- Lastly, I also was a co-supervisor for the topic of “Rural community nurses— Insights into health workforce and health service needs in Tasmania” for the 2013 Primary Health Care Practitioner scholarships.

The current post-graduate study has not only contributed to the current body of knowledge concerning international medical graduates, but also created the opportunity for greater personal and professional development. These skills and

growth have been demonstrated through participating in and being an integral part of many other research activities.

In addition to my many personal opportunities to develop and grow as I traverse the post-graduate research journey, my greatest achievement has been to do it while raising four young children and to motivate and support my wife to return to University to commence a Masters by research degree to investigate the effects of music on women with post-natal depression.

### **9.3 Research strengths**

There are a number of strengths of the research. These include the aims and objectives of the study being relevant and specifically pertain to the identified gaps within the current research. Few studies recognised quality of life and psychosocial needs of IMGs and their families as crucial factors impacting rural acculturation and retention (Alexander, 1998; Colic-Peisker, 2009; Stanley & Bennett, 2005).

In addition to the identified gaps, previous IMG studies have used quantitative or qualitative approach while only two studies had used a mixed method approach when researching IMGs (Hawthorne et al., 2003; Laurence, 2008). The strength of this study is that it utilised a mixed method approach to verify, corroborate and cross-validate the findings of the lived experience of IMGs. In addition, it substantiated this with the data obtained from key informants regarding IMGs as they migrate, work and live in rural Tasmania (Creswell, 2003). The aim was to “strengthen the knowledge claims of the study... [and] offset the weaknesses inherent within one method with the strengths of the other method” (Creswell et al., 2003, p. 229).

Lastly, an observed strength of the study is the questionnaire and the interviews were giving voice to IMGs. It was perceived by the participants that it was a vital opportunity for them to tell their story and that someone was actually listening. In many cases, the IMGs were speaking candidly with me. To demonstrate this, three reflexive journal excerpts state

*About half way through [the interview] his clinical façade was lowered and I could see he was beginning to speak more relaxed and candidly... His story was fascinating and I wish I had more time to talk to him. I got the impression, as he opened up and as those barriers were broken down, he wanted to talk more as well. Coming away from the encounter I felt a little dishevelled, I had planned it one way and it came off another. IMGs have had these experiences and want to talk about it, regardless of the questions I aimed to ask. It was almost like a debriefing session and the subliminal message was 'I have never been able to talk about this outside my close circle of friends and so I want to keep sharing.' (Researcher's reflexive journal entry 23)*

Another poignant journal entry regarding another IMG indicated

*He discussed being isolated and the difficulty of not being to contact his family back home and the challenges he faced with food and getting money for the first month. Some of these experiences, he said, I was the first person he was telling and that he did not even tell his wife about the challenges he was initially having... It was physically apparent this person was still very angry six years after his bad experience. He was in a better head space now, but the wounds were still open and still raw. (Researcher's reflexive journal entry 28)*

In addition, a much later entry stated

*Initially she was all put out and slightly disgruntled that she had agreed to speak with me, but once we started talking, she relaxed and became more open. She discussed a number of challenges and positives about working and living in Tasmania. At the end of the interview she was not agitated, but rather pleased that she could talk – there was something therapeutic about the encounter for her. (Researcher's reflexive journal entry 41)*

As a result, several IMGs have continued to maintain contact with me, mostly to share excitements, such as passing the AMC examination, gaining registration, to inform me of their employment opportunities and permanent residency progression.

## **9.4 Research limitations**

There were a number of limitations within the study that became evident throughout the research process. Firstly, the views and experiences of IMGs' spouses or families were not gathered directly in the study. This data would have provided an additional layer of understanding and greater depth to the acculturation of IMGs and their families as they live and work in Tasmania. Nevertheless, it was noted that when married IMGs were interviewed they spoke about their families and the experiences and challenges they were having.

In addition, there was the potential for recall bias of interview participants to occur, as two IMGs had been living and working in Tasmania for more than 20 years. They may have had some challenges in recalling some of the experiences and challenges they initially had when arriving in Tasmania.

Furthermore, the study focussed on all IMGs within Tasmania and this may have potentially impacted the generalisability of the findings to specific IMGs, those IMGs within a particular specialty or those living and working in very remote contexts. The data may not be transferrable or generalisable to all IMG populations; however, the sampling methods used in the study were to ensure a representative sample from a finite population was collected. This method guaranteed the results of the study sample may be more generalised back to the population (Marshall, 1996). Nevertheless, the study does provide extensive insights and understanding into the motivations and desires of IMGs who live and work in rural communities.

Beyond these limitations, a substantial issue was brought to my attention as the questionnaire was being administered in May 2012. A key informant called me and discussed her concerns. She stated whilst attending an annual meeting with many IMGs, the research and questionnaire were discussed and she noted some of the

IMGs were reluctant to participate in or complete the questionnaire. It was discussed, by those she was speaking with, that completing the questionnaire would somehow impact on their AMC clinical exams, which many were awaiting to undertake.

The questionnaire had a University of Tasmania logo on it which was said to be seen as a 'government organisation' and by completing the questionnaire; it would somehow be traced back to the individuals. The key informant reported this reluctance to participate in the questionnaire was occurring more among the newer IMGs as they were fearful of the consequences. The informant later said that she was happy for me to attend one of the training sessions and discuss the research and speak frankly about the questionnaire. Unfortunately, this did not come to fruition, as federal funding arrangements had been withdrawn from this agency and the training sessions being held were abandoned within weeks of the telephone conversation.

The low questionnaire response rate may be a reflection of the concerns that were raised by this key informant regarding IMGs being reluctant to complete the questionnaire. This concern was echoed within the questionnaire itself, when three participants did not indicate their place of birth. Additionally, when answering the question of where they obtained their first medical qualification; one of these three participants stated that he was "not going to reveal" (IMG questionnaire respondent 55) with regard to his background information.

Moreover, this concern of being identified by participating in the questionnaire was also made apparent when a blank questionnaire was posted back. Attached to the questionnaire was a note stating "I am sorry, I have not completed this questionnaire. Due to the comprehensive personal data requested, my personal identity is easily guessed" (IMG questionnaire response 104). These types of responses and the less willing nature of disclosing data may highlight the volatility which some IMGs may be experiencing as they attempt to live, work and undertake examinations to become registered in Australia.



This reluctance to complete the questionnaire may also provide some insight into why elements of the questionnaire were not completed. For example, no IMGs indicated that they were dissatisfied or very dissatisfied in their current position; however, 14 respondents did not complete this specific question. This non-response may indicate that a number of IMGs do feel dissatisfied, but were reluctant to record their current satisfaction level. Nevertheless, in each of the Likert-scale questions, which related to professional and non-professional satisfaction, there was consistently 12 - 25 respondents who did not answer these specific questions. Not completing this section may be due to a reluctance to complete such questions or the Likert-scales being viewed as too time consuming to be completed.

Furthermore, the interviews conducted with IMGs were to examine their lived experience of IMGs living and working in Tasmania. The interviews were framed by their own experience; however, some of the narratives and experiences being voiced were of their colleagues and friends who were also IMGs. Similarly, key informants were discussing IMGs concerns and experiences which IMGs were relaying to the informants.

As such, it is these silences regarding the key issues and challenges of IMGs which were being heard by me second hand, through colleagues, friends and informants. This relaying of information, through a third party, may also demonstrate in some capacity that there was a reluctance to participate in the current IMG study. It may also explain why there were a lower number of interns, RMOs, or those with less than five years medical experience who were less likely to indicate their willingness to be interviewed.

In addition, IMGs were a large and vastly heterogeneous group of individuals. This cohort was often quite dissimilar in cultural or religious beliefs and medical education they had received. This heterogeneity may also be reflected in the ordinal regression calculations where cultural groups such as IMG from 'Asia' the cultures were group together and included those from India, Singapore and Iraq where cultures are vastly different. Conversely, a number of doctors with the same nationality have similar positions and yet had vastly divergent lived experiences.

Thus, many of the examples and experiences which were provided by those interviewed may not reflect the IMG community as a whole. As such, the data remains problematic to generalise.

Lastly, underlying much of the interview data were the current economic climate and in a number of cases, the key informants and IMGs, particularly those employed through the DHHS were concerned they were going to lose their jobs. This fear of job loss may have created some hesitation or reluctance for some key informants and IMGs to elect to participate in the study. However, one informant did say within the interview when discussing a matter concerning themselves that, “some people will shoot me down in flames for this, but I don’t care” (Key informant 4).

## **9.5 Future research directions**

Beyond the strengths and limitations of this study, a number of future directions for research were highlighted. The future potential research was identified within the study or became apparent as the literature was mined and reviewed. These future research directions include:

- To examine the views and experiences of IMG spouses or families to provide an additional layer of understanding and greater depth to the acculturation of IMGs and their families as they live and work in Tasmania. The views and experiences of IMG spouses or families a phenomenological approach would be used, so as to understand the families’ lived experiences. This would provide an additional layer of insight into the acculturation process of IMGs and their families as they migrate, live and work in a new environment.
- To explore the acculturation process of those IMGs who have already left Tasmania. The aim would be to understand from their perspective about the motivations for leaving the state, rather than gathering this information from those who temporarily or permanently live in Tasmanian. Again, to gain insight into the lived experience, a phenomenological approach would be utilised.
- To study the mental health of IMGs, as this was highlighted as a concern and requires more in-depth investigation. It has been shown that migration and acculturative stress may impact the mental health of migrants. Currently, there

is a paucity of research on IMGs mental health and there is very little research regarding the effect acculturation and social support has on the mental health of IMGs (Atri et al., 2011). The methodologies that may be used would be a similar approach to this study, where a mixed method of questionnaire and follow-up interviews would be conducted. Due to stigma, there may be some hesitation to discuss a number of mental health issues; however, a questionnaire may provide the anonymity to reduce concerns around stigma.

- To understand the perplexing reason why communication skill workshop attendance is high among some IMGs and low among others. Communication skills were identified as a means to overcome perceived cultural barriers. However, communication was an area of great stress and anxiety for IMGs, due to an inability to understand or be understood. As such, further study is required to investigate through methodological approaches that may focus on action research, to identify strategies that may be implemented to improve attendance and outcomes. Action research or practice-led research as a methodology would be suitable as it is focused on working with participants critically reflect on their practice, seek to improve any limitations and then though evidence demonstrate if and how the practice has improved (McNiff, 2013).
- To understand the experiences of networking among IMGs, however, this requires a more comprehensive and longitudinal study (Bagchi, 2001).
- To further understand the relationship between contemporary media discourse and community views of IMGs. In the past media discourse had played a significant role in the perception and view of IMGs (Black, 2011; Harvey & Faunce, 2005; Kunz, 1975). It would be valuable to understand current community views of IMGs and explore how the media has shaped community acceptance of IMGs since the Patel case commenced. Again, a mixed methods approach as a methodology may be best suited to address these questions regarding discourse and views of IMGs.
- To understand the challenges and the acculturation of AMGs from an international background. This was not part of this study, yet remains an area of future research. International students who obtained their medical degrees in

Australia are increasing in numbers. Enrolments were as high as 30% in various Australian universities between 1996-2004 (Hawthorne et al., 2007). These international students who are classified as AMGAs may have cultural similarities which are cognizant with IMGs (ABS, 2006). However, the acculturation processes and challenges they experience when training and working in Australia are not well known.

- Lastly, a longitudinal approach would be useful to monitor and study the long term prospects, outcomes, career trajectories and movement of IMGs within Australia, due to the recent increase in domestic Commonwealth-supported medical students. It was anticipated, by participants of this study, the future for IMGs remained unclear. However, it seemed rural positions that AMGAs are less willing to work would be a niche area for IMGs to seek employment.

## **9.6 Recommendations**

This study has focused on the experiences and challenges of IMGs living and working in rural and remote Tasmania, and how this informs their acculturation and retention. As part of this study, a number of recommendations are provided. Many emulate the recommendations of the 2012 Parliamentary inquiry, “Lost in the labyrinth” and shadow the National Strategy for International Recruitment (House of Representatives Standing Committee on Health and Ageing, 2012a).

Nevertheless, these recommendations focus specifically on the outcomes of this study and are outlined below.

### **9.6.1 Recommendation one**

To have specific recruitment strategies, candidate review processes and policies needs in place as the principal motivator for leaving Tasmania was for career pathway and training opportunities. These policies must ensure the current needs of an employer are met while long-term needs of the state are at the forefront of the selection process. For example, there may be an immediate need for interns in the acute care sector; however, the selection of applicants may also take into consideration long term goals and aspirations of the candidate. For example, selecting IMGs with a special interest in general practice, emergency medicine or

other specialities that are identified areas of needs within the state. In addition, this process is also about ensuring training requirements may be met locally or on-going local opportunities are made available if training is required to be undertaken elsewhere.

#### **9.6.2 Recommendation two**

To develop recruitment policies or selection processes that focus on matching potential candidates, their own or their family's needs and characteristics to communities within the state. In addition, the process needs to focus on greater awareness building of Tasmania for IMGs and their families prior to arrival. It should emphasise the positives of rural communities, lifestyles and ease of access to workplaces, to major centres and proximity to CALD communities or cultural specific foods. In addition, awareness building must focus on indicating some of the initial and longer term challenges potentially encountered by IMGs, spouses and children, such as spouse employment and education for children.

#### **9.6.3 Recommendation three**

To facilitate increased peer and pastoral support within the workplace while greater consistency and a streamlining of support mechanism are required across the various acute care settings. The support required needs to include greater orientation at various intervals in the acute and primary care settings in terms of health care processes, programs and what adjunct services are available. Individual case management may be required for those individuals who demonstrate a lower level of positive transition.

#### **9.6.4 Recommendation four**

To ensure equitable support, awareness and financial assistance for IMGs is commensurate with mainland Australia as they prepare for the AMC clinical examination. As medical registration is one of the major focusses of IMGs, it is vital to ensure timely AMC clinical examinations are available to be undertaken. Conversely, to expand the current AMC Workplace-based assessment (WBA) standard pathway process across Tasmania, this may act as an incentive for IMGs to migrate to the state.

#### **9.6.5 Recommendation five**

To evaluate the current income and financial incentives for IMGs, who work in rural areas to guarantee the competitiveness of the state. In addition, ensure timely remuneration is implemented to guarantee no undue financial hardship is encountered by newly arrived and employed IMGs.

#### **9.6.6 Recommendation six**

To develop greater cognizant regarding IMG cultural backgrounds among patients and workplace colleagues. This is achieved through education of communities, workplaces and individuals. Consideration may be required regarding what role the Tasmania medical school may plan in IMG training or their involvement with medical education as part of the medical integration and socialisation process. It is also about ensuring IMGs and families are able to make social connections through workplace and community participation, particularly if common interests are shared.

#### **9.6.7 Recommendation seven**

To improve IMG communication skills through communication skills workshops as communication was voiced to be the most essential and greatest challenge faced by IMGs. This challenge extended from communication between colleagues to both patient and doctor understanding each other. Greater communication skills and increased workshop attendance, though improved 'quarantined' education time would ensure the doctor-patient encounter is successful, while creating increased workplace and cross-cultural adaptation and acculturation within the community.

### **9.7 Conclusion**

Previous IMG research has focused on employment support and satisfaction as a measure of IMG integration and settlement success. However, this study has identified beyond employment satisfaction, employment itself, coupled with local training to meet career pathway objectives can be used as a means to improve integration and retention. As such, it is understood that obtaining "employment is universally considered – among scholars, settlement service providers and policy-

makers – to be the single most important aspect of migrant integration” (Colic-Peisker, 2009, p. 176).

Nevertheless, greater integration, settlement and retention among IMGs in rural areas may be strengthened through strategic recruitment and greater formal vetting process. This strategy would glean those who desire to follow a certain career pathways and best suit an on-going commitment in the state. In addition, other strategies include providing pre-arrival awareness of the positives and challenges of rural life and timely income once commencing employment. This process would be followed by increased peer and pastoral support within the workplace, the community, while ensuring greater support is provided to gain registration. Lastly, there is a need to effectively reduce stigma and develop greater cultural understanding within the medical and local communities.

As such, the research shows IMG integration and retention becomes a process of marrying IMGs desires, their training requirements with current and long term local needs and goals of the state. However, this process is also about ensuring training requirements may be met locally or on-going local opportunities are made available if training is undertaken elsewhere. The informants perceived there was not a lot that could be done to retain IMGs. They felt Tasmania was viewed as a temporary posting and most IMGs had the objective to leave the state once registration and compulsory scheme obligations were met. In contrast, IMGs demonstrated they loved Tasmania and many enjoyed rural life; however, more local job opportunities and training opportunities were needed to be available to ensure they would stay. In some cases, IMGs have even changed career pathways, so as to stay in the state.

Regardless of the current and future challenges, what was clear is the positive contribution, which IMGs and their families are making in Tasmania. The contribution extended from producing a wonderful horizon of global opportunities within medicine; providing greater multicultural communities especially in rural areas, and reciprocating the care and assistance they received to newly arrived IMGs. This assistance was to ensure a new IMGs transition is made smoother and they are effectively integrated into the community.





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# Appendix A Ethics documentation

Social Science Ethics Officer  
Private Bag 01 Hobart  
Tasmania 7001 Australia  
Tel: (03) 6226 2763  
Fax: (03) 6226 7148  
Katherine.Shaw@utas.edu.au



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HUMAN RESEARCH ETHICS COMMITTEE (TASMANIA) NETWORK

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29 August 2011

Dr Quynh Le  
University Department of Rural Health  
Locked Bag 1372  
Launceston Tasmania

Student Researcher: Daniel Terry

Dear Dr Le

Re: FULL ETHICS APPLICATION APPROVAL  
Ethics Ref: H0012008 - Health and wellbeing of International Medical Graduates:  
Acculturation into the Tasmanian rural and remote context

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We are pleased to advise that the Tasmania Social Sciences Human Research Ethics Committee approved the above project on 29 August 2011.

Please note that this approval is for four years and is conditional upon receipt of an annual Progress Report. Ethics approval for this project will lapse if a Progress Report is not submitted.

The following conditions apply to this approval. Failure to abide by these conditions may result in suspension or discontinuation of approval.

1. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval, to ensure the project is conducted as approved by the Ethics Committee, and to notify the Committee if any investigators are added to, or cease involvement with, the project.
2. Complaints: If any complaints are received or ethical issues arise during the course of the project, investigators should advise the Executive Officer of the Ethics Committee on 03 6226 7479 or [human.ethics@utas.edu.au](mailto:human.ethics@utas.edu.au).
3. Incidents or adverse effects: Investigators should notify the Ethics Committee immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.

A PARTNERSHIP PROGRAM IN CONJUNCTION WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

## Appendix B Newspaper extracts

There is a widely held objection to indiscriminate appointments of foreign medical practitioners... Therefore every effort to safeguard the interests of Australian and British doctors and the interests of their British families should be regarded as worthy of the support of every Australian institution...

(Barron, 1939, p. 5)

The Sydney Morning Herald, 27 November 1939, p. 5

Alien doctors. State ministry criticised. Clergyman's views.

Mr. McDougall said that the refugee doctors were the victims of Nazi aggression and had been told by Hitler that they were not Germans. There were only 36 refugee doctors in this State and there were about 3 000 registered medical practitioners. Every one of the 36 refugee doctors had signed an address of loyalty and had offered to perform military service, or to assist in other national service. It was necessary to look for something other than fear of competition. If the loyalty of the refugee doctors was in doubt it was the duty of the Government to put them in a concentration camp.

("Alien Doctors," 1939, p.

The Sydney Morning Herald, 11 December 1939, p. 9

Defending the Cabinet's decision to exclude alien enemies of German nationality from registration as medical practitioners in New South Wales, the Premier, Mr. Mair, said last night that the first duty of a Government was to safeguard the interests of its own people. 'That duty acquires a special force when the nation is at war,' he added. 'Numbers of Australian doctors will be called on to leave this country to fight for the Empire, and it would seem to be extraordinary to allow a German refugee doctor to become so entrenched during the absence of the Australian doctor as to place the Australian at a disadvantage on his return.'

("Ban on Alien Doctors," 1939, p. 9)

The Sydney Morning Herald, 11 December 1939, p.9

#### Migrant doctors work as labourers

...some 50 doctors left the British, U.S., and French zones of Germany to come to Australia. Among them were members of those 'Allied nations which brought the greatest sacrifices in World Wars I and II in the service of the common cause. Their standard of medical knowledge and experience was highly appreciated and respected by American and British medical authorities in Germany and Italy, and also by the Australian Medical Mission in Germany. Yet, in spite of this recognition of their high medical standards, they are employed in Australia as labourers and their wives as domestics.

(Madirazza, 1949, p. 2)

The Sydney Morning Herald, 21 February 1949, p. 2

The British Medical Association in Tasmania has expressed alarm at the proposed introduction of a bill into Parliament to facilitate the registration of alien doctors into this State without any qualifying examination. A statement issued yesterday said the B.M.A. felt the public and the Government should realise that this bill was potentially dangerous to the community. 'Medical standards in Australia and in this State are high,' added the statement, 'thus guaranteeing that the public are treated only by doctors who have attained the required degree of knowledge, and who have passed the final examinations in medicine at an approved university.'

("B.M.A objects to short cut for alien doctors," 1951, p. 12)

The Mercury, 17 March 1951, p.12

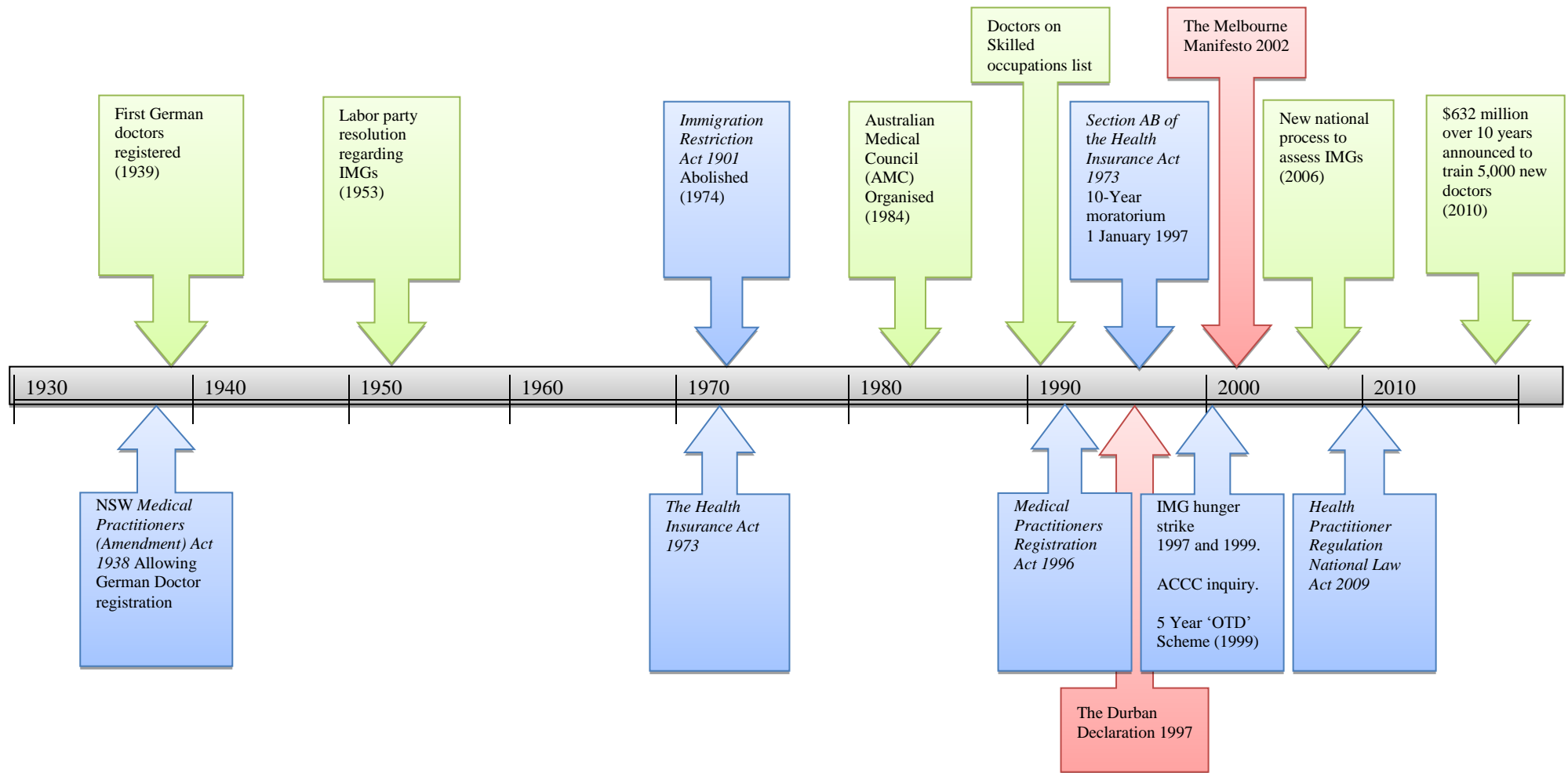
While wanting to give alien doctors the right to practise medicine in Tasmania, the Government [has] a duty to ensure that newcomers maintained the high standard of the profession in Australia.

(Alien Doctors, 1951)

The Mercury, 4 May 1951, p. 5



## Appendix C IMG policy and legislation timeline



## Appendix D Research examining IMG acculturation

**Table D 1: *International research examining IMG acculturation***

Authors	Location	Objective/Aim of study	Methodology	Study results
<b>Klein, et al (2009)</b>	Canada	To explore the personal side of migration and transition experiences of IMGs in Alberta, Canada.	A qualitative study using telephone interviews and a semi-structured interview guide was used to interview 19 IMGs who are currently practicing and have held Part V, restricted or temporary practice licenses for less than 7 years. Grounded theory	Three major themes were identified from the five female and 14 male physicians, aged between 27 to 60 years old. The first was the “push” from their own country of origin and their perception that moving to Alberta would be better for them. Professional opportunities in their home country had been affected by changing policies, lack of infrastructure, and personal/family safety issues culminating in highly stressful work environments. The second was “pull.” An improvement in the quality of personal life was associated with geographical, educational, recreational, and spiritual aspects of daily living for participants and their families in their new environment. The third theme was “plant”—i.e., factors that encouraged them to stay in Alberta.
<b>Wong and Lohfeld (2008)</b>	Canada	This study aims to describe the recertification training experiences of IMGs in Canada in order to help medical training programmes understand how to facilitate the integration of IMGs into recipient medical communities.	A phenomenological (qualitative) research approach was undertaken for this study. International Medical Graduates undergoing recertification training in order to practise in Canada were individually interviewed about their experiences. Data collection and analysis followed the procedures of interpretive phenomenology. Twelve IMGs participated	Analysis of the interviews revealed 4 themes that typified IMG recertification training experiences: training entry barriers; and a 3-phase process of loss, disorientation and adaptation. International Medical Graduates must complete this 3-phase process in order to feel fully integrated into their professional environments.
<b>(Kearns et al., 2006)</b>	New Zealand	What keeps doctors ‘in place’ in New Zealand rural communities and what prompts their departure from practice.	A cross-sectional study using in-depth interviews with 9 overseas-trained medical practitioners within rural areas in New Zealand during 2004. Random sample of IMGs currently working in rural New Zealand was generated from the Medical Council of New Zealand (MCNZ) website. Thematic analysis	Unintended circumstances under which respondents often arrived in their rural communities, as well as some of the ‘pull’ factors which a more relaxed rural lifestyle offers. Recurring themes relating to the attractiveness of place include community loyalty and the enjoyment of ‘fully practicing medicine.’ Themes which corroded the attractiveness of place included ‘entrapment’, lack of choice in secondary schooling, restricted spousal employment opportunities, the lack of cultural and entertainment activities, and difficulties accessing continuing medical education.
<b>(Lillis et al., 2006)</b>	New Zealand	This study aimed to identify and explore the major issues of concern for OTDs who were required to pass the New Zealand Registration Examination (NZREX) when first integrating into the New Zealand medical system. Greater understanding of the difficulties that	The study design was purely qualitative. The data were collected using semi-structured interviews and focus groups involving 10 OTDs who were working in a New Zealand hospital. Of the ten doctors there were four groups with two people and two interviews with a single person. Socio-cultural educational theory provides a useful framework for	The study identified four key issues: work issues which included difficulty finding employment and difficulty integrating into their work role; a bridging programme which improved the ability of OTDs to gain knowledge and experience of the New Zealand medical working environment; financial difficulties which were a major impediment to attaining registration and a career pathway in New Zealand; and bureaucratic barriers (including examinations and information

Authors	Location	Objective/Aim of study	Methodology	Study results
		these OTDs face is the first step to improving their initial integration into a new medical system, with the goal of ensuring they practise safe and effective medicine in New Zealand.	understanding the difficulties faced by OTDs integrating into a New Zealand medical workforce	availability), which were seen as necessary but unsympathetic processes in gaining registration.
<b>(Mpofu, 2008) Thesis</b>	New Zealand	The primary aim of this project is to gain understanding about (i) the experiences of immigrant medical practitioners who come to New Zealand and face the challenges of re-registration in order to continue with their occupations. (ii) How these people manage and cope with the experiences. (iii) To facilitate participants' critical awareness of the shared and individual nature of their experience and give them the opportunity to suggest ways of addressing obstacles they face when they wish to practice in New Zealand.	Qualitative research. Focus groups and interviewing 18 NESB IMGs who were doctors, dentists and physiotherapists. Thematic analysis. 100% response rate. Social critical theory	The participants were mentioning their experience of being deprived of their chosen occupations they mentioned broader implications of the experience rather than narrowing it to just a question of earning income. These findings were consistent with the theoretical tradition of social critical research and occupational science concepts informing this study. It was also found that that the participants have a range of skills and experience that can be valuable to the New Zealand health system but the dominant discourses about them are those that view them with a deficiency lens.
<b>(Wawdhane et al., 2007)</b>	UK	To analyse the experience of clinical attachment (CA) or clinical placements of IMGs and consultants.	Analysis of questionnaires and CVs. 573 IMGs applying for a house officer post and 102 consultant physicians working in North-East England. Statistical analysis	IMGs had spent a mean of 16 months unemployed, of which 3.8 months was spent on CAs. The median number of CAs was two and the average number of applications sent before obtaining a CA was 73. 90% of IMGs found their CA helpful and 57% would not take up a post without a CA first. Criticisms related to lack of responsibility, isolation and poor job prospects. 90% would apply for honorary posts if advertised. 73% had received induction at the onset of placement, but only 32% had been assessed at the end. 50% of consultants took CAs and only 4% were thinking of stopping doing so. Those without CAs blamed work pressure (43%) and pressure from their employer (23%). Conclusions: There are deficiencies in pastoral care, the application process and assessment, but CAs are valued by IMGs and offered by half the consultants surveyed.
<b>(Atri et al., 2011)</b>	USA	The authors investigated whether social support and acculturation could predict the mental health of international medical graduates pursuing psychiatric residencies in the United States.	A 55-item on-line survey was assembled by combining three validated instruments for mental health, social support, and acculturation. A link to the survey was e-mailed to training directors of all psychiatric residency and fellowship programs. Directors were requested to forward the survey to their international medical graduate residents for completion between December 2008 and February 2009. Statistical analysis	One hundred eight International Medical Graduates from 70 different psychiatric residencies and fellowships completed the entire survey. Respondents' mental health scores were normally distributed. The vast majority scored very high on survey items related to mental health. Acculturation, social support, and post-graduate training year were significant predictors of mental health.  Residency training programs should attempt to incorporate measures that would help boost the social support and acculturation of International Medical Graduates (especially junior-level trainees). Acculturation could be improved by language training and courses in American history, culture, and customs, and social support could be

Authors	Location	Objective/Aim of study	Methodology	Study results
<b>(Crouse &amp; Munson, 2006)</b>	USA	To evaluate the retention and acceptance of the J-1 Visa Waiver physicians in rural Wisconsin.	Sites in Wisconsin at which physicians with a J-1 Visa Waiver practiced between 1996 and 2002 were identified. A 12-item survey that assessed the acceptance and retention of these physicians was sent to leaders of institutions that had participated in this program. Retention of J-1 Visa Waiver physicians was compared to other physicians recruited to rural Wisconsin practices by the Wisconsin Office of Rural Health during the same time period. Statistical analysis	expanded by mentoring relationships. There was a general perception that the communities were well satisfied with the care provided and the physicians worked well with the medical community, there was a lower satisfaction with physician integration into the community-at-large. This was found to correlate with the poor retention rate of physicians with a J-1 Visa Waiver. Physicians participating in a placement program without J-1 Visa Waivers entering practice in rural communities had a significantly higher retention rate. Physicians with J-1 Visa Waivers appear to provide good care and work well in health care environments while fulfilling the waiver requirements.
<b>(Polsky et al., 2002)</b>	USA	To examine the influence of place of graduate medical education (GME), state licensure requirements, presence of established IMGs, and ethnic communities on the initial practice location choices of new IMGs.	Data Sources. The annual GME Survey of the American Medical Association (AMA) and the AMA Physician Master file. 19,940 IMGs who completed GME in the United States between 1989 and 1994 and who were in patient care practice 4.5 years later. Conditional logic regression analysis was used to assess the effect of market area characteristics on the choice of practice location	IMGs tended to locate in the same state as their GME training. Foreign-born IMGs were less likely to locate in markets with more stringent licensure requirements, and were more likely to locate in markets with higher proportions of established IMG physicians. The IMGs born in Hispanic or Asian countries were more likely to locate in markets with higher proportions of the corresponding ethnic group. Conclusions. Policy-makers may influence the flow of new IMGs into states by changing the availability of GME positions. IMGs tend to favour the same markets over time, suggesting that networks among established IMGs play a role in attracting new IMGs. Further, IMGs choose their practice locations based on ethnic matching.
<b>(Shuval, 2000)</b>	USA, Israel and Canada	The social and psychological processes by means of which (former Soviet Union) immigrant physicians seek to re-establish themselves professionally in a new society.	The empirical findings are drawn from a study of physicians who emigrated from the former Soviet Union in the early nineties to three different destinations: Canada, Israel, and the United States. The existential quality of the migration experience was explored by means of a set of life-history narratives related by immigrant physicians. Thematic analysis	Despite major structural differences among the three hosts, there are several important similarities in the processes observed in the three settings. The first concerns the high salience of the professional role for immigrant physicians and their determined efforts to regain their lost status. These efforts are constrained by structural elements characterising the three hosts. The second relates to the mediating effects of gender and age in the reconstruction of professional identity: female immigrant physicians are relatively disadvantaged as are older persons in the occupational sphere. Immigrant physicians who decide not to pursue medical licensure often redefine their occupational identity in areas that are close to the health field. Differences noted among the three groups are a function of structural differences among the three host societies.

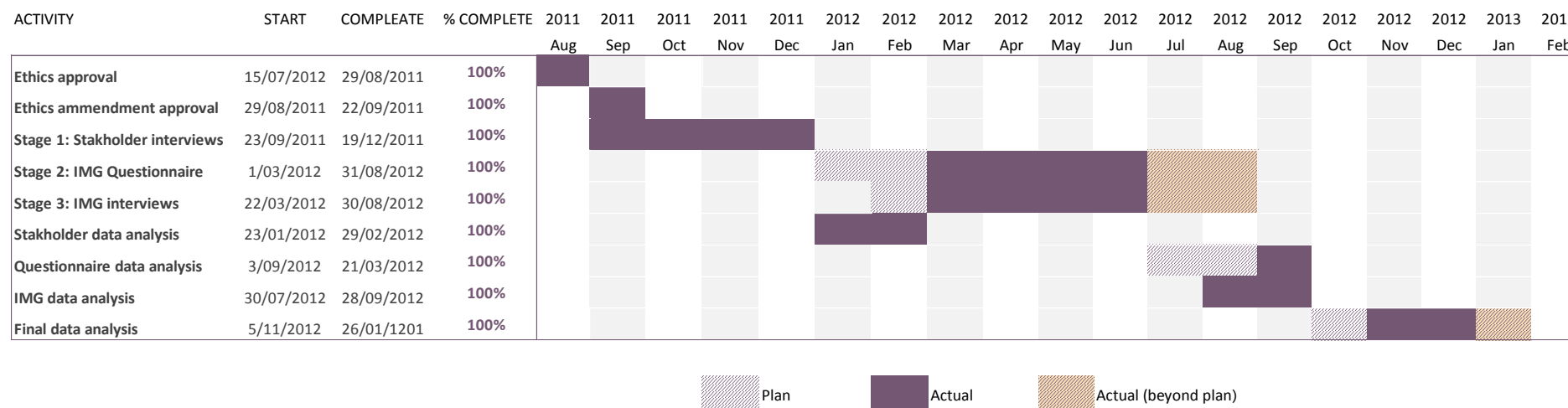
**Table D 2: Australian research examining IMG acculturation**

Authors	Location	Objective/Aim of study	Methodology	Study results
<b>(Alexander &amp; Fraser, 2007)</b>	Rural North-west New South Wales, Australia	The key factors influencing rural Australian medical graduates (AMG) and IMG GPs to stay in rural practice.	Cross-control survey. Two questionnaires one for IMGs and another for AMGs. Analysed using the SPSS v12.0.1. Differences between IMGs and Australian-trained doctors were calculated in respect of selected variables by way of non-parametric $\chi^2$ and, in all cases where the expected frequency count in one or more cells was less than five, Fisher's exact tests. 114 of the 215 identified doctors returned surveys.	Australian medical graduates and IMGs largely agree on key education, training and professional support needs. Continuing professional development, training opportunities, professional support and networking, as well as financial support are the doctors' shared top priority issues. Rural GPs satisfied with their current medical practice, intend to remain in rural practice for 40% longer than those who are not satisfied (11.5 years compared with 8.2 years). Rural GPs contented with their life as a rural doctor intend to remain in rural practice for 51% longer than those who are discontented (11.8 years compared with 7.8 years). Our results support the notion that IMGs should not so much be considered to have special needs, but rather an integral part of the region's medical workforce.
<b>(Carlier et al., 2005)</b>	Rural South Australia IMG GPs	Evaluating the orientation received by new IMGs who had come to work in this division between 1998 and 2003, to find ways of improving orientation for future IMGs.	Self-administered questionnaire developed in consultation with PHCRED staff and with the Flinders and Far North Division of General Practice. EpiInfo™ was used for data entry and analysis. 20 IMGs were surveyed with 100% response rate.	Respondents gave the highest importance ratings to clinical and financial topics such as prescribing, medico-legal issues, clinical support, enhanced Medicare items and billing. The lowest importance ratings were given to social topics such as Australian and Aboriginal culture, community services and divisions of general practice. After orientation, the greatest confidence ratings were in clinical topics and lowest confidence ratings were in special Medicare payments, medico-legal issues and Aboriginal issues. Problems that were most likely to be encountered by IMGs and their families when settling into a rural Australian town could have been made easier by 'more information on the community and its facilities' (55%), 'information on job for spouse' (45%), a 'vehicle on arrival' (40%), 'family orientation to the community' (30%), 'developing local contacts before arrival' (25%), 'support from another medical family' (25%) and 'assistance with loans' (20%). Sources of support on arrival in descending order of helpfulness were practice staff, division, local families, schools, community groups and churches.
<b>Durey (2005a); Durey (2005b)</b>	Rural Western Australia	The impact on IMGs and their spouses of living and working in rural or remote Australian communities. Based on ethnographic research into factors affecting the wellbeing of GPs and their spouses in rural and remote Western Australia this was part of a doctoral research project.	Ethnographic approach which included participant observation, semi-structured interviews and Informal discussions with 14 IMGs and 11 spouses over several months. Participants were chosen via snowball sampling. QSR N6 was used to collation of Information	The overall findings of this study show that factors affecting the settling in process include issues related to security. Cross-cultural adjustment isolation, social expectations of gender roles and medical work practice. Differences emerged in how IMGs and their spouses responded.
<b>(Durey et al., 2008)</b>	Australian rural and remote settings	To examine how IMGs and staff in rural and remote Indigenous health contexts communicate and negotiate identity and relationships, and consider how this may influence IMGs' transition, integration and retention.	10 case studies, purposefully sampled. Semi-structured interviews, Nvivo Thematic analysis.	Identity as 'fluid' emerged as a key theme in effective communication and building good relationships between IMGs and Indigenous staff. IMGs enter a social space where their own cultural and professional beliefs and practices intersect with the expectations of culturally safe practice shaped by the Australian Indigenous context. These are negotiated through differences in language, role expectation, practice, status and identification

Authors	Location	Objective/Aim of study	Methodology	Study results
				with locus with uncertain outcomes. Limited professional and cultural support often impeded this process.
<b>(Gilles et al., 2008)</b>	Australian rural and remote settings including QLD, NT and WA	Analyse factors affecting IMGs' professional, cultural and social integration and examine their training and support needs.	10 case studies, purposefully sampled. Semi-structured interview informed by the findings of a literature review. Thematic analysis of data.	Key themes included the need to better address recruitment, orientation and cross-cultural issues; the importance of effective communication and building community and institutional relationships, both with the local health service and the broader.
<b>(Han &amp; Humphreys, 2005)</b>	Rural Victoria, Australia	To identify the factors that influence foreign doctors' community integration and examine how these affect their intention to stay in the rural community.	Semi-structured questions, based on a biographical, life-history methodology. Based on the principles of grounded theory and utilising N6 computer software, data were thematically coded and analysed. A total of 57 were interviewed (face-to-face and telephone interviews) of the 73 who expressions of interest from a pool of 292 identified IMGs.	Maintaining cultural and religious values, as well as relationships to their respective ethnic communities is important to IMGs. While they do not expect excessive support from the community they appreciated the cultures of welcoming or 'embracing differences.' Supportive communication and supervisory support positively influence IMGs' appreciation of what the rural community can offer them and how they might overcome any difficulties that they face with their rural practice and life.
<b>(Han &amp; Humphreys, 2006)</b>	Rural Victoria, Australia	To identify which factors facilitate or inhibit their integration into rural communities and consequently affect their intention to stay in rural practice.	In-depth interviews undertaken in 2003 with 57 IMGs.	Based on the interview results, four different types of IMGs were identified according to their level of integration into rural communities. They are 'satellite operators' (city-oriented), 'fence-sitters' (affiliated with city fringe areas), the 'ambivalent' (unsure about their future settlement place) and those 'integrated' into rural communities. Recognition of such a typology is useful in assisting to better target support and incentives designed to increase IMG rural retention rates towards those doctors most likely to remain in rural practice.
<b>(Hawthorne et al., 2003)</b>	Rural Victoria, Australia	To explore IMGs experienced of and level of satisfaction with rural general practice in Victoria, including factors contributing to their potential retention and loss. This includes the level of support IMGs and their families received including strategies likely to impact retention. Also to determine the impact permanent residency and full registration on the retention in rural practice.	Secondary analysis of data and a cross-sectional survey of IMG GPs in rural and regional areas. 84 (38%) of the known 245 IMGs returned the survey with 56 IMG spouses also returning surveys. 37 IMGs and 15 Key Australian informants were also participated in in-depth interviews.	The key research finding indicate there is a complex milieu of factors which inhibit and stabilise retention in rural and remote Victoria and relate to issues of hypermobility, prior Australian experience, the level of experience in current position level of colleague acceptance, appropriate remuneration levels including client demand, training and support provision, and spousal perspective on rural general practice and lifestyle.
<b>(Laven et al., 2003)</b>	Australia wide	To determine the factors associated with general practitioners' current practice location, with particular emphasis on rural location. (Australian Medical Graduates).	Observational, retrospective, case-control study using a self-administered questionnaire. Main outcome measure: Current urban or rural practice location. Stratified sample randomly selected 4513 GPs with 2414 completing questionnaires.	For Australia as a whole, rural GPs were more likely to be male, Australian-born and to report attending a rural primary school for "some" or "all" of their primary schooling. Rural GPs' partners or spouses were also more likely to report "some" or "all" rural primary schooling. A rural background in both GP and partner produced the highest likelihood of rural practice. For individual jurisdictions, a trend towards more rural GPs being men was only significant in Tasmania. In all jurisdictions except Tasmania and the

Authors	Location	Objective/Aim of study	Methodology	Study results
<b>(Laurence, 2008) Thesis</b>	Rural South Australian IMGs (GPs)	To examine the adequacy of the 5 year IMG Scheme through an analysis of the patterns of service and quality of the services provided by IMGs in the program. Also to determine if IMGs practiced differently to their Australian-trained counterparts in rural settings.	Mixed Methodology. Quantitative secondary analysis of data sourced from service data of the Medical Benefits Scheme. Qualitative data sourced from two focus groups with a total of 10 IMGs, which were convenience sampled. Thematic analysis. (template analysis).	Northern Territory, rural GPs were more likely to be Australian-born.  A Number of difference in the patterns of service provided by IMGs compared to Australian-trained Doctors did exist on both the micro and macro level, which could be explained by sex age and experience.
<b>(Lê &amp; Kilpatrick, 2008)</b>	Rural Tasmania	The two main study objectives were to examine aspects of the acculturation of overseas-born and Australian-trained health professionals in the Australian health discourse; and identify key coping strategies used by them when in working in the rural context.	Six overseas-born, Australian-trained health professionals were invited to participate in this qualitative study using a snowball sampling. The participants were all born in Vietnam and had experienced working in rural Australia. They included three medical doctors, a dentist, a physiotherapist and a nurse. The interviews were recorded and four participants also provided additional written responses to some of the open-ended interview questions.	The study showed that the acculturation process was affected by the participants' views about and attitudes towards working in an Australian rural context. The study identified these essential strategies used by the participants in adapting to a new workplace: collaborating, distancing, adjusting, repairing, and accommodating.
<b>(McGrath et al., 2009)</b>	Central Queensland	To explore IMGs experience before, during, and after their involvement in the observer program, a hospital based pre-employment program for IMGs conducted in the Department of Medicine at the Redland Hospital, Queensland.	An iterative, qualitative research methodology was utilised, using open-ended interviews with 10 IMGs about their experience and involvement with the observer program. The interviews were transcribed verbatim and thematically analysed.	IMGs wanted a more effective and efficient process for the integration of IMGs. Strategies they believed would improve this process included providing information to IMGs before departure from their country of origin, improving website information, providing more support for bridging courses, funding more observer programs, providing an IMG liaison officer at hospitals, reducing the difficulties associated with passing the AMC examination, providing support for IMGs' families, and relaxing the rules about when and where IMGs can practise medicine.

## Appendix E Timeline of data collection and analysis process





# Appendix F Interview schedules

## INTERVIEW SCHEDULE

PROJECT TITLE: HEALTH AND WELLBEING OF INTERNATIONAL  
MEDICAL GRADUATES: ACCULTURATION INTO THE  
TASMANIAN RURAL AND REMOTE CONTEXT

1. Could you introduce yourself...

For example: age, country of birth, languages spoken, religion, family situation, migration status, arrival in Australia, length of stay in Tasmania.

2. Could you tell me a little about your years of medical experience prior to migration and your current qualifications and any further study you are undertaking
3. What was your motivation for coming to Tasmania, and in particular accepting your current position?
4. What are some positive or negative factors associated with your current position?
5. What level of acceptance and support have you had from your peers? Have there been any other professional issues?
6. What level of acceptance have you had by your patients?
7. What level of acceptance have you had by the community?
8. What sort of social support do you or your family have in this community? Where do you go to get the support you need? (i.e., Access to cultural and/or religious support).
9. What has been your family's experience since living in the community? What are some of their positive or negative experiences? (Including spouse employment and children's education).
10. How has your family's experiences influenced your view of the community.
11. What are some positive or negative factors associated with living in regional or remote areas of Tasmania?
12. In your view, how does the community in which you live affect your health status?
13. What should be done to improve your health and wellbeing in Tasmania?
14. Is there anything that you would like to see in the future to assist IMGs settle into rural communities in Tasmania? If so, please share.
15. Is there anything else that you would like to share with us? If so, please share.

## INTERVIEW SCHEDULE – KEY INFORMANTS

PROJECT TITLE: HEALTH AND WELLBEING OF INTERNATIONAL  
MEDICAL GRADUATES: ACCULTURATION INTO THE  
TASMANIAN RURAL AND REMOTE CONTEXT

1. Could you introduce yourself...

For example: current position, including role/s and experiences working in relation to IMGs in their location.

2. Please tell me about the length of time IMGs typically stay in the area that you are coordinating?
3. What type of medical work is undertaken by IMGs in the area, including hours?
4. What are the professional transition challenges typically faced by IMGs in this area?
5. What are the social transition challenges typically faced by IMGs in this area?
6. What type, level and adequacy of professional support services are provided to IMGs in this location?
7. What type, level and adequacy of social support services are provided to IMGs and their families in this location?
8. What do you perceive as the factors which are likely to increase rural/regional retention of IMGs in this area?
9. What do you perceive as the factors which are likely to decrease rural/regional retention of IMGs in this area?
10. In your view, what should be done to improve IMGs health and wellbeing in Tasmania?
11. Is there anything that you would like to see in the future to assist IMGs settle into rural communities in Tasmania? If so, please share. (i.e., Policy changes etc.)
12. Is there anything else that you would like to share with us? If so, please share.

# **Appendix G    Tasmanian International Medical Graduates questionnaire**

# International Medical Graduates: A Tasmanian Survey

## Assessing the needs of IMGs and their families

Dear Doctor,

Thank you sincerely for taking time to complete this survey, which is the first of its kind in Tasmanian.

The results will make an important contribution to understanding the challenges which face IMGs (formerly known as Overseas Trained Doctors) and their families in Tasmania.

An information sheet has been provided with this survey, which highlights the objective and purposes of the research.

By completing and returning this survey you are giving your consent to participate in the project.

If more convenient, an online version of the survey can be completed at

<http://www.surveymonkey.com/s/IMG-Survey>

There are SIX sections with a total of 41 questions and should take approximately 15-20 minutes of your time.

The questions are based on a survey developed by Hawthorne et al. (2003) which looked at IMGs in regional Victoria and we acknowledge their contribution.

To thank you for your participation in this study, we are offering a prize of an A\$100, A\$50 and an A\$25 ColesMyer gift card. To be eligible, please follow the instructions at the end of survey.

If you have any queried about the survey or the results, please contact:

**Daniel Terry** (PhD Candidate)  
University Department of Rural Health  
University of Tasmania  
Locked Bag 1372, Launceston  
Tasmania 7250 Australia  
Tel: 03 63244060  
Fax: 03 63244040  
[Daniel.Terry@utas.edu.au](mailto:Daniel.Terry@utas.edu.au)

**Dr. Quynh Lê**  
[Quynh.Le@utas.edu.au](mailto:Quynh.Le@utas.edu.au)  
**Dr. Jess Woodroffe**  
[jjwhelan@utas.edu.au](mailto:jjwhelan@utas.edu.au)  
**Dr. Kathryn Ogden**  
[Kathryn.ogden@utas.edu.au](mailto:Kathryn.ogden@utas.edu.au)

**Complete this questionnaire OR the online version not both.**

**Place the survey in the reply paid envelope provided and post to us.**

# International Medical Graduates – Tasmanian Survey

## SECTION 1: YOUR BACKGROUND

Page 1 of 9

Please tick (✓) the correct answer or write your answer in the space provided.

1. What is your gender?

☐

Male

☐

Female

2. What is your age group?

☐

20-29

☐

30-39

☐

40-49

☐

50-59

☐

60+

3. In which country were you born?

4. Which language(s) other than English do you currently speak at home?

5. What is your current marital status?

☐

Never married

☐

Married / de facto

☐

Separated / divorced

☐

Widowed

6. Was your spouse born in Australia?

☐

Yes

☐

No

☐

Not applicable

7. Do you have any children?

☐

Yes

☐

No

8. If yes, how many dependent children do you have living with you?

9. What is your religion?

☐

Christian

☐

Islam

☐

Buddhist

☐

Hindu

☐

No religion

☐

Other (please specify)

☐

# International Medical Graduates – Tasmanian Survey

## SECTION 2: CURRENT EMPLOYMENT AND LOCATION

Page 2 of 9

Please tick (v) most the suitable answer or write your answer in the space provided.

10. Where are you currently employed? (Post code of City or Town)

11. How long have you been working in this location now?

 Years  Months

12. How much longer do you think you will work here in this job?

 Years  Months

13a. How much longer do you think you would like to stay?

☐ Short term  
☐ Medium term  
☐ Long term

13b. How much longer would your family like to stay?

☐ Short term  
☐ Medium term  
☐ Long term

14. Do you feel you have experienced any barriers in practicing medicine in your current position, as a result of being an overseas qualified doctor?

☐ Yes  
☐ No

Comments

15. Do you feel you or your family have experienced any discrimination or disadvantages in living in your current community as a result of being a migrant?

☐ Yes  
☐ No

Comments

# International Medical Graduates – Tasmanian Survey

## SECTION 3: YOUR MIGRATION

Page 3 of 9

Please tick (v) the suitable answer or write your answer in the space provided.

16. Which year did you first arrive in Australia?

17. When you came to Australia, what immigration category did you migrate under?

- ☐ Independent (skilled)
- ☐ Employer nomination scheme
- ☐ Family
- ☐ Humanitarian/ refugee
- ☐ Temporary medical doctor (422 or 457 visa)
- ☐ Occupational trainee Student
- ☐ Other (please specify)

18. What is your current residential status?

- ☐ Permanent resident
- ☐ Australian Citizen
- ☐ Temporary resident

19. When you first came to Australia, did you intend to live in this country:

- ☐ Permanently
- ☐ Temporarily
- ☐ Unsure

20a. How good did you feel your English was at the time you first migrated?

- ☐ English is my first language
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

20b. When using English, how satisfied are you with your communication skills in professional situations? (Tick (v) one)

Very Satisfied      Satisfied      Unsure      Dissatisfied      Very Dissatisfied

☐      ☐      ☐      ☐      ☐

20b. When using English, how satisfied are you with your communication skills in social situations? (Tick (v) one)

Very Satisfied      Satisfied      Unsure      Dissatisfied      Very Dissatisfied

☐      ☐      ☐      ☐      ☐

# International Medical Graduates – Tasmanian Survey

## SECTION 3: YOUR MIGRATION (Continued)

Page 4 of 9

### 21. Many overseas trained doctors have lived and worked in a range of international and Australian locations.

Please tick (v) the statement that best describes your relocation from your place of birth to Australia

- ☐ Moved directly from my country to Australia
- ☐ Moved from my country to live in one other country, then to Australia
- ☐ Moved from my country to live in two other countries, then to Australia
- ☐ Other (please specify)

### 22. Please tick (v) the 3 most important reasons for coming to Australia

- ☐ To accept current medical position
- ☐ To gain better (or better paid) medical employment
- ☐ To gain a safer/more secure environment
- ☐ To gain a better standard of living for self/family
- ☐ To join family/friends/spouse
- ☐ To gain a first medical qualification
- ☐ To gain postgraduate training/ further training
- ☐ Other (please specify)

### 23. If you migrated directly to Tasmania, please tick (v) the 3 most important reasons for coming to this state:

- ☐ To accept current medical position
- ☐ To gain better (or better paid) medical employment
- ☐ To gain a safer/more secure environment
- ☐ To gain a better standard of living for self/family
- ☐ To join family/friends/spouse
- ☐ To gain a first medical qualification
- ☐ To gain postgraduate training/ further training
- ☐ Other (please specify)

### 24. If you migrated to Tasmania, after living in another state of Australia please tick (v) the 3 most important reasons for choosing to relocate here:

- ☐ To accept current medical position
- ☐ To gain better (or better paid) medical employment
- ☐ To gain a safer/more secure environment
- ☐ To gain a better standard of living for self/family
- ☐ To join family/friends/spouse
- ☐ To gain a first medical qualification
- ☐ To gain postgraduate training/ further training
- ☐ Other (please specify)



# International Medical Graduates – Tasmanian Survey

## SECTION 4: YOUR QUALIFICATIONS & REGISTRATION

Page 5 of 9

Please tick (v) the suitable answer or write your answer in the space provided.

**25. What is your highest overseas medical qualification and which country did you obtain it?**

Qualification:

Country:

**26. If you have studied here, what is your highest Australian medical qualification?**

Qualification:

**27. What is your current medical registration? And when did you first get medical registration in Australia?**

Current registration:

Year when first registered:

**28. In which state did you first get registration as a doctor in Australia?**

☐

ACT

☐

SA

☐

NSW

☐

Tas

☐

NT

☐

Vic

☐

QLD

☐

WA

**29. In which state(s) in Australia have you worked in medicine so far?**

☐

ACT

☐

SA

☐

NSW

☐

Tas

☐

NT

☐

Vic

☐

QLD

☐

WA

**30. How quickly did you find medical employment after arriving in Australia? Tick (v) one**

☐

Immediately: recruited for current 'Area of Need' position

☐

Immediately: recruited to fill other 'Area of Need' position

☐

Immediately: recruited to fill other medical position

☐

1-3 months post-arrival

☐

4-6 months post-arrival

☐

7-12 months post-arrival

☐

12-24 months post-arrival

☐

More than 24 months post-arrival

☐

Other (please specify)

# International Medical Graduates – Tasmanian Survey

## SECTION 5: MEDICAL EMPLOYMENT HISTORY

Page 6 of 9

Please tick (✓) the suitable answer or write your answer in the space provided.

**31. Please list the countries you have worked as a doctor prior coming to Australia?**

Downloaded from <http://ajph.org/> at University of California, San Diego on June 11, 2015

**32. How many years' experience did you have working as a registered doctor before you migrated to Australia?**

Number of years:  

**33. Did you have any previous experience working in rural areas before you migrated to Australia?**

Yes

No, go to question 35

**34. If yes, how many years of rural practice did you complete?**

Number of years:  

**35. What is your current medical position, hours work per week and contract length?**

Type of medical work:

Hours per week:

hours

Contract length

--	--

Years

Months

**36. How satisfied are you with your current position? (Tick (✓) one)**

Very Satisfied

Satisfied

Unsure



Dissatisfied

Very Dissatisfied

# International Medical Graduates – Tasmanian Survey

## SECTION 6: CURRENT LIFESTYLE

Page 7 of 9

**37. Can you rate your level of satisfaction with the following aspects of your current position in the chart below?** (Tick (v) the most suitable answer for each row)

	Very Satisfactory	Satisfactory	Fair	Very Unsatisfactory
a). Type of work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b). Medical location	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c). Relevance to your skills/past experience	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d). Good/ supportive colleagues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e). Salary level	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f). Level of professional support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g). Access to training/supervision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h). Medical facilities/ resources	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i). Access to specialist services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j). Friendliness of your patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k). Friendliness of the local community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l). Access to public transport	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m). Access to private transport (own car)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other (please specify)

**38. Can you please rate the following non-professional aspects of your current lifestyle?**

	Very Satisfactory	Satisfactory	Fair	Very Unsatisfactory
a). Appeal of location	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b). Size of city/town	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c). Friendliness of people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d). Quality of facilities (transport, shops etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e). Access to employment for partner/spouse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f). Access to good schools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g). Access to training/supervision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h). Access to religious facilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i). Access to friends/ family members	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j). Access to cultural community & resources	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k). Access to social activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l). Access to cultural or religious foods or goods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m). Access to public transport	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n). Access to private transport (own car)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other (please specify)

# International Medical Graduates – Tasmanian Survey

## SECTION 6: CURRENT LIFESTYLE

Page 8 of 9

**39. To what extent are the following aspects of residential location likely to influence where you work in the future?** (Tick (v) the most suitable answer for each row)

	Very important	Important	Not very important	Unimportant
a). Job satisfaction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b). Improved medical facilities/ resources	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c). Higher salary	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d). Shorter working hours	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e). Less on-call responsibility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f). Improved support from colleagues in health practice or hospital	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g). Access to metropolitan location	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h). Settlement near ethnic community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i). Access to employment for partner/spouse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j). Access to good schools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h). Access to religious facilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i). Access to friends/ family members	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j). Access to cultural community & resources	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k). Access to social activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l). Access to cultural or religious foods or goods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m). Access to public transport	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n). Access to private transport (own car)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other (please specify)

**40. What are your plans at this stage?** (Tick (v) one)

- ☐ Stay in current position for the foreseeable future
- ☐ Change medical positions in Tasmania
- ☐ Move interstate
- ☐ Move to another country

If you are moving where do you intend to move to?

**41. Are your future plans based on:** (Tick (v) all that apply)

- ☐ Employment reasons
- ☐ Family reasons
- ☐ Community reasons
- ☐ Other (please specify)

# International Medical Graduates – Tasmanian Survey

## SECTION 6: CURRENT LIFESTYLE

Page 9 of 9

**42. Please provide any other comments which you feel may be vital for IMGs professional or social health and wellbeing in Tasmania?**

**Thank you sincerely for taking time to complete this survey**

The results will make an important contribution to understanding the challenges which face IMGs and their families in Tasmania.

### **Prize & Interview**

To thank you for your participation in this study, we are offering a prize of an **A\$100, A\$50 and an A\$25 ColesMyer gift card.**

- To be eligible for the participation prize, please email [Daniel.Terry@utas.edu.au](mailto:Daniel.Terry@utas.edu.au) with your name and contact details (To maintain confidentiality from your survey responses)

**OR**

- Complete your personal details on the next page, detach this page from the questionnaire and put in it the confidential plain envelope provided.
- Place the sealed envelope and the completed questionnaire in the reply paid envelope provided and post to us. (Your details will be processed separately to the questionnaire)

# International Medical Graduates – Tasmanian Survey

If you would like to participate in a 20-30minute follow up interview, please indicate your interest

Name:	<input type="text"/>
Address:	<input type="text"/>
Phone:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Email:	<input type="text"/>
I would like to participate in a 20 - 30 minute follow up interview.	
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

# Appendix H Thematic coding tree

International Medical Graduates - Tasmania (NVivo 10) (4).nvp - NVivo

File Home Create External Data Analyze Query Explore Layout View

Rows & Columns Tools Sort & Filter Show/Hide Page

### Nodes

- Nodes
  - IMG 1 Thematic analysis
  - IMG 2 Grounded theory
  - IMG CDA
  - Stakeholder - 1 Thematic A
  - Stakeholder - 2 Grounded
  - Stakeholder - 3 CDA
  - Relationships
  - Node Matrices

Look for: Search In IMG 1 Thematic a Find Now

### IMG 1 Thematic analysis

Name	Sources	Referen	Created	Created	Modified	Modified
Professional	0	0	2/07/20	DT	24/09/2	DT
Professional Supports			0	0	4/07/20	DT
Meeting specific needs of IMGs within ho			1	2	3/07/20	DT
Has a desire to help new IMGs			9	14	3/07/20	DT
Supportive agencies			5	7	3/07/20	DT
Supportive colleagues and peers			18	29	2/07/20	DT
Professional Challenges			0	0	4/07/20	DT
Workplace			0	0	5/07/20	DT
Medical system challenges and difference			14	24	2/07/20	DT
Exam challenges - monetary psycholog			5	13	2/07/20	DT
Bureaucracy and red tape			7	24	3/07/20	DT
Social	0	0	2/07/20	DT	24/09/2	DT
Supports A hierarchy of supports			0	0	4/07/20	DT
Connection through groups			11	21	3/07/20	DT
Support and acceptance from local comm			6	10	3/07/20	DT
Social support from colleagues			6	14	3/07/20	DT
Support of freinds family and cultural com			13	22	2/07/20	DT
Challenges			0	0	4/07/20	DT
Prejudice			6	17	4/07/20	DT
Isolation challenges			11	19	3/07/20	DT
Challenges for children and families			8	11	2/07/20	DT
The way forward	0	0	10/07/2	DT	24/09/2	DT
Provide information regarding migration and g			10	21	10/07/2	DT
Immigration assistance			2	3	10/07/2	DT
Registration support			1	2	10/07/2	DT
Increased rotations			1	1	10/07/2	DT
How to improve things			4	13	10/07/2	DT
Improved training			5	8	10/07/2	DT
Assistance with family migration and informati			2	5	4/07/20	DT
Motivation for moving t	13	22	2/07/20	DT	24/09/2	DT
DHHS offered me a position			3	4	2/07/20	DT
Tasmania the first offer of position			6	7	2/07/20	DT
Tasmania had accredited training positions			2	2	2/07/20	DT

Sources

Nodes

Classifications

Collections

Queries

Reports

Models

Folders

DT 107 Items

# Appendix I Critical Discourse Analysis coding tree

The screenshot displays the NVivo 10 software interface. The title bar reads 'International Medical Graduates - Tasmania (NVivo 10) (4).nvp - NVivo'. The menu bar includes File, Home, Create, External Data, Analyze, Query, Explore, Layout, and View. Below the menu bar are various tool icons for Project, Documents, PDFs, Dataset, Audios, Videos, Pictures, Memos, From Other Sources, and Report. The main workspace is divided into three panes. The left pane, titled 'Nodes', shows a hierarchical tree of nodes: Nodes, IMG 1 Thematic analysis, IMG 2 Grounded theory, IMG CDA, Stakeholder - 1 Thematic A, Stakeholder - 2 Grounded, Stakeholder -3 CDA, Relationships, and Node Matrices. The middle pane, titled 'Stakeholder -3 CDA', shows a search bar with 'Look for:' and 'Search In' dropdowns, and a 'Find Now' button. Below this is a table of nodes and their associated data. The right pane is currently empty. The bottom status bar shows 'DT 19 Items'.

Name	Sources	Referen	Created On	reated	Modified	Modified
CDA	14	43	22/02/2	DT	22/02/2	DT
Micro 'discourse-as-text'	0	0	22/02/2	DT	22/02/2	DT
colloquialisms - turns of phras	2	2	22/02/2	DT	23/02/2	DT
unnamed individuals - dehum	2	5	22/02/2	DT	23/02/2	DT
Assumption - ethnicity and cul	2	2	22/02/2	DT	23/02/2	DT
skin colour defining ethnicity	1	1	22/02/2	DT	23/02/2	DT
How IMGs can be viewed	3	4	22/02/2	DT	23/02/2	DT
Meso 'discourse-as-discursive-pr	0	0	22/02/2	DT	22/02/2	DT
racial and intolerance	2	3	22/02/2	DT	22/02/2	DT
assumption ethnocentrism	3	7	22/02/2	DT	22/02/2	DT
Assumes following mainstrea	2	2	22/02/2	DT	22/02/2	DT
Assumption - financial issues	1	1	22/02/2	DT	22/02/2	DT
simplifying culture	4	6	22/02/2	DT	22/02/2	DT
Power over IMGs	2	3	22/02/2	DT	22/02/2	DT
Macro 'discourse-as-social-practi	0	0	22/02/2	DT	22/02/2	DT
institution	6	17	22/02/2	DT	24/02/2	DT
power of government	2	2	22/02/2	DT	22/02/2	DT
the voice of the people - resta	1	1	22/02/2	DT	24/02/2	DT
positives - unrelated	2	4	22/02/2	DT	22/02/2	DT



## Appendix J Chi-square test data tables

**Table J1: Chi-square test of the relationship between different regions of origin and working in different regions of Tasmania on satisfaction with current employment**

Chi-square test	IMG from different regions of origin				
Total sample (N=105)	(n)	Response (%)	$\chi^2$	df	p-value
Type of work	89	84.8%	13.132	15	.405
Medical location	89	83.8%	9.748	15	.873
Relevance to skills/experience	89	83.8%	18.862	15	.199
Good or supportive colleagues	88	84.8%	17.367	15	.266
Salary level	88	84.8%	10.462	15	.350
Level of professional support	89	84.8%	18.965	15	.226
Access to training/supervision	89	84.8%	10.664	15	.683
Medical facilities or resources	89	84.8%	26.138	15	.018*
Access to specialist services	89	84.8%	20.537	15	.067
Friendliness of patients	89	80.0%	17.763	15	.068
Friendliness of community	89	81.9%	20.429	15	.211
Access to public transport	84	84.8%	30.013	15	.005*
Access to private transport	86	83.8%	7.242	15	.850
Chi-square test	IMG working in different regions of Tasmania				
Total sample (N=105)	(n)	Response (%)	$\chi^2$	df	p-value
Type of work	92	87.6%	3.897	6	.816
Medical location	92	87.6%	1.809	6	.792
Relevance to skills/experience	92	87.6%	1.865	6	.925
Good or supportive colleagues	91	86.7%	8.618	6	.288
Salary level	91	86.7%	6.596	6	.402
Level of professional support	92	87.6%	6.489	6	.586
Access to training/supervision	92	87.6%	4.851	6	.576
Medical facilities or resources	92	87.6%	7.896	6	.572
Access to specialist services	92	87.6%	10.679	6	.101
Friendliness of patients	92	87.6%	4.316	6	.357
Friendliness of community	92	87.6%	12.296	6	.038*
Access to public transport	87	82.9%	13.404	6	.021*
Access to private transport	89	84.8%	9.732	6	.120

\*Significant at the 0.05 level.

**Table J2: Chi-square test of the relationship between different regions of origin and different employment regions of Tasmania on non-professional satisfaction**

Chi-square test		IMG from different regions of origin			
Total sample (N=105)	(n)	Response (%)	$\chi^2$	df	p-value
Appeal of location	90	85.7%	17.704	15	.452
Size of city/town	90	85.7%	14.078	15	.375
Friendliness of people	90	85.7%	14.454	15	.618
Quality of facilities (shops etc.)	90	85.7%	11.695	15	.429
Employment for partner/spouse	82	78.1%	11.532	15	.744
Access to good schools	77	73.3%	9.966	15	.642
Access to religious facilities	79	75.2%	34.015	15	.002*
Access friends/family members	89	84.8%	9.283	15	.878
Access to cultural community	87	82.9%	16.719	15	.315
Access to social activities	90	85.7%	15.318	15	.318
Access cultural/religious foods	82	78.1%	14.014	15	.478
Access to public transport	86	81.9%	23.813	15	.030*
Access to private transport	88	83.8%	10.022	15	.806
Chi-square test		IMG working in different regions of Tasmania			
Total sample (N=105)	(n)	Response (%)	$\chi^2$	df	p-value
Appeal of location	92	87.6%	9.567	6	.816
Size of city/town	92	87.6%	8.597	6	.153
Friendliness of people	92	87.6%	9.267	6	.079
Quality of facilities (shops etc.)	92	87.6%	1.306	6	.996
Employment for partner/spouse	84	80.0%	5.430	6	.508
Access to good schools	79	75.2%	3.048	6	.819
Access to religious facilities	81	77.1%	8.974	6	.143
Access friends/family members	91	86.7%	7.580	6	.276
Access to cultural community	89	84.8%	2.162	6	.928
Access to social activities	92	87.6%	4.861	6	.566
Access cultural/religious foods etc.	84	80.0%	3.319	6	.813
Access to public transport	88	83.8%	11.455	6	.046*
Access to private transport	90	85.7%	12.773	6	.063

\*Significant at the 0.05 level.

**Table J3: Chi-square test of the relationship between different regions of origin and working in different regions of Tasmania on factors influencing future work of IMGs**

Chi-square test		IMG who are from different regions of origin			
Total sample (N=105)	(n)	Response (%)	$\chi^2$	df	p-value
Job satisfaction	89	84.8%	4.632	15	.478
Improved medical facilities	89	84.8%	38.534	15	.038*
Higher salary	88	83.8%	23.825	15	.056
Shorter working hours	89	84.8%	10.830	15	.842
Less on-call responsibility	89	84.8%	8.461	15	.926
Improved support colleagues	86	81.9%	28.823	15	.074
Access to metropolitan location	89	84.8%	20.474	15	.145
Settlement near ethnic community	88	83.8%	27.823	15	.018*
Access to employment for partner	88	83.8%	8.191	15	.838
Access to good schools	87	82.9%	15.659	15	.409
Access to religious facilities	88	83.8%	30.025	15	.014*
Access to friends/ family members	89	84.8%	38.806	15	.086
Access to cultural community	89	84.8%	19.255	15	.081
Access to social activities	88	83.8%	25.811	15	.025*
Access cultural or religious foods	88	83.8%	25.788	15	.028*
Access to public transport	88	83.8%	21.484	15	.063
Access to private transport	88	83.8%	24.290	15	.328
Chi-square test		IMG who work in different regions of Tasmania			
Total sample (N=105)	(n)	Response (%)	$\chi^2$	df	p-value
Job satisfaction	91	86.7%	5.370	6	.372
Improved medical facilities	91	86.7%	4.436	6	.673
Higher salary	90	85.7%	5.753	6	.603
Shorter working hours	91	86.7%	5.669	6	.431
Less on-call responsibility	91	86.7%	2.491	6	.938
Improved support colleagues	88	83.8%	7.501	6	.211
Access to metropolitan location	91	86.7%	11.135	6	.130
Settlement near ethnic community	90	85.7%	5.824	6	.391
Access to employment for partner	90	85.7%	5.316	6	.463
Access to good schools	89	84.8%	7.700	6	.290
Access to religious facilities	90	85.7%	5.456	6	.511
Access to friends/ family members	91	86.7%	4.872	6	.675
Access to cultural community	91	86.7%	4.048	6	.694
Access to social activities	90	85.7%	9.763	6	.207
Access to cultural/religious foods	90	85.7%	1.999	6	.925
Access to public transport	90	85.7%	1.782	6	.945
Access to private transport	90	85.7%	14.315	6	.025*

\*Significant at the 0.05 level.