

**The Cross-Cultural Adaptation of International
Medical Graduates to General Practice in New
Zealand**

By

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Abstract

This study demonstrates that occupational success is an important factor in the adaptation of highly skilled migrants to host societies, as seen through the experiences of the international medical graduates (IMGs) who came to New Zealand and became general practitioners (GPs). New Zealand is reliant on IMGs to support and deliver quality health care to its population: IMGs constitute over 40% of the current medical workforce.

The central contributions of this thesis are to three distinct discourses on the experiences of migrants. The first contribution is an investigation and critical analysis of the experiences of IMGs who came to practise medicine in New Zealand. During the course of analysing the primary data, and relating it to existing literature, it was observed there was a lack of a model that captured the essence of the specific acculturation of highly skilled migrants such as IMGs. Therefore, the second contribution is the development of a concise integrated framework - the Integrated Framework for Acculturative Research (IFAR), for the study of highly skilled migrants' acculturation to new environments. The experiences of the IMGs who came to New Zealand have been used to develop and discuss the application of the IFAR to cross-cultural adaptation research. There is an historical component to these narratives as the IMGs in this research spanned nearly five decades of acculturation into New Zealand society. The third contribution is in the domain of qualitative research, where email interviews (e-interviews) have been used to gather data within the context of ethnography.

While there has been significant literature, theories and models developed about cross-cultural and intercultural adaptation of migrants into host nations, there are gaps in the understanding of the experiences of highly skilled migrants, who are different from other types of migrants, given their predispositions and higher levels of human capital such as education and work experience. There is an emerging literature on this subject, to which this study adds. The IMGs in this study used their human capital to become medical practitioners in New Zealand, achieving their main motivation for migrating in the first place. The reasons the IMGs stated for migration are consistent with existing literature on 'push' and 'pull' factors; however for all of them, the primary reason was to pursue their medical careers in New Zealand. After arrival, most of them had to do additional training before they were allowed to practise independently. The medical training ranged from those required to achieve the registration of the Medical Council of New Zealand (MCNZ), to those needed to achieve the Fellowship of the Royal New Zealand College of General Practitioners (RNZCGP). The participants noted several challenges during their training period, including a lack of clear information on what was required; having to prove their ability despite many years of experience as medical practitioners; dealing with poor teachers for some; having to travel long distances to attend training seminars; and for a few, dealing with financial constraints. However, they

all overcame such challenges and became successful independent GPs. Their age, pre-migration human capital, and post-migration motivation were essential in initiating their desired occupations in New Zealand. These three success factors are supported by emerging literature on highly skilled migrants.

The early participants initially worked in hospital settings before choosing general practice. Some left because they experienced issues in the hospital environment such as tensions with local colleagues, and the need to work long unfriendly hours. All participants noted that the reasons for choosing general practice included their desire to work more closely with communities and to experience a greater variety of medicine. Additionally, many reported that the flexibility of working in general practice gave them a better work/life balance that allowed them to do other things within the community and outside of their general practice. Female participants noted that general practice was more conducive when raising a family, compared to hospital-based specialties. These are the strengths of general practice that are well documented in literature.

While the participants did not note any major ongoing challenges, some reported being frustrated with the poor links between primary and secondary health care that impacted on the timely care of their patients. With an increase in chronic conditions and mental health issues, coupled with an ageing population, many participants reported that they needed more time and frequent consultations to treat certain patients. Given New Zealand's co-payment system, participants reported having to consider the appropriate levels of care for patients with chronic conditions so as not to financially overburden them. For participants working in rural and economically deprived areas, there were other social factors that affected their medical practice, such as the high levels of family violence, sexual health issues, teenage pregnancies and substance abuse. These issues are supported by current literature regarding health and society in New Zealand.

Despite the challenges they faced, all the IMGs planned on continuing to work in general practice in New Zealand for the foreseeable future. Migrants' pledge of continuing in their chosen occupations in host nations can be a very good indicator of acculturation and integration. The MCNZ reported that nearly two-thirds of all IMGs left New Zealand two years post-registration. However, retention rates improved significantly once IMGs obtained their vocational registration. Occupational continuity sheds light on immigrants' level of acculturation because it establishes that they are comfortable living among the hosts, and working in their chosen professions. This study demonstrates that occupational success is a key prerequisite to continuity and long-term integration into host societies. As highly skilled migrants, they could have gone to almost any country but they chose New Zealand. They remain here, having forged their medical careers and a lifestyle of their choosing. They now consider New Zealand their home, at least until they enter a different stage of their lives.

Dedication

This thesis is dedicated to my mum, Rukmani Pande, and my dad, Hriday Nath Pande, for demonstrating what good education can achieve. Their dedication, courage, and determination as educators, remain an inspiration.

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Abbreviations Commonly Used

ACC – Accident Compensation Corporation of New Zealand

AUM – Anxiety/Uncertainty Management

AVE – Advanced Vocational Education

BAB – Branch Advisory Board

CME – Continuing Medical Education

CNIT – Central North Island Town

DHB – District Health Board

ECFMG – Educational Commission of Foreign Medical Graduates

ED – Emergency Department

EI – Email-based interviews (e-interviews)

ESB – English-Speaking Background

EU – European Union

EWTD – European Working Time Directives

FRNZCGP – Fellowship of the RNZCGP

FTE – Fulltime Equivalent

FTF – Face-to-face (interviews)

GMC – General Medical Council

GPs – General Practitioners

GPEP – General Practitioner Education Programme

HPCAA – Health Practitioners Competence Assurance Act 2003

HSIM – Highly Skilled International Migrant

HWNZ – Health Workforce New Zealand

IC – Intercultural Communication

ICT – Information Communication Technology

IFAR – Integrated Framework for Acculturative Research

FMTP – Family Medicine Training Programme

IMG – International Medical Graduate

INZ – Immigration New Zealand

IOM – International Organisation for Migration

LisNZ – Longitudinal Immigration Study: New Zealand

MBIE – Ministry of Business, Innovation and Employment
MCNZ – Medical Council of New Zealand
NBME – National Board of Medical Examiners
NZLocums – New Zealand Locums
NZMA – New Zealand Medical Association
NZQA – New Zealand Qualifications Authority
NZREX – New Zealand Registration Examination
OECD – Organisation for Economic Co-operation and Development
OTD – Overseas-Trained Doctor
PHARMAC – Pharmaceutical Management Agency
PHO – Primary Healthcare Organisation
PRENZ – Probationary Registration Examination of New Zealand
PRIMEX – Primary Medical Examination
RGPN – New Zealand Rural General Practice Network
RNZCGP – Royal New Zealand College of General Practitioners
SMC – Skilled Migration Category
USMLE – United States Medical Licensing Examination
VHSI – Very Highly Skilled Immigrants
WHO – World Health Organisation

1.0 Introduction

1.1 Introduction

The central assertion of this thesis is that occupational adaptation is a key predictor of overall acculturation of migrants to host nations, especially for those who are highly skilled such as international medical graduates (IMGs). While there has been significant literature, theories and models developed on the cross-cultural and intercultural adaptation of migrants into host nations, there are gaps in the understanding of the experiences of highly skilled migrants, who are different to other types of migrants, given their pre-migration dispositions and higher levels of human capital (Fokkema & de Haas, 2011; Tharmaseelan, et al., 2010; Zikic, et al., 2010). During the course of analysing the primary data collected from IMGs who worked in general practice in New Zealand, it was noted that there was a lack of a precise model within acculturation literature that captured the essence of what was emerging in relation to IMGs and more generally, highly skilled migrants. A concerted effort was made to identify the nuances of occupational success, as a confounder of overall acculturation to new environments. Therefore, this thesis proposes a concise integrative approach to the study of highly skilled migrants such as the IMGs who came to New Zealand and became general practitioners (GPs). The integrative approach to studying acculturation draws literature from various scholarly disciplines including sociology, anthropology, economics, and intercultural communication. An integrative approach to migration theory is currently lacking (Favell, 2008). Another key proposition of this thesis is the use of email interviews (e-interviews), as a valid research tool within the context of qualitative and ethnography research paradigms. The e-interview approach within this research is experimental in nature and adds to the discourse on qualitative methodologies.

It is known that for some IMGs, adjusting to a new environment can be very challenging. Literature from New Zealand (Lillies, St George, & Upsdell, 2006; Fletcher & Dickson, 2008; Ineson, 2009; Woodbridge & Bland, 2010) and other countries (Iredale, 2009; Huijsken, et al., 2010; Wong & Lohfeld, 2008; Atri, et al., 2011a; Chen, et al., 2011; Dorgan, et al., 2009; McMahon, 2004; Ramboarison-Lalao, et al., 2012; Meghani & Rajput, 2011; Spike, 2006; Whelan, 2005; Rao, et al., 2006) suggests that IMGs can encounter a number of barriers to getting registered to practise, entering the medical workforce, and continuing to practice effectively. These studies all allude to the fundamental issues faced by IMGs including the lack of:

- Language and communication competence;
- Understanding of the host nation's cultural and social norms;

- Understanding of the host nation's patient-doctor consultation styles and practices;
- Appropriate medical and clinical skills and knowledge;
- Knowledge on how the host nation's health systems work;
- Local social support and assistance for training;
- Match between the medical practice in home countries versus those of the host nation;
- Financial support when juggling the need for further training versus the need to cater to their family's needs;
- Acknowledgement of the difficulties faced in meeting the registration requirements;
- Understanding of the difficulties faced in securing employment in-order to complete registration and ongoing training requirements;
- Friendly and supportive workplaces during and after training; and
- The lack of understanding of the mental strain experienced when there is a mismatch between perceived promises of career advancement and the bureaucracy required to do so in new environments.

By using the experiences of IMGs in New Zealand and abroad, this research aims to validate or challenge these identified issues, which could apply to other types of highly skilled migrants. Many highly skilled migrants do overcome such barriers and do succeed in forging new careers in host nations. However, there is little emphasis on telling these stories within the context of occupational adaptation. Additionally, this research fills some gaps in the knowledge about IMGs in New Zealand. In their reports to the Medical Council of New Zealand (MCNZ), Fletcher and Dickson (2008) and Ineson (2009), recommended more research on IMGs that could identify:

1. Barriers to entry
2. The issues that would assist with the retention and integration of IMGs into the medical workforce
3. The risks IMGs might pose to the public
4. The costs and benefits of employing IMGs

Moreover, they recommended a qualitative study of IMG experiences in New Zealand, which this study will be contributing towards. There are other projects they recommended where this study could make contributions including the dynamics of the medical professional labour market as compared with other professionals. While this study is not comparing different types of highly skilled migrants or contrasting them with less skilled migrants to New Zealand, the

primary data does contribute to the literature on highly skilled migrants to New Zealand as seen through the eyes of IMGs coming to work in general practice. Through this, certain comparisons can be made between migrants in other countries, however they will be theoretical in nature, based on previous findings on such migrants from the disciplines of sociology, anthropology, economics and intercultural communication. Some recent studies on IMGs in other countries have also been used to compare and contrast with the occupational and lived experiences of the participants in this study.

1.2 Background

1.2.1 Migration to New Zealand and the Evolution of Migration Policy

Currently one in four New Zealanders is an immigrant, a figure that is up from approximately one in six in the 1990s (Statistics New Zealand – 2013 QuickStats about Culture and Identity, 2014). There are now over one million overseas-born residents in New Zealand. New Zealand has always been a nation of immigrants dating back to the time when the first Maori arrived – the indigenous population of New Zealand (Ward & Masgoret, 2008; Spoonley & Bedford, 2012). From the mid-1800s until the mid-1900s, migrants from England, Scotland and Australia constituted 70% of the immigrant population in New Zealand. By 2013, the above cohort had decreased to 30% of the total migrant population to New Zealand. While England is still the largest source of immigrants, China and India have replaced Scotland and Australia as the second and third source countries for migrants to New Zealand, respectively. When combined into larger cohorts of source countries, Asian immigrants constitute approximately a third of all overseas-born people in New Zealand; the UK and Ireland make up 26.5% of the total immigrant population in New Zealand. Middle East, Africa, Europe, North America and the Pacific Island nations are the other source countries (Statistics New Zealand – 2013 QuickStats about Culture and Identity, 2014).

The Evolution of New Zealand's Immigration Policies

The main reasons for the change in source countries for migration to New Zealand can be seen through the evolution of immigration policy. The earliest and most important policy change that arguably impacted on the current composition of New Zealand migrant population happened in 1986-87. New Zealand passed a new Immigration Act in 1987 following a review of the 1964 Act. Prior to the 1987 Act, New Zealand did allow *“people here [from around the world] temporarily and lawfully to change to permanent status from the mid-1960s, but there was little encouragement through explicit policy settings for such changes in residence status”* (Bedford, 2006; p 225). One of the key aspects of this policy/legal change was a shift of focus from ‘traditional’ source countries such as the UK and

Australia to 'non-traditional' source countries such as China and India for new immigrants (Bedford et al., 2002; Bedford, 2006; Ward & Masgoret, 2008). In this respect, the new 1987 Act saw not only an acknowledgement of this change but made it explicit that immigrants from any part of the world could come to New Zealand, subject to them meeting certain language, employment and settlement criteria (ibid). Another reason for this shift in policy was the significant net migration losses that New Zealand suffered between 1978 and 1981 (Trlin, 1986; Farmer 1986; Bedford et al., 2002). Between 1978 and 1983, there was a sustained net migration loss of approximately 15% (Bedford, 2005). To reverse the trend, New Zealand decided to open its immigrant pool to more people from non-traditional source countries. In comparison with similar countries such as Canada and Australia, New Zealand's changes to its immigration policy at the time were deemed to be about 20 years behind (Bedford, 2005). While there have been some net migration losses since 1983 it has been compensated by more sustained migration gains.

In 1991, New Zealand introduced a 'points selection system', similar to that of Australia and Canada. This resulted in an influx of migrants from northeast Asia. Due to the low threshold for English language competence within the points system, employment and settlement issues started to emerge for this group (Trlin, 1997; Bedford & Lidgard, 1997). In 1995, the English language requirements were raised but arguably this would have been too late for some Asian immigrants seeking employment. Through discussions with various stakeholder groups at a government-sponsored conference in 1997, it was decided that improved information sources on services might help recent immigrants better adjust to life and work in New Zealand and thereby reduce some of the challenges that they faced (Ho, et al., 1997; Ho, & Bedford, 1998; Ho, et al., 2001, Bedford, et al., 2005). The issues faced by immigrants who came after the policy changes in the late 1980s and early 1990s arguably prompted the government to find better ways of linking its immigration policies to the needs of the nation.

Between the late 1990s and early 2000s, the Labour Government sought to align its immigration policies to those around its economic growth policies. As such, the emphasis shifted to attracting more skilled migrants than ever before, partly to compensate for the loss of skilled New Zealanders and partly to assist with New Zealand's economic growth. An OECD report in 2003 concluded that using a points-based selection system is likely to improve the labour market outcomes of recent immigrants. This revision of the immigration policy in the late 1990s required at least 60% of all immigrants to be 'economic migrants'; 30% for family reunions and 10% for international assistance such as refugees (Bedford, 2005). A major change in 2003 allowed immigrants into New Zealand on temporary work and study visas to transition to residency. This innovation, known as the 'skilled

migrant category (SMC) is still a cornerstone of New Zealand's immigration policy.

Since the shift in focus from traditional to non-traditional countries for immigrants and the better alignment of immigrants' skill base to the economic needs of the nation, New Zealand has continued to make incremental changes to its immigrant policies to better attract the types of immigrants it desires (New Zealand Department of Labour – International Migration Outlook OCED Continuous reporting System on Migration, 2011; Hawthorne, 2011). The Immigration Act 2009 mandated the following changes that are still in effect for the most part (New Zealand Department of Labour – International Migration Outlook OCED Continuous reporting System on Migration, 2011):

- The introduction of interim visas for those who wish to stay longer either for work, study or visiting. The interim visa option allows immigrants to remain in New Zealand while a decision is made on their application for further stay. For workers and students, the interim visa provides similar conditions as those under the original visa issued.
- The establishment of the Immigration and Protection Tribunal to address any appeals to an immigrant's residential status, where all circumstances can be considered and a single decision can be made. The tribunal replaced at least four different government authorities tasked with resolving immigration related issues.
- The strengthening of the sponsorship framework where the New Zealand sponsors have to carry the appropriate level of burden for meeting the maintenance, accommodation and repatriation needs of visiting family members. The aim of this change was to better protect individuals including visitors, and the New Zealand taxpayers from arguably unintended consequences such as the unexpected illness of visiting family members who could become a burden on New Zealand's public health system.
- The introduction of special visitors visas for visiting academics from 50 countries with which New Zealand has a reciprocal agreement. The new visa replaced the need for a work visa which was viewed as a deterrent for academics visiting New Zealand. The new visa is issued to those academics who have been invited by tertiary institutions to undertake academic work, research or teaching.
- The introduction of policy to better deal with victims of human trafficking. Upon the recommendations of New Zealand Police, immigration officials may grant appropriate types of visas to the victims such as open work visas for adults and study visas for children.

- The introduction of the Migrant Investment policy to offer residency to those migrants who may want to invest in New Zealand either through opening a business or through investing in bank bonds, equities, and/or residential property investments.
- The strengthening of the Student Policy to better ensure that applicants are of the necessary standard, that they attend approved institutions of study, that they have the necessary funding, and that they successfully complete their courses. Other minor barriers to study have also been removed such as the recognition of certain certification (police and medical) for the duration of the visa period, especially where visas are issued for more than a year. Under the new Student Policy, key emphasis is placed on finding pathways to better integrate international students into the labour market should they wish to remain in New Zealand. The New Zealand government believes that international students can play an important role in its labour market, especially if they can be retained in sectors with skill shortages. The majority of those approved for study are from Asia, with India and China being the main source countries. Approximately a fifth of all international students were granted a residency visa within five years of their first student visa.

Further to the above, the National government announced in 2012, its vision for the immigration for the next three years to 2015 (Ministry of Business, Innovation & Employment –MBIE, 2012). The key messages in their vision were to build upon the initiatives of the past decade and to strengthen some of the areas of greatest gains in terms of immigration. These include:

- Focusing on attracting those who bring the most economic benefit to New Zealand such as skilled workers, business people and investors, academics, entertainers and students.
- Providing opportunities for highly skilled young people to find jobs by granting them the new Silver Fern Visa.
- Attracting wealthy retirees through the Retirement Visa scheme.
- Improving the Registered Seasonal Employer (RSE) scheme.
- Changing the Entertainer Visa to acknowledge the growing film industry.
- Boosting the export education scheme to allow more people to study while on work or visitor visas.

An unintended opportunity to attract more skilled tradespeople arose as a result of the Christchurch earthquakes. Skilled workers from Ireland and the Philippines were recruited to fill in shortages in key construction areas. Recently the Government relaxed some of the immigration rules so that lower-skilled workers who are assisting with the Canterbury rebuild can stay for longer, and

work for different employers those ones stated on their original visa. The aim of these changes is to retain as many of the good migrant workers as possible for longer, and to provide workers greater job security and safety from exploitation (Jones: New Zealand Herald, 13th May, 2015). Much like what has transpired around the Canterbury rebuild, the National government also indicated that it is looking at incentivising new skilled migrants and business investors, through the points selection system, to move to the regions to help boost local economies and to take some pressure off Auckland, the mainstay for many new arrivals (Stanford: New Zealand Herald, 27th July 2015). Such a move, if successful, will be welcome as the pressure on the Auckland housing market and the infrastructure is deemed unsustainable and could negatively impact on New Zealand should there be any instability (Auckland Economic Quarterly, March 2015).

Another issue currently being discussed is whether New Zealand needs to increase its refugee quota of 750 which was set in the mid-1980s (Ellingham: New Zealand Herald, 5th September, 2015). The refugee crisis from the Syrian conflict is being used as a platform to discuss whether New Zealand is doing enough to assist its European counterparts with sharing an appropriate level of burden in resettling these refugees. As a result of a public debate and overwhelming support from key public institutions and international organisations such as Amnesty International, the National Government has announced that it will introduce a Syrian refugee quota of 750 over the next three years (Dougan & Trevett: New Zealand Herald, 7th September, 2015). Of the new Syrian refugee quota, 600 will be dedicated to a special emergency intake and the remaining 150 will come from within the existing general refugee quota of 750. The Government will revisit its commitment to the Syrian refugee issue in 2016 when a review of the existing quota will be undertaken.

Net Migration to New Zealand

As at June 2015, migrant arrival to New Zealand was 115,700 for the previous 12 months while departures were 57,400, giving a net gain 58,300 (Statistics New Zealand – International Travel and Migration, June 2015). This net gain is very close to the 60,000 target used for economic forecasts by the New Zealand Treasury. The profile of the new permanent and long-term migrants includes:

- Over two-thirds being aged 18-34. This indicates the high volumes of students coming to study in New Zealand as seen by the visa types issued. Students from India were over twice that of China (10,100 versus 4,900, respectively).
- India, Australia, China and the Philippines were the main source countries however the next gains in migration did not include those moving

between New Zealand and Australia. However the year ending June 2015 recorded the lowest net migration loss to Australia since the early 1990s.

- UK was the biggest source of immigrants for the work visa, including those who were here on working holidays.
- The majority of immigrants settled in Auckland, followed by Canterbury and Waikato.

Overall, New Zealand is doing well in meeting its immigrant quota to sustain and develop its current economy. In the literature review and the subsequent discussion of the results, the experiences of immigrants to New Zealand will be presented, as researched through the Longitudinal Immigration Survey: New Zealand (LisNZ). Other literature will also be discussed on the economic returns of migration, and the attitudes of New Zealanders to immigrants.

While New Zealand does not seem to have problems attracting appropriately qualified migrants, including medical professionals, it does have issues with retaining them. In this thesis, the work and life experiences of a select cohort of international medical graduates (IMGs), who became general practitioners in New Zealand, will guide the discussion on what made them stay here, their experiences of migration and acculturation, and how can their experiences inform institutional policies to help retain more migrant health professionals in New Zealand.

1.2.2 Practicing Medicine in New Zealand

The Medical Council of New Zealand (MCNZ) is the registration authority for doctors wanting to practise in New Zealand. The regulation of medical practise in New Zealand is currently governed by the Health Practitioners Competence Assurance Act 2003 (the HPCAA 2003). The core purpose of this legislation is to *“protect the health and safety of the public by establishing mechanisms to ensure that health practitioners are competent and fit to practise medicine”* (Dunbar, 2013 cited in St George, 2013: p. 215). The HPCAA 2013, like its predecessors, provides the MCNZ with a framework within which it can devise policies, procedures and standards to apply to the regulation of medical doctors. It should be noted that medical practice in New Zealand has been regulated for nearly 150 years.

Brief History on the Regulation of the Medical Profession in New Zealand

Georgina Jones, former Chief Executive, Secretary and Registrar of the MCNZ (1986 to 2000), wrote a comprehensive account of the evolution of the regulations governing medical professionals in New Zealand – the MCNZ website lists her work as ‘Our History’. The following key developments around the legislation of medical practise in New Zealand are from her informative narrative, *The Medical*

Council of New Zealand: A Personal and Informal Perspective of Events during My Time as Chief Executive/Secretary/Registrar from 1986 to 2000:

- The Medical Practitioners Act 1867 was the first statute to regulate medical professionals in New Zealand. This law was passed in the UK and implemented in New Zealand by the Governor of New Zealand. The Governor appointed a Medical Board that assumed responsibility for the enforcement of the Act. The main purpose of the Medical Board was “*to keep a register of doctors, to change their addresses on the register when necessary, and to remove from the register the names of doctors who had died. Physicians and surgeons applying for registration were required to produce evidence of their qualifications and their addresses*” (Jones, 2002: p. 8).
- Medical qualifications accepted for registration (diplomas, degree or licence) had to be from a University, College or other body, of no less than three years of study.
- The Medical Board was allowed to register doctors from England, Scotland, Wales and Ireland without further assessments. Doctors qualified in medicine in any of the Australian colonies were not required to register separately in New Zealand. All doctors on the medical register had to pay a registration fee.
- A certificate of practice was issued to all registered doctors. To protect the public from unregistered doctors or ‘quacks’, the Act protected the following terms *physician, doctor of medicine, licentiate in medicine, doctor, surgeon, medical and general practitioner, apothecary, surgeon-apothecary, accoucheur (male ‘midwife’) and licentiate or practitioner of midwifery*.
- The Act did not cover the practice of chemists or druggists – the British Pharmacopoeia was used in New Zealand hospitals.
- Georgina Jones commented that “*it is remarkable how closely the provisions of the 1869 Act mirror 21st century legislative provisions*” (ibid, p. 10).
- The Medical Practitioners Act 1869 resulted after a repeal of the 1867 Act by the General Assembly of the New Zealand Parliament. In the preceding period, New Zealand’s parliament was moved from Auckland to Wellington.
- Registers for doctors were kept in several different localities including Auckland, New Plymouth, Napier, Nelson, Hokitika, Picton, Christchurch, Dunedin and Invercargill.
- Doctors wanting to register had to publish their intention in a newspaper and the New Zealand Gazette, 30 days prior to being registered. Doctors could appeal any decision of the Registrar to not register them.

- Doctors had to produce evidence of their qualifications. Where necessary, copies of the evidence had to be certified by a Justice of the Peace. Doctors were removed from the register if they provided false or fraudulent information or qualifications, or who had been convicted of a felony in any of the British Dominions including Great Britain and Ireland. The punitive measures for the above misdemeanours at the time included imprisonment which could include hard labour for up to three years.
- The Medical Practitioners Act 1905 consolidated the amendments that had been made to the 1869 Act.
- The amendments allowed the registration of medical graduates from foreign universities whose qualifications were not recognised but who had passed the University of New Zealand's final medical examination.
- The Otago Medical School was set up 1875, with a Faculty of Medicine in place from 1891. A four year medical training programme was introduced based on recommendations from the General Medical Council (GMC) of UK. In 1904, 90 students graduated with MBChB (NZ).
- The Medical Act 1908 consolidated four previous Acts including Medical Practitioners Act 1869, the Anatomy Acts of 1875 and 1884, and the Medical Practitioners Act 1905.
- This new Act had two separate parts – the first was to regulate the registration of medical practitioners, and the second, to regulate the practice of anatomy.
- The regulations on the practice of anatomy included the identification of recognised schools of anatomy and the development of rules pertaining to them.
- Registers were still kept at local levels and were open to public inspection. The complete register of medical practitioners was published annually in the New Zealand Gazette.
- All fees collected from the registration of doctors went into a public account.
- The Medical Practitioners Act 1914 came into effect during World War I. The new Act had become more prescriptive than its predecessors apparently reflecting the climate of distrust at the time. The Act was entitled as "*An Act to make better provision for the registration and control of medical practitioners*" (ibid, p.11). The 1914 Act was considered to be the first modern Act and was similarly formatted to the 1995 Act.
- There were no non-doctors on the Medical Board. There were some other governance changes that allowed for decision-making based on a majority

voting system and the Board could regulate its own procedures if no rules were present at the time of decision.

- Medical degrees required no less than five years of study to be considered for registration. Additional qualifications could still be entered into the register. Provisional registrations were issued to some doctors for up to three months.
- Among the other misdemeanours noted previously, doctors could now incur a penalty for accepting commissions from chemists. This Act however did not affect or regulate the activities of chemists, dentists, midwives or nurses.
- Georgina Jones noted that the 1914 Act “*demonstrated that the government had a direct relationship with, and control over, the registration of medical practitioners. In the climate of the time, safety and conserving scarce resources took precedence*” (ibid, p. 12).
- The Medical Practitioners Act 1924 saw the establishment of the first Medical Council of New Zealand (MCNZ), replacing the previous Medical Board. The MCNZ had more autonomy than the previous Medical Board, and for the first time, had powers to discipline medical practitioners.
- The MCNZ was empowered to mandate that all foreign doctors, except for those from Great Britain and Australia, had to pass an examination on medicine and surgery from the University of New Zealand prior to getting registration.
- While the disciplinary powers allowed the MCNZ to take action against doctors who were deemed to be guilty of ‘impropriety’ or ‘infamous conduct in a professional respect’. However no doctor could be found guilty for the two reasons stated above if they were honestly and openly adopting and practicing a theory of medicine.
- This Act also for the first time addressed the issue of ‘impaired’ doctors such as those who had been in a mental institution as a patient. Such doctors had to seek re-registration of the MCNZ before being allowed to practice again.
- Before the passing of a new Act in 1950, a couple of important amendments were made through the Finance Act 1933 and some emergency regulations in 1941. The Finance Act required the issuing of Annual Practising Certificates (APCs) to all doctors except for those employed by the government, those who provided services in an emergency or those who held a provisional certificate of registration. The reasons for these exemptions remain unclear.

- The emergency regulations introduced in 1941 were in response to New Zealand's participation in World War II that saw some doctors actively join overseas missions. This created a shortage of doctors so the emergency regulations authorized the MCNZ to issue provisional registration to medical students to practise medicine so long as they intended to graduate after completing all the examination and practical requirements of their medical degree.
- The Medical Practitioners Act 1950 saw the amalgamation of the amendments of the Acts of 1914, 1924, and amendment Act passed in 1949 and the Finance Act of 1933.
- This Act made the internship year compulsory for all medical students. This change was aligned to provisions of the GMC in the UK to allow for reciprocity to continue. Doctors doing their internship were given 'conditional registration', differentiating them from fully registered doctors. Georgina Jones noted that "*this innovation was designed to prepare graduating doctors for private practice*" (ibid, p. 15). Doctors on conditional registration could only work in approved hospitals.
- The Medical Practitioners Disciplinary Committee (MPDC) was also established together with a second tier disciplinary structure for the different localities in New Zealand – the divisional disciplinary committees (DDCs). The MPDC could request the DDCs to investigate and action disciplinary matters within their localities, either in full or in part, and report all matters back to the MCNZ.
- The New Zealand Medical Journal (NZMJ) is mentioned for the first time in the context of the MCNZ being allowed to publish its disciplinary findings in it.
- Between this Act and the next one in 1968, several 'ad hoc' amendments were passed including changes to the qualifications required for conditional registration and registration as a medical doctor; a new penalty for wrongful use of the doctor title was introduced; provisions were made for temporary registration of doctors who came for postgraduate teaching or to gain experience; the MCNZ became a body corporate; notifications of doctors' disability became mandatory; and changes were made to strengthen the function of the disciplinary committees. All these amendments made it necessary to pass a new Act.
- The Medical Practitioners Act 1968 actually came into effect in April 1969. This Act was described as "*an Act to consolidate and amend the law relating to the registration and control of Medical Practitioners*" (ibid, p. 16).
- The Medical Education Committee (MEC) was established as a separate entity to the MCNZ. The MEC had its own functions and powers, and

included in its membership the Dean of the newly formed University of Auckland School of Medicine, established in 1968.

- The Investigation Committee was renamed the Penal Cases Committee (PCC), established to investigate complaints made to the MCNZ regarding misconduct of doctors. The MPDC was still functional in its established role. The PCC acronym has changed a few times, known as the Preliminary Proceedings Committee in the 1980s, and currently known as the Professional Conducts Committee. Its core function to investigate complaints remains the same.
- A register for specialists was set-up.
- It took 27 years before a new medical practitioner Act was passed in 1995. There were several amendments and changes regulated in that period. The following section highlights the very important and main changes gazetted in that period.
- Between the 1968 Act and 1995 Act, these key changes occurred to the regulation of medical practitioners:
- In 1970, the 'probationary registration' category was created to register foreign graduates after an assessment of knowledge and English language competence. Certain postgraduate and overseas qualifications were recognised for consideration regarding probationary registration.
- In 1970 the Minister of Health was empowered to request the MCNZ to produce statistical data on its activities.
- In the 1970s, several amendments were passed to address the recognition of foreign graduates. In 1974, recognition of Sri Lankan graduates for provisional registration was withdrawn given changes in how medical education was being delivered through the emergence of new medical schools in there. The same rule was applied to Hong Kong, Singapore and Malta in 1976 after some MCNZ members visited these countries to inspect some medical schools.
- In 1977, clauses and guidelines were developed to define doctors' duty of care in relation to family planning, contraceptives and abortion services.
- In 1979, the Royal New Zealand College of General Practitioners (RNZCGP) got permission from the British College to use that title. An amendment allowed the MCNZ to recognise the RNZCGP.
- English language competence was added as a requirement for conditional and probationary registration.
- In 1983, the first lay person was added to MCNZ's governing council.

- From 1985, the registration of foreign graduates became increasingly complex partly due to the increased volumes in medical migration to New Zealand. While the reciprocity arrangements were working well for graduates from the UK, Ireland, Canada, Australia and South Africa, many challenges were emerging when dealing with graduates from other jurisdictions. This is arguably the beginning of an increased emphasis on the similarities of training and health systems in other countries not similar to New Zealand. This period also put pressure on the MCNZ to develop robust assessment procedures and processes to ensure the increasing number of foreign graduates were fit to practise medicine in New Zealand.
- During this period, Georgina Jones noted that the MCNZ was pushing for new legislation for medical practitioners but it was not getting much traction from the Government due to economic reforms. She reported that *“we had hoped legislation would come into effect in the 1980s, but wide-ranging economic policy reform took precedence. The reforms, driven by competition policy development, were generally averse to legislated occupational regulation, unless there were significant public safety issues”* (ibid, p. 40). The MCNZ continued to ensure that the public could be kept safe from incompetent doctors under the provisions of the 1968 Act.
- In the mid-1980s, a Register of General Practitioners, known as the ‘Indicative Register’ was set up for doctors working in general practice without arguably full general practice training. This was possible under what had come to be known as the ‘grand parenting clause’. The RNZCGP, on behalf of the MCNZ, evaluated the applications from doctors working in general practice, and *“those with formal qualifications equivalent to the membership of the RNZCGP, as well as those recognised by their peers as having comparable experience and competence, were eligible to apply”* to be on the indicative register for GPs (ibid, p. 42). According to the MCNZ Annual Report 1990, the year in which the ‘grand parenting clause’ expired, a total of 1329 doctors had been approved and registered in the Register for GPs (Indicative Register), with 65 pending a decision and 55 being declined registration. Some reasons stated for declining applicants included lack of evidence of GP training, insufficient experience in general practice, applicants currently not in general practice, applicants currently overseas, and applicants not confining their practice as far as possible to general practice.
- In 1988, the MCNZ and the MEC invited the Renwick Committee (chaired by retired Director General of Education – Bill Renwick) to review the undergraduate curriculum of the four medical schools in New Zealand, under the Universities of Otago and Auckland. This review resulted in the

MCNZ giving its own accreditation to the medical schools, and opened the door for further collaboration with the Australian Medical Council (AMC), as it did the same thing among the Australian medical schools in the different states and territories. This review strengthened the reciprocity arrangements between New Zealand and Australia, and also further abroad such as with the UK. Further to this, a meeting between the MCNZ and the AMC in 1990 saw the development of *“practical sets to involve New Zealand in the AMC’s process for accreditation of medical schools in New Zealand and Australia, subject to recognition of New Zealand’s bicultural imperatives”* (Jones, p. 47).

- In 1989, the New Zealand Registration Examination (NZREX) was introduced, replacing the PRENZ (Probationary Registration Examination of New Zealand).
- One of the major issues of contention during the later years of the 1968 Act was the disjoint between Immigration New Zealand’s (INZ) point system for migrants, the evaluation of overseas qualification by the New Zealand Qualifications Authority (NZQA), and the MCNZ’s mandate to regulate medical practitioners. The NZQA was evaluating and approving medical qualifications against the WHO Directory for qualifications from around the world. The INZ was using the NZQA approved list to award points to immigrants for permanent residence without any reference to the MCNZ’s regulations and policies. This saw an influx of overseas trained doctors to New Zealand who did not meet MCNZ’s registration criteria. A snippet from Georgina Jones demonstrates the MCNZ’s and overseas doctors’ predicament:

“Despite meetings with NZQA to try to persuade them that their misleading policy and procedures were resulting in unrealistic expectations and distress for the overseas trained doctors and the Council, it was impossible to persuade them to do otherwise. After about four years of frustrating “stand-off”, the only concession I managed to achieve was to get them to add one sentence to the letter provided to doctors with the decision on their eligibility for permanent residence, pointing out that they would need to approach the Medical Council of New Zealand concerning registration. The way the form letters to successful migrants were phrased was most misleading in that they were congratulated on the fact that they were now eligible for permanent residence and told they would be able to “live and work in New Zealand”. That phrase was misleading, as it did not refer to work as doctors, nor to any procedures for registration. From afar and not knowing the culture of New Zealand or its institutions, it was not surprising

that doctors interpreted that letter in the best light possible, taking it to mean that they would be able to practise immediately on coming to New Zealand. This, in my view, constituted possible breaches of human rights and international relations more than any action taken by the Council under the provisions of its governing legislation” (Jones, 2002: p. 109)

- To remedy the above situation, the government finally agreed to fund a ‘bridging programme’ by MCNZ, targeted at overseas doctors who did not qualify for registration under any of the existing provisions of the MCNZ. The programme was only available for a limited time and many overseas doctors benefited from it.
- The Medical Practitioners Act 1995 came into effect in July 1996. Under this new Act the MCNZ devised policies to better reflect the regulations’ intentions.
- The specialist colleges were asked by the MCNZ to assess the qualifications of overseas doctors who were seeking vocational registration. The MCNZ would then decide the appropriate type of registration for these doctors – temporary, probationary or general. This new process did make things more difficult for employers of these doctors as under the previous Acts, employers could work with the MCNZ in securing registration for doctors they wished to employ.
- Additionally, the changes to the registration regime meant that only graduates of medical schools in New Zealand and Australia could practise permanently without having the need to do the registration examination. This change impacted on overseas doctors from the UK, Ireland, Canada and South Africa who were given the opportunity to get temporary registration of up to three years before the new legislation came into full effect. Georgina Jones noted that *“as expected, there was a tremendous flood of applications under the 1968 Act through until 28 June 1996, the last working day on which any such applications could be actioned. A great many applications came from South African qualified doctors who on 1 July 1996 lost automatic access to ‘full’ registration without examination”* (ibid, p. 69).
- The MCNZ chose the United States Medical Licensing Examination (USMLE) as a screening tool for the NZREX. The USMLE included an English test and therefore was considered to be an ideal assessment for overseas doctors wanting to practice in New Zealand. In the earlier years (1970s), the Educational Commission for Foreign Medical Graduates (ECFMG) examination, also from the USA, was used by the MCNZ to assess and register overseas doctors from outside the recognised

jurisdictions. The USMLE was developed/refined by the ECFMG and the National Board of Medical Examiners (NBME).

- The Health Practitioners Competence Assurance Act 2003 (HPCAA 2003) containing the current regulations governing health professionals in New Zealand. Much of the established regulations from the previous Acts remain intact within the HPCAA 2003, primarily with the purpose of protecting the health and safety of the public through ensuring that medical practitioners are competent and fit to practise medicine in New Zealand (Dunbar, 2013). The HPCAA 2003 is designed to “*increase consistency, transparency and efficiency in the regulation of health professionals*” (ibid, p. 215). Under the HPCAA 2003, the MCNZ is required to:
 - Determine the scopes of practice and qualifications required for registration.
 - Register doctors in specific scopes of practice.
 - Request doctors to demonstrate competence at registration and thereafter when applying for annual practising certificates.
 - Conduct competency reviews (performance assessments) and where necessary, require doctors to do additional training to upskill or improve their performance.
 - Receive notification regarding any mental or physical conditions that might be affecting a doctor’s ability to practise competently.
 - Set standards for cultural and clinical competencies as well as ethical conduct.
 - Accredit branch advisory bodies and medical schools within New Zealand.

Under the HPCAA 2003, the registration process for locally-trained doctors can be straightforward, but for IMGs, there are several pathways that they can go down depending on their country of origin, the type and level of medical training, their prior work experience and their intended length of stay in New Zealand.

The MCNZ recommends the following registration pathways based on how long an IMG plans on working in New Zealand. Each of the pathways has its own assessment and registration criteria:

- IMGs who decide to come for short periods of time can register under the ‘Special Purpose Pathway’. This pathway is divided into the following specific pathways, and IMGs can choose one based on their reasons for coming to New Zealand:
 - Locum tenens for <12 months;

- Visiting experts;
 - Post-graduate trainees;
 - Researchers;
 - Emergency situations;
 - Pandemic or disaster; and
 - Teleradiology.
- IMGs that come for long-term or permanent stay have two broad pathways, depending on whether or not they intend to practise as specialists. If IMGs decide **not to practise** as specialists then they can register under the 'General Pathway'. However, this pathway is limited to IMGs who meet very specific criteria, where country of training and work experience are key elements to registration. IMGs on this pathway have to:
 - Be New Zealand or Australian graduates;
 - Be from a 'competent authority' (for IMGs registered with the UK and Irish Medical Councils);
 - Be from a comparable health system (for IMGs from countries with comparable health systems to New Zealand)¹; and
 - Have passed the New Zealand Registration Examination (NZREX).
 - IMGs that decide to practise as specialists can register under the 'Vocational Pathway'. Under this pathway, IMGs need to have their qualifications and work experience assessed by the Branch Advisory Boards (BABs) of their respective medical specialties. The BABs recommend to MCNZ what the criteria for registration should be on a case by case basis.

Furthermore, the majority of IMGs seeking registration to work in New Zealand have to provide documented evidence of their:

- Primary medical qualification and any other relevant qualifications;
- Work experience;
- Certificate of Good Standing (from their respective home country's medical registration body);
- Employment offer in New Zealand (not a necessity); and

¹ In 2012, there were 22 countries with comparable health systems - Belgium, Germany, Italy, Israel, Sweden, Austria, Ireland, Netherlands, Switzerland, Australia, France, Greece, Spain, Canada, Finland, Iceland, Norway, Denmark, Singapore, UK, Czech Republic, and the USA.

- Provisions for supervision in their work environments in New Zealand.

The criteria for assessing is individualised, however, there are certain universal standards that apply to all IMGs, such as:

- Ability to communicate effectively;
- No criminal conviction that could adversely affect fitness to practise;
- No mental or physical condition that may impair ability to practise;
- No current investigations into professional disciplinary proceedings; and
- Not subject to any orders from disciplinary tribunals (MCNZ website, 2011).

Taking into account all of the above provisions from the pathways and the assessment criteria, IMGs are also personally interviewed and could still be asked to prove their competence to practise in New Zealand by completing the NZREX and/or an English test. Some IMGs, especially those in the 'Vocational Pathway' may have to complete the training programmes of their specialities in order to get full registration. Additionally, if IMGs in short-term work decide to remain in New Zealand then they have to meet the registration criteria applicable to long-term applicants. While there are reports of discontent with the registration process, the MCNZ has always operated on a 'safety-first' basis to ensure that patients are not put in harm's way when there are doubts about the competence of any of the IMGs (Ineson, 2009). The emphasis on safety does create extra work for both IMGs and the MCNZ however it is seen as necessary to keep both the doctors and the public safe from incompetent practices, and practitioners, respectively.

In a recent comparative between Australia and New Zealand's registration policies, Kate Elkin (2015) argued whether medical registration boards are likely to compromise on the quality of IMGs in order to address critical workforce shortages. While MCNZ still follows the mantra of public protection first and seems to be doing relatively well, Elkin noted that "*it is reasonable to conclude that there may be particular groups of IMGs practising medicine in Australia who are at a greater risk than their non-IMG colleagues of providing medical services that do not meet quality and/or acceptability criteria*" (p. 169). This is due to remote and rural communities facing critical shortages and thereby, the argument that it would be better to have a doctor providing lower quality services than having no doctor at all for those communities. She suggests that medical boards still ought to measure IMGs against minimum quality standards for registration and thereafter, invest in quality improvement over the longer term. It is possible that New Zealand could face critical shortages however it remains to be seen if the MCNZ and/or the relevant authorities compromise on current quality standards for registration.

1.2.3 Defining International Medical Graduates

According to the MCNZ, an international medical graduate (IMG)² is a doctor who has achieved their primary medical qualification from a country other than New Zealand (St George, 2013). This definition also applies to New Zealand-born doctors who attain their primary medical qualification outside of New Zealand. Internationally, the definition of IMGs varies from country to country and region to region. For example in the United States of America (USA), an IMG is a doctor, who has achieved their primary medical qualification from a country other than the USA, Canada and Puerto Rico (Segen, 2006). Additionally, some countries redefine their IMGs as locals based on their length of stay and the postgraduate qualifications achieved within host nations after migration (Fletcher & Dickson, 2008). Interestingly, one of the MCNZ's prominent publications, *Cole's Medical Practice in New Zealand* (St George, 2013), makes a case for changing the current definition of IMGs in New Zealand because it supposedly does not:

- give an accurate view of situations and contributions made by IMGs;
- encourage acculturation, and negatively influences doctors' perceptions of New Zealand;
- acknowledge the importance of the global flow of ideas and expertise in medicine; and
- fully acknowledge the valuable contribution made by IMGs to New Zealand's health system (St George, 2013)

Despite the above concerns, the MCNZ has decided to maintain the current definition for administrative reasons and for purposes of clarity whenever the term 'IMG' is used in the New Zealand context (Registration Manager, MCNZ, personal interview, October 29, 2012). Periodically, the MCNZ also reports to the Minister of Health the percentage of IMGs who have gone on to achieve New Zealand post-graduate qualifications. While the data on IMGs with New Zealand post-graduate qualifications is not used for any known purpose, it could be construed that IMGs who undertake post-graduate studies may be indirectly indicating their desire to remain in New Zealand.

1.2.4 International Medical Graduates in New Zealand

IMGs make up approximately 43% of the 14,381 medical practitioners on the New Zealand medical register (MCNZ Annual Report, 2014).³ These 6200 plus

² Some other terms used to refer to IMGs include 'Overseas Trained Doctor'; 'Foreign Doctor'; 'Foreign Trained Physician', 'Foreign Medical Graduate'.

³ If an alternative definition of IMGs is applied, such as the number of IMGs who have gone on to achieve a post-graduate qualification in New Zealand, and thereby re-classifying these IMGs as

IMGs serve in most of the branches of medicine, with general practice being one of the biggest benefactors. Approximately 43% of all GPs in New Zealand are IMGs (MCNZ workforce statistics, 2013). In comparison, 60% of medical officers, and 42% of registrars and specialists are IMGs. Furthermore, over 50% of doctors in the 'vocational scopes' of accident and medical practice, basic medical sciences, family planning and reproductive health, obstetrics and gynaecology, palliative medicine, psychiatry, radiation oncology, rehabilitation medicine, cardiothoracic surgery and neurosurgery are IMGs.

New Zealand attracts IMGs from approximately 90 different countries, with the majority (80%) coming from the UK, South Africa, India, Australia, Sri Lanka, China, the USA and many parts of Europe (MCNZ Annual Report, 2014; MCNZ workforce statistics, 2013; RNZCGP Workforce Reports, 2014, 2008). While comparisons with other countries are problematic given the different definitions of IMG being used, New Zealand does have a higher proportion of IMGs among countries in the Organisation for Economic Corporation and Development (OECD) (Dumont & Zurn 2007). Furthermore, in New Zealand, IMG immigration rates exceeded local medical professional graduate rates (OECD, 2008). In 2005, when IMGs comprised 34% of New Zealand's medical workforce, countries such as Australia, Canada, USA and the UK were reporting between 23-28% (Mullan, 2005). It is clearly evident, especially from current health workforce statistics, that without IMGs, New Zealand's health system would find it very challenging to meet its health obligations to the public.

New Zealand does well in attracting IMGs despite having to compete with much wealthier countries on the global market. As at June 2014 the MCNZ had, in total, registered approximately 12,527 IMGs compared to 10,633 New Zealand-trained doctors (MCNZ Annual report, 2014). Of these, 8,141 New Zealand graduates and 6,240 IMGs had current practising certificates (refer Appendix A for the New Zealand Medical Register, 2014). Furthermore, over 3,800 of these doctors are in general practice.

Within the first year post-MCNZ registration, New Zealand loses nearly 40% of its IMGs to other countries; by year two post-registration, 65% of IMGs have left; by year 10 post-registration, only 25% of IMGs are retained. Among New Zealand-trained doctors, two-thirds remain after 10 years post-registration (MCNZ workforce statistics, 2013). IMGs from North America and the UK have the lowest retention rates while those from North Africa and Asia tend to stay longer in New Zealand.

The possible reasons as to why retention rates decline over time include:

local doctors now, then the percentage of IMGs in New Zealand drops to between 25-30% (Registration Manager - MCNZ, 2012).

- Many IMGs from UK and North America only come for short durations to work;
- North African and Asian IMGs possibly remain here for longer periods due to the investments they have made when seeking registration. The countries these IMGs come from are not recognised as ‘comparable nations’ by the MCNZ and therefore, they often have to do the registration exam and subsequent specialist training which does cost time and money;
- The lure of better pay attracts both IMGs and New Zealand-trained doctors to work in places like Australia that pay substantial sums of money to those willing to work in rural and remote areas;
- Some IMGs move to be closer to their families - the travel times to New Zealand from other countries such as the UK and Europe can be long and therefore a constraint on remaining for extended periods;
- The time it takes to get permanent residence has also encouraged IMGs’ to settle elsewhere;
- As highly skilled migrants, IMGs are known to be mobile, usually doing short to medium stints in a number of countries;
- The age at the time of registration is also a factor; the MCNZ data shows that IMGs between 30-49 are more likely to remain in New Zealand than those aged 60+;
- IMGs who are recent graduates (<5 years) are more likely to leave once they get registration;
- IMGs who have registered in the ‘vocational scope’ are more likely to remain in New Zealand; nearly 75% of these IMGs continue to practise in New Zealand five years post-registration. The retention rates are much higher for locally trained doctors who register in the ‘vocational scope’- 89% (MCNZ, 2014; Fletcher & Dickson, 2008; Registration Manager - MCNZ, October 29, 2012; Recruitment Manager -NZLocums⁴, personal interview, November 2, 2012).

While some information is known about why IMGs leave, little is known about why they stay. This thesis sheds some light on why IMGs choose to stay and some of the benefits of doing so. The findings could help retain more IMGs in due course.

⁴ NZLocums is a New Zealand Government funded recruitment agency which was set-up to assist with short-term placements of IMGs in rural settings, to alleviate staff shortages. More on their role is discussed in Chapter 6 – Institutional Perspectives.

1.2.5 General Practice in New Zealand

General practice is the backdrop against which the participants in this study shared their occupational experiences. General practice is the foundation of medical care in New Zealand (Adams, 2011). It is also the main channel for the delivery of primary health care in New Zealand with over 17 million GP visits in the last year.⁵ There are approximately 1,150 general practices servicing a population of just under 4.5 million New Zealanders (Pande – A Profile of General Practice in New Zealand, 2008). The majority of practices belong to one of the 32 Primary Healthcare Organisations (PHOs). PHOs receive capitated government funding through their respective District Health Boards (DHBs) to subsidise the cost of patients' visits to their GPs. Most patients are also expected to make a co-payment for their GP visit. In order to benefit from the government subsidy, people are encouraged to enrol with a general practice. To date, nearly 95% of New Zealanders are entitled to receive the government capitated funding for GP visits (MoH – PHO Enrolment Demographics, 2014).

In 2013, there were approximately 3,600 GPs in New Zealand, approximately 82 GPs per 100,000 people or 75 FTE GPs per 100,000 people (MCNZ workforce statistics, 2011). Central Auckland has the highest ratio of 100 FTE GPs/100,000. In comparison, Counties-Manukau, which is just a short distance from central Auckland, has the lowest ratio of 55 FTE GPs/100,000. Furthermore, it is worse in rural areas such as the Waikato district which has only 15 FTE GPs servicing a population of 65,000 people: an average of 1 GP for 4,300 patients. While New Zealand seems reluctant to set a standardised GP to patient ratio, one study has shown that if GPs want a good working environment, with adequate consultation time, time for continuing medical education (CME) and time for a healthy lifestyle, then somewhere in the region of 96-106 GPs per 100,000 would be ideal (Fretter & Pande, 2008). This workforce capacity model also takes into account variables such as the percentage of part-time workers currently in the workforce, and the amount of time spent on various activities undertaken by GPs in the normal course of their work.

As in most other countries, the GP workforce in New Zealand is ageing; more female graduates are choosing general practice because it allows them the flexibility to work part-time when raising a family; more GPs are opting to be

⁵ An official total number of GP visits for 2012 is not readily available but can be estimated based on previous government statistics and the capitated funding formula. The MoH estimates that a person is likely to make, on average, four GP visits per year. The number of GP visits for children and the elderly is nearly twice the average whereas for adults of working age it is slightly less than the average. The government provides capitated funding for four GP visits per year per enrolled patient. Therefore an informed estimate of the total number of GP visits is 4 (average no. of GP visits) * 4.4 million (people) = 17.6 million GP visits per year.

salaried as opposed to self-employed; and there is an increasing reliance on IMGs to alleviate the workforce shortages, especially in many rural areas (Pande, 2009; RNZCGP – Workforce Report, 2009). These trends, including some others, will have an impact on the number of fulltime equivalent (FTE) GPs available to deliver primary care services in future (Pande, 2009; Pande & Stenson, 2008; NZIER, 2004; NZMA, 2004).

The current and emerging trends will negatively affect the future GP workforce. For example, the older cohort of GPs retiring in the next 5-15 years will need to be replaced with proportionally larger numbers of new GPs, mainly because the older GPs, who are mostly males, have worked the longest hours for most of their careers (RNZCGP Workforce Report, 2014, 2009). In comparison, the new cohorts of GPs are increasingly females, who choose to work part-time when raising a family. A significant portion of female GPs prefer to continue in part-time and locum type positions even when their children have grown (RNZCGP, 2009). However, there is some evidence that female GPs who take time off will return to fulltime practice when ready (Mckinstry, et al., 2006; Mckinstry, 2008). It is important to note that in New Zealand, the current and future shortages in workforce numbers are not due to female graduates making a choice that suits them; rather it is more to do with the government's lack of foresight when they halved the number of training places for GPs in the 1990s. By the early 2000s, the shortage of GPs was at crisis levels mainly due to the fact that not enough GPs were being trained (NZMA, 2003; 2004). Furthermore, many young male graduates are also looking to work more reasonable hours to maintain a good work-life balance and avoid burnout (Mckinstry, 2008; Houkes, et al., 2011). There is an overall trend towards not working the long hours that many of the older GPs have done for years (RNZCGP Workforce Report, 2009).

Since 2009, the numbers of training places at medical schools and in the Royal New Zealand College of General Practitioner's (RNZCGP) training programme have been substantially increased, and other incentives such as the voluntary bonding scheme were introduced to attract and retain GPs. However it is going to be a while before the benefits of such measures are visible in the workforce, if at all. New Zealand medical graduates arguably have a global market value, and due to this, nearly a quarter of New Zealand graduates leave to work overseas by the fourth year post-registration with the Medical Council (MCNZ workforce statistics, 2012). It can be expected that some of these doctors will never return to work in New Zealand due to better wages, better working conditions, and the formation of life-long relationships overseas that may not warrant a permanent move back. For the future GP workforce, there is an expectation that 50% of medical school graduates will choose general practice as opposed to the current 20% (RNZCGP Annual Report, 2014). For many years and possibly in the long term, the shortages in the workforce have been alleviated by attracting IMGs to

boost workforce numbers and help deliver the necessary health care. As noted earlier, many specialties are now dependent on IMGs.

It is also important to note that GPs are part of primary care teams that provide timely, appropriate and holistic care to their patients, in conjunction with other primary care practitioners such as physiotherapists, pharmacists, nurses with expertise in chronic conditions and other health professionals (MoH – Primary Health Care Strategy, 2001). This model of care is meant to better utilise primary care professionals with certain expertise and at the same time free-up some of the GPs' time to do what they do best. It is also about patients having access to appropriate care when they need it. This is an ideal model for primary health care delivery if it can be adequately resourced with human and other necessary capital (Barnett & Barnett, 2004).

1.3 Research Focus

This research focuses on the cross-cultural adaptation of international medical graduates to general practice in New Zealand (Chapters 4-6), and uses the findings to support the development of an integrative framework for acculturative research, where occupational adaptation is shown to be a key predictor of overall acculturation of highly skilled migrants to host nations (Chapter 7). As mentioned earlier, there are gaps in what is known about IMGs in New Zealand (Chapter 1). There are also gaps in what is known about the experiences and acculturation of highly skilled migrants to host nations (Chapter 2). An additional methodological aim is to see if email-based interviews (e-interviews) can be used within the context of qualitative and ethnographic research (Chapter 3). Together, these three aims and objectives form the core of this research.

Some specific questions to be answered include:

- What are the barriers and enablers faced by IMGs when cross-culturally adapting to general practice work in New Zealand?
- For highly skilled migrants, what is the role of occupational success in their overall acculturation to new environments?
- How appropriate are e-interviews, as a research tool, in qualitative and ethnographic research?

Primarily, IMGs are highly skilled migrants in global demand. Therefore, the principal context of this thesis is using the experiences of IMGs in New Zealand to contribute to the overall understanding of highly skilled migrants' experiences internationally. Secondly, this thesis contributes to the understanding of IMGs' experiences in the New Zealand context. This will add to existing literature as well as identify opportunities for policy development and future research.

Thirdly, the results provide a historical perspective on the changing experiences of IMGs over the years depending on when they first arrived in New Zealand. It is envisioned that this historical analysis identifies new areas for research with other types of migrant groups.

The use of e-interviews as an ethnographic data collection tool will contribute to existing literature on the use of technology for collection of primary data. This is discussed in the context of ethnography.

1.4 Structure of Thesis

This thesis is presented in eight chapters. This chapter has introduced the concept of IMGs, provided a background on general practice and primary health care in New Zealand, provided a background on IMGs in New Zealand and stated some of the known challenges to their successful adaptation to the work and social environments. The research focus of the thesis has also been articulated.

In Chapter Two, a literature review is presented that covers the sociological, anthropological and economic perspectives of migration. Where appropriate, emerging literature on IMG experiences have also been included. This is followed by an extensive look at what is known about the migration experiences of highly skilled migrants in New Zealand and internationally. An overview of New Zealand's immigration policy impact on settlement and acculturation are also discussed. Further to this, the review looks at the intercultural communication and psychological models of acculturation and adaptation of migrants. The gaps in knowledge are also identified, some of which will be filled by the findings of this study.

In Chapter Three, the research methodology is presented, including the author's theoretical background that underpins the choice of the sampling, data collection, analysis, and interpretation methodologies. In this research, the ethnography of communication influenced the data collection methods but the author also sought to experiment with e-interviews for collecting primary data. E-interviews are different from the traditional methods of face-to-face interviews and participant observations. Through this research, the advantages, disadvantages and the appropriateness of e-interviews are discussed.

Chapters Four and Five present the results on the experiences of IMGs working in general practice and living in New Zealand. Where appropriate, historical trends, urban and rural, and gender differences are articulated.

The results are presented under the following headings:

- Predispositions and Self-Concepts (Pre-migration demographic and professional attributes)
- Motivation to Interact with Hosts (Occupational Enthusiasm)

- Connecting with Hosts and Understanding Situational Processes (Occupational Adaptation and Home versus Host Comparisons)
- Living among Hosts (Social and Family Adaptation)

Chapter Five also discusses the results pertaining to the professional and occupational adaptation of IMGs. Further to the cross-case variables of historical trends, urban and rural and gender differences, the results are discussed in the context of IMGs from English-speaking countries versus those from non-English speaking countries.

Chapter Six provides an institutional perspective on the IMG experiences. Three key institution representatives (MCNZ, RNZCGP and NZLocums) were interviewed on their organisation's respective roles in supporting IMGs who want to practise medicine in New Zealand.

Chapter Seven discusses the results and literature, making a case for how occupational adaptation is a key predictor for overall acculturation of highly skilled migrants to host nations. This discussion articulates the need to take a more holistic approach to understanding, documenting and interpreting the acculturative experiences of highly skilled migrants. This chapter also discusses the merits and appropriateness of e-interviews as an ethnographic tool.

Chapter Eight concludes the thesis by highlighting the key elements and findings of this study. It explains the strengths and limitations of this research and explores possible new research topics. It articulates the implications for future policy development and concludes with recommendations on how to better understand, appreciate and utilise IMGs for the mutual benefit of all in New Zealand.

2.0 Literature Review

2.1 Introduction

In the past two centuries, hundreds of millions of people have immigrated to new countries. The International Organization for Migration (IOM) estimates that there are more than 200 million international migrants in the world today, comprising 3% of the global population; 49.6% are women; Asia is the largest source of migrants; and New Zealand is one of the main destination countries for migrants per capita. The OECD and IOM reports (2009–2014), as well as Statistics New Zealand data suggest that currently approximately 21% of New Zealand's population is foreign-born. Historically, New Zealand has been a land of migrants, with Eastern Polynesians (now known as Māori) arriving several hundred years prior to the arrival of Europeans (Dutch and the British) between 1600 and 1800 (Smith, 2005). Today, New Zealand continues to attract people from all over the world with the majority coming from the UK (Statistics New Zealand - Migration data, 2014).

The study of international migration has a long history and has been prominent among social scientists from many disciplines (Brettell & Hollifield, 2008). One problem, however, is that the social scientists approach the study of international migration from several paradigms (Massey, et al., 1993, 1994, 1998, 1999). This has resulted in theoretical viewpoints being fragmented, narrow, inefficient, and competitive. There have been numerous calls for an interdisciplinary approach to theorising about international migration (Brettell & Hollifield, 2008; Favell, 2008).

Another major issue has been the American and European bias in most literature, with an underlying assumption that the experiences of migrants are universal when clearly they are not (Kuo, 2014; Favell, 2008). There is a need to include regional, cultural, social, political and other variables that affect and reflect the immigrant experience, possibly from a multi-disciplinary approach. Some of these perspectives are starting to come through in new studies (Terry & Lê, 2014; Terry, et al., 2011; Zikic, et al., 2010; Tharmaseelan, et al., 2010; Ariss, 2010; Iredale, 2001; Coates & Carr, 2005; Mace, et al., 2005).

Of late, most of the social sciences are trying to use interdisciplinary rhetoric to support their main theories on international migration. This literature review attempts an interdisciplinary approach when looking at migration, especially the experiences of the highly skilled and qualified professionals. The interdisciplinary platform is informed by the main scholarly disciplines of Sociology, Anthropology, Economics, Business/Management and Intercultural Communication. Thereafter, the models of cross-cultural and intercultural adaptation form the basis for integrating the literature to inform the research of the experiences of highly skilled migrants.

2.1.1 Highly Skilled Migrants

It is becoming increasingly complex to define what we mean by 'highly skilled migrants'. At the basic level, an immigrant with a tertiary education can be viewed as highly skilled (IOM –World Migration Report, 2009). Often relevant work experience is also important. However not all tertiary qualifications yield the same level of recognition; for example a medical graduate is likely to be better recognised nationally and internationally, compared to a graduate in world history. Also while tertiary education covers a very broad spectrum of various qualifications, a university degree would be the minimum for an immigrant to be considered highly skilled (OECD – Global Competition for Talent Mobility of the Highly Skilled, 2008).

Furthermore, most countries define highly skilled immigrants in terms of education, occupation and their needs to develop a knowledge-based society (IOM 2009). The value of an immigrant's qualifications is often determined by the country they intend to migrate to (Coates & Carr, 2005). The economic needs of countries change over time and so do the needs for skilled migrants. Even the most qualified professionals such as medical doctors can become undesirable immigrants as seen in the UK and Canada over the last few years when medical employment opportunities reduced (Torjesen, 2012; Milne, et al., 2014). However for the most part, developed and developing countries rely on skilled migrants to fill the gaps in their labour markets to assist economic development.

So for the purposes of this study and in line with international definitions, migrants with a university degree are regarded as highly skilled. Their occupational type and years of experience are added qualities of being highly skilled. There is also an opportunity in this study to further define what we mean by 'highly skilled immigrants' who come with more than just a university degree and relevant work experience. For example, there are immigrants in New Zealand who possess a number of university degrees including PhDs, who have extensive international work experience, and who arguably have a very different migration and cross-cultural experience here. These types of immigrants can be seen as 'Very Highly Skilled Immigrants - VHSI, and could possibly form a distinct branch of study within migration literature. It can be argued that international medical graduates are part of the VHSI pool of immigrants given their training and specialist skills.

2.1.2 Acculturation

In this study, acculturation, cross-cultural adaptation and intercultural adaptation are the favoured terms as they encompass the essence of this study's focus, and are widely used in intercultural communication literature. Acculturation can be seen as the process of change that takes place when individuals of a given ethnic/social/religious background come into contact with

a different culture and thereby adopt certain beliefs and behaviours previously alien to them (Kuo, 2014; Sam & Berry, 2010; Berry, 2003). The acculturative changes usually have impacts on individuals' dietary norms, clothing, language, social behaviours, and their psychological and physical wellbeing.

This chapter begins with an explanation of the literature searching strategy, critical analysis of the social science literature on migration, critical analysis of studies on highly skilled migrants and finally an analysis of cross-cultural adaptation in migration literature. As noted in the Introduction Chapter, there was a lack of a precise model that captured the importance of occupational success in new environments, and therefore, an overarching framework is proposed for the study of the adaptation/acculturation of highly skilled immigrants. When developing the framework, several existing models within intercultural communication and psychology literature were studied to understand which might be the best fit for the emerging themes from the results. Existing literature on the experiences of IMGs and other highly skilled migrants were also explored. What resulted was a hybrid model, the Integrated Framework for Acculturative Research - IFAR that achieved a better fit for explaining the journey of the IMGs who came to New Zealand.

2.2 Literature Searching Strategy

An initial search using the terms international migration, migration and emigration in Google Scholar, ProQuest and Ovid Medline, yielded over 190,000 scholarly journal articles, with the earliest article having been written in 1885 by Ravenstein on 'The Laws of Migration'. For this study, a literature searching strategy was needed given that there are effectively four distinct but overlapping topic/discipline areas, namely international migration, migration of highly skilled immigrants, the cross-cultural adaptation of migrants including highly skilled migrants, and the adaptation experiences of IMGs. Literature on IMGs' experiences of migration and adaptation was simultaneously searched under each of the previous three broad headings as well as a separate area of interest.

Each of the topic areas is dominated by one or more of the scholarly disciplines, and the majority of literature on international migration is from sociology, anthropology and later on from economics.⁶ The disciplines of geography, history, law and politics (Brettell & Hollifield, 2008), were not included due to no

⁶ International migration has also been extensively researched in geography, history, law and politics (Brettell & Hollifield, 2008), but it was decided that their relevance to this study is limited due to no data being collected from participants to inform these disciplines main theoretical leanings. Future research among IMGs could better inform the key arguments of these disciplines.

data being collected from participants to inform these disciplines main theoretical leanings. Future research among IMGs could better inform the key arguments of these disciplines.

The migration of highly skilled immigrants, an expanding area of research, seems to be dominated by business/management and organisational behaviour literature (Benson-Rea & Rawlinson, 2003; Zikic, et al., 2010; Ariss, 2010), while literature on the adaptation experiences of migrants is mostly from the human psychological and human communications literature (Tharmaseelan, et al., 2010; Mace, et al., 2005; Kim, 2001, 2005; Gudykunst, 2005, Berry, 1997). Research on IMGs' experiences has been included in the above-mentioned disciplines as well as in medical education literature (Selvarajah, 2004; Iredale, 2009; Huijskens, et al., 2010).

These academic disciplines have their own paradigms, methodological differences, and areas of priority. For example, while the sociological and the anthropological literature on migration almost always looks for the complete migrant experience, usually using ethnographic methodologies, they differ in that sociologists are more concerned with impacts on societal structures whereas anthropologists like to know about the place, its culture and even people's adaptation experiences as a concept of human evolution (Brettell and Hollifield, 2008). At times, it can be very difficult to differentiate between the two disciplines.

An important cross-sectional component of the literature search across the main topic areas focused on immigrants in New Zealand. Some of this has already been presented in the introductory chapter and the remainder will be discussed later in this chapter.

2.2.1 Preferred Databases

A literature search was undertaken using the search terms as listed in Table 1.

Given the thesis topic, Medline was initially searched for all IMG related articles, using a combination of terms such as 'foreign medical graduates', 'acculturation', 'highly skilled', 'professional', etc. Over 80,000 articles were listed, mainly due to the effect of 'AND', 'OR', 'NOT' and 'XOR' Boolean operators.

Further refinement, through adjusting the Boolean operators around the search words resulted in approximately 900 articles. After a purposive glance at most of the 900 articles the search was further refined to include only articles since the early 2000s - there were 205 related articles. During the searching, purposive glancing and refinement process, articles of interest were downloaded and saved for future reference. In total approximately 50 articles were chosen from the Medline database for further review.

The ProQuest database, which includes a wider range of publications and disciplines, was also searched using a similar combination of terms as those used for Medline. The results were in the thousands so it was decided that only the most recent articles (2000-2014) would be viewed - there were still approximately 1,000 articles. However ProQuest lists the 'most relevant' articles based on the search terms first. This functionality of ProQuest was very helpful despite the fact that nearly half the listed articles still needed to be purposively glanced at. In total approximately 80 articles were downloaded for review.

Table 1: Literature Review Search Terminologies

International migration	Highly skilled migrants	Acculturation	International medical graduates
<ul style="list-style-type: none"> • Theories of international migration • Migration of highly skilled immigrants • Migration of doctors/IMGs • Migration to New Zealand • New Zealand immigration policy • Globalisation and New Zealand immigration policy 	<ul style="list-style-type: none"> • Highly skilled specialists • Skilled professionals qualified migrants • Expatriates • Self-initiated expatriates (SIEs) • IMGs • Foreign professional personnel • Professional protectionism • Labour market segmentation 	<ul style="list-style-type: none"> • Cross-cultural adaptation • Intercultural adaptation • Social integration • Assimilation • Adaptation • Integration • Migration to New Zealand 	<ul style="list-style-type: none"> • Foreign medical graduates • General practitioners • Physicians • Family physicians • Primary care doctors • Foreign professional personnel • International medical students • International nurses • Health workers • New Zealand medical workforce

Further to the above searching, the references/bibliographies of the most relevant articles were scanned for related material. This was a very useful exercise mainly due to the fact that it highlighted important literature excluded from the Medline and ProQuest databases. A similar literature search approach to the above was used closer to the writing of the Discussion chapter to gather more recent publications especially in the context of highly skilled migrants and IMGs. Interestingly, this yielded a substantial volume of valuable new research, most of which is included in this chapter and in the discussion of the results.

The literature search was stopped when saturation of new ideas and perceptions was reached. This literature review presents most of the early and current ideas, perceptions, and research findings related to the cross-cultural adaptation of

IMGs (as highly skilled immigrants) to general practice in New Zealand, as well as other types of migrants in general.

Finally, the database searches excluded literature on the linguistics and interpersonal communications of immigrants. While it was difficult to ignore psychological literature on immigrant adaptation given the extensive research done in this field, the majority of such literature was excluded except for those that proposed models for acculturative research such as John Berry's important work on adaptation and integration. Also, within the New Zealand context most of the relevant literature on migrant experiences has been within the psychological discipline, and therefore some of it has been selectively included. This will be explicitly stated where necessary.

The following section discusses migration theory as researched and documented within the three main disciplines of interest to this study - sociology, anthropology and economics. The sociological and anthropological perspectives are important because they historically explored the interactions of immigrants with host nations' social structures, and discussed how these social structures and other factors assisted or hindered adaptation to host nations. The economic perspective is also important because immigrants are viewed as human capital and have the ability to create wealth within the host nation. Immigrants can also pose an economic burden on host nations; therefore a lot of focus on immigration policies is based on economic needs of the recipient nations.

2.3 Migration Theory

It is important in the first instance to understand why people migrate. People migrate from their home to other places for a number of reasons. According to Ernest Ravenstein (1885, 1889), a geographer who is regarded as the earliest migration theorist, his 'Laws of Migration' concluded that migration was governed by a 'push-pull' process. Using the census data of England and Wales, he noted that people are likely to migrate if they perceive an economic benefit. He noted that those people who choose to move will most likely travel short distances; that those who choose to travel longer distances will target bigger cities; and that rural dwellers and younger people are more likely to migrate.

Essentially push factors will 'force', and pull factors will 'motivate' people to consider migration (Ravenstein, 1885; Lee, 1966; Manning, 2006; Zikic, et al., 2010; Clark et al., 2006; Pang et al., 2002). In the extreme, push factors include war and persecution but could also include the lack of job opportunities and opportunities for advancement. Pull factors motivate migrants to move to destinations where there are opportunities for career and economic advancement, and safety for one's wellbeing.

In the context of highly skilled migrants, there is arguably a third factor where migrants are not pushed or pulled but are 'actively incentivised' to move. For example, a person may have a good job, all the opportunities they may need in their home country and therefore would not consider moving anywhere else. However they may be actively pursued and provided with substantial financial incentives to relocate to another country. The incentive to move/migrate, often temporarily, can be too good to ignore and people who would not necessarily consider migrating do so, often at a great loss to the sending countries (Chaloff & Lemaître, 2009). Another example shows that New Zealand doctors are being offered as much as \$600,000 per year to relocate to and service remote parts of Australia, where no Australian doctor wants to go and work (TVNZ – High pay luring New Zealand Doctors, 2011). Also, at many medical conferences in New Zealand, it is common to see Australian recruiters actively pursuing New Zealand doctors. Unfortunately, such offers and recruitment strategies have seen many New Zealand-trained doctors move to Australia and further afield; a third of all New Zealand graduates are overseas 10 years post-graduation (MCNZ – Workforce Statistics, 2013).

Most of the literature on IMGs has suggested that the same push and pull factors are at play as those noted for other types of migrants, the only difference being that IMGs are better placed to capitalise on migration opportunities due to economic factors (Hatzidimitriadou & Psinos, 2014; Groutsis & Arnold, 2012; Harvey, 2011; Brown & Connell, 2004).

2.3.1 Sociology and International Migration

Sociologists have extensively researched and theorised about immigration (Heisler, 2008). For most of its history, sociology has focused primarily on the social, political and economic experiences and consequences of migration on the receiving societies (Park, 1928; Gordon, 1964; Agueros, 1971; Edwards, et al., 1975; Lieberman, 1980). However, increasing attention is being given to the reasons for migration and how it might be sustained in the long run (Castles & Miller, 1993).

In the Beginning: Assimilation

Assimilation of migrants into receiving societies was one of the earliest contributions American sociologists made to the study of migration (Park & Burgess, 1921; Park, 1928; Thomas & Znaniecki, 1930). They argued that over time immigrants will adapt to their new environment and lose their originally differentiating traits such as dress and mannerisms. The hosts will be able to force the migrants to conform. It was understood that the first generation or foreign-born migrants would assimilate to a lesser extent than their children and grandchildren who are born and raised in a new country (Gordon, 1961 & 1964). These notions raised questions about what immigrants were expected to

assimilate to. Alba and Nee (1997) noted that in the American context it was the middle-class American-Anglo-Saxon cultural patterns.

However, the assimilation theory was challenged because it could not explain the existence of racial and ethnic inequities and conflicts despite second and subsequent generations of immigrants' children being exposed to the opportunities to assimilate (Glazer, 1993; Heisler, 2008). Therefore, assimilation as a migrant adaptation strategy, despite its merits, could not fully explain the actual 'immigrant experience'.

Sociologists then shifted their attention from assimilation to integration or incorporation, and to segmented assimilation of migrants (Pedraza, 1999). From the American perspective, changes experienced since the 1970s (cultural, social, economic, and political) led to a conceptual and analytical focus on interactions between immigrants and structures of society; i.e. on existing economic/labour markets, ethnic and class structures, inequalities, human capital, and on social networks and organisations, that eventually led to the development of multiple models for explaining a variety of conditions and possible outcomes of immigration (Heisler, 2008). An interdisciplinary approach was being nurtured. Despite the new models of migrant integration, 'traditional' assimilation was still considered to be relevant in some contexts where the immigrants' and host society's cultural/social/political backgrounds were very similar, thereby enabling the settlement process (Gordon, 1964; Glazer, 1993; Alba & Nee, 2003; Kivisto, 2004).

Ethnicity, Economics and Integration

Among the new models of migrant integration, Edna Bonacich's 'Middleman minority model', (1973; Bonacich & Modell, 1980), and Ivan Light's 'Ethnic entrepreneur/ethnic economy model' (1972; Light & Bonacich, 1988) pioneered some of the first quasi-interdisciplinary models for looking at integration of immigrants from an economic and ethnic networking point of view. In developing the 'Middleman minority model', Bonacich studied Asian immigrants who became small-scale traders and merchants only because they were systematically excluded from mainstream employment opportunities. She argued that 'middleman minorities' occupied a distinct class that acted as a go-between for subordinate groups and at the same time had no special use for the ruling class (Heisler, 2008). Regardless of the constant economic and racial inequalities in America, in the 1960s-1980s, the social solidarity among the Asian immigrants was one of the reasons they succeeded as small-scale traders and merchants (Bonacich & Modell, 1980).

Ivan Light's (1972; 1979; 1984) 'Ethnic entrepreneur/ethnic economy model' also acknowledged the above but he argued that the experience of immigration generated a reactive solidarity among immigrants that did not exist before

immigration. This 'ethnic entrepreneurial' solidarity becomes a resource for the ethnic groups and is more defining of an ethnic group than their class status. These defining resources for an ethnic group could include their entrepreneurial heritage, values and attributes, the social networks, and the presence of underemployed and/or disadvantaged workers (Light & Rosenstein 1995). In Bonacich's later study with John Modell (1980), they found that social solidarity eroded with the second generation's attempts at integration/incorporation, leading them to conclude that assimilation was highly likely even if it took several generations (Heisler, 2008).

The 'ethnic enclave economy model', developed by Alejandro Portes and colleagues (Portes & Bach, 1985; Wilson & Portes, 1980; Portes & Manning, 1986; Portes & Rumbaut, 1990), used the economic notion of dual labour market theory to explore the segmentation of Cuban workers in Miami. Portes and Associates presented evidence of an existing alternative labour 'enclave' among some ethnic groups in response to one of the dualities. The dual labour market theory divides the labour market into primary and secondary markets; primary jobs are those that provide high wages, good working conditions, employment stability, chances of advancement, equity, and due process in work rules whereas the secondary market tends to have low wages and fringe benefits, poor working conditions, high labour turnover, little chance of advancement, and often random and unpredictable supervision (Doeringer & Piore 1971; Piore 1975; Tomaskovic-Devey 1993a, 1993b). Given that immigrants are more likely to be confined to the secondary labour market, the 'enclave economy' provides immigrants with an alternative opportunity to gain meaningful employment, social solidarity, and possibly ethnic solidarity (Portes & Sensenbrenner, 1993). The enclave economy is more likely to provide language and training opportunities and a better chance for social mobility (Portes & Bach, 1985).

Another important characteristic of the 'ethnic enclave economy model' is termed 'spatial clustering', meaning that ethnic businesses that initially serve the culturally defined needs of co-ethnics branch out to serve the larger community (Portes & Jensen, 1989). This indicated that ethnic enclaves can be economically diverse by engaging in many types of business opportunities but success would depend on their size, skill level, and access to capital resources (Heisler, 2008). There are numerous examples of these types of ethnic economic enclaves in New Zealand that not only meet the needs of their ethnic members but also serve the wider community, such as the Asian spice shops, the halal butchers for Muslims or the weekend vegetable markets.

While looking at a different aspect of the labour market and the public sector as opposed to the private sector, Roger Waldinger (1996) and Associates (Waldinger & Bozorgmehr, 1996) developed the 'ethnic niche model' that focused on occupational skill and knowledge as the basis for integration. Unlike the previous

models that focused on trade, small businesses, and the variety of businesses, the 'ethnic niche model' argued that certain ethnic groups are able to dominate certain occupations thereby giving privileged access to their members, possibly at the expense of other ethnic groups (Heisler, 2008). Waldinger argued that ethnic niches appear in all market economies and jobs are ranked according to desirability and availability. These ethnic niches exist in industries employing more than a thousand people where a group's representation in that industry is at least 150% of their representation in the total population. The information technology sector in New Zealand could be one such example where Asian Indian immigrants have been able to develop and arguably dominate that niche due to their skill-base and their global demand, given the emergence of computer-based technologies (Benson-Rea & Rawlinson, 2003).

The 'middleman minority model', the 'ethnic entrepreneur/ethnic economy model', the 'ethnic enclave model' and 'ethnic niche model' all provide insights into different pathways immigrants have taken to either survive, assimilate or integrate into host societies through economic activity. These models demonstrate that immigrants are often disadvantaged and need to find alternative means for economic survival, upon which is constructed other social and political realities. However, the economic behaviour of immigrants demonstrated through these models does not fully capture the immigrant experience even though their behaviour is shaped by these socio-economic structures (Heisler, 2008).

Within the UK setting, a study of migrant doctors showed that they needed to use the social networks of local doctors to advance their careers (Raghuram, et al., 2010). For highly skilled migrants such as doctors, the need to engage in local networks such as medical specialty groups could yield better career prospects than remaining in ethnic networks. The authors of the above study concluded that *"migrants' cultural capital, education and skills can only be validated through the social capital they generate through relations with non-migrants. These networks shape the contexts in which migrants attempt to convert their pre-migration capital in the post-migration context, limiting but not foreclosing opportunities for migrants"* (p. 26). Arguably the role of ethnic networks for the very highly skilled could be limited when it comes to occupational adaptation or progression in host nations.

Assimilation Rejuvenated

Some sociologists have argued for the 'rehabilitation' of the assimilation theory, given that assimilation happened in the past and is still taking place (Morawska, 1994; Alba & Nee, 1997; Brubaker, 2001). The new theory of assimilation, as proposed by Richard Alba and Victor Nee (1997, 2003), builds on the behavioural assumptions of the new institutionalism in sociology that emphasises the important influence the host nation's institutions and the immigrants' social

capital and networks play in shaping the actions of the immigrants. The original theory has been discarded, that was rooted in Anglo-Saxon conformity, naïve images of the melting pot, and the propositions that assimilation is universal, inevitable and has straightforward outcomes. Rather, it is argued that assimilation is often an unexpected and unplanned outcome for many immigrants (Alba & Nee, 1997; Heisler, 2008).

'Segmented assimilation' was introduced as a concept to revitalise the discussions on assimilation (Portes & Zhou, 1993, 1995a; Gans, 1992). This concept focuses on the children of immigrants who as second generation 'immigrants' have different opportunities for social mobility. Portes and Zhou argued that depending on their parents' social class, the children of immigrants may assimilate into different segments of the existing class structure, whereby children of middle-class immigrants may take advantage of the educational and other opportunities offered by society to assimilate into that society's middle-class. However, children of lower-class immigrants may have a very different outcome depending on their social experiences. In this context, an immigrant's skill base or the size of their human capital (highly skilled may equal high human capital) may determine what 'class' they may become part of in the host society. However, the class system of any country, regardless of how subtle it might be, can be very difficult to explain just in terms of skills or human capital.

Segmented assimilation does put a greater emphasis on the immigrants' initial economic status (predisposition) when entering a new society, and the use of that status by subsequent generations to gain social mobility, which may not necessarily be positive as envisioned by the host society or the immigrants themselves. This adaptation strategy seems to place less importance on a host society's social structures that may impede or assist positive assimilation and more emphasis on immigrants' predispositions in assisting assimilation or integration.

A recent study of immigrants who were doctors in their home nations but were struggling to pursue their careers in New Zealand, noted they felt great emotional consequences due to the existing occupational barriers (Mpofu & Hocking, 2013). The feelings of frustration, disappointment, depression, and hopelessness were taking a great toll on them and their families to the extent that some felt that their children were being negatively affected by impressions that people of their ethnicity could never be doctors in New Zealand. Additionally, while these 'doctors' were still acknowledged as such within their own ethnic communities, the fact that they were not real doctors any more deprived them of that identity and caused mental health issues. So arguably if segmented assimilation is to occur, then a host society's social institutions and structures may have a greater role to play than is currently being acknowledged. In other recent studies of IMGs in rural Australia, the support from the local communities

and institutions was seen as critical to the integration or assimilation of the doctors (Terry & Lê, 2014; Dywili, et al., 2012; Terry, et al., 2011; Arkles, et al., 2007; Alexander & Fraser, 2007).

In the Global Era: Citizenship, Belongingness and Transnationalism

Citizenship has emerged as a complex area of study primarily focusing on an immigrant's post-migration legal status, their possession of rights, their identity, their political activity, and the protection immigrants are entitled too in host nations (Bosniak, 2000; Heisler, 2008). Within the emerging global society, some of the primary notions of citizenship and belongingness are easily challenged because it espouses a monopolistic relationship between an individual and a nation-state, which somewhat contradicts the increasing mobility of many immigrants for a variety of reasons such as business, education, government postings, and military service (Frey, 2003).

For sociologists such as Marshall (1964), Schmitter (1979 cited in Brettell & Hollifield, 2008), Brubaker (1989, 1992) and Faist (1995), the European context provided more variations in conceptualising citizenship because unlike America, many European countries used different principles of citizenship that imposed more significant barriers to naturalisation and restrictions on birth-right citizenship. These studies focused on citizenship as a mechanism for social and political inclusion/exclusion, to explain how immigrants influence host societies' social and political structures and how these structures affect immigrants' incorporation or assimilation (Heisler, 2008). The common conclusions drawn despite some disagreements is that immigrants need to have full social, civil and political rights to foster a greater degree of economic and social integration into host societies; and that access to political rights for immigrants was necessary for full citizenship and a prerequisite for incorporation or assimilation.

A variety of disciplines such as law (Schuck, 1998), political sciences and political philosophy (Smith, 2003; Kymlika, 1995; Bauböck, 1994), anthropology (Ong, 1999) and sociology have contributed to the development and understanding of citizenship (Heisler, 2008). These scholars used the principles and values of their disciplines to construct a myriad of 'citizenship' discourse that included all of the four basic concepts of legal status, rights, identity, and political activity.

Using these concepts there are five main types of citizenship; cultural, flexible, diasporic, fragmented, and post-national. Briefly, these different types of citizenship are meant to capture the rights of immigrants' to equality that is void of racial, class and sexual orientation discrimination (Cultural); to be citizens of two or more states simultaneously (Flexible); to belong to organised ethnic communities (Diaspora); to belong to supranational unions without losing their rights to their home nations such as in the context of the European Union (Fragmented); and to belong to 'globalised realities' that are not defined by

nation-states but by contextual issues such as human rights, the maintenance of a healthy global environment, labour rights, women's rights and to minorities who struggle to find a voice post-national citizenship (Rosaldo, 1994; Kymlicka & Norman, 1994; Turner, 1993; Frey, 2003; Ong, 1999; Lahneman, 2005; Laguerre, 1998; Jenson, 2007; Sassen, 1996 & 2002; Soysal, 1994; Jacobson, 1996).

In a study of Muslim IMGs in the USA, the issue of citizenship and belongingness came to the fore post-September 11, 2001 (Laird, et al., 2013). The participants were not a homogenous ethnic group but rather connected via Islam. The authors noted that the Muslim participants considered themselves to be like other IMGs in the USA, and that their success as physicians was the key to foster that sense of belongingness to broader American society. However, there was also a difference noted in that the Muslim IMGs saw a need to use their human capital and societal interactions to improve the public's understanding of Islam. This was a representation of their belongingness to wider society which some of the other IMGs groups did not have to do. The Muslim IMGs mentioned that their role as physicians gave them leverage to influence public discourse on Islam both within their communities and within the wider context of American society.

As we experience rapid technological advances, new alliances between nation-states and increased mobility of individuals across borders, we are likely to witness erosion or a redevelopment of the traditional concepts of citizenship. In recent discussions in most social sciences, *transnationalism* has emerged as an area of focus in relation to citizenship and the integration or assimilation of migrants into host societies.

Transnationalism – A Sociological Perspective

The discourse on transnationalism is complex and multitudinous. Primarily, transnationalism captures the recent shift in migration patterns where a 'transnational citizen' denotes an individual able to belong to multiple nation-states because of their political, economic, cultural and social activities in the globalised world (Bauböck, 2003; Morawska, 2005; Heisler, 2008). Immigrant transnationalism refers to the process by which immigrants 'maintain, build and reinforce multiple linkages with their countries of origin' for whatever reason (Basch, et al., 1994; Glick-Schiller, et al., 1995). While scholars from many disciplines are refining original concepts within their theoretical contexts, sociologists are interested in how immigrant transnationalism is enhancing, opposing or complementing the traditional notions of migrant incorporation (Portes, et al., 2002; Morawska, 2003b; Kivisto, 2003; Snel, et al., 2006; Heisler, 2008).

The main point of contention with immigrant transnationalism is the ability to maintain home-country ties and at the same time attempt to assimilate into the host society. How can it be done? Or should it matter if assimilation of

transnational immigrants into the host society is unachievable or even undesirable? In the European context, it was noted that often host nations' discouraged permanent settlement of immigrants while sending nations encouraged the maintenance of ties with their emigrant communities (Schmitter Heisler, 1984, 1985; Heisler & Schmitter Heisler, 1986). In the USA, immigrants from Mexico, El Salvador, Haiti, Dominican Republic, and Philippines maintained very strong ties with their home countries or their families at home despite some of these immigrants being 'forced' out of their home countries as was the case for many El Salvadorians who ended up in the USA (Orozco, 2005; Levitt & Jaworsky, 2007).

The emergence of transnationalism has led to a new look at the economic, social, cultural and political institutions within host nations that facilitate incorporation or assimilation. This relates to the economic models mentioned earlier such as the ethnic economic model, ethnic niche model, ethnic enclave economic model, middleman minority model, and ethnic entrepreneur model that described the assimilation or integration of first and second generation migrants into American society. Using some of the descriptions and conceptualisations of the above models, sociologists defined transnational communities as system of networks, institutions, and relationships that connect people in receiving countries including those people who may not be immigrants (Heisler, 2008; Portes, et al., 1999; Levitt, 2001a).

In a study of Mexicans living in California, Sarah Horton (2013) found that many were returning to Mexico to access what they deemed to be better health care than that in the USA. The migrants' medical return to their home nation was seen as a form of transnationalism that allowed the best of both worlds, by permitting them to earn enough money in California to access private health care in Mexico. Their return to California was also not hindered post-treatment. It should be noted that the participants in this study had access to public health care in California but chose to access private care in Mexico that was cheaper than in the USA.

At another level of transnationalism, Levitt and Schiller (2004) envisioned Diasporas as 'building blocks' of transnational communities while Faist (2000) argued that Diasporas were examples of transnational communities themselves because they tended to be relatively stable, with long histories, and with strong sets of ties between various nation destinations. Both viewpoints are valid because Diasporas by nature and definition are vital links between host nations and sending countries but not all members of a Diaspora take part in transnational activities, and in many cases, non-migrants in host nations may utilise Diasporas to engage in transnational activities, thereby building new quasi-transnational communities. This is discussed in more detail in the next section – anthropology and international migration.

Furthermore, in relation to the tensions between transnationalism and assimilation into host nations, Morawska (2003b) argued that it was possible for migrants and their children (born in host nations) to be transnationals and also assimilate into host societies. Levitt and Schiller (2004) disputed this notion and considered the connection between assimilation and enduring transnationalism as 'incompatible' or 'binary'. Leo Chavez (2008) studying the Latino population in the USA found that a negative perception existed for this community that could partially be blamed on government policy, the existence of large numbers of illegal immigrants in the Latino community, the frequent travel of immigrants to home countries, and the perception that migrants benefit from host nations but remain loyal to their countries of origin. A similar argument could be made for the Mexican community in California who seek health care back in Mexico (Horton, 2013). The irony is that globalisation and national institutions are nurturing this pattern of incorporation and assimilation by promoting return migration and transnationalism.

In an earlier study Roger Waldinger (2007) found similar patterns to those in Chavez's 2008 study on Latinos, but added that subsequent generations of 'immigrants' such as second and third generations reduced the amount of transnational activities they engaged in. This finding supports earlier research on assimilation and incorporation into host societies whereby second and subsequent generations are likely to acquire beliefs, mannerisms and 'way-of-life' ideas from their host societies (Morawska, 2003b). A small and possibly significant portion of a particular immigrant population such as senior citizens may still resist assimilation or even incorporation altogether due to the impact of mass media on the maintenance of strong links with their countries of origin and culture. In the same way, it also seems inappropriate to consider second and third generation off-spring of immigrants as 'immigrants' if they were born in the host nation.

While transnationalism presents new challenges and raises many perspectives, assimilation or the lack of it is very context specific. This could also be the case for immigrants not involved in any transnational activities. 'Segmented assimilation', as proposed by Portes (1995a) and Portes and Zhou (1993), is a more likely and possibly desired outcome for most immigrant groups. This facilitates full or partial assimilation of immigrants into segments of host societies based on the immigrants' socio-economic status, their educational background, political affiliations, and cultural needs. However, host nations' social structures and institutions have a role to play in the assimilation or integration process, if that is the desired outcome.

The following section considers the anthropological perspectives on immigration. There are many synergies between the sociologists and the anthropologists when discussing migration.

2.3.2 Anthropology and International Migration

With its roots in the study of humanity, anthropology has contributed extensively through research and theory to the field of international migration. While most of the early work of anthropologists (1920-50s) centred around ethnographic descriptions of indigenous peoples' cultures in Africa, Oceania, Caribbean, and Latin America, it was not until the early 1960s that they started looking at migration mainly due to the increasing number of people moving from rural to urban areas within and across national boundaries (Brettell, 2008). These early studies on migration focused on the adaptation of rural dwellers and peasants to the urban, city environment where employment opportunities created new challenges and cultural norms (Mangin, 1970; Mayer, 1962; Plotnicov, 1967).

The scope for further anthropological research on international migration grew when people from different countries and cultures moved from one country to another and from one city to another. There are numerous studies that document these movements such as 'Sikhs in Britain and UK' (Bachu, 1985; Gibson, 1988), 'Jamaicans in London' (Foner, 1979, 1985), 'Senegalese in Italy' (Carter, 1997), 'Portuguese in Canada' (Brettell, 1977), 'Algerians in France' (Silverstein, 2004), 'Vietnamese in the USA' (Nash & Nguyen, 1995), 'Yemeni Jews in Israel' (Gilad, 1989), and 'Shanghai Chinese in Hong Kong and London' (Watson, 1975) to name a few. These studies provide excellent insights into the cross-cultural adaptation of immigrants into host societies.

In the context of highly skilled migrants, there have been studies that are insightful, such as those looking at 'Return migration of Slovaks from the UK' (Williams & Balaz, 2005), 'Transnational highly skilled Finnish migrants in Europe' (Koikkalainen, 2012), and the 'Brain circulation'⁷ of highly skilled migrants' (Daugeliene & Marcinkeviciene, 2009; Saxenian, 2002). In the medical context many studies have recently documented the experiences of IMGs and other health professionals across national borders such as 'Spanish medical professionals in the UK' (Blitz, 2005), 'Migration of Romanian physicians' (Toader, 2012), 'Foreign health professionals in Portugal' (Ribeiro, 2008), 'IMGs in Canada' (Neiterman & Bourgeault, 2012; Harvey, 2011; Stenerson, et al., 2009); 'Muslim IMGs in the USA' (Laird, et al., 2013); 'Non-English speaking background immigrant health professionals in New Zealand' (Mpofu & Hocking, 2013), 'Non-EU migrant doctors in Ireland' (Humphries, et al., 2013), 'Overseas-

⁷ The term 'Brain Circulation' refers to the transfer of migrants' high value skills, in the form of knowledge (brain) to other countries. Other terms used in a similar context are 'Brain Drain' – loss of highly skilled migrants from home nations; 'Brain Gain' – the acquisition of skilled migrants by receiving countries; and 'Brain Waste' – receiving countries underutilising highly skilled migrants that they attract.

trained doctors in Australia' (Terry & Lê, 2014; Terry et al., 2011; Groutsis & Arnold, 2012; Harris, 2013; Han & Humphreys, 2005); 'IMGs in the USA' (Falcone, et al., 2013; Chen, et al., 2011); 'IMGs and nurses in the UK' (Hatzidimitriadou & Psinos, 2014; Young & Schartner, 2014; Raghuram, et al., 2010; Prescott & Nichter, 2014) and 'Migration of doctors and nurses from the South Pacific Island nations' (Brown & Connell, 2004). These studies have investigated one or more aspects of the migration experiences of IMGs but fall short of capturing the entire journey from arriving in host nations to becoming successfully adapted, both socially and professionally. Nonetheless, these studies fill gaps in our understanding of IMGs as highly skilled migrants and the challenges they face when adapting to new environments.

While it is usually assumed that most migration is voluntary, there are many instances of involuntary migration or 'conflict migration' (Gonzalez, 1989, 1992) or 'enforced migration' (Indra, 1999). In these contexts, the migrants are usually referred to as refugees.⁸ Despite the different circumstances under which 'refugees' leave their country of origin, some anthropologists have argued that their experiences once having left their country are no different to those of other types of migrants or other displaced people (Brettell, 2008; Malkki, 1995; Du Toit, 1990). While there is some validity to this argument, literature on mental health issues has identified refugees as particularly vulnerable to long-term mental health conditions (Steel, et al., 2006; Mpofo & Hocking, 2013). Some voluntary migrants also suffer mental health issues but they are often free to return to their home countries to live there again, something that refugees cannot easily do. Therefore treating the adaptation experiences of refugees as different to those of ordinary migrants has merit and should be pursued as such.

In New Zealand, some recent refugees (in the last decade) have been highly skilled people such as doctors who struggled to pursue their professions because after receiving government-assisted settlement benefits they were left to their own devices to pursue their careers, like other immigrants have to do.⁹ The lack of targeted career assistance relegates them to menial jobs that underutilise their skills. These issues were well articulated by Mpofo and Hocking (2013) in their study of voluntary migrant and refugee doctors in New Zealand who were

⁸ Most refugees come from some of the most troubled countries/regions of the world. However not all migrants from these places are refugees. As an example, the mass migration of Fiji Indians following the coups in 1987 and 2000 was mostly achieved through proper immigration channels. While many of the immigrants saw this as somewhat 'enforced' or due to a 'conflict', very few have ever claimed to be genuine 'refugees'.

⁹ This was cited from a presentation given by the New Zealand Overseas Refugee Doctors Group at a symposium on overseas doctors held at Auckland University of Technology in 2008.

struggling to further their medical careers. Both cohorts' of participants felt hopeless, disappointed, and lost because they were being under-utilised and faced many occupational constraints. Unlike the volunteer migrants in the study, the refugee participants could not return home for better opportunities because of the threat of persecution. Mpofu and Hocking (2013) study supports that notion that poor occupational outcomes can lead to similar post-migration experiences for voluntary and involuntary migrants.

There are also other factors that disadvantage highly skilled refugees such as language skills and a lack of official paperwork from home nations but they will not be discussed here because they are beyond the scope of this study. It would make for another interesting future study.

The study of 'return-migrants', while not a focus of this thesis, has highlighted some interesting observations that are relevant in the context of transnationalism (Stack, 1996, Long & Oxfeld, 2004; Williams & Balaz, 2005; Brown & Connell, 2004; Koikkalainen, 2012; Daugeliene & Marcinkeviciene, 2009). Research has shown that often strong family ties are the main reason for immigrants to return home, usually when their presence is required to solve family issues, when families back home are facing difficulties or when feeling a 'sense of mission to redeem a lost community' (Stack, 1996:xv; Gmelch, 1980). 'Return' can also be seen to be part of the migration strategy as is envisioned in the concept of 'sojourner' (Brettell, 2008). In a study of the return of South Pacific Island doctors and nurses to home nations, Connell (2009) reported that while the participants reported positive aspects of returning home such as being close to family and better climates, they did struggle with the lower wages and standards of living, the nepotism in the workplace and the culture shock upon return. Williams and Balaz (2005) reported that Slovakian return migrants who had spent varying amounts of time in the UK were usually better skilled and more confident if their occupational experiences went well in the UK.

Inherent in the previous examples is the concept of brain circulation where the movement of migrants from one destination to another leads to them acquiring, sharing and spreading their knowledge (Daugeliene & Marcinkeviciene, 2009; Blitz, 2005). This notion attempts to counter the concepts of migrant 'brain drain' and 'brain waste' (Oberoi & Lin, 2006; Guzder, 2007).¹⁰ Daugeliene and Marcinkeviciene stated that the return of highly skilled migrants has to be

¹⁰ The term 'Brain Circulation' refers to the transfer of migrants' high value skills, in the form of knowledge (brain) to other countries. Other terms used in a similar context are 'Brain Drain' – loss of highly skilled migrants from home nations; 'Brain Gain' – the acquisition of skilled migrants by receiving countries; and 'Brain Waste' – receiving countries underutilising highly skilled migrants that they attract.

stimulated by home nations so that the migrants can contribute to economic growth. Connell (2009) noted that some of the nurses and doctors that returned to their Pacific homes did not practise medicine any more but instead started up small businesses to supplement the income they had accumulated overseas (Maron & Connell, 2008; Connell, 2009).

Ruth Mandel (1989; 1990) found that among some cultures such as the Turkish, migrant returnees are looked down upon, often mocked. Similar experiences were noted among returnee Portuguese migrants in the nineteenth and early twentieth century (Brettell, 1995). Returning home was seen as a sign of failure. Also scholars within the discipline of cultural studies have extensively theorised on the concepts of 'home' and its relationship with returnees in the last two decades (Massey, 1995; Robertson, et al., 1994; Ahmed, 1999; Falzon, 2003; Markowitz & Stefansson, 2004). Connell (2009) also noted that there was resentment from locals noted by the returnee Pacific nurses and doctors both in the workplace and wider society.

There is evidence that many New Zealanders overseas would one day like to return home to retire, invest or come for holidays (Lidgard & Gilson, 2002). While this might be a welcomed move, there is little evidence/research on the impact 'Returning New Zealanders' would have on the economy, social services and socio-cultural fabric of New Zealand.

Whatever the reasons migrants may have for returning to home countries, or 'yo-yoing' between countries, most of them have to re-adapt to their once familiar environments where they may or may not experience similar situations as do new immigrants.

Transnationalism – An Anthropological Perspective

The passive status of migrants in influencing development given their mobility and newness to host societies, as conjured by the effects of global economic forces, has led anthropologists to explore the concept of transnationalism. Transnationalism is extensively discussed in the section on the 'Sociology of International Migration'. Anthropologists do not view transnationalism differently from sociologists, but have focused more on Diasporic communities. The improved modes of transportation and communication have led migrant communities to meaningfully interact with their home countries and communities. This has led to change in financial and social aspects within the local communities in both the home and receiving societies of immigrants (Levitt, 1998).

The anthropologists are challenged by the political and economic spaces within which Diasporic communities operate (Shukla, 2001; Tseng, 2002; Werbner, 2002), the process of Diaspora formation (Brodwin, 2003; Watson, 2004), and how a Diaspora influences the formation of localised cultures, identities and

communities including family and ethnic networks (Fortier, 2000; Gordon & Anderson, 1999; Alfonso, et al., 2004).

Most anthropologists see Diaspora as 'transnational communities' rather than 'building blocks' for transnational communities. Appadurai and Breckenridge (1989) argued that the true meaning of Diaspora is found in the members' collective memory about another place and time, and how this memory affects the nature of Diasporic members' cultural consciousness. Furthermore, Gupta and Ferguson (1992) argued that immigrants may use their collective memory of home countries to construct their new lived world in host nations - the concept of 'imagined communities' to immigration (Chavez, 1991, 1994; Smith, 1999).

Chavez (1991) further noted that the 'imagined communities' of migration are not only influenced by the views of the immigrants but also by the views of the host societies, once the migrants acquire the local cultural knowledge and reconcile that they are part of the host society. Much of the research on the acquisition of local cultural knowledge and the creation of Diaspora can be seen in the study of the reception accorded to immigrants by the hosts, some of which has been explored in the section on Sociology of International Migration.

Essentially, tensions arise between immigrants and hosts when the immigrant refuses or is reluctant to 'learn the rules' of the host nation, when they have more educational and economic power than the locals (Goode, 1990); when host societies are deemed to have institutional and structural racism, class and regional identities (Cole, 1997); when immigrants are labelled and stigmatised due to their home countries' political and social history (Grillo, 1985; Gonzalez & McCommon, 1989; Riccio, 2000), and when an immigrant's socio-cultural beliefs affects their interpretation of the host country's laws, where the outcome may contradict the norms and values of the host nation (Koptiuch, 1996). In terms of medicine, the rules that govern IMGs are the same internationally, with arguably bureaucratic variations based on specific requirements of host nations, such as Pharmac rules that govern prescribing in New Zealand.

In recent discourse, the concept of Diaspora has expanded beyond the bounds of ethnicity, culture and religion to include professional groups. Some of the abovementioned tensions were felt by Muslim IMGs in the USA post-9/11 (Laird, et al., 2013). However, while the Muslim IMGs were not a homogenous ethnic group, they were united by their religion and their professions as highly skilled migrants and therefore, were able to influence societal perceptions that went far beyond their professional roles. In this situation, Chavez's 'imagined community' of migrant believers became transnational actors, who were left with the role of educating and enhancing the image of their Diaspora after a terrorist attack in their host nation.

Neiterman and Bourgeault (2012) took the concept of Diaspora beyond ethnicity to professional links. In their Canadian study of IMGs who were struggling to get

proper professional and social recognition, they observed that the IMGs from different backgrounds had banded together to form a professional Diaspora. They concluded that *“the formulation of a professional diaspora of IMGs is stimulated by the formal and informal exclusion of IMGs from the local medical community. Unable to receive social recognition of their status and skills, IMGs seek recognition among themselves, and during this process, they form the community that we call diaspora...they redefine themselves as IMGs while nostalgically reflecting on who they were back in their home countries. A commonly shared medical past is what unites this community in their efforts to survive in Canada.”* (p. 56)

Several Australian studies have also noted that community integration is important to meet the ethnic, cultural, social and religious needs of IMGs in rural Australia for the purposes of retaining them (Terry & Lê, 2014, 2013; Terry et al., 2011; Dywili, et al., 2012; Le, et al., 2009; Arkles, et al., 2007; Durey, 2005; Han & Humphreys, 2005). In rural settings, the involvement of locals in facilitating community integration becomes very important, and while this does not necessarily depict a Diaspora, it does lead to a formation of a group that may hold similar values and purpose for the migrants.

Family and Social Networks, Migration and Transnationalism

Anthropologists have also started looking at how transnationalism affects the lives of immigrants and families in relation to their personal, economic and social connections within the new environment (Brettell & Hollifield, 2008; Goodson-Lawes, 1993; Mahler, 1995; Min, 1998; Pessar 1995a; Wong, 1998). Using ‘network analysis’, anthropologists such as Barnes (1954), Mitchell (1974) and more recently Wilson (1994), studied the role of kinship and social organisation within emerging complex and urban societies that resulted due to migration. The core argument presented by network analysis focuses on how family and friends through migration are able to create social structures that enable and sustain migration over a period of time.

To further support the use of networks during migration, Grasmuck and Pessar (1991), in their study of Dominican immigrants, noted that rather than individuals, it is the household of the individual that resources the migration process, and thereafter, reaps the benefit of that success through remittance and increased opportunities for future migration. Therefore, the larger these social and kinship networks, the more resources migrants and households have at their disposal, to assist the stable settlement and adaptation of new migrants (Rodriguez, 1987; Anwar, 1995; Poros, 2001; Clarke, 2004).

Cultural capital is a term often used to explain the acquisition and use of resources from family and social networks that assist migrants. Bourdieu (1986) stated that cultural capital includes non-financial assets made up of the educational, intellectual and social resources that people either inherit from

family through socialisation or consciously acquire over time. These non-financial assets are mobilised at the time of migration to achieve favourable outcomes, for all involved in the sending and receiving countries. Several studies have noted the importance of such networks that may be formal or informal, familial or professional, social or cultural in IMGs' pursuit of career progression (Raghuram, et al., 2010; Hatzidimitriadou & Psinos, 2014; Prescott & Nichter, 2014; Humphries, et al., 2013; Ribeiro, 2008). Despite having such support systems and networks, most of the above studies concluded that IMGs faced many barriers professionally, which affects their social integration into host societies.

Women and Migration

The application of network analysis also highlighted the role of women in the decisions, processes and outcomes of migration. Prior to this approach, women were seen as mere followers of their male counterparts who initiated the migration process, or who remained at home to manage the tasks that their male counterparts had once assumed responsibility for (Brettell, 1986; Connell, 1984). However, recent anthropological and sociological studies on migration have brought women to the fore as they have been seen to be central to the decision-making and management of the migration process through the networks they had (Brettell & Hollifield, 2008; O'Connor, 1990; Aranda, 2003; Curran & Rivero-Fuentes, 2003). In some cases, such as among the Caribbean migrants, women have been documented as often being the first to migrate because they were likely to get employment first, and as a result were favoured to initiate the migration process (Brettell & Hollifield, 2008).

Of interest are the changes that occur when migrant women start earning a wage, especially if they have never been in waged labour, and how this affects their power and status in the household, how it affects the allocation of domestic duties, and how being in employment changes their family structure and their sense of wellbeing (Stafford, 1984; Meintel, et al., 1987; Parreñas, 2001; George, 2005)

Some of the studies on IMGs have documented the experiences of female doctors and the challenges they faced when pursuing their careers. Mpofu and Hocking (2013) noted that female trainees in New Zealand were finding it extremely difficult to juggle studying and being a mother at the same time. Many of the female participants also reported frustration with what they were experiencing in the workplace. One participant eventually decided that she could no longer pursue her dream: *"I said goodbye to the profession...and I couldn't imagine my life without being a specialist surgeon. It was basically my time of grieving and saying goodbye to the profession...the process was quite traumatic"*. Similar struggles have

been noted by female health professionals in other studies (Prescott & Nichter, 2014; Connell, 2009; Humphries, et al., 2013)

In terms of the political-economic theoretical framework regarding employment, migrant women may often have limited choices of employment opportunities due to factors such as class, ethnicity and gender affecting their ability to secure desirable employment (Mortimer & Laporte, 1981; Segura, 1989; Chavira-Prado, 1992). While for some women the limited employment options may provide opportunities to become legitimate members of societies through citizenship and upward mobility, for others it may reduce the status they had acquired in their own countries. This has been seen among migrant women who were doing skilled work back home but were limited to menial labouring in host countries (Sanjek & Colen, 1990; Margolis, 1990; Stafford, 1984). Some male migrants have also experienced this type of downgrade in their post-migration employment in receiving societies (Margold, 1995; Mpofu & Hocking, 2013).

Interestingly, studies have shown that in some situations, migrant women have used their struggles in host nations to instigate political action through existing groups or their own ethnic enclaves to assume leadership roles for their communities (Giles, 1991, 1992, 1997; Giddens, 2013). In a study on female leadership among Cambodians in the US, Shiri Ui (1991) concluded that *“despite traditional culture and gender roles, female leadership will develop and emerge when groups are in a situation in which ethnic identity and unity are strong, the employment opportunities for women are greater than those for men, and the intervention of the welfare state is significant”* (p. 175). In the study of Muslim IMGs in the USA, some of the female participants noted that post 9/11 they started to wear the hijab (headscarf) again to openly express who they were and to ‘regain control’ of their image so as to dispel stereotypes of Muslims (Laird, et al., 2013). The actions of the female Muslim IMGs can be considered to be political, and their professional status provided good leverage for creating awareness and reducing anxieties about Islam in the host population.

The following section discusses the impact of ethnic identity and culture on the setting of boundaries for interaction with hosts and other immigrant groups within the host nation. This provides an important insight into how migrant groups may interact with each other to better adapt to a new environment.

Ethnicity, Identity and Migration

A number of anthropological studies validate the argument that ethnicity is a strategic response to a particular situation. Rouse (1995b), in a study of Mixtec migrants from central western Mexico living in California, observed that these migrants came from a society where identity was not a central concern but once they settled in California, they were compelled to *“adopt understandings of personhood and collectivity that privileged notions of autonomous self-possession and a*

formal equivalence between the members of a group” (p. 370). Similarly, Lessinger (1995) in a study of Asian Indians in the US noted that they soon realised that *“US society divides itself along ethnic and racial lines...many Indian immigrants conclude that it is preferable to develop an ethnic group identity rather than accept a racial categorization”* (p. 6).

However, migrant ethnic groups have to juggle other important factors when developing their identities in host nations such as class, caste, ‘twice immigrants and direct immigrants’ for Sikhs in Britain, and class, ethnic, and religious loyalty for Turks and Greeks in Germany. For the Turks and Greeks, their identities in host nations were further complicated by the fact that they are bitter enemies but have a common purpose as immigrants (ibid; White, 1997). The above studies demonstrated that for immigrants, developing an acceptable identity for themselves and their hosts is a complex process that is influenced by their present-past history, and their present-future potential in host nations as seen from the host’s expectations and prejudices, and that this is more often than not situation-based (Cohen, 1978; Brettell & Hollifield, 2008).

In recent times, it has become rather common to see members of host nations’ re-visiting their perceptions of immigrant identities, and arguing whether it is representative of the values of their own identities. In France, Muslim women are banned from wearing the burqa in public, as it is seen not to be in-line with French societal values (Willsher - The Guardian, 2014; Beriss, 1990). A similar debate ignited in New Zealand however, it is still legal for ‘burqed’ women to engage in public activities. In the study of Muslim IMGs in the USA, there was a concerted effort by the participants to use the post-9/11 environment as an opportunity to promote ‘good Islam’. This was seen by the participants as regaining control of their image and reinforcing their ‘belongingness’ to American society (Laird, et al., 2013).

It is usually seen that while immigrants may be accepted in host societies without much antagonism, often the display of symbols such as religious attire can cause angst. In many studies using anthropological migration theory (Brettell & Hollifield, 2008), religion and its institutions play a critical role in assisting migrants to adapt to host societies by either providing ‘ethnic enclaves’, and opportunities for new migrants to make contacts, defining entrepreneurial opportunities, or just providing avenues to maintain their cultural and ethnic heritage.

Furthermore, in host nations that are liberal about the rights of immigrants to pursue their ‘way of life’, some immigrant groups take appropriate advantage of this, and introduce certain religious/cultural festivals that are open to the wider community to participate in and enjoy such as Diwali - the festival of lights, organised by the Hindus, or the Chinese New Year, as celebrated in New Zealand every year. The majority of these religious/cultural festivals have a

'transnational link' because they are celebrated simultaneously in the immigrants' country of origin and in the host nation. The ethnic activities also provide the Diaspora with an opportunity to demonstrate the value they add to a host society, and thereby reinforce their belongingness.

The following section will discuss the economic perspective on migration. It has been argued that the majority of migrants move for economic reasons such as for better jobs, better living conditions and better opportunities for wealth creation. However, these motivations create challenges and issues for both the migrants and the receiving societies. What these challenges are and how they can be dealt with will be discussed next.

2.3.3 Economics and International Migration

While relatively new when compared to the preceding disciplines, the economic studies of international migration have made major contributions to the understanding of migration for both sending and receiving countries. Scholars such as Sjaastad (1962), Becker (1964), Long (1974), Chiswick (2008), Borjas (1994), Maré and Stillman (2009), Masgoret et al., (2012), Hawthorne (2011) and many others, have provided some conclusive economic evidence on the type of people who become migrants; why they choose to move; how they are selected for migration including self-selection; what resources assist migrants when choosing to move; what resources assist in the settlement process in the new environment; and the impact of migration on the children of migrants. Taking into account the questions above, this section will broadly cover the:

- Economics models developed to understand the selection of migrants and subsequently to measure their success in destination countries
- Integration of immigrants into destination labour markets including the impact of labour market segmentation on immigrants in the long term
- Professional protectionism and labour market integration
- Economic outcomes for countries sending and receiving of migrants.

Where available, evidence from New Zealand and other OECD countries are presented to support the current understanding of the economic implications of immigration on host countries as well as on countries of origin.

The Models for Analysing the Economic Impact of Immigration

Using quantitative methodologies, the discipline has developed various models to understand and explain the behaviours of 'economic' migrants. Migrants who move to another country or to other regions within a country, for better jobs and for better wealth creating opportunities, are referred to as economic migrants. It is proposed within the literature that *"economic migrants tend to be favourably self-selected on the basis of skills, health and other characteristics...[and that they] on*

average, [tend] to be more able, ambitious, aggressive, entrepreneurial, healthier, or otherwise have more favourable traits than similar individuals who choose to remain in their place of origin" (Chiswick, 2008: p. 64). Arguably, these traits can be seen among the highly skilled as well as among the not-so-skilled migrants. The emerging studies on IMGs also support Chiswick's conclusions (Mpfu & Hocking, 2013; Brown & Connell, 2004; Connell, 2009; Blitz, 2005; Harvey, 2011; Hatzidimitriadou & Psinos, 2014; Groutsis & Arnold, 2012).

In many OECD countries, the migrant selection policies are favouring those with higher skills however a possible unintended consequence of this policy has seen an increase in the migration of lower skilled people as well. Jean and Associates (2007) noted that *"in many OECD countries, the distribution of educational attainments among immigrants has thus been increasingly U-shaped, with an over-representation of both highly-skilled and unskilled persons. While the former reflects the increasing mobility of highly-skilled workers (generally facilitated or encouraged by migration policies), the latter is driven by both economic and family reunification motives, and it is the main cause for concerns on labour market outcomes among natives...the significant inflows of unskilled workers also explains why labour market integration of immigrants is increasingly seen as a challenge, in numerous OECD countries"* (p. 4). As noted previously, New Zealand has one of the highest ratios of migrants to natives in the OECD; one in four people are migrants in New Zealand and arguably as a result of this high proportion, it has invested considerable resources into understanding the outcomes of immigrants' integration into the labour market and society in general (Spoonley & Bedford, 2012; Hodgson & Poot, 2010).

Some insightful research from New Zealand, spanning over a decade, focused on issues related to immigrant selection based on migration policies, including comparisons with Australia (Hawthorne, 2011; Stillman & Velamuri, 2010); the labour market adjustments and outcomes of immigrants (Grangier, et al., 2012; Stillman, 2011; Hodgson & Poot, 2010; Maré & Stillman, 2009; Nana & Sanderson, 2008); attitudes towards immigrants and immigrant experiences (Ward, et al., 2011; Ward & Masgoret, 2008; Spoonley & Bedford, 2012); globalisation and immigration to New Zealand (Bedford, et al., 2002; Bedford, 2003); gender and migration (Badkar, et al., 2007); sustaining skilled migration from various source countries (Johnston, et al., 2006); impact of transnational immigrants in New Zealand (Ho & Bedford, 2008); re-migration of skilled migrants (Krassoi-Peach, 2013) and trend data on migration patterns and outcomes (Census 2013 & Internal Migration - Statistic New Zealand, 2015). In addition to the above, there have been numerous studies (too many to list all) on immigrant cultural identity in New Zealand, experiences of international students in New Zealand educational institutions, and the acculturation of different ethnic migrant cohorts. The OECD has also published various in-country reports on migration to New

Zealand with the most recent being on 'recruiting immigrant worker' (OECD - Recruiting immigrant workers to New Zealand, 2014).

Between 2005 and 2009, Statistics New Zealand and the Department of Labour, partnered to better understand the experiences and outcomes of immigrants, by way of a major longitudinal study - the Longitudinal Immigration Survey: New Zealand (LisNZ) (Hawthorne, 2011). The LisNZ was a variant of an Australian study done between 1993 and 2006; the Longitudinal Survey of Immigrants to Australia (LSIA). In total, 5,144 permanent immigrants, reflective of New Zealand's source countries, were interviewed at six-months (Wave 1), 18 months (Wave 2), and 36 months (Wave 3), after gaining their permanent residence in New Zealand. While Statistic New Zealand provided initial insights into the findings of the LisNZ, the Department of Labour commissioned various studies looking at the different aspects of the immigrant experience and outcomes including their motives for coming to New Zealand, their skills, qualifications and work experiences – pre and post-migration, their housing arrangements, their labour market outcomes, their use of government and community services, their social networks, and their settlement and satisfaction with New Zealand. The findings of the LisNZ, together with the other studies noted above, have been used to support or contradict important assertions in migration literature.

In the following section, three predominant economic models for understanding immigrant outcomes in host nations will be discussed; the Human Capital Migration Model, the Asymmetric Information Model, and the Roy Model.

The Human Capital Migration Model

The Human Capital Migration Model is probably the most dominant economic model to explain the predisposition and post-migration factors that have an impact on settlement success in host nations (Chiswick, 2008). It assumes that migrants are human capital, and that they have the ability to add value to the destination country as well as improve their human capital investment over time, either in the host nation or upon their return home (Becker, 1964; Sjaastad, 1962; Chiswick, 1986b).

Pierre Bourdieu (1986) discussed three key forms of capital: economic, cultural and social. The latter two can under certain conditions be converted to economic capital. *"Bourdieu's concept of 'capital' is broader than the monetary notion of capital in economics; capital is a generalized 'resource' that can assume monetary and nonmonetary as well as tangible and intangible forms"* (Anheier, et al., 1995: p. 862). Cultural capital can exist in three forms; in an 'embodied state', 'objectified state' and an 'institutional state'. In the embodied state, cultural capital is cultivated by people through the use of their physical form in achieving skills, knowledge, and educational qualifications. In the objectified state, a person uses their 'embodied capital' to produce material objects such as writings and paintings that can be

converted into economic capital. In the institutionalized state, capital is viewed as recognition gained by achieving academic qualifications of particular educational institutes that provides the recipient of such qualifications with added value when compared to a non-recipient. According to Bourdieu (1986), *“one has only to think of the concours (competitive recruitment examination) which, out of the continuum of infinitesimal differences between performances, produces sharp, absolute, lasting differences, such as that which separates the last successful candidate from the first unsuccessful one, and institutes an essential difference between the officially recognized, guaranteed competence and simple cultural capital, which is constantly required to prove itself”*(p. 88). The fellowship or membership of professional bodies such as the Royal New College of General Practitioners can be considered to be an ‘institutionalised state’ of cultural capital. Such recognition provides it holders added value and arguably, greater opportunities to convert their cultural capital into economic capital.

The other key concept besides economic and cultural capital is ‘social capital’. Bourdieu (1986) provided an additional dimension to the discourse on human capital, and in a simplified definition noted that social capital *“is the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintances and recognition – or in other words, to membership in a group”* (p. 88). The key attribute of social capital is the size of the network of connections that can be mobilised for a given purpose. The network can be an informal one such as a family unit or a formal institution such as the Royal Society of New Zealand. Each of these networks will have its own set of rules and boundaries that all members have to adhere to. In return, the ‘collective network’ endows its individuals with an identity, respect, friendship and in some cases, certain rights. Anheier and Associates (1995) noted that *“the [three] types of capital differ in liquidity and convertibility and in their potential for loss through attrition and inflation. Economic capital is the most liquid, most readily convertible to form for transformation into social and cultural capital. By comparison, the convertibility of social capital into economic capital is costlier and more contingent; social capital is less liquid, ‘stickier’ and subject to attrition. While it is difficult to convert social into cultural capital, the transformation of cultural into social capital is easier”* (p. 862).

In practical terms, the various forms of cultural and social capital can be viewed as factors impacting on migrants’ economic success in destination countries. These factors include the skill and educational background of migrants; the general abilities of migrants and their language proficiencies; their individual and family wealth; their connections within home and host countries, and to a certain extent, their political and social affiliations. Favourable selection for migration is based on the factors noted above as they are often included in migration policies to help determine a migrant’s ability to adapt to the host’s labour markets and society (Schultz, 1975; Chiswick, 2008; Masgoret, et al., 2012).

New Zealand's migrant selection criteria also take into account several of these human capital factors when determining suitability for permanent residence, such as skills and qualifications, English language proficiency and local work experience in New Zealand (Masgoret, et al., 2012).

In terms of self-selection for migration, immigrants with high human capital such as a good education and a well-paid job in home countries will have the necessary resources to meet the costs of migration (Chiswick, 2008). However, for highly skilled people, if the wages in the destination country are not favourably comparable to what they already earn at home then they are unlikely to consider migrating. For people with less human capital, the decision and the process of migration will be very challenging. However, if the wage differential between the destination and origin countries is substantial then the costs of migration can be seen as a portion of foregone earnings, in anticipation of recouping some of it when better paid employment is available in destination countries (ibid).

However, favourable self-selection and appropriate levels of human capital do not guarantee successful adaptation to labour markets. A study of non-EU IMGs in Ireland found that while the IMGs were favoured immigrants due to workforce shortages, their professional experiences were dissatisfying (Humphries, et al., 2013). The participants reported that there were no opportunities for training and career progression, and due to this, many felt they were losing valuable skills that they had acquired pre-migration. While income did not seem to matter much, the loss of skills together with stalled careers made Ireland an unfavourable destination, as perceived by the participants.

In another study of IMGs in the UK (Healy & Oikelome, 2011), a comparison was made between IMGs and UK graduates on a number of factors. The authors concluded that IMGs were contracted to work longer hours, sometimes in non-compliance with the European Working Time Directives (EWTN). While the annual income of both cohorts was relatively similar, IMGs had worked more hours to earn as much as their UK counterparts. Some of the findings supported the perception that IMGs were being exploited (Cooper & Burr, 2003). In terms of career progression, over 50% of IMGs wanted to become consultants compared to only 18% of UK graduates. The most telling finding was that over 60% of IMGs had low or very low morale when compared to UK graduates (47%). Arguably many local graduates were also dissatisfied with the health system which in turn made things more challenging for IMGs.

In contrast to the above experiences, a cohort of health professionals followed through the LisNZ study reported very positive experiences of labour market integration in New Zealand. In the LisNZ study, approximately 1900 of the 5144 (36%) participants were health professionals (68% midwives and nurses; 12% medical practitioners; 12% health therapy professionals, and 8% health diagnostic and promotion professionals), and overall 'satisfaction with their main job' was

84% (at Wave 1 & 2), and 92% at Wave 3 (LisNZ Data Extract from Statistics New Zealand, 2015). The LisNZ also found that the labour market integration of immigrants to New Zealand was over 90% across the three waves of the study. However, despite the high levels of job satisfaction and labour market integration, the LisNZ study (Wave two - 18 months) revealed that approximately half the participants reported they were not using their skills and experience, and that their wages/salaries were too low (Hawthorne, 2011). The author noted that this was an improvement on previous findings where approximately 67% and 75% stated the same thing, respectively. As many studies have noted, immigrants' labour market and economic outcomes do improve with time, and in the New Zealand context, it could take approximately 10 – 15 years for immigrants to gain relative parity with local workers (Maré & Stillman, 2009). Overall, the two measures of 'satisfaction with their main job' and 'the rates of labour market integration' are good indicators that New Zealand's selection policies are effective in attracting and using the human capital of immigrants.

So while the Human Capital model alludes to economic gains that can be made through migration, especially for the highly skilled, it may not be all that immigrants need in order to have fulfilling careers. As found in the UK and Ireland studies, other non-economic factors such as career progression and a good working environment may have a greater role in migrants' adaptation and integration into host societies (Humphries, et al., 2013; Healy & Oikelome, 2011).

The Asymmetric Information Model

Another model for understanding migration processes is the 'Asymmetric Information' model by Katz and Stark (1984, 1987), that focuses on employers' perceptions of migrants' abilities to perform productively in destination countries. Employers may find it difficult to ascertain the 'true ability' of any given migrant, whether or not the migrant was highly skilled or otherwise in their country of origin. Together with the above, if the wage differences are small between the destination and origin countries then there is little incentive for the highly skilled to migrate. Furthermore, Katz and Stark concluded that *"the increase in low-ability migration relative to high-ability migration would drive down the expected wage of migrants in the destination, further discouraging high-ability migration"* (Chiswick, 2008: p. 70). To get around this, they discussed the use of 'asymmetrical information' gathered by employers from highly skilled immigrants, through work trials or related activities. They suggested that highly skilled migrants are likely to take up these offers for lower wages because given some time they will be able to prove their 'true ability' and then earn better wages. Less skilled migrants are likely to avoid such opportunities because they will not be able to demonstrate the levels of skill necessary.

From an employer's perspective, this model is critical in understanding what they value most when employing immigrants. A New Zealand study found that overall employers had *"very positive experiences in employing immigrants, and were particularly appreciative of their skills, performance, work ethic, and their richness of greater diversity"* (North, 2007: p. vi). The same study also noted that employers felt that often immigrant employees worked harder than their local counterparts, and that many employers had become dependent on an immigrant workforce to deliver their services. For employers, the greatest traits that they looked for in immigrant workers included English language proficiency, cultural and organisational fit, and New Zealand work experience and qualifications. A small New Zealand study on immigrant entry into the workforce found that recruitment agencies might be discriminating against immigrant workers with similar skill levels to native candidates (Ward & Masgoret, 2007). Comparative to international findings, Ward and Masgoret concluded that ethnicity and migrant status were strongly related to recruitment agencies and possibly employers' bias towards native-born workers and immigrants from countries with relatively similar characters to New Zealand such as Australia, Great Britain and South Africa. When recruiting immigrants from countries dissimilar to New Zealand, the challenges faced by employers include their ability to verify migrants' overseas qualifications and work experiences, employees being over-qualified which would affect retention, and whether immigrant workers might be disruptive in the workplace due to cultural differences (North, 2007). It is therefore not unreasonable to see why employers may seek work trial periods. However, in the New Zealand context, very few companies had policies directly aimed at immigrant workers (ibid). Those companies that did have such policies focused on mentoring, coaching, and training support, translating manuals and policies into different languages, and providing English language tuition. Often these types of support were offered to all employees regardless.

With globalisation and improved information technology, it is now possible for employers in host nations to better understand highly skilled migrants' work environments in home nations and thereby, eliminate the need for a trial period to ascertain skill levels (Chau & Stark, 1999). Arguably, the MCNZ's competent authority, and the list of countries with comparable systems have their roots in the 'Asymmetric Information model'; as more information on IMGs' training and work environments became available, more countries got added to MCNZ's comparable countries lists, therefore, allowing graduates from those countries some dispensation from the full registration process. Where information is not available on the quality of training and work experiences, MCNZ requests IMGs to complete all essential elements of the registration process to prove their ability to practice in New Zealand – much like the work trials discussed by Katz and Stark (1984; 1987) and Chiswick (2008). There is an economic impact on the IMGs who have to go through the full registration process, and as Katz and Stark (1984;

1987) and Chiswick (2008) have indicated, there is an expectation among the IMGs and other skilled and low-skilled migrants that they will recover some of the costs when they have proved their ability, and can demand the remuneration available to others with similar skill levels.

The Roy Model

The Roy Model (1951) is one of the most important models in economics that discusses the self-selection of occupations by some workers and thereby, such workers may gain a comparative advantage over other workers (Heckman & Taber, 2008). *“Roy’s Model was developed to explain occupational choice and its consequences for the distribution of earnings when individuals differ in their endowments of occupation-specific skills”* (Heckman & Honoré, 1990: p. 1121). George Borjas (1991) presented this as an alternative to the Human Capital model, and argued that *“if the income distribution in the sending country is more unequal than that of the United States (and the correlation in earnings is positive and strong), emigrants will be chosen from the lower tail of the income distribution in the country of origin”* (p. 552). Chiswick (2008) disagreed with this conclusion, citing that *“a larger skill differential in the origin than in the destination does not necessarily imply negative selectivity, but rather only less favourable (positive) selectivity”* (p. 72). In other words, Borjas implied that in countries where income distribution is far more unequal, highly skilled migrants with better jobs and more income may be overlooked for migration by destination countries, in favour of less skilled and lower paid migrants. This may be because the highly skilled and highly paid are not likely to consider migration anyway. Whereas Chiswick argued that despite there being more incentives for highly skilled migrants to remain in the origin country, destination countries are still likely to favourably select highly skilled migrants from those countries, even if there are fewer of them.

Chiswick’s (2008) assertions seem more plausible given the evidence from the previous models on the impact of predisposing factors in favourable selection, the propensity for migrants with high human capital to succeed in adjusting to destination countries, and the recent evidence on the recruitment or migration of IMGs from non-EU countries into Ireland and the UK (Humphries, et al., 2013). Furthermore, most receiving countries such as New Zealand look for skilled migrants who can add value to the economy immediately after arriving by working in sectors and industries that are facing workforce shortages (Masgoret, et al., 2012; Hawthorne, 2011; Hodgson & Poot, 2011; Benson-Rea & Rawlinson, 2003). This is not to say that less skilled migrants may not be needed but the emphasis of most receiving country’s migration points systems clearly show that the more skills and experience one has, the more points they are likely to get, and thereby, more chances of being selected for migration (Castles et al., 2005, 2014). Borjas does however have a point in that, countries with greater income inequities are likely to have many less skilled people self-selecting for migration,

and for destination countries in need, it will be easy to attract such migrants. However, Belot and Hatton (2008) found that often poverty in source countries constrained such immigrants from self-selecting anyway.

As noted by Jean and Associates (2007), the labour markets of the destination countries would need to find employment for less skilled migrants or they would end up being dependents of the state. Arguably, destination countries may even create segmented labour markets prior to attracting migrants with related skills. An example of this would be the seasonal worker programme designed to get Pacific people to work on New Zealand farms as noted in the New Zealand's Recognised Seasonal Employer Immigration for Pacific Nations (Ministry of Business, Innovation & Employment, 2014; New Zealand Department of Labour – Final Evaluation Report of the Recognised Seasonal Employer Policy, 2010). The growth in the manufacturing sector in the 1970s also saw an influx of Pacific people to New Zealand to fulfil the demand for labour. The seasonal worker schemes are often for temporary migration for specified periods of time. These schemes are designed to benefit both the sending and receiving countries, in the short and medium terms (ibid).

The Short-Term Migrants Model

The Short-Term Migrants model alludes to the gains and losses made in human capital by short-term economic migrants (Chiswick, 2008). Some observations made included:

- Migrants who make an investment in destination-specific human capital will experience a loss upon leaving the destination;
- The investment in origin-specific human capital would depreciate when they are absent;
- To avoid such losses in country-specific human capital, short-term migrants may invest in internationally transferable human capital; an idea that Chiswick considers incompatible in nature because short-term migrants may not get any capital gain due to the short time they spend in host nations.

The above observations align somewhat with those discussed under the 'Brain Circulation of Migrants' literature (Daugeliene & Marcinkeviciene, 2009; Williams & Balaz, 2005; Blitz, 2005). In New Zealand, the government has been funding a recruitment agency, NZLocums, which is part of the Rural General Practitioner Network (RGPN), to recruit IMGs from countries with comparable health systems, to do short periods of work in hard-to-staff rural areas. These short-term IMG sojourners are deemed to have medical skills that can be transferred easily into the New Zealand context. In contrast to Chiswick's notion that losses in country-specific human capital cannot be mitigated by

internationally transferable skills, it can be argued that the medical knowledge and skills are transferable to a great extent. In fact, there can be an appreciation of the skill levels when such migrants return to home countries. A similar observation can be made about the transfer of information technology skills given the standardisation of technology across international boundaries (Benson-Rea & Rawlinson, 2003). While there is some validity in Chiswick's assertions, they may not hold true for certain highly skilled migrants who venture to other countries for short-term work experiences, primarily due to their high levels of skill in the first instance.

In terms of New Zealand's seasonal worker scheme for Pacific nations, the aim has been that both New Zealand and Pacific nations benefit from such arrangements. For example, one of the critical success factors of New Zealand's temporary seasonal worker arrangement in relation to Fiji is that *"Fiji nationals enjoy fair access to the RSE (Regional Seasonal Employer) Immigration Instructions, fair and reasonable treatment by RSEs, adjust to New Zealand conditions, derive income and skills, have successful re-entry into their home community and heighten the prospect of return employment in New Zealand"* (RSE - Ministry of Business, Innovation & Employment, 2014: p. 3). Therefore such schemes are not only designed for short term economic gain by host nations and immigrant workers but are also designed as an opportunity for development of source countries and as a way of identifying potential permanent immigrants in the longer term.

The three predominant economic models (The Human Capital, The Asymmetrical Information and the Roy Model) discussed above are critical for understanding how migrants are selected and integrated into host nations. Higher levels of the human capital create better opportunities for immigrants to be selected by host nations because of the assumption that such types of immigrants would better integrate into the labour market and achieve economic success. However there is some evidence that economic success alone does not guarantee overall success and satisfaction in host nations. Often highly skilled migrants want adequate opportunities to further their careers as seen among the IMGs in Ireland and the UK.

Labour Market Integration of Immigrants

When attracting immigrants, countries often look for those types that are more likely to integrate into their labour markets and thereby become economically productive members of host societies (Castles, et al., 2014; Chiswick, 2008; Borjas, 1995). As noted earlier, these types of migrants are referred to as 'economic migrants', as opposed to other types such as refugees (those who are forced out of their home nations due to conflict), tied movers (those who move to be with family members) and ideological migrants (those who move for religious, political or other ideological reasons) (Chiswick, 2008). Castles and Associates

(2014) stated that *“economic migration is vital for advanced economies. Migrant workers – both highly skilled and less skilled – provide additional labour at a time of high demand resulting from economic, demographic and social shifts. They also provide special types of labour to fill gaps that native workers are incapable or unwilling to fill. Migration thus helps to maintain labour market flexibility, encouraging investment and economic growth”* (p. 261). If immigrants, especially economic immigrants fail to secure employment then they become a burden on the host nation’s welfare system, if there is one readily accessible to new immigrants (Jean, et al., 2007). In countries such as New Zealand and Australia, two of the four ‘Traditional Settlement Countries’ according to the OECD¹¹, their migration selection policies have resulted in approximately 60% of the total pool of migrants that have arrived in the past few years being skilled migrants (Hawthorne, 2011; Masgoret, et al., 2012). In comparison, historical trends show much lower rates of skilled migration into most other OECD countries but this trend is changing rapidly – for example, in France, Ireland, Belgium Luxembourg and the UK, the number of skilled migrants doubled to approximately 50% of all migrant types in recent times (Jean, et al., 2007).

As noted in the Sociology section of this literature review, the dual labour market theory divides the labour market into two main categories – the primary and secondary markets. The primary labour market provides workers with higher wages, good working conditions, employment stability and opportunities for career advancement while the secondary market tends to give workers lower wages, poor working conditions and fewer opportunities for advancement. Secondary markets may also see a higher turnover of staff (Doeringer & Piore 1971; Piore 1975; Tomaskovic-Devey 1993a, 1993b). Castles and Associates (2014) further noted that *“over the last 40 years, economic restructuring in rich countries has been linked to a new international division of labour, in which migrant workers play an important but varied role. The shift to neo-liberal economic policies has reshaped the conditions under which migrant workers are employed...formal employment within large-scale enterprises has in many cases been replaced by a variety of work arrangements that differentiate and separate workers along ethnic, class, education and gender lines...chains of subcontracting, informalization and new forms of labour market segmentation affect both native and migrant workers”* (p. 261-262). An analysis of the economic outcomes of immigrants to New Zealand, as observed through the LisNZ study, showed that nearly all types of migrants had positive labour market integration and outcomes (Masgoret, et al., 2012). Some of the findings indicated that:

- New Zealand’s skilled migration policy requirements of a job or a job offer prior to being considered for residence resulted in over 90% of such

¹¹ The other two countries in this category are Canada and USA (Bauer, et al., 2000; OCED, 2006d)

migrants immediately joining the labour market. The migrants in other categories such as business, family partner, and secondary migrants had lower rates of initial integration into the labour markets but there were significant improvements over time.

- Principal applicants in the skilled migrant category earned considerably more than migrants in other categories, again reflecting the intentions of the migration policies.
- Applicants from the Pacific category also had high labour market integration but often had lower wages than other categories of migrants. This is also a reflection of the migration policy where Pacific applicants need a job offer but it can be from a lower income threshold labour market.
- Immigrants from countries similar to New Zealand such as the UK, Ireland, Canada, USA and Australia constituted the majority of new arrivals¹², and these migrants had higher labour force participation and incomes than immigrants from other international regions. An interesting point of difference between New Zealand and Australia, being traditional countries for settlement, is that approximately 17% of all immigrants to Australia are from English-speaking backgrounds (ESB) compared to between 40-46% in New Zealand (Hawthorne, 2011; Migration data September, 2015 – Statistics New Zealand). In the mid-2000s, over half of all immigrants to New Zealand were from ESB countries but like Australia, there seems to be an emerging trend towards non-ESB source countries for future migrants to New Zealand (Internal Migration 2007 – Statistics New Zealand). This trend, in part, is actively being driven by a deliberate international student recruitment policy of transitioning some students from study to work to permanent residence. This is a labour market driven initiative of getting students from countries like India to gain educational and work skills in New Zealand to benefit and possibly develop its critical industries and sectors in the long term (Migration Trends: Key Indicators December 2014 – Ministry of Business, Innovation & Employment).
- In line with other New Zealand and international studies, the LisNZ study observed that migrants from certain minorities (North Asia) faced difficulties integrating to the labour market and therefore, tended to earn less than their counterparts from other source countries. Male migrants aged 55-64 also had very high work seeking rates. Some possible

¹² These countries are often considered similar to New Zealand because of their English-speaking background (ESB), in some instances a shared culture and ideals and in the context of this thesis, a similar health system (Hawthorne, 2011; St George, 2013)

explanations for unemployment among immigrants in New Zealand, also in line with international literature, point towards sex, category of migration, region of origin, family composition, qualifications, English language proficiency, and prior work experience.

- New Zealand work experience is a significant factor for immigrants to gain entry into the labour market. Immigrants with such experiences often have an advantage over migrants with no New Zealand experience. However, there is some evidence that this advantage only exists short term, possibly due to nearly all skilled migrants gaining entry to the labour market almost immediately upon arrival. As noted earlier, labour market integration may not necessarily mean that immigrants are doing what their pre-migration skills would enable them to do (Hawthorne, 2011). Therefore, in some instances, just focusing on labour market participation of immigrants may overshadow the fact that their skills are being underutilised in host nations. In relation to this, the LisNZ also found that qualification level was not a significant predictor of labour market participation but it did impact on the level of wages an immigrant got if their qualifications mattered in the work they did.
- When taking a closer look at labour market integration of immigrants and income, the following observations were made regarding New Zealand:
 - As expected, skilled migrants earned more than other types of migrants.
 - Migrants with higher degrees earn more than those with lesser or no qualifications. English language proficiency also increased wage rates.
 - Interestingly, in the longer term, immigrants with no New Zealand work experience earned more than those who had such experience.
 - Migrants from ESB countries earn more than their non-ESB counterparts.
 - Male migrants and those aged 35-54 earn more than other cohorts.
 - Migrants working in Wellington earn more than those in other regions.

When comparing hourly wages and returns on human capital of immigrants and New Zealand born workers, some conflicting arguments have emerged. After approximately 20 years in New Zealand, New Zealand workers earned about 10% more than immigrants with similar skills (Stillman & Velamuri, 2010; Maré & Stillman, 2009). Workers born in the Pacific, India or South-East Asia earned approximately 20% less than their equivalent New Zealand born counterpart. The authors argued that other factors such as discrimination or lower quality

networks may be affecting immigrants' earning potential. George Borjas (2013) has continued to argue since his earlier studies in the USA (1991, 1994, 2004, & 2005) that immigrants, regardless of their education and age, reduce the wages of native workers in host societies by several percentage points. From the current research, it is unclear if this is an effect of immigration to New Zealand, and one could possibly argue that immigrants are having no effect on the wages of New Zealand born workers because of the existing wage differences between the two groups.

In a conflicting but interesting assessment in the same study, Stillman and Velamuri (2010) noted that the return on human capital in New Zealand was higher for immigrants than non-immigrants. They stated that *"for each additional year of education, an immigrant worker in New Zealand earns, on average, an additional 1.7% more per hour than an equivalent New Zealand-born worker"* (p. 21). To explain why this might be the case, they state that *"this strongly suggests that immigrants to New Zealand are, on average, positively selected on unobservables. In other words, they are more motivated and ambitious than New Zealand-born workers with the same observable characteristics"* (p. 21). In comparison, the authors found little difference between immigrants and Australian-born workers' return on human capital, and where there were differences the immigrants had lower returns than their Australian counterparts.

Professional Protectionism and Labour Market Integration

While the economic literature suggests that skilled people are better at self-selecting for migration, and that many countries often want such migrants to address skills shortages, for some types of skilled migrants there can be significant barriers to entering the labour market, mainly due to additional professional hurdles and compliance issues imposed by occupational groups within host nations (Bourgeault & Grignon, 2013; OECD, 2008)). One of the main barriers imposed by occupational groups in host nations is the recognition of qualifications/credentials gained in home nations. There are several occupations where the need for credentialing is mandatory prior to professionals being allowed to work either independently or under supervision, such as for health professionals, engineers, architects, teachers, and accountants, to name a few (Hawthorne, 2013, 2015).

It is recognised that certain qualifications such as medical degrees from different countries are often not of similar quality and therefore the skills and knowledge attained through such qualifications may not be directly transferable into host nations' work environments (Hawthorne, 2015, 2013, 2007; Bourgeault & Grignon, 2013; Marques, 2012; OECD, 2008). Medicine, including nursing and allied health professions, is one of the specialist occupational areas that probably has the most rigid market entry criteria, especially for skilled migrants

(Bourgeault & Grignon, 2013; Hawthorne, 2013). While medical education is relatively standardised around the world, its applicability could be challenging if a medical practitioner does not understand the structure of the health system and the socio-cultural environment within which host societies operate (Hera J cited in St George, 2013; Hawthorne, 2013). While some of the host country's context-enhancing training may not be stated explicitly as a requirement for initial registration, it does make it almost impossible to by-pass them for initial or ongoing registration. For example, an extension of the MCNZ's mandate is conveyed through the vocational training programmes of professional bodies such as the RNZCGP. If an IMG wants to practice as a general practitioner in the long term then they have to fulfil the training requirements of the RNZCGP. According to the MCNZ, all IMGs are required to work under supervision for a specified period, and fulfil some or all of the requirements of their scopes of practice should they want to remain and work in New Zealand. For IMGs and other skilled migrants, some of these requirements pose significant barriers to entry into their pre-migration careers. Some economists and migration policy experts consider such measures by occupational registration authorities and associated professional bodies as professional protectionism and anti-labour market. While there is some validity to such arguments by economists and other migration experts, the registration authorities also present a compelling case.

Medical registration bodies such as the Medical Councils of OECD countries argue that such rigid regulation of the profession is necessary to keep the public safe from incompetent practitioners (Bourgeault & Grignon, 2013; MCNZ Annual Report, 2014). As such, medical registration bodies are often governed directly by respective legislation – in the case of New Zealand, it is the Health Practitioner Competence Assurance Act 2003 (HPCAA, 2003). This Act allows the MCNZ to undertake certain mandatory activities to ensure the public are safe from harm by incompetent doctors, and that the standards of practice for the profession are adhered to by all its registered members. Therefore, the MCNZ for example, has the full authority to scrutinise international medical graduates' (IMG) qualifications, work experiences, and any criminal history to determine eligibility to practice medicine competently. After registration, the professional practise standards apply to all doctors regardless of where they have initially trained.

The case for such comprehensive checks and balances found renewed support when medical practitioners such as Drs Harold Shipman (UK) and Jayant Patel (Australia) went undetected for serious malpractice by the regulatory bodies in their respective jurisdictions (Alsop & Saks, 2002; Royal Australasian College of Medical Administrators (RACMA), 2011). However, there is concern whether the medical profession has gone too far with its regulations and thereby might be serving purposes other than keeping the public safe. Bourgeault and Grignon (2013) noted that the *“changes to professional regulation in health care seem to be more*

structural and motivated by deeper social, political and economic considerations” (p. 199).

One of the consequences of an increase in medical regulation has seen the number of complaints against doctors’ rise. Williams and Lees (2015) found that since 2010, there was a 63% increase in the number of complaints against doctors received by the General Medical Council (GMC - UK). This was approximately equivalent to one in 28 licensed doctors being cited for misconduct of some sort. Their analysis also found that in total only 17% of all complaints investigated led to a sanction or warning; these sanctioned doctors were less than 5% of the total number of doctors who have incurred a complaint. In an Australian and New Zealand comparative study, the authors noted that 65% of cases that went to the respective tribunals for investigation involved GPs (Elkin et al., 2012, 2011). This study only included the cases that went to tribunals for further investigation once there was evidence that the doctors had a case to answer. Of the approximately 17,000 doctors in New Zealand, this study included cases for 71 doctors who were disciplined (<1% of all doctors). The study concluded that doctors were often removed from the medical register due to behaviour flaws that led to unprofessional conduct towards patients rather than failings in the delivery of medical care. Another study in Australia found that IMGs were more likely than locally-trained to get complaints (Elkin, et al., 2012).

In one respect the outcomes of the tribunal work is good for the public safety argument but on the other hand the toll it takes on all the other doctors who receive a complaint about their practice can be severe. Bourne and Associates (2015), who undertook an important study looking at the impact of complaints on doctors in the UK, found that the majority were likely to suffer from moderate to severe depression as a result of the complaints investigation process and the risk of self-harm and anxiety doubled. These mental conditions led to an increase in other illnesses such as cardiovascular and gastrointestinal disorders and other behavioural issues such as anger, relationship problems and sleep difficulties.

While Bourne and Associates (2015) could not show causation, they did state that *“it is possible that doctors with depression, anxiety and suicidal ideation are more likely to have complaints made against them, similarly, being complained against may be the causative factor rather than the processes themselves”* (p. 10). The authors also found that the increased health implications of the disciplinary process were disproportionate given that *“the vast majority of doctors who were referred to the GMC are found to have no significant case to answer”* (p. 11). The doctors in the Bourne study reported that as a result of going through a complaint investigation they tended increasingly practise defensive medicine – more referrals to other specialists, ordering more tests, and prescribing more medication. Defensive practice is concerning and is *“not in the interest of patients and may cause harm, while they may also potentially increase the costs of healthcare provision”* (p. 11). Williams

and Lee (2015) further argued whether the regulators, politicians and media are unjustifiably using the need for more medical regulation to include a new role of 'promoting and maintaining public confidence in the medical profession' when there does not seem to be the need for one. They rightly argue that the medical profession is consistently rated as one of the most trusted by the public and therefore, more regulation will only make for more unwarranted complaints against doctors.

Taking a very different angle on the regulation of the medical profession, sociologists and economists have argued that the use of the term 'profession' denotes a system of self-governance, restricted recruitment, legal sanctions for a professional domain, social closure leading to monopolisation of opportunities which eventually lead to higher rewards and privileges when compared to other types of workers (Johnson, 1972; Parry & Parry, 1976; Parkin, 1979; Saks, 1983; Brante, 1988; Bourgeault & Grignon, 2015). From a market theory perspective, economists see the dominance of the medical profession as *"motivated by self-interest of members of the profession rather than social welfare: professions are described as anomalies of regulation, remnants of the pre-capitalist past of the guilds that professions managed to keep alive due to the capture of the regulator"* (Bourgeault & Grignon, 2015: p. 202). Such types of professional protectionism do not sit within the labour market model where competition is one of the key cornerstones for consumer choice. From among nearly all the 'professional' occupations, the medical/health profession is possibly among the very few, if not the only one, that is not subjected to market forces when viewed from the lens of competition and pure consumer choice. For example, even architects and engineers are subjected to market forces despite being subjected to some forms of professional protectionism (Hawthorne, 2013; Bourgeault & Grignon, 2015).

Therefore, medical/health professionals through licensure and self-regulation are allowed *"to by-pass the market and extract a 'rent' from consumers: Doctors and nurses earn more than what their human capital should allow them to earn if they were not protected by professional licensure and regulation (known as the wage premium of health professions)"* (Bourgeault & Grignon, 2015: p. 202). However, such arguments were challenged in the context that what health professionals 'sell' needs to be justified through licensure, scope of practice, and institutional protection so as to not expose the public to harm (Arrow, 1963). The concept of asymmetrical information is used to justify the professional protectionism of the medical/health practitioners. It is argued that health professionals sell information and this information could be resold at discounted rates if it were open to competition from non-professionals. Therefore one of the key reasons for professional protectionism through licensing systems is to control who can sell this information as it could cause harm to the public if anyone were allowed to do so. Bourgeault and Grignon (2015) succinctly stated that *"licensure is also meant to protect the customers/users: because second-hand resellers cannot be trusted and the*

value of what professions sell cannot be assessed with certainty, customers would be at the mercy of medical imposters" (p. 203). Further to this, members of the profession are disciplined if their practice goes beyond the scope of their licensure; this is a key reason for the level of trust the public has in medical/health professionals.

Another argument for the health profession sitting outside the competitive labour market model is the not-for-profit environment they operate in (Pauly & Redisch, 1973). Even where health professionals work in for-profit hospitals, they still have far more autonomy to act as needed due to the type of work they do; this level of autonomy is often not allowed for other types of professionals within the same environment such as lawyers and professional managers (Pauly, 1988; Bourgeault & Grignon, 2015). The wages or fees that health professionals earn are also based on a slightly different model than would be expected in a competitive setting. *"It is impossible to infer the value of their [health professionals] service from the outcome. The patient may die through no fault of the doctor or nurse, and survive without any real input from them. As a result, they are not paid on the basis of the value of what they produce (since it is impossible to tell) but rather on a conventional, socially agreed upon fee"* (Bourgeault & Grignon, 2015: p. 205). In New Zealand the government subsidises the fees that GPs charge their patients. Those general practices/Primary healthcare Organisations (PHOs) that receive a government subsidy need to seek permission from the government before increasing their co-payment fees over and above the set percentage.

Despite the good arguments made for strict professional regulations to govern the health profession, many commentators argue that more could be done to reduce some of the social closure that pervades the medical profession. The main areas of contention are the recognition of foreign qualifications and the licensing of skilled migrant workers in host nations. Hawthorne (2013) has rightfully stated that *"flexible systems for recognizing foreign qualifications are highly attractive to multiple stakeholders...new and superior qualification recognition systems are undoubtedly required...more agile credentialing systems should be informed by input from government, industry, regulatory bodies and transnational organizations. This is needed to meet the three major challenges of modern credential recognition: accommodating contemporary migration modes, upholding public safety and standards, and ensuring that migrants use, rather than waste, their skills"* (pp.13-14). While New Zealand and other OECD countries recognise the medical qualifications from a number of countries, this may not be flexible and comprehensive enough to cater for the increased flow of migrants from unrecognised countries. A global qualification recognition system may allow for better accreditation of immigrants prior to them migrating and thereby, reducing the chances of skill wastage or underutilisation in host nations, post-migration.

Migration and the Economic Impact on Sending and Receiving Countries

Depending on the sending country's economic status, the migration of its people can be either positive or negative. In most economics literature on migration, often sending countries suffer a 'brain drain' i.e. the loss of the brightest and smartest people from their country (Siyam & Poz, 2014; Taylor, 2006; Chaloff & Lemaître, 2009; OECD, 2008; Gaston & Nelson, 2013; Oberoi & Lin, 2006; Guzder, 2007). This can be devastating for poorer, developing countries, as it directly affects their ability to develop economically (Siyam & Poz, 2014; Taylor, 2006). However, recent studies have further blurred the true impact of international migration on sending countries.

New studies (Kapur, 2010; Batista, et al., 2012; OECD, 2008; Taylor, 2006) found that many developing countries are actually benefitting from the 'brain drain' through remittances sent home by migrants, the wealth of knowledge from return migrants assisting with development, and that international migration has actually spurred the remaining citizens to get better education which they can either use for migrating or for local development. According to the World Bank (2011), immigrant workers remitted over \$370 billion to their home nations; for some nations remittance can be as much as 20% of their GDP (Gross Domestic Product).

The studies in the context of brain circulation of migrants have argued that certain highly skilled migrants and other migrants in general, after a period of time in another country, return to their homes bringing in more skills and knowledge than they previously possessed (Daugeliene & Marcinkeviciene, 2009; OECD, 2008). This type of skill transfer and gain for sending countries would depend on migrants wanting to return home. There are several studies that show that migrants are generally reluctant returnees (Blitz, 2005; Connell, 2009).

Interestingly, among OECD countries, New Zealand has the worst brain-drain of skilled people (Gibson & McKenzie, 2010). The skilled New Zealanders migration rate is nearly 10 times that of Australia; the out-migrants are likely to earn nearly double than they earn at home; and for every out-migrant, New Zealand's fiscal loss per highly skilled migrant is approximately US\$10,000. The Medical Council of New Zealand (MCNZ) noted that, 10 years post-registration, a third of New Zealand-trained doctors go overseas, validating the findings of Gibson and McKenzie (MCNZ –Workforce Statistics, 2012). Furthermore, as noted earlier, the majority of IMGs who come to New Zealand (65%) leave for another country within two years of post-registration. Overall though, New Zealand has seen a positive net migration since 2002, meaning that new migrants were readily replacing the New Zealanders who had gone overseas. In the last decade, new migrants came mostly from the UK, India, China, Philippines, Germany, South Africa and Fiji (Statistics NZ, 2012).

In relation to the recent global economic crisis, the WHO noted that the crisis did not have a significant effect on the levels of health workforce migration (Siyam & Poz, 2014). This report further noted that *“although foreign-trained doctors and nurses make up a significant share of the health workforce in the major English-speaking destinations, these flows seem have not been strongly affected by the global economic crisis and are expected to remain strong in coming decades as aging populations increase demand for health services”* (p. 198). The authors concluded that there is still a need for cooperation among all nations to see that knowledge and research continues to inform workforce planning, policy development and the strengthening of the health systems for countries most in need. To facilitate this, WHO has proposed a ‘Code of Practice on the International Recruitment of Health Professionals’ to better understand and guide countries that recruit substantial numbers of migrant health professionals. Unfortunately, New Zealand has not completed the WHO National Reporting Instrument (NRI) to gauge whether its policies meet the ethical norms for recruiting health professionals. The OECD is also supportive of the ethical management of immigrant health professionals and does advocate that it members ought to reduce reliance on immigrant health professionals from poorer countries by improving health workforce planning and training more of their own people to meet future demand (OECD, 2008).

Beyond the migration process, it is important to understand what types of impact migrants have on receiving countries. There have been arguments that immigrants, for the most part, negatively affect the labour markets and the opportunities of receiving country employees. However, extensive research has shown that this is inaccurate to the extent that migration is mostly a positive economic experience for receiving countries (Gaston & Nelson, 2011; Rutten, 2009; Trade Union Congress (UK), 2007; Longhi, et al., 2006). It has been empirically proven that many host nations gain from migration even though there is debate about the size of the gain (Hodgson & Poot, 2010; Masgoret, et al., 2012). Additionally it has been noted that immigrants do not harm the wage and employment opportunities of host employees even though there may be short term negative consequences for migrants; that labour migration can positively affect trade and they can complement each other; and that migrants also pay more in taxes than the value of public services they receive or use (Longhi, et al., 2006). There is some anecdotal evidence that in New Zealand, some migrant groups under-utilise the public health services including the treatment provisions of the ACC scheme. Some migrants do not qualify for certain public services but the ACC scheme is available to anyone who gets injured in New Zealand, including tourists. While generally most migrants have positive experiences, there have been cases of exploitation and social exclusion by host nationals (Shelley, 2007). Additionally, as seen in the socio-anthropological studies, migrants themselves can be the perpetrators of exploitation of other migrants in host nations (Kwong, 1997).

Migrants do provide host nations with certain opportunities to further develop economically and socially. In the New Zealand context, migrants have reduced workforce shortages in some sectors like IT and medicine (Benson-Rea & Rawlinson, 2003; Tharmaseelan, et al., 2010; Coates & Carr, 2005). The various diaspora in New Zealand have introduced new commodities that have led to increased trade in items previously not found here such as cooking spices, traditional delicacies, ethnic clothing and jewellery, ethnic entertainment and movie-making opportunities such as those from Bollywood, and the introduction of ethnic festivities such as the Chinese New Year. Some migrant groups have also facilitated the opening up of new destinations for travel enthusiasts by creating demand for direct flights to and from their home nations.

As in most host nations, migrants have also challenged New Zealand society with their perceived lack of the 'New Zealand way of life', their lack of proficiency in the English language, their inability to adapt and integrate, and sometimes their inability to appreciate the diversity inherent in this society (Mpofu & Hocking, 2013; Benson-Rea & Rawlinson, 2003; Tharmaseelan, et al., 2010; Coates & Carr, 2005). In a study on attitudes towards immigrants, it was noted that hosts living in places that had a greater concentration of immigrants (Auckland) were more likely to perceive greater threat than people living in areas with less concentration of immigrants (Wellington and Christchurch) (Ward, et al., 2011). International literature suggests that when hosts perceive threats from immigrants they adopt strategies that minimize competition with immigrants (Esses, et al., 1998, 2001; Rustenbach, 2010; Stephen, et al., 2005; Palmer, 1996). The strategies used by the hosts often create a very unfavourable environment for immigrants to integrate into. However, the sum of the parts, like the economic literature suggests that migration has benefited New Zealand (Masgoret et al., 2012). Additionally, attitudes towards immigrants are generally positive, and immigrants have reported fewer incidences of discrimination and high levels of satisfaction with life in New Zealand (Ward, et al., 2011).

Overall, contrary to international evidence regarding many OECD countries, New Zealand seems to achieve relatively good integration of immigrants into its labour markets (Masgoret, et al., 2012; Hawthorne, 2011; Stillman & Velamuri, 2010; Hodgson & Poot, 2010; Maré & Stillman, 2009; Jean et al., 2007). As many of these studies have noted, the successful integration of immigrants into the different labour market segments can be attributed to the immigration policies that have been implemented. Hodgson and Poot (2010) concluded that *"immigration has made a positive contribution to economic outcomes in New Zealand and that fears for negative economic impact such as net fiscal costs, house price inflation, lower wages, and increasing unemployment find very little support in the available empirical evidence. Moreover, the economic integration of immigrants is broadly successful. Once migrants are in New Zealand for more than 10-15 years, their labour market outcomes are predominantly determined by the same success factors as those for*

the New Zealand born" (p. viii). It is possible that one of the reasons for good labour market outcomes for New Zealand regarding immigrants is due the fact that most immigrants are skilled, mature and have good English language skills (Hawthorne, 2011; Masgoret et al., 2012; Plumridge, et al., 2012). Another important distinction for positive integration of immigrants, both economically and socially, into New Zealand is the implementation of 'planned immigration policies'. Castles and Associates (2014) observed that "*planned entries are conducive to acceptable social conditions for migrants as well as to relative social peace between migrants and local people. Countries with immigration quota systems generally decide on them through political processes which permit public discussion and the balancing of the interests of different social groups...this approach facilitates the introduction of measures to prevent discrimination and exploitation of immigrants, and to provide social services to support successful settlement*" (p. 326). A recent case-in-point for this has been the political and public discussion and the subsequent increase in the quota for Syrian refugees coming into New Zealand over the next three years (Dougan & Trevett, 2015). This planned approach is to prepare New Zealand to meet the needs of these refugees when they arrive here.

The following section discusses and sheds more light on the experiences of highly skilled immigrants. In the last decade there has been a growing interest in the experiences of highly skilled migrants in adjusting to new countries. Essentially the main question is whether the migration experiences of the highly skilled are any different from those of not-so-skilled migrants, and if so, then what are these differences?

2.3.4 The Adaptation of Highly Skilled Migrants

The migration of highly skilled professionals has increased significantly over the last few decades and poses certain challenges for the migrants themselves and the receiving countries. Some of these challenges include adequately accommodating highly skilled migrants for short-term work to protect local labour markets (Iredale, 2001), providing appropriate work for such migrants to utilise their skills (Zikic, et. at., 2010; Benson-Rea & Rawlinson, 2003; Tharmaseelan, et al., 2010; Coates & Carr, 2005), and providing support to assist settlement and adjustment to new environments (Tharmaseelan, et al., 2010; Mace, et al., 2005; IOM, 2008).

In previous discussions looking at the sociological, anthropological and economics literature, there is evidence to suggest that many highly skilled migrants have good occupations and lifestyles in their home countries, and therefore could possibly be seen as reluctant migrants when compared to other types of migrants such as the less skilled and refugees. Studies have shown that the highly skilled such as IMGs can become disenchanted quickly when they face significant barriers in host nations to achieving similar occupational status as in their home nations (Mpofu & Hocking, 2013; Humphries, et al., 2013; Neiterman

& Bourgeault, 2012; Mace, et al., 2005; Coates & Carr, 2005; Iredale, 2001). However, some studies have also shown that IMGs as highly skilled migrants can be reluctant returnees when dissatisfied (Connell, 2009; Maron & Connell, 2008). In the New Zealand context, Tharmaseelan and Associates (2010) found that after an average of six years in their country of choice, migrants' careers declined rather than advanced. This was mainly because host countries were not utilising the skills migrants brought with them which saw *"immigrants with high-level academic and professional qualifications forced to stack supermarket shelves or deliver junk mail because they can find nothing better"* (p. 232). Mpofu and Hocking (2013) also found similar trends among migrants who once were doctors. This supports the notion that not all tertiary qualifications have the same value and therefore, prior education may not be an automatic prerequisite to career success in new countries.

There are other factors that have an impact on career success in host nations such as the availability of relevant work, the socio-cultural perspectives that hosts have regarding certain immigrants, and the immigrants' own preparedness to adapt and adjust to new environments. In theory, as suggested by economists, the highly skilled are attractive migrants for their human capital; however studies have shown that local labour markets can exhibit many forms of bias in the selection of certain migrants for employment. Some employers did not hire certain immigrants because they had negative stereotypes of people from some lower-income countries (Mattoo, et al., 2008; Tharmaseelan, et al., 2010). These can also be seen with certain occupational authorities that do not recognise qualifications from certain countries due to a lack of information on the quality of training received (Mattoo, et al., 2008). Arguably, this is unjustifiable given that a country's migration policies and regulations permit the entry of migrants from such countries but the internal authorities create hurdles that are often unknown pre-migration, especially among those who come voluntarily. Perhaps it would be better for these potential migrants to be left in their home countries where they would have a better chance of success or the labour market regulators in host nations should better inform immigration policies and selection processes to avoid 'brain waste' by under-utilising the skills of qualified migrants. Refugees especially have been known to suffer disproportionately given their reasons for migration, and their lack of contact with home nations, from their inability to properly verify their pre-migration occupational status. Refugees' interactions with government agencies and other important professional institutions can be very challenging when trying to resurrect previous career pathways (Castles, et al., 2014; Mpofu & Hocking, 2013; Healy & Oikelome, 2011).

While some host nations can better utilise highly skilled migrants, research suggests that migrants themselves should manage their careers to better utilise the opportunities they are provided with, especially in the face of adversity (Tharmaseelan, et al., 2010). In some sociological and anthropological studies

discussed earlier, migrants of certain ethnicities who returned home to live and work again were regarded as failures (Heisler, 2008). A similar argument can be linked to the highly skilled who would be very reluctant to return home to their old jobs as this would be seen as sign of failure. Some anecdotal evidence is available from many host nations that migrants would rather drive a taxi or work in a supermarket than return home (Mattoo, et al., 2008). In New Zealand, it was found that many professionals had taken up lower-skilled jobs even after doing some occupational training (Williamson, 2000).

The following section discusses what could make highly skilled immigrants successful in another country. There have been a number of studies that have clearly articulated what these attributes might be and how these set the highly skilled apart from the rest of the migrant types. It has been stated that highly educated people have more secular and open world views (Kalmijn, 2006), and that they are likely to face less class and attitudinal discrimination from natives (Fokkema & de Haas, 2011). These covert factors possibly increase the migration chances for the highly skilled when compared to other types of migrants.

The Predisposition of Highly Skilled Migrants

Predisposition refers to the human capital highly skilled migrants possess prior to migration. All studies on this topic alluded to three critical attributes: formal tertiary education, relevant work skills and appropriate work experience (Fokkema & de Haas, 2011; Zikic, et al., 2010; Ariss, 2009; Mattoo, et al., 2008; Tharmaseelan, et al., 2010; Iredale, 2001; Coates & Carr, 2005; Benson-Rea & Rawlinson, 2003; Mace, et al., 2005). Furthermore, the predisposing attributes have to be of good quality which can correlate with occupational success (Mattoo, et al., 2008).

Fokkema and de Haas (2011) in studying the experiences of Africans migrating to Italy and Spain identified five factors that could predispose immigrants towards achieving occupational and acculturative success in host nations – (1) level of education, (2) the reason for migration, (3) appropriate information about host nations, (4) the age at the time of migration and (5) prior migration/overseas experience. The level of education is the primary factor for pre- and post-migration success. One of the key indicators of quality in education, especially among immigrants of non-western origin, is the ability to communicate in English (Mattoo, et al., 2008; Tharmaseelan, et al., 2010). Immigrants who had their tertiary education in the English language have an added advantage in the selection process for migration and later employment (Coates & Carr, 2005). However, Mattoo and Associates (2008) noted that the quality of education is adversely affected when there is conflict in home nations, and also when host employers have negative perceptions of or a lack of information on immigrants' occupational capabilities from such nations (Tharmaseelan, et al., 2010; Katz and

Stark, 1984, 1987) in the Asymmetric Information Model. Some of the above challenges were also noted from refugee 'doctors' in New Zealand (Mpofu & Hocking, 2013).

The reasons for migration can also have an impact on migrants' success in a new country (Fokkema & de Haas, 2011). While economic reasons are predominant amongst most migrants, conflict is also a factor for some having to move. If the reason for migration is economic in nature, then the chances of occupational success in host nations are enhanced. Interestingly, Fokkema and de Haas found that *"the degree of social integration is particularly low when financial needs or improving the working conditions were the main migration motives"* (p. 27). This contradicts notions that immigrants who come for work and wealth creation have to interact with hosts thereby facilitating social integration. However, Fokkema and de Haas's findings are more supportive of the ethnic enclave type of network interactions, as suggested in sociological and anthropological literature (Heisler, 2008). Ethnic enclaves can provide employment for their ethnic migrants as well as shield them from the rest of society, thereby limiting social integration into host societies. However, it is unclear whether highly skilled migrants who succeed in getting work in their area of expertise would consider such segregation. Neiterman and Bourgeault's (2012) study of IMGs in Canada supports some of the notions about the lack of social integration by some highly skilled migrants, especially when social and professional institutions hindered their process of career development and progression.

The level of information a person has prior to migration has become a very important determinant of success (Fokkema & de Haas, 2011; Mpofu & Hocking, 2013). Often the lack of information from the host nation can make it difficult for the immigrant to gain any useful insights pre-migration. The sources of information can be formal (mass media including formal publications) or informal (personal contacts). In their study of highly skilled business migrants to New Zealand, Benson-Rea and Rawlinson (2003) found that migrants had difficulty in finding relevant information on business and employment opportunities before migrating which had affected migrants' expectations of settlement and the reality of the migration process. Furthermore, they found that migrants had very little information at the 'meso' level - the level at which local companies, immigration agents, business firms and trade bodies operate in New Zealand. For example when listening to stories from taxi drivers who 'once were doctors' or other professionals, it is this lack of information from the 'meso level' that created challenges for them when they got here (Mpofu & Hocking, 2013). Receiving countries that actively seek migrants have an ethical obligation to provide the most accurate information so that they are not complicit in 'brain waste'.

The age of the migrants at the time of migration is a critical factor due to the fact that the younger migrants can accumulate more migration points, especially among skilled migrants (Fokkema & de Haas, 2011). While the impact of age on highly skilled migrants has not been extensively researched, there is evidence that international student programmes in various receiving countries, such as New Zealand, are designed specifically to attract and retain young migrants to accommodate a rapidly ageing population (International Organisation for Migration – World Migration, 2008, 2009). In New Zealand, a Department of Labour report on foreign students (2007) noted that *“New Zealand, along with many other host countries, has developed immigration policies aimed to attract and retain international students. New Zealand has introduced a range of policies that make it easier for international students to work during and after completing their studies, as well as recognising the value of their New Zealand qualifications if they choose to apply for residence as a skilled migrant”* (p. 6). The majority of the students coming to New Zealand are from Asia - India and China.

Additionally, in terms of occupational and settlement success, highly skilled younger migrants¹³, as economic migrants, would have the fortitude to better adjust to the work and social environments. However, they may also be mobile enough to move to other countries should their needs not be met by host nations. For example, the overall retention of IMGs in New Zealand post-registration is very poor; just below 20% of all < 29 year old IMGs remain in New Zealand (MCNZ, 2011). Ironically, older IMGs (60+) have even poorer retention rates, possibly due to similar reasons as the younger IMGs. However, this would need to be explored further. Additionally, while the retention rates for other age cohorts are not good either, there is strong evidence that IMGs between the ages of 30-50 years, from Asian countries, are more likely to remain in New Zealand, and therefore are likely to be targeted for migration purposes. Fokkema and de Haas (2011) observed through their study that *“immigrants who were well-educated and well-informed prior to migration, and who accumulated migration experience at relatively young age, tend to achieve higher levels of social integration”* (p. 33). The Human Capital theory predicts greater success for younger migrants as they would have longer periods to reap the returns of their migration decision (Hercog, 2008).

Prior overseas experience, other than work experience in home nations, was also a good predictor of occupational and settlement success (Fokkema & de Haas, 2011; Tharmaseelan, et al., 2010). It is assumed that work and life experience in

¹³ It is difficult to define what age range is appropriate to designate as ‘young’ given that people are living longer, working for longer and having families later. For the purpose of this study 20-55 years can be considered ‘young’ based on productive years of working life left ahead. This is based on guidance provided by Immigration NZ for the ‘Skilled Migration Category’.

other countries further develop the human capital that would be useful in the migration process. However, it can also be argued that migrants who show tendencies for frequent migration may not remain in their present country of choice for any longer than they deem necessary. Transnationalism would suggest that these types of migrants do not belong to any country specifically but will most likely call a number of destinations their home, based on their motivations for being there (Heisler, 2008).

The experiences of non-EU IMGs in Ireland are testimony to the highly skilled migrants' desire to move to other destinations where they are likely to gain more career success (Humphries, et al., 2013). Migrants who travel to their destination countries for holidays or business trips prior to migration may have a better chance of obtaining occupational and settlement success, mainly because prior visits inform them about what may lie ahead in host nations.

In addition to the five pre-migration factors identified by Fokkema and de Haas (2011), motivation to succeed is also a predictor of success but its impact on individual migrants can be limited if the other pre-migration factors have not been adequately met (Tharmaseelan, 2010; Mace, et al., 2005). Furthermore, high levels of pre-migration motivation could easily be depleted should the initial experiences in host nations be negative (Zikic, et al., 2010; Mpofu & Hocking, 2013; Hercog, 2008). Similarly, having family or friends in host nations may assist with the migration processes but it is unclear whether it would also have a similar impact on occupational and acculturative success. For less skilled migrants, having contacts in host nations can be both beneficial and dangerous, as seen in sociological and anthropological studies where migrants are exploited by other migrants and hosts (Kwong, 1997; Heisler, 2008; Shelley, 2007). Interestingly, it has also been noted that migrants with a similar socio-cultural background to host societies have better occupational and acculturative success (Coates & Carr, 2005). It is assumed that people with a similar cultural heritage and language would integrate easily and therefore, that would lead to more favourable migration and occupational outcomes.

Together with having a solid predisposition, migrants need to do the right things in host nations to achieve occupational and integrative success. The following section will discuss the post-migration factors that are likely to predict success or failure of highly skilled migrants in host nations.

Post-Migration Factors Affecting Highly Skilled Migrants

Managing post-migration factors can be challenging and difficult, especially for migrants unfamiliar with new environments, and their inherent processes and institutions (Tharmaseelan, et al., 2010). The post-migration challenges can be exacerbated if the information seeking behaviour of migrants is inadequate or if host nations do not make available the information necessary for good decision-making, pre-migration (Benson-Rea & Rawlinson, 2003). However, once in their country of choice, migrants have to deal with whatever is deemed necessary to facilitate full employment and satisfactory settlement.

Zikic and Associates (2010), in a study of qualified immigrants in Canada, France and Spain, proposed three career orientations (Embracing, Adaptive and Resisting) that typified occupational and integration success. They suggested from their study that the qualified immigrants who 'embraced' and 'adapted' to host environments were able to successfully navigate six post-migration elements:

1. 'Maintain their motivation' to succeed despite facing many hurdles;
2. 'Manage their identity' throughout the migration experience;
3. 'Develop new credentials' by re-training and re-establishing their careers;
4. 'Develop local knowledge' of how things are done;
5. 'Build social networks' to gain support and develop relationships to enhance career opportunities; and
6. 'Evaluate their career success' by judging whether they were satisfied with their occupation and life in general.

While these attributes may be found among all types of migrants, highly skilled immigrants with their higher levels of human capital, and an economic reason to migrate, may have better chances of achieving success, and thereby may portray the positivity as shown by immigrants in Zikic's study. However, there are studies (Tharmaseelan, et al., 2010; Mattoo, et al., 2008, 2012; Benson-Rea & Rawlinson, 2003; Mpofu & Hocking, 2013; Humphries, et al., 2013) that show that some professionals such as IMGs just do not achieve the level of success that they had envisioned. Not surprising however, is that some unsuccessful highly skilled migrants would rather remain in host nations doing better paid less skilled work than return home to their previous employment (Mattoo, et al., 2012). This behaviour could support the sociological findings associated with failure and shame that some return-migrants encounter. Some migrants such as refugees do not have the opportunity to return home, at least not while their home nations remain in conflict situations.

Maintaining one's own identity was also a critical factor for occupational and acculturative success. Zikic's findings showed that while qualified immigrants wanted to maintain their own cultural beliefs and behaviours, they also wanted

to interact and learn more about the host nation. These sentiments are consistent with many sociological and anthropological findings that integration is the preferred adaptation strategy, where immigrants have the ability to maintain their own identities as well as adopt some of the host nation's identities (Heisler, 2008). The Muslim IMGs in the USA reported having to regain and reassert their own identities in the aftermath of 9/11, and used their occupational success as physicians to demonstrate their contribution and belongingness to American society (Laird, et al., 2013).

Likewise, maintaining one's own identity is linked to two other post-migration factors - 'developing local know-how' and 'developing social networks' (Zikic, et al., 2010). In the latter factor, there are two further levels of sub-factors, namely intra-ethnic and inter-ethnic social networks. Each of these types of networks requires the migrant to maintain their identity, one as an insider and the other as an outsider/foreigner, respectively. Additionally, if migrants are able to successfully interact at both these levels (intra and inter) then they are likely to develop knowledge of host nation values, beliefs and behaviours. For highly skilled migrants, it can be assumed that their predispositions would allow them to successfully navigate these elements. However, where there may be a lack of intra-ethnic networks, highly skilled migrants may struggle just like their less skilled counterparts to get the necessary support and guidance. Neiterman and Bourgeault (2012) found that IMGs from different backgrounds in Canada, who did not have ethnic communities to link to, created a professional Diaspora of their own to facilitate their integration into Canadian society.

For highly skilled migrants, their ability to develop new credentials is possibly the most important for occupational and integrative success. Zikic and Associates (2010) noted that many qualified immigrants in their study had to re-train or update their education in order to get employment. The re-training or upgrading of necessary skills is a constant theme across most studies on highly skilled migrants and IMGs (Benson-Rea & Rawlinson, 2003; Tharmaseelan, et al., 2010; Coates & Carr, 2005; Mpofu & Hocking, 2013; Harris, 2013; Harvey, 2011; Connell, 2009; Blitz, 2005; Prescott & Nichter, 2014; Raghuram, et al., 2010; Hatzidimitriadou & Psinos, 2014). No matter how highly skilled migrants are, there will always be subtle differences in host nations that will need to be learnt, to facilitate proper occupational integration. In the context of IMGs, New Zealand presents many challenges that are unique and therefore, cannot be fully understood without structured training.

Furthermore, Fokkema and de Haas (2011) noted that the pre-migration tertiary training of some highly skilled immigrants is not of the quality required by host nations and therefore, additional education is needed, a notion that has been challenged because of the burden it places on new immigrants (Mpofu & Hocking, 2013). While the request for additional training may be deemed

acceptable by host institutions, anecdotal evidence suggests that for some migrants, especially those with families to support and limited financial resources, the burden to complete such training is often too great (Mpofu & Hocking, 2013; Neiterman & Bourgeault, 2012; Hatzidimitriadou & Psinos, 2014). For such migrants, alternative employment opportunities with no further training requirements become their only option. This is supported by Zikic's 'Resisting' career orientation, where *"the objective barriers [institutional re-certification requirements] not only prevented them [qualified immigrants] from finding satisfactory employment and pursuing successful careers, they also led to psychological problems and adaptation difficulties for themselves and their families"* (p. 678). This is supported by the findings on refugee and other IMGs in New Zealand (Mpofu & Hocking, 2013). Furthermore, it has been shown that such migrants use their career capital to find other employment that may compensate for the loss of their professional identity but at the same time allow them to earn sufficient income to progress in host nations (Fokkema & de Haas, 2011; King, et al., 2005).

Having the ability to evaluate their occupational success in host nations is an interesting way for migrants to consider whether they have integrated into society. Migrants' ability to negotiate the subjective and objective barriers of a host society is linked to their occupational and existential satisfaction in host nations. Ironically, it has been shown that fulltime employment, especially in alternative sectors to immigrants' areas of expertise, did not bring full occupational or acculturative satisfaction (Fokkema & de Haas, 2011; Zikic, et al., 2010; Tharmaseelan, et al., 2010; Mpofu & Hocking, 2013). Even in the context of IMGs in the UK, who were working as doctors, and had relatively high incomes when compared to local graduates, reported lower levels of occupational satisfaction and morale (Humphries, et al., 2014; Healy & Oikelome, 2011). The very concept of measuring satisfaction can be difficult given that it will mean different things to different migrants. Additionally, migrants could be either satisfied or dissatisfied for other reasons such as being able to achieve career progression, or finding suitable partners and getting married, or experiencing tragedy through natural disasters, arguably all of which could have happened had they stayed home.

In addition to Zikic and Associates' six post-migration success factors, Fokkema and Haas (2011) proposed several more. They asserted from their study of Africans in Europe that current occupational status affected social integration where the higher the occupational status the more positive the social integration outcomes. Additionally, the longer the length of stay in the host nation the more positive the outcomes can be for social integration. Also, where migrants show a tendency for further migration the less likely they are to socially integrate. There has been anecdotal evidence of the latter in New Zealand, in relation to many South African immigrants using New Zealand as a stepping stone to Australia because they could not enter directly.

The three success factors of integration (Fokkema & Haas, 2011) also have reverse causality supported by other sociological and anthropological studies discussed previously, that if occupational status is less than favourable, and if length of stay is short, and if migrants consider further migration then social integration can be difficult. Conversely, difficulties in social integration itself could force migrants to consider other destinations for better employment opportunities and therefore, shorten the time spent in host nations.

The following section focuses on cross-cultural adaptation theories and models which have their roots in the social sciences, psychology and intercultural communication literature. There are synergies with what has been discussed previously.

2.4 Cross-Cultural Adaptation

Generally, individuals crossing cultures struggle to cope with feelings of inadequacy and frustration in their new environment, and react in several ways such as resisting change and fighting for their old ways, or trying to 'go native' and living with an acute sense of failure and despair, or shuffling between the two extremes on a situational and individual basis (Kim, 2001). While most immigrants voluntarily migrate, refugees have little option but to move reluctantly. Most refugees have little chance to prepare for a life in host nations and therefore, tend to suffer from severe psychological dislocation and sense of loss (Kim, 2001; Chan & Lam, 1987b; David, 1969). However, regardless of resettlement circumstances, all immigrants need to make adjustments for daily survival. A lack of adjustment to the new environment will compel immigrants to either return to their home country or live in almost complete isolation in the host country. The latter option could eventually lead immigrants to interact with the host culture, which may or may not ease the psychological anguish of being a newcomer.

The process of crossing cultures challenges the very basis of migrants' cultural being, by providing opportunities for learning and growth while at the same time helping individuals redefine themselves and other immigrants and hosts, with clarity and insight that may not have been possible without leaving home. Therefore, adapting to new cultures is more than just survival. The adaptation process becomes a journey of discovery, transformation, and growth, thereby expanding the boundaries of migrants' personal existence (Kim, 2001). This process does not dictate that an individual forgets who they are but rather compels them to find themselves as if for the first time, particularly those 'cultural invariants' within them that they hold dear and refuse to compromise on (Neumann, 1992). If anything, this process makes one a stronger cultural being.

Cross-cultural or intercultural adaptation¹⁴, therefore, involves working out a fit between the person and the new cultural environment (Gudykunst & Hammer, 1988). The 'person' in this context can be an immigrant or a member of the host culture, and the 'new cultural environment' can be perceived from the immigrant's point of view or from the host culture's point of view, whereby the former is experiencing something new and the latter is experiencing changes to something old.

2.4.1 Theories of Cross-Cultural Adaptation

Cross-cultural adaptation is defined as the *"entirety of the phenomenon of individuals who, upon relocating to an unfamiliar sociocultural environment, strive to establish and maintain a relatively stable, reciprocal, and functional relationship with the environment"* (Kim, 2005: p. 380). It is a process of change over time that takes place within immigrants, who come into continuous, prolonged first-hand contact with a new and unfamiliar culture, while still maintaining aspects of their primary socialisation (Kim, 1988, 2005). Within the psychological context, acculturation or cultural adaptation is viewed as an inevitable human process that immigrants go through to manage stress, anxiety and uncertainty, as they come into prolonged contact with their new hosts (Berry, 1997; Gudykunst, 2005; Kim, 2001; Ward, 2001). The process of acculturation is based on an open systems model, where communication between the migrants and the hosts is essentially the key driver, and that regardless of the circumstances under which individuals move from one society to another, cross-cultural adaptation continues to occur (Kim, 1988; Berry, 1997).

People will depend on the host society because they are uncertain and unfamiliar with the practices of the host society. The degree of dependence may depend on the person's familiarity with the host society. For example, it could be said that a person from England may find it easier to adapt to New Zealand than a person from Croatia, mainly due to New Zealand having strong historical and cultural links to the UK.

It is also true that people do not stop whatever they are doing in order to adapt. Cross-cultural adaptation is an ongoing process. Strangers in new cultures can never learn everything there is to be learnt. However, they strive to learn as much as possible in order to make their life more comfortable and easy. When new things about the host culture do not make any difference to the way strangers/immigrants live, then learning becomes involuntary; immigrants just come to know about new things as opposed to making a concerted effort to find out (Kim, 2001; Gudykunst, 2005).

¹⁴ 'Cross-cultural adaptation', 'intercultural adaptation' and 'acculturation' are used interchangeably throughout this thesis.

The pervasiveness of movement of people across societies, along with the technological and social changes within host societies, requires that immigrants cope with numerous situations in which their experiences simply do not apply. Kim (1988) noted that some migrants get overwhelmed by the level of change expected of them in host societies and therefore, they can get frustrated and resist change. As stated in the sociological and anthropological studies (Heisler, 2008) and in recent studies of highly skilled migrants (Zikic, et al., 2010), migrants who resist change often experience frustration in all aspects of life, including work. On the other hand, when a person tries to 'go native', he or she may despair in situations where they do not fit in.

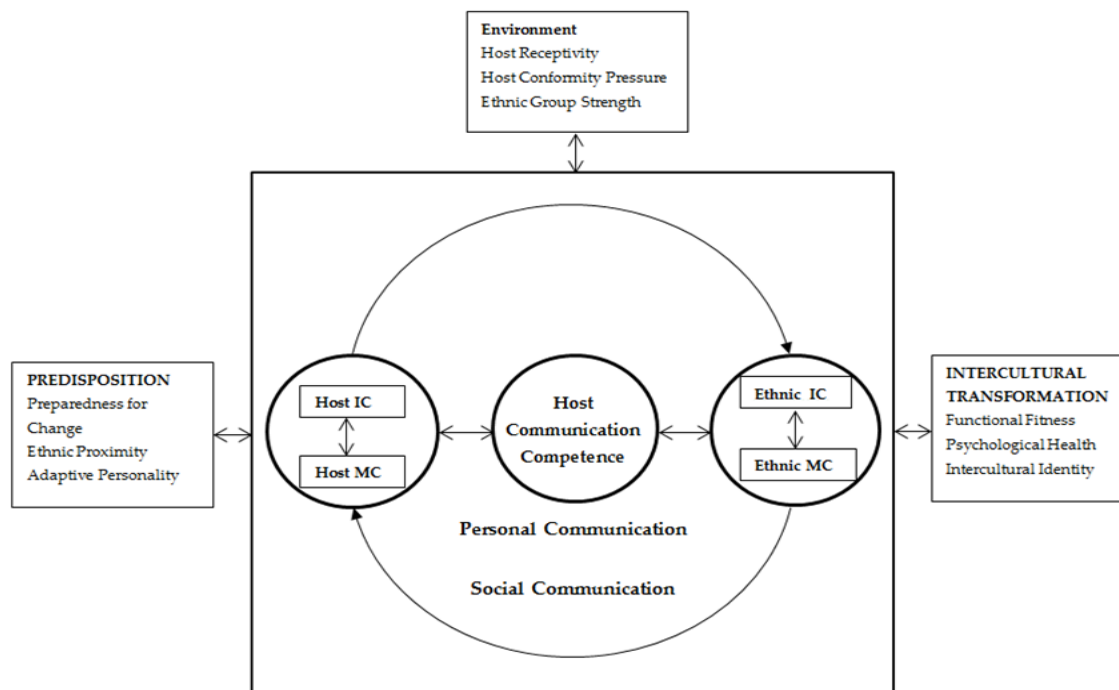
Within the discipline of intercultural communication there are three distinct approaches/theories/models to understanding and explaining cross-cultural adjustment and adaptation. For the purpose of this thesis, the focus will only be on two of the theories: Young Yun Kim's (1988, 1990, 2001, 2004, 2005) *Adapting to a New Culture- An Integrative Communication Theory*, (Figure 1) and William Gudykunst's¹⁵ (1988, 1993, 1995, 1998, 2005) *An Anxiety/Uncertainty Management (AUM) Theory of Strangers' Intercultural Adjustment (AUM Theory)* (Figure 2). The third theory, Hiroko Nishida's (1985, 1999, 2005) *Cultural Schema Theory*, is very much focused on in-depth psychological and cognitive processes that strangers use to determine their behaviour in host nations or new environments. While Nishida's theory is an interesting and valid approach to understanding cross-cultural adjustment, it is very detailed in explaining the cognitive processes of human memory of strangers in new environments which is beyond the scope of this review.

In the IC theory, Kim (1988, 1990, 2001, 2004, 2005) identified six key dimensions to intercultural adjustment:

- **Host Communication Competence-** This refers to the capacity for strangers to receive and process information appropriately and effectively, and to design and execute mental plans in initiating or responding to messages.
- **Host Social Communication-** This refers to the individual/stranger's competence in understanding and effecting interpersonal and mass communications within host societies.

¹⁵ Initially, Gudykunst and Hammer (1988b) developed the anxiety/uncertainty management theory of intercultural adjustment. However it was in subsequent years that Gudykunst developed the complete AUM theory as it is known today.

Figure 1: The Factors Influencing Cross-Cultural Adaptation – A Structural Model



Source: Adapted from Kim (2001, p. 87)

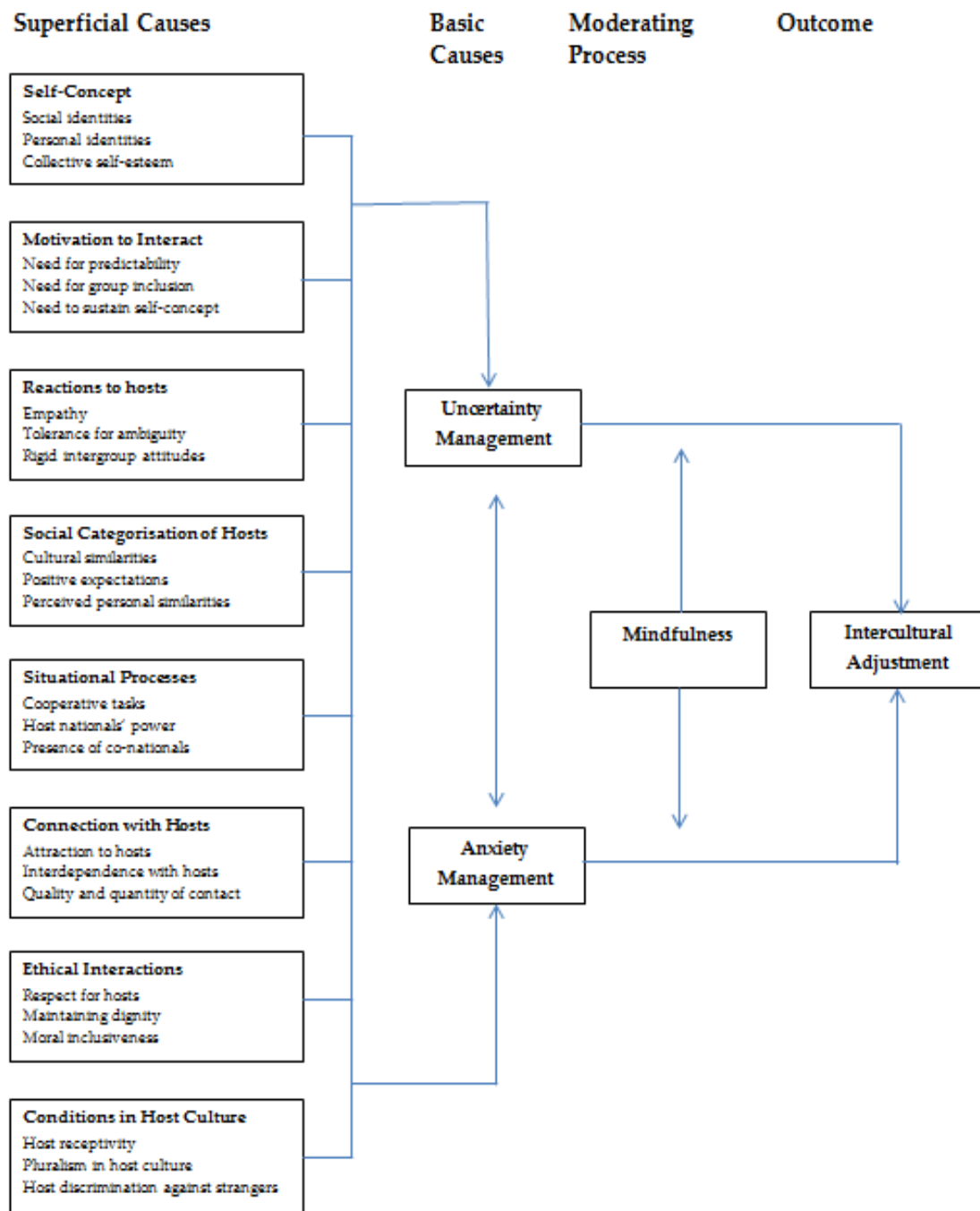
- **Ethnic Social Communications-** This refers to the function of co-ethnics/co-nationals' existing support systems in host communities that facilitate cultural adaptation/adjustment. These can constitute interpersonal and mass communication systems, and also include Diasporas.
- **The Host Environment-** This relates to what 'strangers' can expect or experience in the host environment in terms of 'host receptivity', 'host conformity pressure', and 'ethnic group strength'.
- **Predisposition-** This refers to the prior internal conditions and ability of 'strangers' themselves that would assist with adaptation/resettlement into the host society.
- **Intercultural Transformation-** This relates to the changes that take place within 'strangers' as they adapt to their new environment. The focus is on 'deculturation' and 'acculturation'. This can be an ongoing process.

Gudykunst's (1988, 1993, 1995, 1998, 2005) AUM theory proposed the following key 'schemas' to facilitate intercultural adjustment (Figure 2):

- **Self-concepts-** This refers to the views strangers have of themselves in terms of their 'social', 'cultural' and 'personal' identities that affect their self-esteem and self-construal.

- **Motivation to Interact with Host Nationals-** This refers to the extent to which the needs of strangers are met within host societies, which influences their motivation to interact with hosts. 'Needs' broadly refers to a stranger's ability to predict hosts' behaviour, their need for group inclusion, and their need to avoid anxiety and to sustain/maintain their self-concept.
- **Reaction to Host Nationals-** This refers to the cognitive process whereby strangers understand and interpret hosts' behaviours, values, etc., so that communication and understanding is fostered between them to reduce anxiety and uncertainty when adapting.
- **Social Categorisations of Hosts-** This refers to the social categorisation of hosts by strangers that is based on previous and current knowledge to facilitate interactions and understanding, and reduce anxiety and uncertainty when adapting.
- **Situational Processes-** This refers to the inherent 'scripts' strangers use when faced with different situations within host environments. The focus is on adjusting existing 'scripts' or developing new ones when faced with similar or very different situations. Furthermore the power difference between strangers and hosts (presumed to have more power) can increase anxiety and uncertainty. How 'strangers' learn to adapt to new situations is also influenced by the presence of their own co-ethnics.
- **Connections to Host Nationals-** This refers to how strangers may find some hosts more 'attractive' than others based on cultural or other similarities - the more attractive strangers find some hosts, the more positive the influence for appropriate communication and interactions among them.
- **Ethical Interactions-** This refers to the level of respect, dignity and moral inclusion strangers show towards their hosts. A lack of respect, etc., towards hosts can lead to maladjustments to host societies or even resentment from the hosts.
- **Conditions in Host Culture-** As in Kim's IC model, this refers to hosts' receptivity and the level of inclusion/adjustment expected of 'strangers'. This concept is similar to 'Ethical Interactions' as stated above except that the onus is on the hosts to be respectful strangers.

Figure 2: A Representation of the AUM Theory of Adjustment



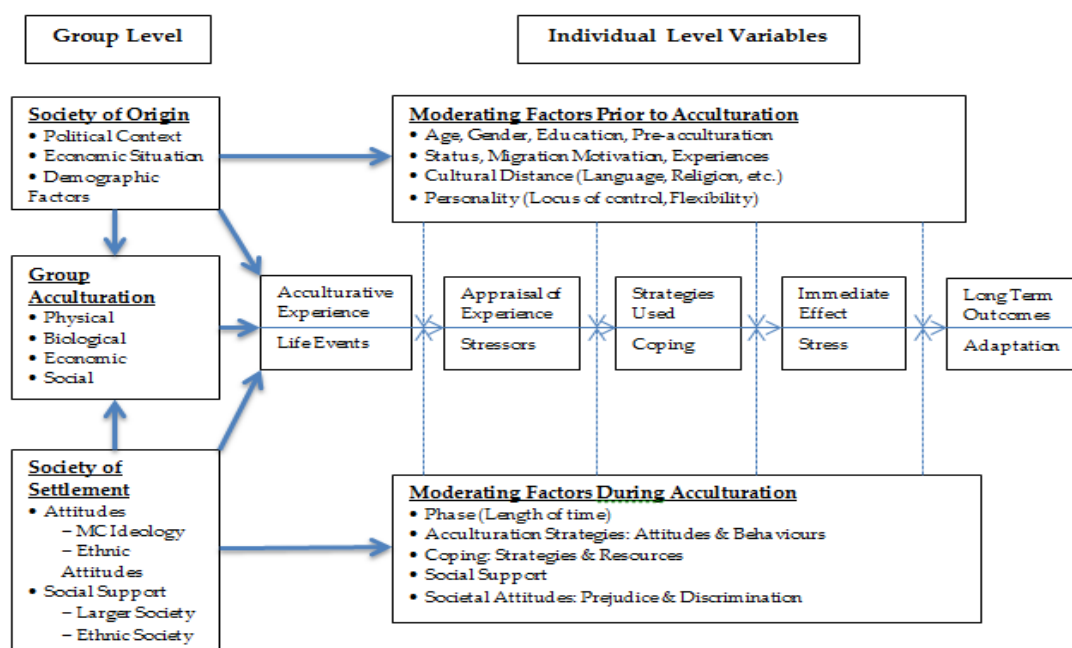
Source: Adapted from Gudykunst (2005, p. 426)

- Mindfulness-** This is an overarching factor that controls all of the above to varying degrees. The argument is that when 'strangers' are mindful about the various aspects of their interactions with the hosts, then they are more likely to better manage their anxiety and uncertainty when adapting to the host nation/culture. Strangers are said to be more mindful of their intergroup interactions than are hosts and may also use 'mindfulness as a

defensive strategy' when hosts' behaviours are unpredictable (Frable, et al., 1990).

The IC and AUM theories of adjustment and acculturation have many synergies. While both theories see strangers as open systems ready for change and new experiences, the AUM theory more specifically discusses the need for strangers to reduce their uncertainty, and limit their anxiety, when interacting with hosts in order to successfully adjust and acculturate (Kim, 2001; Gudykunst, 2005). In managing uncertainty, strangers have to be able to predict the behaviours of hosts in given situations. In reducing anxiety, strangers also need to be able to manage their own behaviours when interacting with hosts. If host behaviours are unpredictable then strangers are likely to experience more anxiety. Similarly, if strangers are anxious among hosts then they may behave inappropriately or may limit their interactions with hosts until such time as they are more comfortable. Kim (1988, 1990, 2001, 2004, 2005) proposed the 'Stress-Adaptation-Growth' model to capture anxiety and uncertainty that strangers experience in host societies. Over time, as strangers become familiar with the hosts and the new environment, their level of stress reduces, their adaptation increases and they grow as individuals.

Figure 3: A Framework for Acculturation Research



Source: Adapted from Berry (1997, 15)

Within the discipline of psychology, John Berry's (1997) model of immigration, acculturation and adaptation has been used extensively to understand the acculturation of migrants (Figure 3). While he took a psychological approach, some of his observations are at the level of intercultural communication and

adaptation, similar to Kim’s and Gudykunst’s approaches. Berry’s (1997) framework proposed that certain group and individual level variables are universal when explaining the acculturation experiences of migrants (Figure 3). Some of the universal variables such as attitudes towards migrants in host nations may be beyond the influence of migrants, but would have an impact on the adaptation process.

At about the same time as Berry presented his model, Bourhis and colleagues (1997), using a similar approach, developed their list of the adaptation strategies that migrants are likely to use when confronted with different situations in host societies (Figure 4). The four key strategies/orientations are integration, assimilation, segregation and exclusion or marginalisation. A fifth ‘orientation’ – individualism sees “host community members define themselves and others as individuals rather than members of group categories...individualists will therefore tend to downgrade the importance of maintaining the immigrant culture or adopting the host culture as a criteria of successful acculturation” (ibid, p. 381). In acculturative research, reference is usually made only to the prior four strategies.

Figure 4: The Integrative Acculturation Model – IAM

Host Community: Low-Medium High vitality group	Immigrants Community: Low, Medium vitality groups				
	Integration	Assimilation	Separation	Anomie	Individualism
Integration	Consensual	Problematic	Conflictual	Problematic	Problematic
Assimilation	Problematic	Consensual	Conflictual	Problematic	Problematic
Segregation	Conflictual	Conflictual	Conflictual	Conflictual	Conflictual
Exclusion	Conflictual	Conflictual	Conflictual	Conflictual	Conflictual
Individualism	Problematic	Problematic	Problematic	Problematic	Consensual

Source: Adapted from Bourhis, et al., 1997 (p. 382)

Berry (1997) also used the four adaptation strategies to explain the outcomes of the interplay between the universal variables that immigrants experience. These four strategies are still relevant when determining the adaptation status of migrants, where integration is the most preferred option, and exclusion or marginalisation the least (Berry, 1997; Schwartz, et al., 2010; Kuo, 2014). Berry’s model has been used extensively within psychology to develop other similar models however, for the purposes of this thesis, they have not been considered in detail, primarily due to them being variations of the original.

Strangers are deemed to have successfully adjusted and acculturated to new environments when they manage to:

- Cope with culture shock (David, 1971);
- Achieve satisfaction when living among the hosts (Church, 1982); and
- Portray socially appropriate behaviours that allow for interpersonal effectiveness in host cultures (Grove & Torbiörn, 1985).

The two approaches of psychology and intercultural communication to adaptation studies are very similar, and as Berry (1997) noted *“it is often difficult in practice to distinguish the research done, or the conclusions drawn from the two approaches”* (pg. 8). One difference between psychological and social adjustment approaches is that the former focuses and reflects on the feelings, well-being and satisfaction of migrants as they transit into new cultures while the latter refers to how and what migrants do in order to fit in and interact effectively in their new environments (Ward, 2001). In communication terms, the former focuses on intrapersonal processes, and the latter on interpersonal processes, and successful interpretation of the adaptation process can be deemed to be the productive interaction of the two in any given situation. Gudykunst’s (2005) perspective supports this when he stated that *“intercultural adjustment [is] a process involving feeling comfortable in the host culture, as well as communicating effectively and engaging in socially appropriate behavior with host nationals”* (p. 425). Both Kim (2001, 2005) and Gudykunst (2005) agreed that strangers can go through a process of acculturation and deculturation for a period of time as they learn new things, discard old/inappropriate/unnecessary behaviours and concepts, and again learn new things. This process is likely to continue until strangers reach their comfort zones within host societies.

The acculturation models from Kim, Gudykunst and Berry are important and valuable within the current research paradigm. However, the emerging themes from this study’s findings were not being entirely captured by any of their models, possibly because the primary focus was on occupational adaptation and how that affected participants’ overall acculturation to New Zealand society. Therefore, an opportunity arose to adapt the existing models, and to include emerging literature on highly skilled migrants, to develop and test a hybrid, concise and integrated framework that would better capture the essence of this study’s findings, and at the same time contribute towards a model for researching the experiences of highly skilled immigrants. Using migration literature from sociology, anthropology, economics, skilled migration, and to a certain extent psychology, the Integrated Framework for Acculturative Research – IFAR was developed subsequent to the data collection to categorise, analyse, interpret and discuss the findings of this research. The process used to develop and test the IFAR is discussed in the Methodology chapter, and the application of the IFAR is analysed in the Discussion chapter.

2.5 Summary

- Just over three percent of the global population (200 million) has been involved in international migration.
- Approximately 21% of New Zealand's population is foreign-born.
- Highly skilled migrants for the purpose of this thesis are those who possess a university degree and have some work experience in their areas of expertise.
- Acculturation is a process of change that takes place when individuals of a given culture/social/religious background come into contact with a different culture and thereby adopt certain beliefs and behaviours previously alien to them.
- Cross-cultural adaptation refers to migrants being able to navigate their new environments to achieve social, cultural, and occupational integration, and possibly assimilation in the long term.
- The theory of migration, as discussed in this study, focused on the sociological, anthropological, economic and intercultural communication perspectives.
- There are many different push and pull factors that have an impact on people's decisions to migrate. Push factors can include war or persecution in home nations as well as lack of opportunities for career and social advancement whereas pull factors can include opportunities to travel, to further careers and economic status as well as to reunite with family.
- For most migrants, economic betterment is the main reason for migration. Migrants who have the most human capital are favourably disposed to achieve migration when desired. Human capital can be in the form of higher education, extensive experience in particular work environments that are desirable in receiving nations and wealth to facilitate the migration process. Less skilled migrants could compensate for a lack of human capital with cultural capital (social, cultural, and personal networks).
- Assimilation into host societies was seen as the ideal state for immigrants, however many immigrants have shown that they do not want to totally assimilate because that would mean losing their pre-migration identity.
- While total assimilation into host societies was undesirable, migrants showed a tendency for segmented assimilation and integration. This means that the children of immigrants will assimilate into segments of the host society based on the achievements of their parents, as the initial migrants.
- Involuntary migrants such as refugees often face many difficulties in host nations, especially if they are unable to pursue their pre-migration occupations.

- The ease with which migrants can travel today allows them to be transnational 'actors'. Transnationalism means that migrants can choose to belong to one or more nations through the activities they undertake such as those of expatriates, business people, and other types of economic and social actors. Migrants, while in host nations, may still engage in transnational activities such as agitating for political change in home nations through activities in host nations.
- Transnationalism can have an impact on the assimilation and integration of migrants into host nations, due to divided allegiances.
- Diaspora in host nations can be considered to be forms of transnational communities because they create opportunities for migrants and non-migrants to participate and share in ethnic and cultural activities of significance.
- In recent studies, some have argued that Diaspora can be professional in nature, where highly skilled professionals who face challenges with a host nation's institutions may band together to offer each other support with integration. Professional Diaspora would not be limited to ethnic groups but would extend to all who may consider themselves part of that professional group.
- Migrants use networks when adapting to new environments. Migrants, especially those with lower skill levels, may use and leverage ethnicity-based networks that already exist in host nations.
- Family units and friends can be valuable support networks for immigrants, both pre- and post-migration, as they can increase the level of cultural capital immigrants need to succeed in host nations.
- Often, women have been negatively affected by migration of family members. However, many studies have shown that women do better than men in host nations, especially in terms of quickly gaining employment and thereby becoming the main income earner. In some cases women can be the principal applicant in the migration process.
- Sometimes, migrants are reluctant to adapt to host environments by strictly adhering to their ethnic and cultural identities, which can cause tensions with hosts. Ideally, migrants ought to make an effort to adapt to the host nation's way of life and have the ability to maintain their own identities.
- The impact of migration on sending countries has been deemed to be positive due to the high levels of remittances. Similarly, migration has also been considered to be beneficial for receiving countries due to the opportunities for new trade it can create.
- The predisposition of highly skilled people with higher levels of education and income makes them attractive for migration to receiving countries.
- Skilled migrants such as IMGs can often face significant barriers to the recognition of their education and pre-migration work experiences.

- As a result of qualifications and skills not being adequately recognised, highly skilled migrants could end up doing unskilled work and thereby under-utilising their human capital in host nations. Despite such challenges, many decide to remain in host nations rather than return home.
- Research has shown that highly skilled migrants are likely to be satisfied in host nations if they can use their prior skills, knowledge and attributes to pursue similar or better careers in host nations.
- Post-migration, success and acculturation are likely to occur if migrants can maintain their motivation to succeed, manage their identity, develop new credentials, develop local knowledge and knowhow, build new networks, and are able to evaluate their career successes.
- This study primarily focuses on two models of cross-cultural adaptation by Kim (1988-2005), and Gudykunst (1988-2005), with consideration of aspects of a third model by Berry (1997). As this study is about the journey the IMGs took to adapt to general practice in New Zealand, Kim's and Gudykunst's models were a good starting point because they emphasised the importance of interpersonal interactions with host members and institutions to acculturative success. However, given that these models focus on migration experiences and adaptation in more general terms, an opportunity arose to develop a framework that captured the themes that were emerging regarding the participants' key motivation to migrate; to continue as doctors in New Zealand. The existing models of Kim, Gudykunst, and Berry, and emerging literature on highly skilled migrants form the basis for a proposed hybrid model – the IFAR that places occupational success at the heart of overall acculturative success in host nations. Occupational success was used as the key emphasis when designing and implementing this study on highly-skilled migrants such as IMGs. The majority of the questions in the interview schedule focused on the occupational experiences on the IMGs. this is discussed in more detail in the Methodology chapter.

The following section presents the methodology used in this research.

3.0 Methodology

3.1 Introduction

This study utilised a qualitative approach to data collection, analysis and interpretation of the experiences of international medical graduates (IMGs) who became general practitioners (GPs) in New Zealand. While there is statistical data published to capture the overall status of IMGs in New Zealand (MCNZ, 2013; RNZCGP, 2009), there is very little published material that discusses their actual experiences of migration, occupational adaptation and settlement. In order to get detailed insights into such experiences, the qualitative methodologies provided the best options for fieldwork, data analysis, data synthesis and interpretation. However, to improve the validity and reliability, a mixed-methods approach was employed that combines existing statistical information with the primary qualitative data collected specifically for this study.

This chapter begins with a brief background on the author's theoretical perspectives. This is followed by a discussion of the data collection methods, data analysis and synthesis approaches, and the underlying methodological rigour necessary to justify the discussion of the findings.

3.2 Theoretical Perspective

I would like to think of myself as an interpretivist, and a constructivist. In the interpretive paradigm, one seeks to *"understand the world as it is, and understand the fundamental nature of the social world at the level of subjective experience"* (Burrell & Morgan, 1979: p. 28). In order to do this, the interpretivist looks for meanings that explain why certain things are done or have come into being. Constructivism deals with *"constructs we carry around in our head in order to make sense out of the world"* (Griffin, 1991: p. 123). It is a phenomenological orientation to inquiry in which 'meaning' is the prime focus (Stewart, 2005). The constructs comprise not only physical features, but the categories of personality and action that a person uses to describe another individual. I would argue that the constructivist way of thinking fits into the interpretive paradigm where it requires the researcher *"to seek to understand (rather than judge) other people's beliefs, and to document the multiple perspectives to be found within and between societies [and individuals]"* (Huberman & Miles, 2002: p. 67). It fits because individuals have different ways of mentally constructing the world around them. These constructs may be very subjective, and likely to depend on an individual's own experience. If the interpretive paradigm is all about seeing the world as it is, then it can be argued that individuals see the world as it is to them. This vision of the world is influenced by their experiences of the world. The above paints a broad picture of

how I understand researchers like myself can make sense of how and why people view the world and their place in it as they do.

In the context of data collection methodologies, this study was guided by the ethnography and ethnography of communication (communication competence). *"Ethnography attempts to be holistic - covering as much territory as possible about culture, subculture, or program - but it necessarily falls short of the whole"* (Fetterman, 1989: p. 21). There are many reasons why ethnography cannot explain all of reality and, therefore, cannot project its findings as generalisable. According to Huberman and Miles (2002), first, it cannot be assumed that all the accounts that are observed and recorded are true or rational. Secondly, ethnographers are independent from the phenomena they are observing which may conflict directly with the premises of interpretivism. It is not possible to ethnographically understand a reality by being independent of it. Most interpretivists state that *"researchers are no more detached from their objects of study than are their informants...researchers have their own understandings, their own convictions, their own conceptual orientations and are members of a particular culture at a specific historical moment...they will be undeniably affected by what they hear and observe in the field, often in unnoticed ways"* (Miles & Huberman, 1994: p. 8). Thirdly, most ethnographic studies have small samples given the nature of the data collection methods. Therefore, the views and beliefs of the small cohort of participants can at best only be representative of individuals in society who have similar cultural and social characteristics. For example, in this study, the IMGs' views, beliefs and experiences may only be relatively applicable to those who came from a similar social and cultural background, which is further restricted by the period in which they migrated to New Zealand.

The options to address these issues of ethnographic research lie in the purpose and use of any individual study. Huberman and Miles (2002) argued that if a researcher merely aims to understand and explain a social phenomenon then the truth and rationality of informant accounts is not important given that it is the informants' perceptions. In this context, it is important that the ethnographer does not bias the documenting of informants' perspectives with their own. *"Here we must ignore our judgements about their validity and rationality, since this is not relevant to the task of understanding them"* (p. 75). However, if informants disclose information about events that the researcher themselves could not have witnessed, such as historical events, then there is a need to seek the truth.

Triangulation of various sources of information becomes an important analysis and reporting mechanism, to not only understand the informant's account of events but also to validate them for reliability purposes. In some ethnographic studies, such as this one, triangulation becomes important to validate the findings. In this study, IMGs expressed their perspectives on how the migration process went for them, while at the same time they also referred to the policies,

procedures, rules and regulations of the institutions they encountered when adapting to New Zealand. The latter forms of narratives have to be validated with relevant information from the institutions themselves, so that a balanced, true account is documented. Other sources of information can also be used to authenticate subjective observational and interview data, such as through local and international literature, media reports, and field expert testimonies (Miles & Huberman, 1994; Huberman & Miles, 2002).

Ethnographers are known for keeping an open mind about the group or culture they are studying. Fetterman (1989) stated that *“ethnographers enter a field of study with an open mind, not an empty head”* (p. 11). This statement means that it is acceptable to have some knowledge or pre-understanding about the subject area, prior to the commencement of a research project. According to Gummesson (1991), *“pre-understanding refers to such things as people’s knowledge, insights, and experiences before they engage in a research program...a lack of pre-understanding will cause the researcher to spend considerable time gathering basic information”* (pp. 50-51). Therefore, it is not unusual to see researchers from various disciplines and methodological paradigms doing research in areas of their interest. The migration and adaptation experiences of IMGs are of interest to me because I am also an immigrant to New Zealand.

I am a Fijian Indian. I migrated to New Zealand in 1989 following the coup of 1987. As a migrant, I have heard many interesting stories about what it was like for migrants when they first came to New Zealand. During my undergraduate and postgraduate studies, I had opportunities to do research on various student migrant groups, investigating their adaptation to educational practices in New Zealand. Furthermore, I worked for the Royal New Zealand College of General Practitioners (RNZCGP) in the mid to late-2000s, where I came into contact with many immigrant doctors. As a Research Fellow at the RNZCGP, I was regularly collecting statistical data on IMGs, but could not capture their actual experiences of being GPs in New Zealand. This lack of information was the genesis of this study, however without my previous knowledge and understanding of research among immigrants, this study may not have been possible for me to do.

Some researchers may be against the idea of having any form of pre-understanding because of concerns about biased results. However, as Fetterman (1989) stated, like researchers in other fields, *“Ethnographers also begin with biases and preconceived notions about how people behave and what they think”* (p. 11). He stated that biases can be controlled to actually benefit the researcher. Biases keep a researcher focused on their effort. If the biases are not controlled then the quality of ethnographic research could be undermined. As an ethnographer, it is my responsibility to describe a social or cultural scene from the ‘emic’, or insider's perspective. In order to achieve this, it was important for me to have a certain level of pre-understanding about this research area, but at the same time

not let that bias my results. In being transparent, I acknowledged in the designing of this study that IMGs are different from other migrant workers in New Zealand and therefore, may possibly have had different expectations and experiences. I was also aware that IMGs had to make changes in order to succeed here. However, prior to doing this study, I did not wish to know what these changes were, and how they had affected IMGs' adaptation to general practice in New Zealand. The ethnography of communication methodology allowed me to design a study that acknowledged my pre-understanding of immigrants but also permitted me to explore new areas of migrant experiences.

The following sections discuss the processes for completing the fieldwork and the subsequent analysis of the data.

3.3 Study Design

3.3.1 Ethical Approval

This study received ethical approval from the New Zealand Health and Disability Multi-region Ethics Committee in 2007, and has since received ongoing approval on an annual basis (refer to Appendix B). As part of the ethical approval process, feedback was sought from the RNZCGP's Māori Faculty, regarding the proposed study, and how it might affect Māori. While the study was not going to affect Māori directly, it was envisioned that participants were likely to discuss any training they may have received to address Māori patients, and their burdens of disease, within the context of general practice.

Additionally, the Participant Information Sheet and Informed Consent form were also submitted for approval. Some minor alterations were suggested to both documents, and approval was given once those changes were completed. Ensuring the anonymity of the participants, maintaining confidentiality of the interviews, securely storing all interview material and undertaking the destruction of all interviews at the end of this study, were all addressed for ethical approval. As part of the informed consent process, participants were asked to provide an 'alias' that could be used when presenting their experiences. The majority of them did so, however, for a couple of them, a name was chosen because they had not supplied an alias. It is important to note that pseudonyms have been used to identify the participants in this study. Additionally, where participants made direct references to small towns, the names of those centres have been replaced with references to bigger regional centres to maintain participants' confidentiality. On the successful completion of this study, all interview recordings, transcripts and interview notes will be destroyed.

It was initially planned that if participants agreed, video-recordings of the interviews would be the ideal way to collect the data. Ethical approval for this

mode of data collection was given however, most participants preferred to be audio-recorded. In hindsight, the latter worked better for transcribing purposes, keeping research costs low, and eliminating potential technological failures that accompany the use of video-recording equipment. However, video-recording of migrant experiences remains an attractive option for future research among IMGs, and other migrant worker groups.

Another unique feature of this study design that needed specific justification for ethical approval was the use of e-interviews, as a data collection tool. E-interviews depend on emails as the main form of interaction between the interviewer and interviewee. The interview schedule was to be the same as that for face-to-face interviews, but the mode of data collection was to be via email. Ethical approval for this mode of data collection was also given, and it is discussed further in the 'Fieldwork' section.

In summary, ethical approval was given for:

- Collecting information from IMG GPs from around New Zealand;
- Using the approved participant information sheet and informed consent form;
- Collecting interview information either through face-to-face interviews or e-interviews; and
- Using either video-recordings or audio-recordings, and field notes as the modes for collecting data.

The participant consent form (refer to Appendix C) allowed the face-to-face participants to receive a copy of their transcripts, however only one participant requested it. The request for the transcript was verbally confirmed at the end of all face-to-face interviews.

This study has abided by all of the above ethical criteria.

3.3.2 Recruiting Participants

When this study commenced, I worked for the RNZCGP (the College), as a Research Fellow. In the study proposal, I had sought and received approval from the College to advertise the study, and recruit IMGs, through the College's electronic weekly newsletter, ePulse. ePulse proved to be an ideal recruitment tool as it was read by a significant number of GP members of the College, and did not incur any extra research costs.

The advertisement in ePulse stated the purpose of the study, the selection criteria, the number of participants sought, the data collection methods, and other relevant information as declared in the ethics application. Given the nature of the study, approximately 20 participants were sought based on the following criteria:

- The GPs had to be overseas-trained; their basic medical qualification had to be from an institution outside of New Zealand;
- The IMG GP had to be vocationally registered, and a Fellow of the College. It was important from the perspective of the study's objectives and intentions that participants had fully experienced the educational and qualifying processes to become independent practitioners;
- The participants had to be in fulltime general practice. However there was interest from some IMG GPs who were working part-time (<30hrs/week), and who were very keen to take part. Part-time work is not unusual in general practice so they were included.
- The participants had to be willing to participate given the aims and objectives of the study, especially given the two different modes for collecting data.

In the interest of investigating diverse perspectives on the adaptation experiences of IMGs, the study sought to recruit participants from:

1. English-speaking as well as non-English speaking countries¹⁶;
2. Urban and rural areas;
3. Both genders;
4. North Island and South Island.

The recruitment of IMGs went well, and within a month of first advertising the study, 20 participants put their names forward, and were accepted into the study. However, two participants withdrew just before the interviewing process started, citing work and family commitments as the main reasons for non-participation. Another participant withdrew after giving an interview. At the time of the interview, this particular participant did not want to be audio-taped, so extensive field notes were taken, summarised and provided to her for review. She withdrew soon after which was a real loss as her story was unique. However, it was understandable and her withdrawal was within the criteria for participation in the study. The final cohort included 17 IMGs, who fulfilled all the criteria for participation, and also provided the diverse perspectives that were being sought:

- Eight were from English-speaking countries (UK - England & Scotland, Canada, and Australia), while nine were from non-English speaking countries (India, Sri Lanka, Germany, Philippines, and Zimbabwe). It is

¹⁶ English-speaking countries are predominantly those where English is the main language used for official government business, the education system, and the language used for most internal and external business dealings. Some of these countries include the USA, UK, Canada, Australia, and New Zealand.

important to note here that IMGs from some non-English speaking countries, such as Sri Lanka and Zimbabwe, had done their medical training under Commonwealth arrangements as former colonies of Great Britain. There were implications of this in terms of the recognition of their qualifications, and their subsequent entry into New Zealand to work. This is discussed in more detail in the next chapter;

- While five IMGs were working in rural settings at the time of the study, nearly half the participants had worked in rural settings sometime during their careers in New Zealand;
- Six IMGs were females. In the initial cohort there were eight female participants but two withdrew;
- While four IMGs were working in the South Island at the time of the study, another two participants had worked in the South Island, earlier in their careers in New Zealand.

The decision to recruit more IMGs was considered but decided against as the data collected from the 17 interviews was considered sufficient because the participants' had fulfilled the basic criteria as stated above, there was a variety of narratives spanning nearly five decades of acculturation into New Zealand society, and the number of participants was sufficient for a qualitative study of this nature.

However, there is a possibility of testing some of the findings from this study in a much wider context of IMGs in New Zealand, possibly through a survey methodology.

3.4 Fieldwork

The fieldwork started immediately after the participants were recruited. One of the key methodological aspects of this study was the option for participants to share their migration and adaptation experiences either through a face-to-face, semi-structured interview, or through a structured e-interview option. Participants made a choice after being informed of the two options, especially after being informed about how the e-interviews would work. Nine participants chose to do face-to-face interviews and eight chose to do e-interviews, giving a good balance to test both options.

3.4.1 Face-to-Face Participant Interviews

Interviewing is a common research tool for data collection in many qualitative and ethnographic studies (Huberman & Miles, 2002; Pope, Mays & Popay, 2007). There are several other data collection tools available to ethnographers such as participant observation and content analysis, but interviewing is more common

for small qualitative studies, given the cost-effectiveness and the convenience factor for the researcher. Interviewing however, has its limitations, as the interviewer only interacts with an interviewee for a brief period of time, gathering information on experiences that usually span over longer periods. Also, interviewing may not allow the interviewer to observe any behaviour linked to information disclosed during the face-to-face interviews. For example, in this study, IMGs discussed their interactions with patients from diverse backgrounds in clinical settings; however, the opportunity to observe such interactions was not immediately available. This was mainly because 'participant observation' was beyond the scope of this study, and had numerous ethical considerations. Also, observing such behaviour would not have added any further value to the intended outcome of this study.

An interviewer can only discuss and interpret information that is shared by the interviewee. While interpretations about some missing elements can be drawn based on an interviewer's understanding of the context and background, there are limitations on how generalisable the interpretation can be. Huberman and Miles (2002) succinctly summarised that *"interviewing poses some special problems for internal generalizability because the researcher usually is in presence of the person interviewed only briefly, and must necessarily draw inferences from what happened during that brief period to the rest of the informant's life, including his or her actions and perspectives. An account based on interviews may be descriptively, interpretively, and theoretically valid as an account of the person's actions and perspective in that interview, but may miss other aspects of the person's perspective that were not expressed in the interview, and easily lead to false inferences about his or her actions outside the interview situation"* (p. 54). Often, to remedy such limitations to interpretation, researchers use robust data analysis methods and triangulate various sources of information to validate their conclusions (Briggs, 1986; Mishler, 1986).

The 'face-to-face' participants were also given the choice of selecting a time and place for the interviews. Four interviews were done in Auckland and five in Wellington. Of the four interviews in Auckland, three participants chose to do it at their general practice clinic, and one chose their home. In Wellington, one participant chose her general practice clinic, one chose their home, two chose their office in an academic institution, and one chose a coffee shop.

The interview schedule had five distinct adaptation experiential categories (refer Appendix D). Some categories and questions were informed by previous literature while others were developed for this research, given the sparse literature focusing on occupational adaptation as a key predictor for overall acculturation:

1. Demographics, including information on prior medical training, prior medical experience and a brief note on current medical work status and setting;
2. Migration to New Zealand and their professional adaptation including the registration process and the initial medical work experiences upon arrival;
3. Training to become an independent general practitioner;
4. Working as a general practitioner in New Zealand;
5. Social and cultural adaptation including observations of life outside of general practice in New Zealand. This aspect of the interview sought to investigate the acculturative challenges in general. Most studies on migration and adaptation tend to focus on this area, and it was opportune to do so with the participants.

Open-ended questions were used to get detailed information on IMG experiences. It should be noted that while some things were known about IMG experiences in New Zealand, it was not sufficient to have closed questions with limited options, given that each of the IMGs were assumed to have had unique experiences in their own right. In total, there were 65 main questions with a further set of sub-questions based on the type of responses expected and given. If individually tallied, then there were approximately 95 questions in total.

Four face-to-face interviews were approximately an hour long, with five being much longer. A couple of interviewees conversed for nearly two hours. While all the interviewees openly shared information related to the interview schedule, many went beyond that and shared information of a very personal nature. After one of the longest interviews in this study, the interviewee stated that they had found the 'session' very therapeutic. In terms of ethnography, the face-to-face interviewees not only described and stated their adaptation experiences, but also provided the interviewer with a brief, albeit fascinating look into their personal, and in some instances, their private lives. This often happens when the interviewer is able to build and sustain a good rapport with the interviewee (Fetterman, 1989). In the majority of these interviews, the interviewees were gracious, and offered refreshments before, during and after their respective interviews.

3.4.2 Face-to-Face Stakeholder Interviews

There are some key stakeholders involved in the recruitment, registration, and training of IMGs who come to New Zealand to pursue their medical careers. The Medical Council of New Zealand (MCNZ) is the registration authority that all doctors, regardless of country of origin and training, have to register with before practising in New Zealand. The MCNZ is responsible for ensuring that the public are protected from incompetent doctors by setting the standards for medical

practice and practice competence. Over time, the standards for practice, supervision and registration have changed. A representative of the MCNZ was interviewed to gather information on what these changes were, the rationale behind the new standards, and the ongoing support provided to doctors, especially IMGs who want to practise in New Zealand.

The RNZCGP is instrumental in providing the appropriate training needed for doctors who wish to become general practitioners. They also provide ongoing professional development, and set the standards for general practice. Similar to the MCNZ, the RNZCGP has also reviewed and improved their requirements, standards and delivery of training over time. A representative of the RNZCGP, with verbal approval awaiting official consent, was interviewed. However, their responses were not approved for use in this study, as some disclosures were deemed inconsistent with the College's official stance. Subsequently, written responses to a set of questions were submitted via emails, which rather reiterated what was already known from information on the RNZCGP website.

Another source of information was the NZLocums, a not-for-profit, government funded recruitment agency, specifically setup to ensure that rural New Zealanders have access to quality health care. NZLocums works closely with overseas partners, and local registration authorities such as the MCNZ, RNZCGP, and Immigration New Zealand, to attract and place IMGs in rural employment. Their main areas of focus are rural general practice and provincial hospitals, and their target markets include IMGs who wish to work short-term in New Zealand. NZLocums is managed by the Rural General Practitioner Network (RGPN) that advocates for quality rural health care provision. A representative of NZLocums was interviewed to gather information on their recruitment strategies, and the ongoing support they provide to doctors, especially IMGs who practise in rural New Zealand.

These three organisations were chosen primarily for their critical roles in assisting IMGs to adapt to general practice, through meeting the regulatory requirements and better understanding of the role of general practitioners in New Zealand. The representatives from MCNZ and NZLocums agreed to be identified in this study by their job titles (refer to Appendix E for consent form and Appendix F for the stakeholder interview schedule), while the Group Manager – Quality, Research and Policy at the RNZCGP referred the interview schedule to several staff for responses and therefore, other than their Medical Director, no other staff have been identified in this thesis. The information gathered from these key stakeholder interviews was used for triangulating the adaptation experiences expressed by the IMGs in this study. The interview data also supplemented the routine quantitative data these organisations produce, to give snap-shots of the medical workforce in New Zealand. It should be noted that though the institutional representatives that were interviewed knew of policy

changes, they were not able to clearly articulate any previous policy regimes, especially those that existed a few years or decades ago. This gap in knowledge was filled from other institutional documents including the 'personal and informal perspectives' regarding the MCNZ by their former Chief Executive, Georgina Jones, and from recollections of the participants where possible. Some of this information has already been presented and discussed in the Introduction chapter. Huberman and Miles (2002) noted that "*the triangulation made possible by multiple data collection methods provides stronger substantiation of constructs and hypotheses*" (p. 14). Through these different sets of data, it will be possible to provide more holistic perspectives of IMGs' adaptation into general practice and life in New Zealand.

3.4.3 E-Interviews

When this study was initiated, emails had become a common and effective communication tool for the exchange of large amounts of data among people in close proximity, as well as across regional, national and international boundaries. It was felt that this study provided the opportunity to explore the use of collecting interview type data using emails, if the participants agreed to it. As noted earlier, nearly half the participants chose this option.

A review of literature on email usage in research was undertaken during the study proposal phase, primarily to convince the supervisors that emails could be a viable option for collecting interview data. The main aim of this experimentation with emails, as a research tool, was to determine how well it would fit into the qualitative research paradigm, and possibly into ethnographic research.

Information and communication technologies (ICT) in the form of computers have long been used by quantitative researchers. However, their use by qualitative researchers had been somewhat limited until new technologies such as internet-based chat rooms, teleconferencing, and video-conferencing facilities were developed to allow for more timely and cost-effective communications (Bampton & Cowton, 2002; Illingworth, 2001; Gibbs, et al., 2002). In terms of qualitative research, ICT has the potential to transform, or at least enhance, many other facets of the research process, including the initial acquisition of data (Mann & Stewart, 2000). The introduction of emails especially has revolutionised the way we communicate with each other. It has improved the quality of the communication experience by linking people who are geographically isolated, by providing a written record of the interaction, and in some cases, by providing records of oral conversations conducted via telephone. While the use of ICT, including internet and email, has been widespread, little research has been done to show its effectiveness for the purposes of qualitative research (Illingworth, 2001; Hine, 2000; Jones, 1999). Access to ICT can be an issue if the research participants do not have computers or email accounts. In the beginning of this

study it was determined that access would not be an important issue because nearly 90% of GPs in New Zealand have a computer, and an email account (RNZCGP, 2008).

As with other research tools, e-interviews have their advantages and drawbacks. One of the main advantages of e-interviews is the proximity of interviewers and interviewees, despite being in different geographical locations across many time zones (Bampton & Cowton, 2002; Selwyn & Robson, 1998; McCoyd & Kerson, 2006; Mann & Stewart, 2000). Emails provide connectivity to virtually anyone with access to a computer with an email account. The constraints of physical distance in research become a non-issue. Distant geographical locations may also reveal variations in experiences, and allow for easy follow-up as needed (McCoyd & Kerson, 2006). The e-interviewees in this study were located all over New Zealand, from Auckland to Dunedin, from urban to rural areas, and hailed from diverse countries of origin, and educational backgrounds.

Asynchronicity is another advantage of e-interviews. Bampton and Cowton (2002) use 'asynchronicity' to describe the delay in the interactions between interviewer and interviewee. Sometimes, the interviewee may respond immediately (within minutes or a few hours) to a research question, while at other times they may take several days or weeks. McCoyd and Kerson (2006), in their study of women who terminated their pregnancy after being diagnosed with foetal anomalies, found that interviewees preferred to do the interview in small chunks, in their own time, instead of needing to set aside a longer period of time during business hours. While the participants in the above example possibly had some underlying psychological reasons for delaying their responses, there is a strong argument that busy people may also prefer to take their time to respond. GPs are very busy people who prefer to spend their working days attending to the health care needs of their patients. In the face-to-face interviews, only four participants chose to meet during their clinical hours or during their lunch breaks. It is possible that some of the IMGs who did participate in this study would not have done so if the e-interview option was not available.

Additionally, the e-interview schedule was broken up into the five respective categories as stated previously. This was deliberately done so as to not overwhelm the participants with the entire 95 questions in one email. Furthermore, as McCoyd and Kerson (2006) alluded to above, the aim of the e-interviews was to allow the participants time and space to think about their responses, and then respond when they were ready. To manage this process, e-interviewees were emailed a set of questions based on one of the five categories at a time, and given two weeks to respond. Once the responses were received, another set of questions was emailed. This continued until the responses to all the sections were completed.

Another important advantage of e-interviews is the *ready-made* transcripts of the interview. In face-to-face interviews, the researcher has to either transcribe the tape-recorded or written notes into transcripts or hire someone to do it for them. Sometimes, interviewers and interviewees may disagree on what was said, with what was intended differing from what was actually transcribed and used in research reports. However, with e-interviews, it is easier to prove the accuracy of the responses because they were written or transcribed by the interviewees themselves (Mann & Stewart, 2000). In this study, the e-interviews saved a lot of time and costs associated with transcribing because nearly half the participants chose this option.

In some research contexts, especially where sensitive issues are being investigated, participants may be reluctant to openly discuss their experiences or even be known as a potential participant. In such scenarios, e-interviews can be an ideal tool for collecting data because emails can provide such people with the physical privacy and safety, even when participants may choose to disclose their real names (McCoyd & Kerson, 2006; Roberts, et al., 1997). It is unclear whether any of the participants in this study had such privacy and safety issues.

Additionally, it has been suggested that e-interviews can be used in some longitudinal studies, where traditionally the only mode for collecting data would have been through face-to-face interviews (McCoyd & Kerson, 2006; Mann & Stewart, 2000). E-interviews, in longitudinal studies among geographically diverse participants will save a lot of research costs associated with travelling, interviewing and transcribing. Furthermore, other noted advantages of e-interviews include the researcher's ability to access hard to reach populations; to access dangerous or politically sensitive sites for research; to conduct educational and business research among a wide audience; and to testing ideas (Mann & Stewart, 2000). In comparison to telephone and face-to-face interviews, e-interviews can provide detailed and possibly rich data with no inherent disturbance such as the interviewee being disrupted by spouse or children or work colleagues, and little possibility of an interviewer's reaction to answers influencing the interviewee's subsequent responses (McCoyd & Kerson, 2006).

One of the main disadvantages of e-interviews is the loss of spontaneity that is a key advantage of face-to-face interviews (Bampton & Cowton, 2002). Often, in face-to-face interviews, spontaneity from interviewees can be the basis for the richness of the narratives. In this study, the majority of e-interviewees did not share personal experiences to the extent that face-to-face interviewees did. While a few of the e-interviewees shared great insights into their experiences of adapting to New Zealand, the majority just responded to the questions as they were asked. One e-interviewee shared his memoirs, which he briefly kept upon arriving in New Zealand. Others gave more detailed accounts of certain events that shaped their perceptions of general practice in New Zealand. However,

some e-interviewees answered with a 'yes', 'no' or with no more than a couple of sentences for each main question.

Another disadvantage is the anxiety that researchers feel when e-interviewees fail to respond within the allocated timeframes (Bampton & Cowton, 2000). There is often a need to follow up and prompt participants. In this study, for the most part, the participants responded within the timeframes but some did need prompting. In one unfortunate case, a participant was adamant that they had completed a couple of sections of the e-interview, and had emailed them back. However, there was no record of the responses in my email inbox or my participant logbook. It was made known to them that this information was missing but they seemed reluctant to do those sections again, even when they could not find a record of the responses on their own computer. In order to maintain this particular IMG as a participant, no further effort was made to persuade them to complete the missing sections, even though that was desirable. However, they had shared enough information to add value to this study.

In face-to-face interviews, the interviewer has the opportunity to observe facial expressions and other body language to gauge emotion. This is not present in e-interviews, even though some people do use emoticons at the end of sentences to express themselves at the time of writing (Lofland & Lofland, 1995; Bryman, 2001; Bampton & Cowton, 2002). In this study, some of the e-interviewees clearly demonstrated their displeasure, frustration and even anger with certain aspects of the adaptation processes through the choice of words to describe their experiences. Some also used humour, as seen through the way they conveyed their responses. However, e-interviews did not allow many opportunities to delve further into the emotions that seemed apparent from the responses. Some follow-up questions were asked via emails but these usually garnered straightforward responses, as opposed to any form of ranting or raving that might be expected in face-to-face interviews. The e-interviewees provided meaningful insights into their experiences that possibly would not have been shared, if not for the e-interview option. This data may not be as rich as those from face-to-face interviews but without a doubt, this study is better off for it.

One other important aspect of doing e-interviews was the process for getting informed consent (Mann & Stewart, 2000). With online research, obtaining informed consent poses some different challenges when compared to obtaining consent during face-to-face interviews. The main issue is the ability/ease with which potential participants can ask questions and receive satisfactory answers prior to signing the informed consent form (Garton, et al., 1997). The other features of the Internet, such as chat rooms could complicate the consent process. If the participants are known to the researcher, and email is going to be used for research, then obtaining informed consent may not be as difficult as one could experience with online chat rooms, discussion groups, and with other forms of

online communities. McCoyd and Kerson (2006), in their study, sent a modified consent form via email to participants, and they answered the questions the participants had, through email, prior to the participants giving consent. This study used a similar approach that was clearly articulated in the ethics application form. All participants received the 'Participant information sheet' and the 'Informed consent form' via email, and their questions or queries were responded to through the same mode. Face-to face interview participants completed the consent form at the time of the interview.

E-interviewees had a number of choices for completing the informed consent form. Some completed a hardcopy of the form and sent it back as an e-copy or some put a statement in an email such as *I have read the informed consent and have had the opportunity to ask questions. I understand that I can withdraw from this study at any time with no negative effects. My responses confirm my ongoing consent*". There were no issues with getting informed consent from participants in this study.

The confidentiality of the e-interviewees was managed by first creating separate electronic folders using their chosen alias. Their e-interview responses were in Word documents, and therefore were easily saved in these folders, together with their consent forms. For each of the e-interviewees, all their individual responses were collated into one document resembling a transcript. For all participants, case outlines were prepared from these transcripts, and only alias were used to identify them. Upon the completion of this study, the e-interviewees' transcripts and other related notes will be destroyed, including their email contact details.

Finally, the merits of e-interviews as a qualitative and ethnographic tool, as experienced through this research, are articulated in the Discussion chapter, as it is one of the main methodological contributions of this study. Briefly however, the use of e-interviews will depend on the type of study, the aims and objectives of the study, the context of the research, and how the results are likely to be reported.

The following section discusses the process used to develop the data analysis framework that later informed the development of the proposed hybrid concise model for the research of the acculturation of highly skilled migrants. The Integrated Framework for Acculturative Research – IFAR is a contribution of this study and it is important to understand how it got developed.

3.5 The Development of an Integrated Framework for Acculturative Research

The process underlying the development of the Integrated Framework for Acculturative Research – IFAR was structured and in line with best practice qualitative data analysis (Miles & Huberman, 1994). First, 'Within Case Displays' were developed for each of the participants. These within case displays were in

the form of 'case outlines' using clustering of related interview questions as headings and subheadings. They were checked for quality by the supervisors. Secondly, 'Cross-Case Displays' were created using the case outlines. The cross-case displays were based on the structure of the interview schedule and its five distinct categories of inquiry. These were also checked for accuracy and quality by the supervisors. A short workshop was conducted with the supervisors to determine if the emerging themes were being captured adequately and under appropriate thematic headings. The analysis of the cross-case displays presented the first main challenge of trying to cluster the findings in a manner that fitted one of the existing models of acculturative research, as noted by Kim (1988, 2005), Gudykunst (2005), and Berry (1997), and which made sense from the viewpoint of the emerging literature on highly skilled migrants. None of the above models really worked in explaining the journey that the IMGs took when adapting to general practice in New Zealand. Therefore, a framework was created using more meaningful categories to cluster and present the research findings – the 'analysis framework'.

The analysis framework was based on the premise that in order to understand how occupational adaptation affects overall acculturation, the investigation has to start right from the time of arrival of the immigrants into their new environment, and finish with an understanding of their current situation. All the adaptation activities in between these two points ought to be accurately sequenced to better appreciate the acculturative status of immigrants at the time of study. Another consideration of the analysis framework was to account for the different time periods in which the participants had made their way to New Zealand. The historical timeline became one of the key variables for the subsequent thematic analysis. The longitudinal nature of the data made for interesting comparisons across different time periods pertaining to arrival to New Zealand, meeting the MCNZ registration requirements and adapting to New Zealand society.

The next challenge was to take the categories used in the analysis framework and develop a further framework that could be used to interpret and discuss the emerging themes. The intention was to utilise the existing models and the cross-cultural adaptation theories of Kim (1988, 1990, 2001, 2004, 2005), Gudykunst¹⁷ (1988, 1993, 1995, 1998, 2005), and Berry (1997). Additionally, the literature on highly skilled migrants was used to inform the formation of the hybrid concise and integrated framework. The result of this methodological exercise was the

¹⁷ Initially, Gudykunst and Hammer (1988b) developed the anxiety/uncertainty management theory of intercultural adjustment. However it was in subsequent years that Gudykunst developed the complete AUM theory as it is known today.

formation of the Integrated Framework for Acculturative Research – the IFAR, which has been specifically designed for the study of highly skilled migrants.

The process for the formation of the IFAR is discussed in greater detail below.

3.5.1 Data Analysis

In ethnography, thematic analysis is a commonly used data analysis methodology (Aronson, 1994; Miles & Huberman, 1994; Huberman & Miles, 2002). Additionally, thematic analysis is also used in interpretive studies through the use of meta-ethnography. According to Pope, Mays and Popay (2007), *“Meta-ethnography attempts to transform interpretations offered by individual studies in such a way that they can be expressed in each other’s terms, thereby enabling direct comparison of seemingly distinctive pieces of evidence”* (pp. 75-76). As noted in the Literature Review chapter, many studies have emerged that document the experiences of IMGs in different settings, as doctors and as highly skilled migrants. These settings, while unique in nature, present some universal challenges that IMGs face, regardless of where they are from, and where they have gone to pursue their careers. Together with findings of this study, they add validity and reliability to the emerging themes as shown in the Discussion chapter, so all the individual IMG cases in this research have been compared for recurring themes, through a cross-case analysis approach (Miles & Huberman, 1994), and where appropriate, meta-analysis is presented as discussion points (Pope, et al., 2007).

During the study design phase, it was envisioned that a computer-assisted qualitative data analysis tool such as NVivo would be used. Upon further discussions with other researchers who had used NVivo, it was determined that given the completed interviews in this research were less than 20, it might be better to consider other data analysis options such as manual coding and analysis using Microsoft Word and Excel spreadsheets. Also given that much of the preparation work for the analysis phase had already been done using the two programmes, it was easier to continue with them. Distinct codes were created to capture what the participants had shared regarding their experiences. A robust method was adhered to, ensuring regular feedback from the supervisors on the accuracy and quality of the analysis process. The outputs of this approach led to tables that show clear themes and trends for the reader, in the Results chapters.

3.5.2 Within Case Displays

Within case displays refers to *“a series of displays for drawing and verifying descriptive conclusions about the phenomena in a bound context that make up a single ‘case’ - whether that case is an individual in a setting, a small group, or a larger unit as a department, organisation, or community”* (Miles & Huberman, 1994: p. 90). The IMGs in this study can be viewed as individuals within the overall medical

professional community or more specifically as individuals within the overseas-trained general practitioner group.

The initial stage of within case displays in the context of qualitative research methods is to create transcripts of the conversation between the interviewer and interviewee (Aronson, 1994; Fereday & Muir-Cochrane, 2006). In this study, the e-interviews provided ready-made transcripts but the audio-recordings of the face-to-face interviews needed to be transcribed; these transcriptions were completed by a professional recommended by the University of Otago. The transcripts were checked for quality by randomly selecting written texts from several interviews, and then cross-checking them with the respective audio-recordings. In all cases the transcripts were an accurate reflection of the audio-recording.

The second stage was to distil the transcripts, including the e-interviews, into concisely written summaries that reflected the intent of the interviewees including relevant quotes to support them. These summaries were done by me and were called 'case outlines'. The structure of case outlines followed the five categories used for the interview schedules: Demographics; Migration to New Zealand and professional adaptation; Training; Working in general practice; and Social and cultural adaptation. There were sub-headings under each of the five broad categories. The case outlines were subjected to further quality checks by providing the supervisors with the initial summaries, and the respective transcripts for review. They specifically reviewed the case outlines to see whether all relevant information had been documented well enough to reflect the interview, and that interesting and relevant quotes were included. There were no major concerns expressed about the structure and content of the case outlines.

A similar approach was used for the stakeholder interviews however the case outline structure was slightly different to reflect the role, purpose and policy implications of each of the organisations.

3.5.3 Cross-Case Analysis

The idea of cross-case analysis is not new to ethnography, especially where the researcher has collected data from and described multiple single cases that at some levels of analysis can provide common threads and themes, as well as differences. The key reasons for doing cross-case analysis using multiple single cases is to enhance generalisability, better understand what is happening in any given situation or setting, and thereby improve the explanation of those situations by having multiple points of reference (Miles & Huberman, 1994).

Some have argued that 'generalisability' in qualitative cross-case studies can be limited, mainly due to the small samples and the subjectiveness of the data that is collected (Denzin, 1983; Guba & Lincoln, 1981). There is still the opportunity to ascertain the relevance and applicability of findings to other settings but that

would depend on the careful selection of cases and their subsequent analysis (Firestone & Herriott, 1983; Miles & Huberman, 1994). However, there is agreement that cross-case analysis in qualitative studies has its own merits where *“multiple cases not only pin down the specific conditions under which a finding will occur but also help us form the more general categories of how those conditions may be related”* (Miles & Huberman, 1994: p. 173). Furthermore, cross-case analysis assists with *“reconciling an individual case’s uniqueness with the need for more general understanding of generic processes that occur across cases”* (Silverstein, 1988 cited in Miles & Huberman, 1994: p. 173). Silverstein (1988) further stated that the comparisons of processes can be done in a historical context to see how they developed over time. This study also presented such an opportunity, as small cohorts of participants represented different time periods of migration to New Zealand. The earliest IMGs interviewed came in the late 1960s and early 1970s, and the most recent ones came in the mid-2000s. The processes of migration, registration, and occupational adaptation are very different for those who came earlier compared to those who came in the last decade. Even for organisations such as the MCNZ, their processes have changed considerably in that time period, and therefore using the historical timelines of migration as the first level of analysis made sense.

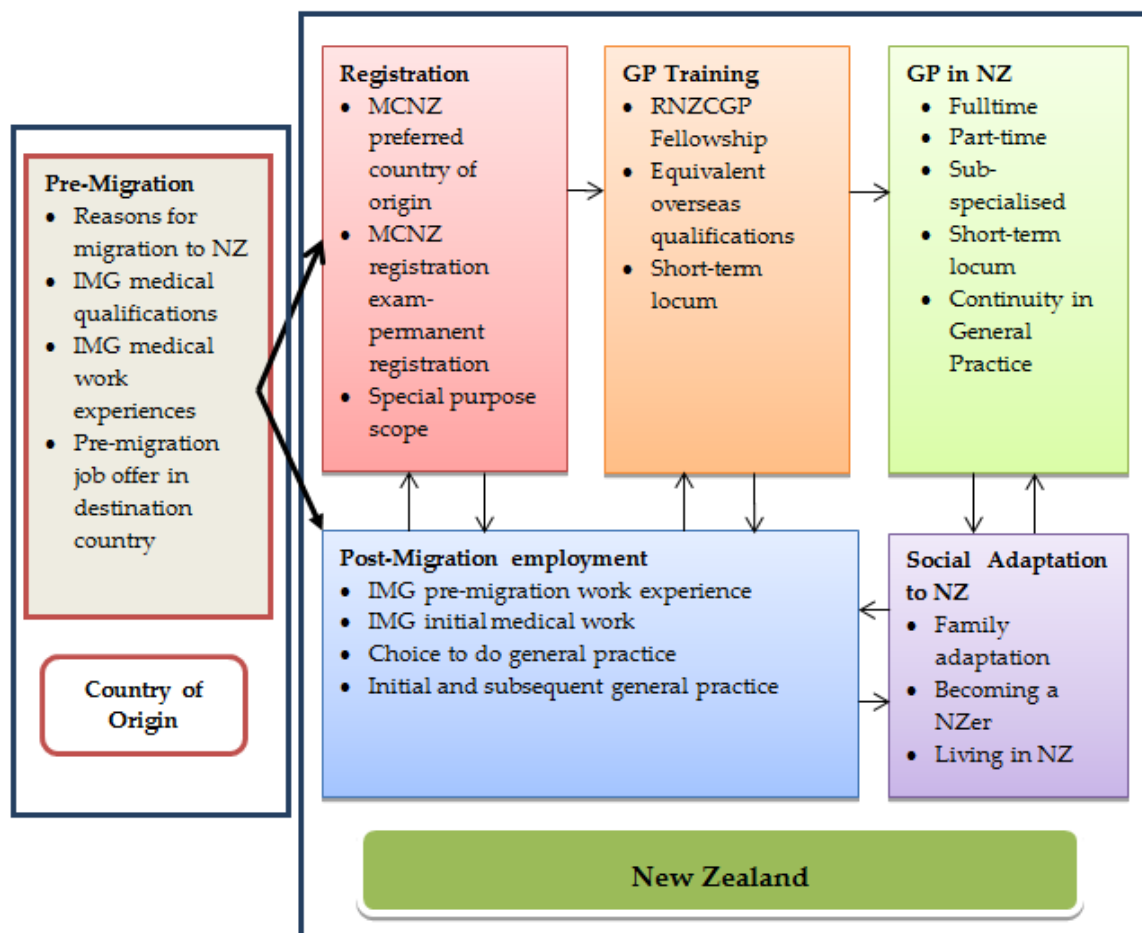
This study used a variable-oriented cross-case analysis method where each case is compared for specific overarching variables as well as other sub-variables under those. For example, one of the key over-arching variables is the IMGs’ pre-migration human capital that they brought with them to New Zealand. Under this, there are a number of sub-variables such as their country of origin, their basic medical qualifications, their reasons for migrating, and their date of migration. The IMGs can be compared across these sub-variables based on the field data that sequentially documented their journey into general practice in New Zealand – this is the ‘analysis framework’ referred to earlier (Figure 5).

This illustration (Figure 5) defines the IMG journey from being a doctor in their home nation to becoming a GP in New Zealand. The concepts inherent in the framework are intertwined with and across each other. This is important to fully understand why the results are presented as they are, and to appreciate that, despite being from different countries, there are some experiences that are common to all IMGs who chose to become GPs in New Zealand.

The journey for IMGs as highly skilled migrants first and foremost starts with their educational and occupational attainments in their home nations. Their prior educational and occupational accomplishments are often factors that determine the reasons for migration and influence the choice of a destination country. While there could be many reasons for migrating overseas, the opportunity to carry on with their chosen career supersedes other reasons for migration. This is possibly

one distinguishing factor between highly skilled migrants and other types of migrants.

Figure 5: IMG Journey to General Practice in New Zealand



Once an IMG arrives in their destination country, in this case New Zealand, there are a number of requirements that need to be fulfilled before they can continue to pursue their pre-migration careers. In the situation of IMGs, the pathway to a career in medicine is well defined by the Medical Council of New Zealand (MCNZ), the authority that certifies doctors as fit to work in New Zealand. While the overarching pathway to certification seems clear, there are many inherent subtleties primarily based on the IMG's country of origin, their medical qualification and the educational institution they obtained it from, their prior medical work experiences and their choice of medical work in New Zealand. Additionally, having employment offers prior to arrival in New Zealand also has an impact on the ease of achieving certification. The process to certification can be easy as well as challenging, depending on the aforementioned factors.

When an IMG decides to become a GP, they need to fulfil further training requirements to become independent practitioners. The GP training itself is made up of many different pathways to Fellowship of the Royal New Zealand College

of GPs (RNZCGP). There are some key competences that need to be demonstrated on the way to fellowship of the College. This is common to all medical specialties. In this study, the participant IMGs ranged from those who came in the late 1960s to those in the mid-2000s. Over this period, the pathways to certification and fellowship changed, affecting the IMGs in different ways.

As noted in Figure 5, there are essentially six key steps to becoming a GP in New Zealand. The first step is coming to New Zealand, the second is getting registered to work in medicine, the third is initiating medical or other employment in New Zealand, the fourth concerns further training needed to become a GP, the fifth involves working and continuing in general practice, and the sixth comprises other social factors that enable adaptation to New Zealand. Additionally, the six steps are not linear in nature and thereby overlap each other such as 'registering to work' and 'doing general practice training' intersecting with post-migration employment for some IMGs on a number of occasions on their journey to occupational adaptation. For some, the extent to which success has been achieved in the work environment intersects with their social adaptation status.

The next stage of the cross-case analysis was to use the analysis framework to create matrices of the overarching variables and sub-variables, and to populate them with the interview data. Health researchers have employed the matrix approach to data analysis, especially for meta-analysis across various studies on single topic areas (Pope, et al., 2007).

Table 2: Example of Cross-case Analysis Matrix

Participant	Year of migration	Country of Origin	Work arrangement & Current location & Practice type	Years of medical practice prior to coming to NZ & type of work	Years of general practice prior to coming to NZ
Dr. Jon	1969	Sri Lanka	Fulltime self-employed GP in Auckland working in an urban practice	3 years as medical officer in Sri Lanka	None - general practice was not a specialty at that time
Dr. Manu	1970	Sri Lanka	Fulltime self-employed GP in Auckland working in an urban practice	2 years in hospital setting	None
Dr. Lou	1972	Australia	Part-time salaried GP working in rural South Island practice	No prior medical experience	Some general practice experience during intern years

The matrices in this study were designed to incorporate two fundamental cross-analysis displays into one data display. The first was the conceptually-ordered display, and the second was the time-ordered display (Miles & Huberman, 1994). The matrix tables (e.g. Table 2) had the conceptual headings such as the key variables and the sub-variables in the row titles, while the participants were ordered by their date of migration to New Zealand in the column titles. This allowed the examination of findings across different time periods. The matrices

were fluid in the sense that participants could be re-organised to compare them by countries of origin, gender and urban/rural split. Several codes were developed to depict the narratives of the participants, which were then used to populate the matrices. The different matrices form part of the Results chapter.

The following stage of the data analysis was to better understand the contents of the matrices to determine the emerging themes and, where appropriate, the policy implications for institutions that deal with IMGs in New Zealand. Additionally, the contributions to international literature on highly skilled migrants were also explored. This was done in several stages including identifying common migration and adaptation experiences, identifying unique experiences as well as those that were important but not common to the majority of the participants. Some emerging themes were unique to certain cohorts of participants, especially when analysing the data for country of origin, gender, and urban/rural split.

To maintain the quality of the interpretation of findings and the emerging themes, a workshop was undertaken with the supervisors. In this workshop, the data in the form of the matrices and its subsequent interpretations were scrutinised. Some themes were pre-identified as part of the initial stages of cross-case analysis, and the supervisors were asked to provide feedback and comment on their relevance and importance, from their perspectives.

The subsequent stage was to prioritise the emerging themes and the relevant quotes to inform the Results chapter. This was an important exercise to rationalise the most significant aspects of the adaptation processes that had to be presented and discussed in the context of this study's focus and the literature on migration theory, cross-cultural adaptation and highly skilled migrants. In doing so, nearly all the interview material informed any one of the many aspects of the migration and adaptation processes involved in becoming a general practitioner in New Zealand.

Taking into account all of the above processes, the following structure was developed for presenting the results in the next two chapters – four and five:

1. Coming to New Zealand:

- a. Demographics
- b. Country of origin
- c. Reasons for migration
- d. Prior Training and Occupation
- e. Information on New Zealand
- f. Initial challenges
- g. Registration

2. Motivation to Become a General Practitioner in New Zealand:

- a. Initial medical work in New Zealand

- b. Choosing to do general practice
 - c. Training to become a GP
 - d. Cultural competence needed to be a GP
 - e. Support for becoming a GP
3. **Working as a General Practitioner in New Zealand:**
- a. Working in general practice
 - b. Patient populations and burden of disease
 - c. Cultural issues pertaining to working in general practice
 - d. Continuity in general practice
4. **Key Features of General Practice In New Zealand:**
- a. Similarities and differences in general practice between host and home nations
 - b. Key features of general practice
 - c. Likes and dislikes about general practice in New Zealand
5. **Living among the Hosts:**
- a. First impressions of New Zealand
 - b. Communicating with locals
 - c. Key features of New Zealand when compared to home nations
 - d. Becoming a New Zealander

In addition to the narratives from the participants, key institutional perspectives are presented separately in Chapter 6. The institutional perspectives are meant to provide an insight into their organisations' mandate, and to provide balance and validate or debate any claims made by the participants in this study, with regard to their interactions with these institutions.

The final outcome of the data analysis phase was the creation of the Integrated Framework for Acculturative Research – the IFAR, which specifically focuses on highly skilled migrants, such as the IMGs in this study.

The IFAR has four main components:

1. Predispositions and Self-Concepts at the Time of Migration;
2. Initiating the Occupational Process
3. Occupational Adaptation in Host Nations
4. Living Among the Hosts

Under each of these components are key variables that have been derived from existing literature on migration, acculturation and highly skilled migrants. The value proposition of the IFAR to the study of highly skilled migrants is provided in great detail in the Discussion Chapter.

3.6 Summary

- This study utilised a qualitative approach to data collection, analysis and interpretation.
- The interpretivist and constructivist paradigms informed the author's approach to data collection, analysis and interpretation of the results and the subsequent discussions.
- The author is an immigrant to New Zealand and therefore, the choice of this study's topic was influenced by that.
- Ethical approval for this study was sought from the New Zealand Health and Disability Multi-regional Ethics Committee.
- Participants in this study were recruited using the RNZCGP's electronic newsletter – the ePulse.
- In total, 17 participants agreed to take part, out of an initial 20 responses. All the participants had achieved vocational registration, and the Fellowship of the RNZCGP.
- Participants were offered the opportunity to do a face-to-face interview or an email-based interview – e-interview. Nine participants chose the former while eight chose the latter option.
- The interview schedule for both cohorts was the same.
- Eight participants were from English-speaking countries: UK, Canada and Australia.
- Nine were from non-English-speaking countries: India, Sri Lanka, Germany, Philippines, and Zimbabwe.
- Nearly half of the participants had worked in a rural setting at some stage in their careers – five of them were in rural practice at the time of data collection.
- Six participants were females.
- Four participants were working in the South Island at the time of data collection.
- The face-to-face interviews occurred in a variety of settings including general practice clinics, cafeterias and in some participants' homes.
- The e-interviews were staggered over a period of 4-6 weeks, with five different sets of questions forwarded after the completion of the preceding set.
- There are many advantages of e-interviews including having access to hard-to-reach populations, having the ability to investigate sensitive issues without compromising participants' privacy, allowing participants to

respond in their own time, reducing research costs associated with field work, and having readymade transcripts given the nature of information exchange. Some disadvantages include the lack of spontaneity of the participants' responses, and the lack of observation of participants' non-verbal cues when interviewed.

- Representatives from the key institutions of MCNZ, RNZCGP and NZLocums were also interviewed to gather their perspectives on IMGs in New Zealand.
- Thematic analysis was the primary data analysis methodology. This involved preparing individual case outlines for all the participants, doing within-case analysis and thereafter, cross-case analysis.
- The cross-case analysis took on the form of various matrices which informed the emerging themes across the numerous analysis variables. These variables were cross-analysed with the different time periods of the participants' migration to New Zealand.

4.0 Results Part One: Becoming a General Practitioner in New Zealand

4.1 Introduction

The overarching theoretical perspectives informing this thesis are based on the cross-cultural adaptation of highly skilled migrants to new environments. In this theoretical context, the analysis and the discussion of the cross-cultural adaptation of international medical graduates (IMGs) to New Zealand's general practice environment is the key purpose of this study. Furthermore, this thesis identifies and discusses the challenges faced by IMGs on their journey to becoming successful general practitioners in New Zealand.

The participants in this study are part of a very large workforce of immigrant doctors that New Zealand is dependent on for the delivery of primary health care. IMGs constitute over 40% of the general practitioner (GP) workforce (MCNZ, 2013), and some expert commentators have stated that without IMGs, New Zealand's health system would be in a state of crisis (NZMA, 2003, 2004). In real terms, in 2012, there were approximately 1,600 IMGs out of a total of 3,600 GPs in New Zealand (MCNZ, 2013).

The Results section of this thesis is presented in three separate chapters. The first part of the Results covers the early experiences of participants as they initiated and made career adjustments to become general practitioners in New Zealand. The second part focuses on the key aspects of their occupational adaptation to general practice and challenges they faced in doing so. The second part also presents the results of their social adaptation to New Zealand. The third part presents the views of the key institutions involved in IMGs' journeys to becoming general practitioners in New Zealand – the Medical Council of New Zealand (MCNZ); The Royal New Zealand College of General Practitioners (RNZCGP); and NZLocums.

The two Results chapters – four and five are guided by the 'analysis framework' (Figure 5) as discussed in the Methodology chapter. The next section presents the pre-migration factors that were important for IMGs when they first decided to come to New Zealand and their initial experiences once they got here.

4.2 Coming to New Zealand

4.2.1 Meet the Participants

In total there were 17 IMG participants in this study who came from a variety of countries (Table 3). Pseudonyms have been used to identify the participants in this research. IMGs from all major source countries for New Zealand's medical workforce are represented in this study sample except for South Africa – no GP of South African origins expressed an interest in taking part in this study. It should be noted that one participant, Dr. Manu, unfortunately passed away in 2010, prior to the completion of this thesis.

The participant who arrived earliest, Dr. Jon, came to New Zealand in 1969 and the most recent, Dr. James, came in 2005. Three participants (Drs. Jon, Manu and Lou) arrived in New Zealand in the late 1960s and early 1970s; five IMGs (Drs. Jean, Ras, Deborah, Christa and Dr. Rogers) came in the 1980s, with two of them (Drs. Christa and Rogers), returning home before returning to New Zealand in the 1990s. In the 1990s, eight participants arrived including the return of Dr. Christa and Dr. Rogers, with the other IMGs being (Drs.) Nathan, Michael, Tina, Alyssa, Tily, and Henri. In the 2000s, Drs. Phil, Charles and James made their way to New Zealand.

Six IMGs (Drs. Deborah, Nathan, Michael, Rogers, Phil and James) came from the UK, four participants (Drs. Jon, Manu, Ras, and Tily) came from the Indian sub-continent (Sri Lanka and India), and three (Drs. Christa, Tina, and Henri) came from Germany. The remaining IMGs came from Australia (Dr. Lou), Canada (Dr. Jean), the Philippines (Dr. Alyssa), and Zimbabwe (Dr. Charles).

Eleven participants were males and six were females. At the time of migration, seven participants were in their 20s, five were in their 30s, and a further five were 40 and over. It should be noted that eight participants (Drs. Lou, Christa, Nathan, Michael, Rogers, Henri, Phil and Charles) had made prior visits to New Zealand before migrating. Drs. Christa and Rogers had been to New Zealand for short-term work in the 1980s before migrating in the 1990s. Dr. Henri had also come to New Zealand to complete his medical training in the 1990s, then left New Zealand for the UK, before returning here a few years later.

It is interesting to note that most of the IMGs who arrived between the 1960s and 1980s were much younger than those who came more recently. Those IMGs who came when they were in their 20s and early 30s were likely to have come alone and be single. Drs. Jean and Christa came alone but married New Zealanders. Drs. Rogers, Henri and Tina also married New Zealanders but they met their partners overseas. Seven participants (Drs. Nathan, Tina, Tily, Rogers, Henri, Phil, and James) came with their families, with Drs. Jon and Charles initially coming alone but with their families arriving soon after. The age, gender and family status of the IMGs provide insights into their reasons for migrating.

Table 3: Pre-Migration Status and Reasons for Coming to New Zealand

Participants	Intw type	Year of Migr.	Age at Migr.	Family Status	Reasons for Migr.	Source of Infor on NZ	First location in NZ	Initial Challenges
Dr Jon (SL)	FTF	60s	33	J+	F J	♦ ♠+	City	X, XX, XXX
Dr Manu (SL)	FTF	70s	31	J	J S	♥+ ♠	Small town	X, XX, XXX
Dr Lou (AUST)	EI	70s	25√	J	J	♥+ ♠ √	City	X+
Dr Jean (CAN)	FTF	80s	25	J+	J N	♠+	Med-town	
Dr Ras (IND)	FTF	80s	25	J	T J	♦ ♦+ ♠+	City	X, XX
Dr Deborah (UK)	EI	80s	24	J	T J	♥ ♠ ♠+	Small town	X, XXX
Dr Christa (GER)	EI	80s then 90s	26√	J+	R N	♠ ♥ √	City	XX, XXX, X+
Dr Nathan (UK)	EI	90s	40√	J	P J	♥+ √	City	X
Dr Michael (UK)	EI	90s	31√	J	J	♦ ♥+ √	City	X
Dr Tima (GER)	FTF	90s	29	J	N F	♠ N	Med-town	X+
Dr Alyssa (PHIL)	FTF	90s	28	J	G	♥+	City	X, X+
Dr Tily (SL)	FTF	90s	34	J	T W	♠+ ♥	City	XXX, X+
Dr Rogers (UK)	FTF	80s then 90s	46 √	J J	J N	♥+ N √	City	X,
Dr Henri (GER)	EI	90s	37√	J J	F N	√ N	Large town	X++
Dr Phil (UK)	EI	2000s	43√	J	K J	√ ♠+ ♥♥+	City	X+
Dr Charles (ZIM)	EI	2000s	44√	J+	C J	♥+ ♠+ √	Med-town	X+, XXX
Dr James (UK)	FTF	2000s	54	J	J S F C K	♠+ ♠+ ♥♥+	City	X+, XXX

FTF = Face-to-face interview
EI = Email Interview/e-interview
√ = had visited prior to full migration
J = came alone/single
J+ = came alone but family joined soon after
J = came with family
J+ = came alone but married a NZer
F = to start/raise a family
J = job offer in NZ
K = partner had job offer
S = to specialise in an area of medicine
T = to travel
R = for research work
G = for 'greener pastures'
C = wanting change
N = spouse was from NZ

P = to achieve professional autonomy
T = to get away from unrest in home country
W = NZ was recommended by friends
♦ = Colleague
♥ = friends & family
♥+ = friends/family in NZ
♠ = library, general reading, travel books
♠+ = job adverts in professional journals
♠ = media
♠+ = internet
♦+ = iconic NZ personalities
X = workplace/employment issues
XX = language issues
XXX = settlement issues
X+ = qualification/training issues
X++ = family issues

4.2.2 Reasons for Migrating to New Zealand

The participants in this study could have migrated to a number of countries to pursue their careers but they chose New Zealand. A variety of reasons were given for why they chose New Zealand including having job offers, wanting to travel and see the world, raising a family and wanting a change in their lives. Twelve of the participants had job offers in New Zealand prior to arrival. The early IMGs such as Drs. Jon, Manu, Jean and Ras, were aware that there was a shortage of doctors in New Zealand so they applied for jobs and got them.

“Well, I think basically it was, when you’re young, you try to look at doing things differently. So I was young, I was single, and I wanted to explore this part of the world. And I met some New Zealand doctors while I was over in Leeds. And they suggested that there was some requirement for junior doctors in New Zealand, and I said, OK, I’ll just give it a try. So I applied, and got a job. And the intention was to see as to what the lie of the land is in this part of the world, and see how it goes from there.” (Dr. Ras - FTF¹⁸)

Dr. Jean initially came only for work but met her future husband here so decided to stay on. Like her, Dr. Christa initially came to do research and to do some “English-spoken medicine”. However, while here she met her future husband and decided to return to New Zealand after completing her studies back in Germany.

“Once here, I met my husband, fell in love and got married, extended my stay by 3 months. I then returned to Germany, completed my finals and my M.D. thesis in the following 9 months and then returned to NZ to live and work. Never set out to migrate to NZ; came to do an elective in obstetric research, met my husband-to-be, married and then decided to stay.” (Dr. Christa - EI)

Having future spouses of New Zealand origin was also a factor for some of the other IMGs. Drs. Tina, Rogers and Henri also married New Zealanders but while overseas. All of them stated that their New Zealand spouses were one of the reasons for them to come to New Zealand.

“I was offered a job. I’d worked near Wellington, up in Wainuiomata before. My partner was a Kiwi. We talked for quite a long time about whether, you know, we would work in New Zealand again at some point. So a whole bunch of things just came together, both personal and professional. I’d had no, you know, burning desire to work in New Zealand again, but it seemed like a cool place to be.” (Dr. Rogers - FTF)

¹⁸ Please note that FTF (Face-to-face) or EI (E-interviews) have been denoted next to the participants’ names to indicate the type of interview method they chose. This may add more to the context of what and why they shared that information.

Additionally, some of these doctors also provided other supporting reasons for migrating such as Dr. Jon who had heard that New Zealand was a great place for raising a family; Dr. Manu wanted to specialise in Paediatrics, and he would be able to do it in New Zealand; while Drs. Ras and Deborah wanted to travel and see new places, and having a job offer made that possible.

Dr. Nathan was looking for “*professional autonomy*” as a medical practitioner. Dr. Alyssa had a good friend here and was looking for “*greener pastures*”. Initially, she wanted to go to the USA but this did not eventuate so she decided on New Zealand.

Dr. Tily came from a country that was in political turmoil, and wanted to go somewhere to get away from it. Her husband was also a doctor, and their friends recommended New Zealand as a destination. For somewhat similar reasons but not due to any particular conflict, Dr. Charles felt “*a sense of calling, wanted a change*”.

Drs. Phil and James noted that their spouses had work offers in New Zealand, and this was one of their motivations for coming here. Additionally, Dr. James had always wanted to be a GP but regulation changes in the UK meant that he was ineligible. He found that New Zealand was willing to give him that opportunity so he came.

“Actually, because of my age - and I was 54 - I came under my wife’s [as the principal applicant]...because my wife is a management consultant, and she’s very high-powered, and very well-qualified. And it was easy... she’s seven years younger than me, which made her more attractive as a primary applicant. And I came in as a sort of essential support staff, if you like, you know, shortage of GP’s. But we had no intention of staying...I always wanted to be a GP, and I never got there. It never occurred to me that at one time that I would be prevented from doing it, because accreditation came in only ten years ago in the UK. Prior to that, anybody could be a GP. But with the Royal College [UK] developing, and the vocational scheme developing, everybody that had qualified no longer qualified. So by definition, I was suddenly ineligible to do what I always wanted to do. So I was in a dilemma, really, how I was going to do it. In New Zealand and Australia, both gave me opportunities. Which was quite a big leap of faith, I have to say. But New Zealand was more attractive, because it offered me the Primex [Primary Medical Examination] opportunity. We were just going to stay for two years, and go back home. Which we didn’t do.” (Dr. James - FTF)

For nearly all the participants the opportunity to pursue a career in medicine was the underlying reason for coming to New Zealand, while still having other motivating factors to complement that decision. The next section looks at the initial sources of information for the participants when they were deciding on

New Zealand. The literature mentions this as a critical factor in the decision-making process for potential migrants.

4.2.3 Information about New Zealand

The participants had a variety of sources of information on New Zealand. Some IMGs had little information on New Zealand whereas others had more prior to migration. For recent migrants the internet and media were key sources whereas for the earlier ones, word-of-mouth and library resources were important sources. Some IMGs also had the opportunity to visit New Zealand prior to deciding on migration.

Eight of the participants (Drs. Lou, Christa, Nathan, Michael, Rogers, Henri, Phil and Charles), had been to New Zealand prior to deciding to migrate (Table 3). They thus had the opportunity to get first-hand information on New Zealand.

Drs. Phil, Charles, James and Tily, who were relatively recent migrants, had the opportunity to use the internet to find information on New Zealand which was unheard of for those IMGs who came between the 1960s and 1980s, even to a certain extent for those IMGs who came in the early 1990s, when computers and the internet were still relatively rare in normal life.

Drs. Jon, Manu, Jean and Ras, who came early on, recollected that there was little information about New Zealand that was easily accessible, and often the information was second-hand and inaccurate. Dr. Jon remembered being told by a colleague that “*Māoris are man-eaters*”, an attempt he thought was aimed to dissuade him from migrating.

For other early IMGs, famous icons and institutions were often the only things known about New Zealand. Dr. Manu had heard of the All Blacks rugby team. He got some information from a colleague who had been to New Zealand before, and he had also taken the opportunity to do some research in local libraries when considering where to work in New Zealand.

Dr. Ras got some information from a friend whose brother was in New Zealand but also mentioned some iconic New Zealand personalities, as the only things he knew about New Zealand.

“Well, at that time, it was mainly coming from place like India. There were two very iconic personalities of New Zealand: one was Edmund Hillary, and the other one was Richard Hadlee from cricket. So those were the two things that I knew about New Zealand at that time, and not much else.”
(Dr. Ras - FTF)

Dr. Lou who lived in Australia mentioned that he got his information on New Zealand through the media, and still had some misconceptions. This is interesting given the proximity of the two nations.

“Very little [information on New Zealand] - snippets through the media. E.g. I had thought the North Island was mountainous - even about Auckland - but it was merely hilly.” (Dr. Lou - EI)

Those early IMGs who had managed to secure medical work in New Zealand prior to arrival (Drs. Jon, Jean, Ras and Deborah) also mentioned professional publications such as the *British Medical Journal* (BMJ), and the *New England Journal of Medicine*, as sources of information.

Other important sources of information for the participants were friends and family in New Zealand and abroad, spouses who were New Zealanders, magazines, and travel books.

“Well, I do like nature I do like the outdoor activities. So I mean, I’m a lot into tramping and biking, and spalting [wood art]. And I knew that New Zealand is great for those opportunities.” (Dr. Tina - FTF)

“The exact truth to that was at the traveller’s anecdote level. A then girlfriend, or someone that had been a girlfriend when I was working in Africa, and was still a friend, had travelled part of the way back from her OE back to the UK, with someone who was a New Zealander. And so when I finally pitched up in London, I started hanging around with a group of people that included a couple of New Zealanders, one of whom then became my wife. Before that, had I heard of New Zealand? I mean I’d heard of it, in the same way as you hear of Australia. It was all very far away, and very exotic.” (Dr. Rogers - FTF)

“We did our own research about New Zealand, and we bought the travel guides. And the other thing was, we had friends who’d been to New Zealand, and they loved it. They just said it was the most wonderful place they’d been on holiday. And they’re actually our best friends, so they were really important people to us, because they came back with some mementos of New Zealand, and we had met through adopting our children.” (Dr. James - FTF)

When comparing the early IMGs to the more recent ones, the amount of information and the information sources available to the more recent ones was plentiful. The internet, media, travel opportunities and knowing someone in New Zealand were stated far more frequently by more recent IMGs. Additionally, nearly all the IMGs who had travelled to New Zealand on holidays were from English-speaking or Western countries – the UK, Australia and Germany. Overall, the IMGs who had not made prior visits, found the information on New Zealand either useful but limited or not useful at all.

4.2.4 Initial Location for Settlement in New Zealand

The initial place of settlement for most IMGs depended upon where they had secured employment. For others it was where their spouses had employment or where they knew someone. Those who came in later decades appeared to have more options, and possibly knew exactly where they wanted to be. Dr. Rogers had been to New Zealand before so knew where he was heading for his new job, upon his return in the 1990s. Similarly, Drs. Henri, Nathan, Michael and Christa all knew where they would like to practise, due to their previous travel experiences.

Of the twelve participants who had secured employment, eight settled in a city, two in medium-sized towns, and the remaining two in small, rural centres. Auckland and Wellington were the most common destinations for the majority of the city settlers. However, Dr. Manu, who was young and single at the time, was not concerned about where he was going. To him it made little difference.

“In fact, you know, places like Auckland, they said, “Look, we take people in...or they were taking people in January, or whatever, and I applied in the middle of the year; and Whangarei was one of the places that they said, ‘We could... we don’t have it [job], but we’d love to give your letter to [Hospital in Central North Island town - CNIT¹⁹]. It’s far away. Would you...So then [CNIT] wrote, and I said, “Look, it doesn’t worry me, I don’t know where Whangarei or [CNIT] is, I’ll accept your job.” So they gave the background of what the town is like, and they said, ‘We’ll pay your air fares.’ Everything was organised, and it was done in a very professional and helpful way. I mean, I just arrived, and the medical superintendent was there, at the airport to meet me. That’s how good it was, yes.” (Dr. Manu - FTF)

Not all the IMGs felt the same level of comfort as Dr. Manu did. Dr. Jon, who came to Wellington, said that it was a “frightening experience” mainly due to there not being any instructions for migrants so he had to navigate his own way. Similarly, Dr. Tina, who came with her New Zealand husband, had a few anxious moments on their way to their new home. Even though her husband was from New Zealand, they were both heading to a new destination and they got lost.

“That drive to [CNIT] and then we got lost as well. I mean, we were driving through really no-man’s land, in really back country in [CNIT], saw nobody... [laughs]. And I really thought, ‘Oh my God, where are we

¹⁹ As noted in the Methodology, to maintain the anonymity and confidentiality of some of the participants, it was important to remove references to the smaller towns that they worked in. Where appropriate, reference will be made to the region in which the town is.

getting here?’ I mean, this is a little village... you know it’s 5000 inhabitants, and I mean it’s fine. I mean, I was very happy. Especially, I needed to study, and yes, just had young kids, that was a good start. I really liked it. So I wouldn’t have liked it in Auckland or anything like that.” (Dr. Tina -FTF)

In addition to the above, the IMGs also expressed their early impressions of New Zealand which are discussed when looking at their social adaptation. Their early and subsequent experiences were important in the decision-making processes that eventually led to their careers in general practice, and their social adaptation. The next section will present the challenges that the IMGs initially faced in New Zealand, and how they went about resolving them.

4.2.5 Initial Challenges in New Zealand

The majority of the participants had faced some challenges when they first arrived. The challenges included adjusting to their new workplace, understanding the spoken language, getting recognition of their qualifications, getting settled into New Zealand, adapting to poor public infrastructure, and dealing with family-related issues (Table 3).

Drs. Jon and Manu, who came early on, reported having issues in the workplace mainly due to them not fully understanding how things worked and what was expected of them. Dr. Jon was expected to take on medical work that he was not trained for. He felt that the doctor he initially worked with, who was a registrar, was trying to *“palm all the work to me”*. Dr. Manu noted that he went straight to work upon arrival, and had no time to learn about how the hospital system worked in New Zealand. Contrary to Dr. Jon’s initial experience, Dr. Manu was asked to do a range of medical work, mainly due to the hospital lacking enough qualified personnel, and he took the challenge on. Drs. Ras, Deborah, Nathan, Michael, Alyssa, and Rogers, also reported initial challenges in their workplaces - the hospital system versus general practice. For those who working in hospitals, the systems and ways of working posed the greatest challenges. However, the medical or clinical practices were considered to be the same.

“So I was put to work immediately. And the systems were quite different in New Zealand and in Sri Lanka, so I had to get adjusted to the New Zealand hospital system at that time...I came as the house surgeon for medicine, but I also had to cover the outpatients and the surgical side, and whatever else was going around.” (Dr. Manu -FTF)

“I think the challenges were more on the clinical side, on the work side, because the work culture, the work ethics, the organisation of the hospital systems, getting to grips with the administrative things... so the whole side of that was different, which took a little while to adapt to. But the clinical work, meaning the day-to-day work was exactly similar.” (Dr. Ras - FTF)

Dr. Deborah, who also started work in a hospital, was faced with a workers' strike not long after she started. She was unsure of her role in that but was told that the workers strike did not affect her work as a house surgeon.

Drs. Michael and Rogers who came from the UK and went to work in general practice reported having to overcome or adapt to charging patients for services, adjusting to the concept of the Accident Compensation Scheme (ACC) and adapting to quite a broad scope of medical practice. When Dr. Rogers first came to work in general practice in the 1980s, obstetrics and gynaecology (O&G) care was provided by GPs. This was new to him but his previous experiences in Africa were helpful.

"The adaptation to some aspects of New Zealand medicine were interesting. The fee for service, and the payment side of it, I found very bizarre, coming from an NHS background. So in a sense, to start with, we didn't make a lot of money, because there was this tendency to see people either cheaply, or you know, if they were wanting a follow-up, you wouldn't [charge]. I guess then did realise that in a sense, if you weren't working, you weren't eating. And that was much more of a private business than I had been used to in my very brief experience of general practice in the UK. If I hadn't previously done the work in Africa (Malawi), I think I would have found the clinical responsibility relatively high-level...for example, I picked up the obstetric workload for like three out of the five doctors in the health centre. Because that's what the other guy had done. I'd done a lot of obstetrics at that point, and sort of picked it all up again. So things like the clinical responsibility, insofar as the expectation was that you managed patients to a greater extent than in the UK, yeah, that was different." (Dr. Rogers - FTF)

Dr. Nathan, who also came from the UK, and joined general practice, reported being challenged by *"professional antagonism from local GPs"*. He did not elaborate further on what this actually constituted. Dr. James, who also started in a large general practice with nearly 13 doctors, found that practice *"particularly dysfunctional"* mainly due to colleagues' unfriendliness.

"Very sort of poor levels of friendship, professional friendship. We'd come 20,000 kilometres, and nobody even invited us to their house, which may have been a Kiwi thing, I don't know. But it was very unusual for us, having come from London, where everybody invites you to their house, and then coming here, and finding out nobody cares a toss what you did from six o'clock on a Friday night until Monday morning." (Dr. James - FTF)

Another major challenge faced by some of the early IMGs (Dr. Jon, Manu, Ras and Christa) related to understanding New Zealand English and the colloquial language. While they knew formal English well they had some difficulty with the

colloquial language of New Zealand. The need to adapt to the colloquial language was reported more by IMGs from non-English speaking countries.

Dr. Jon, who came from Sri Lanka and had done his medical training in English, reported some confusion with terms such as *“Bring a plate”* when invited to a social event, and *“I went on a binge”* used by one of his patients. In another case a patient was having some urinary tract issues and said *“I can’t pass...my waterworks are blocked”*, to which Dr. Jon initially responded *“Ring a plumber, why ring me?”*. Dr. Jean also came across colloquial terms but it did not take long to figure out what they meant – *“box of fluffy ducks”* and *“happy as Larry”*. Similarly, Dr. Ras also recollected his patients using colloquial language to explain medical problems.

“And I still remember the first patient that I saw. He said that he’s got the runs. Now that is a very colloquial term. So I thought he was talking about cricket. So I said, “How many runs did you score?” Whereas he was talking about that he had an upset stomach.” (Dr. Ras - FTF)

Dr. Christa reported problems with understanding the New Zealand accent. Similarly, Dr. Manu, who had good English but spoke with a very strong accent also reported having issues with the New Zealand accent. In this case, it worked both ways where New Zealanders had some difficulty understanding him and he felt the same about how they spoke.

“Even though I was quite good in my English, the accent was a problem. So in the night, for instance, if you get a call-out, you know, I had to get up and go and see what this is all about. Sometimes I found it a bit difficult to understand over the phone what the nurses were saying.” (Dr. Manu - FTF)

Settling into New Zealand also challenged the participants. Dr. James, who came in 2005, was surprised that he could not make friends easily, and had to rely on his children to get to know people. This made him reconsider his stay in New Zealand.

“I mean, if it wasn’t for the kids, we probably would have gone home in a year. The kids created a world for us which was really interesting, and was our lifeline, actually. They were our saviours. Sadly - because it should have been my professional connections that kept me connected.” (Dr. James - FTF)

Similarly, Dr Tily also reported that she found it hard to settle down mainly due to not having the type of support she had prior to migrating. Coming to New Zealand meant having to re-create that supportive environment with people she did not know before.

“Oh yes, settling down wasn’t that easy, because when we went to England, my brother was there, so he helped us staying with him early on.”

So when we came here, it was really hard...I mean, you could rent a house, but it's just settling down is really hard, because you have to start from the scratch everything, you know: exams, work, and those things, so." (Dr. Tily - FTF)

Dr. Christa echoed similar sentiments.

"Only once I was married [to a New Zealander] and I had to address the practicalities of everyday life, the practical difficulties become more apparent: minimal public transport, having to re-sit exams, starting all over with new friends, developing support systems, etc." (Dr. Christa - EI)

Access to good housing was also problematic for some early IMGs. Dr. Deborah was not prepared for the "cold, un-insulated hospital accommodation". Dr Jon reported that landlords were reluctant to rent him a place unless they first met his wife, who at the time was back in Sri Lanka. Additionally, IMGs who came with families such as Dr. Charles had to arrange schooling for their children.

While he did not have any particular settlement issues, Dr Henri had divorced prior to arrival, and mentioned this as a bit challenging.

The other key challenge faced by the most recent IMGs, in comparison to the earlier ones, involved getting registered with the MCNZ. Nearly all the participants who came in the 1990s and 2000s mentioned having varying levels of issues with getting registered. While this will be discussed in more detail in the next section, it is important to note some of the frustration felt by the participants. Dr Tina was one of those IMGs, and she was frustrated that her qualifications were not recognised, despite having full registration from the UK, and a PhD. In addition, there was a shortage of doctors in New Zealand but that was not considered important enough to allow recently arrived IMGs to help resolve it.

"I was frustrated that I couldn't work, because of qualification problems, but I knew that before...I anticipated that. But it's still frustrating, coming with full registration from the UK, and having only worked in an English-speaking country, and coming here to New Zealand, and being not qualified enough. I mean, I'd done a Ph. D. in Germany as well, and had a lot of qualifications, and coming to New Zealand; and I think most New Zealand doctors were less qualified than what I was, and I wasn't allowed to work here. And I lived in [CNIT], where they had huge staffing problems, and it was exactly the job that I'd done in the UK...And I wasn't allowed to work there, because of qualification problems. And so that was very frustrating." (Dr. Tina - FTF)

Similarly, Drs. Alyssa, Tily, Rogers, Henri, Phil, Charles, and James, all had issues with getting registered and this will be elaborated on in the next section looking at the registration process.

All the IMGs were resolved to overcome the initial challenges they faced by employing various adaptation strategies. Early arrivals such as Drs. Jon, Manu and Ras, mentioned that they got to know other doctors and attempted to integrate in order to learn more about the health system, and the colloquial language. The more they integrated the more friends they made.

“Language was very easy, because as I said our first language was English at that time, even in the medical schools. So it was just a matter of getting used to the accent and the other things. Also, I’m a relatively young house-surgeon coming into a hospital environment, and you mix with the other house surgeons. And we all lived in the hospital premises, so very quickly you get to know the people, and the hospital itself. It’s extremely helpful.”
(Dr. Manu - FTF)

Dr. Deborah, who was not used to cold homes, had to start *“using sleeping bags and then acquiring blankets from the hospital laundry”*. Dr. Christa, who had married a New Zealander, and faced settlement issues, remained positive in her outlook *“Nothing seems all that difficult when one is freshly in love”*. Dr. Nathan, who felt professional antagonism, just *“got over it”*.

Dr. Charles’ friends helped arrange accommodation and schooling for his children, as well as helping with preparing for medical registration. Dr. James, who had problems making friends, was thankful to his children for introducing people they knew through their networks in school.

4.3 Registering to Work in New Zealand

IMGs who want to practise in New Zealand have to achieve MCNZ registration. This is legally sanctioned and an absolute for all IMGs, regardless of country of origin, previous qualifications and work experience, the offer of employment and their duration in New Zealand. For the IMGs in this study, the registration experiences varied depending on the abovementioned factors. The main problems they faced with the registration process were the lack of recognition of their prior medical qualifications because the MCNZ was unsure of the quality of their training, the country in which they trained did not have a comparable health system to that of New Zealand, and/or the training had not been done in English. In some instances, where the qualifications were appropriate, the work experience was not considered adequate to warrant registration.

As part of his contribution to this study, Dr. Phil who came from the UK, also shared extracts of his memoirs documenting his early experiences, capturing some of the angst and frustration with the registration process. This demonstrates that issues with the MCNZ were not limited to IMGs from countries with very different health systems but also happened to those from the UK, arguably where many aspects of our health system originated from.

“The alien landed in October – Dr. Alien MBChB should I say. He had tried to prepare as best he could with the information received in outer space on the ether waves, but as I imagine Captain Cook also discovered, things in New Zealand are markedly different from that which he had anticipated. Despite modern communication systems it is very difficult to discover what being a GP in New Zealand involves and, in fact, how the Health Service works here, from outer space.

The first obstacle to overcome was the New Zealand Medical Council. Dr. Alien had the foresight to set up communications with this august body long before he embarked on his trip. Having read the information provided, he filled in forms, sent off the money and waited...and waited...and waited. His application was eventually considered in August but then there was some disagreement between the Council and the College of GPs, the outcome of which was considered at the next meeting of the Council...in October. Following this, which was after his landing, he was informed that he was eligible to fill in more forms to apply for registration provided he found a fairly long-term job. His grouse with the Medical Council isn't the lengths they go to make sure that an alien doctor is suitable to work in New Zealand...but rather that even allowing for intergalactic postal costs, communication was poor and information about the process involved was very much on a one-step need-to-know basis...having got over one hurdle more information was released about the next previously unmentioned hurdle.” (Dr. Phil - EI)

4.3.1 Medical Qualifications and Prior Medical Work Experience

All IMG participants came with a medical degree gained in their home countries (Table 4). With exception of Dr. Tina, all the other IMGs had done their medical training in English. Additionally, Drs. Tina and James had also acquired post-graduate qualifications as well. As noted earlier, Dr. Tina had a PhD in surgery and Dr. James had post graduate training in pain management.

All participants except for Drs. Lou and Christa had some medical work experience prior to coming to New Zealand (Table 4). However, Dr. Lou was a student when he first came to New Zealand, and had done most of his intern training in a hospital setting in Auckland. He, like Dr. Christa, returned home to complete his medical studies before coming back to New Zealand.

Drs. Manu, Jean, Nathan, Michael, Rogers, Henri, Phil, Charles, and James, had some general practice work experience. Given their age at the time of migration, Drs. Nathan, Rogers (when returning in the 1990s), Phil and Charles had considerable general practice experience.

Table 4: Getting Registered to Practice Medicine in New Zealand

Participants	Year of Migration	Medical Qualifications	Prior medical work experiences	IMG country of origin and registration in a comparable country	Job offer prior to coming to NZ (type of work)	Outcome: Easy of MCNZ registration
Dr Jon (SL)	60s	√ ♪	Y	PC	W (H)	♦♦
Dr Manu (SL)	70s	√ ♪	YG	PC	W (H)	♦♦
Dr Lou (AUST)	70s	√ ♪	N	P	S (H)	♣
Dr Jean (CAN)	80s	√ ♪	YG	P	W (H)	♦
Dr Ras (IND)	80s	√ ♪	Y O	R-UK	W (H)	♦♦
Dr Deborah (UK)	80s	√ ♪	Y	P	W (H)	♦
Dr Christa (GER)	80s then 90s	√ ♪	N	P	S (H)	♥ ♣
Dr Nathan (UK)	90s	√ ♪	Y G O	P R-HK	W (GP)	♦♦
Dr Michael (UK)	90s	√ ♪	Y G O	P R-AU	W (GP)	♦
Dr Tina (GER)	90s	√ ♪	Y O	P R-UK		♣♣♥
Dr Alyssa (PHIL)	90s	√ ♪ ♪	Y			♣♥
Dr Tily (SL)	90s	√ ♪	Y O	R-UK		♣♥
Dr Roger (UK)	80s then 90s	√ ♪	Y G O	P	W (GP) (A)	80s-♦90s-♣
Dr Henri (GER)	90s	√ ♪	Y G O	P R-UK	S	♣♥
Dr Phil (UK)	2000s	√ ♪	YG	P	W (GP)	♣
Dr Charles (ZIM)	2000s	√ ♪	YG		W (H)	♦
Dr James (UK)	2000s	√ ♪ ♪	Y G O	P	W (GP)	♦

√ = had medical qualification
 ♪ = training done in English
 ♪ = had post-grad medical or other qualifications
 N = No prior medical work experience
 Y = had prior medical work experience
 YG = had prior general practice experience
 O = Overseas work experience (other than in country of origin)
 R = registration in another comparable country
 PC = Preferred country under Commonwealth

P = Preferred country of origin for registration
 ♦ = Immediate registration upon arrival
 ♦♦ = Pre-arrival registration
 ♥ = had to do MCNZ registration exam
 ♣ = had to do English test
 ♣ = registration was difficult or delayed due to training status
 W = prior medical work offer in NZ
 S = did medical work as student in NZ
 (H) = Hospital work
 (GP) = General practice
 (A) = Academia

Additionally, eight of the participants, Drs. Ras, Nathan, Michael, Tina, Tily, Rogers, Henri, and James, had medical work experience in countries other than

where they did their basic medical training. Drs. Ras, Tina, Tily and Henri did some work and training in the UK, while Dr. Nathan worked in Asia as a GP for some years. Dr. Michael did a short stint in Australia as a GP while Drs. Rogers and James worked in Africa doing both primary and secondary care.

In the case of Drs. Jon and Manu, they trained under the British Commonwealth system in Sri Lanka, so they were regarded as having medical qualifications comparable to other British medical training systems. This was advantageous to them. This has now changed for graduates coming from Sri Lanka and other countries who had such recognition under the Commonwealth system.

“That time, the special skills, they were looking for doctors from other countries who had less parochial registration, and Sri Lanka at that time, my degree was recognised in New Zealand, because of the British Medical Council affiliation. Because we had only two medical schools, both affiliated to the British Medical Council. It’s only now we lost that recognition, mainly because there were many other medical schools started, and also the language of instructions changed from English to Sinhalese and Tamil, which meant the assessment was very difficult for the New Zealand Medical Council, because the teaching was done in a different language.” (Dr. Manu - FTF)

Drs. Ras, Alyssa, Tily, and Charles, received their basic medical training in countries that did not have the ‘preferred country for registration’ status in New Zealand. Dr. Ras, who came in the 1980s, noted that he had a telephone interview for the job he had applied for, and had his qualifications assessed by the MCNZ while still in the UK. His job offer was confirmed shortly after his medical registration was approved, and he arrived in the country and started working in Middlemore Hospital immediately. This was also the case for Drs. Jon and Manu, who had their medical registration approved prior to coming to New Zealand. Dr. Jean, who also came in the 1980s with a job offer, noted that getting registration was not difficult, even though it was an unusual experience compared to what the process is now.

“That was all quite dramatic. Again, that was because at the time...it [MCNZ registration] was all done in a bit of a rush... but I arrived in Auckland, and someone from the Medical Council lived in Auckland, and I had to take a taxi to his house, with my degree and some other papers. And he signed off my application for a New Zealand medical license there and then. So it was quite interesting at the time.” (Dr. Jean - FTF)

Up until the 1990s, it would seem that the registration process was straightforward because Drs. Deborah, Nathan, Michael and Rogers, who came just prior to that, did not encounter any issues with getting registration, mainly due to them being from the UK, which has ‘preferred country for registration’ status in New Zealand. However, the MCNZ made changes to their registration

policies soon after, and the once straightforward process became difficult for many IMGs, including those from the UK and other similar countries.

Dr Rogers, who had no difficulties with the MCNZ when he first came in the 1980s to work in general practice, faced many issues with getting registered when he returned in the late 1990s. The main challenge was getting his qualifications and work experience recognised.

“When I came back again in '97, I think my expectation was that as a Member and Fellow of the UK College, and coming to be an academic, with that part of the job being set up, and I'd been doing general practice then for twelve years, as a principal, in the UK- that it would be relatively straightforward. And of course it wasn't. So to start with...there was quite a bit of hassle in terms of getting the Medical Council side of things sorted out. My expectation was that coming to that sort of job, coming from the UK, it would be “tick, tick, tick, thank goodness you're here.” You know. “Thanks very much, good to see you...Sign here.” Well of course it wasn't like that at all. It was [like] were you of good standing?, do you know a JP and an MP?, and a this and a that, and a Minister of the Crown?; and then there was a lot of waiting around, and if I remember correctly, at one point there was something like non-recognition of one of the references, or some bizarre thing. So it was about three months before I was allowed to practice at all, and then within a restricted scope of practice.” (Dr. Rogers - FTF)

Dr. Phil encountered very similar issues to Dr. Rogers. The process for getting registered cost him the job he had arranged to start at, mainly due to the long time it took dealing with the MCNZ.

“Medical Council – one hoop at a time; despite starting application for registration well in advance of coming here I missed the job that I had arranged because of time taken to register.” (Dr. Phil - EI)

Other IMGs such as Drs. Tina, Alyssa, Tily, and Henri, also noted that the registration process posed many challenges for them. Dr. Alyssa, who trained in the Philippines, had no option but to do the MCNZ's New Zealand Registration Examination (NZREX). Since she had completed the United States Medical Licensing Examinations (USMLE), she was not required to do an English exam.

Similarly, Drs Christa, Tina, Tily and Henri, some of whom had work experiences in the UK and had achieved registration with the British Medical Council, were required to do the NZREX, and a recognised English exam, to demonstrate their competence in the English language. It was only after completing these that they were given registration to work in New Zealand.

All the IMGs who had registration issues persevered with the challenges. Drs. Tina, Tily and Henri, who were required to sit English exams, found it easy due to their prior training and work experience.

“I mean, we studied in English, back home, and under British system, the university studies all were in English. Exams were in English. So I think I didn’t find it that difficult, because if somebody speaks different, if their language is different, and if they are exposed to English for the first time, then it can be quite difficult. But I mean, it’s just a matter of... it’s personal, I think. Yes, because some people they do it well, some graduates from other countries.” (Dr. Tily - FTF)

Like some of the other participants, Dr. Henri, noted having to be persistent when dealing with the MCNZ bureaucracy about his registration.

“Nope [Sarcasm intended], very collegial relationship with MCNZ bureaucracy...No luck with the administrator?...talk to the office manager...no luck there?- ring them daily until they simply want to get rid of you and give you what you asked for in the first place. Not that difficult a technique!” (Dr. Henri - EI)

The process for MCNZ registration, as noted by the participants, was varied mainly due to their time of arrival in New Zealand. While the early arrivals had an easier passage to registration, the ones that came in the mid-nineties to early 2000s had faced considerable challenges with the registration process. The more recent IMGs, such as Drs. Charles and James, did not note any particular difficulties. Dr. Charles was given temporary registration immediately to start his job in a hospital, and was given time to work on getting his full registration. It would seem that the MCNZ had rationalised some of its demands so that IMGs were not disadvantaged in terms of employment like Drs. Rogers and Phil had been.

4.3.2 Post-Migration Employment in New Zealand

Of those IMGs who had secured a job prior to coming to New Zealand, the majority started in hospital settings, while the rest went straight into general practice (Table 4).

All the IMGs who initially worked in hospitals were junior doctors or house surgeons/officers in sub-specialties such as anaesthetics (Dr. Jon), internal medicine, surgery, outpatients (Drs. Manu, Jean, Deborah, Christa, and Charles), obstetrics and gynaecology (Drs. Lou, Jean, and Christa), and accident and emergency (Dr. Ras).

Drs. Jon, Manu, and Ras also worked in other hospitals than the ones they originally started in. Dr. Jon moved to a provincial hospital in upper North Island from Wellington where he had opportunities to do chest medicine,

paediatrics and geriatrics. Dr. Manu moved from a provincial hospital in central North Island to one in upper North Island where he did paediatrics and orthopaedics. He then moved to a provincial hospital in lower South Island as a paediatrics registrar. He was offered a senior role with further training opportunities there, however it was here that he felt that he did not want to continue working in a hospital setting.

Dr. Ras worked in nearly all the major hospitals in Auckland doing various medical specialties. He too, like Drs. Manu and Jon, was not quite satisfied with working in the hospital settings.

“So I spent time in the various specialties at that time. And specialties are good, they’re fascinating, but they’re very narrow. And what you see, if you’re a cardiologist, you are basically restricted to one organ of the body...In the hospital, you basically fix their problem, and out they go. And then you don’t know what happened to them after that, and they move on.” (Dr. Ras - FTF)

The next section further elaborates on the IMGs’ motivations for choosing general practice as a medical career in New Zealand. The pathway to general practice is explored in the different time periods being covered, as well as the different backgrounds that IMGs brought with them.

4.4 Motivation to Become a General Practitioner in New Zealand

The preceding discussion showed that of the 17 participants, only five went straight into general practice (Table 4). For the rest of the IMGs, their first medical employment was in hospitals, indicating that general practice was a deliberate choice at some point in their emerging medical careers in New Zealand. All those IMGs who went straight into general practice had prior work experience and training in that specialty. Even then, their reasons for becoming general practitioners in the first instance provided valuable insights into their pre-migration work and life experiences.

IMGs that chose general practice as a career after having worked in hospitals, found general practice to be an attractive option given the issues they were facing in hospitals. Some others chose general practice because it provided better lifestyle choices (Table 5). Understanding the various motivations is important to better appreciate the subsequent decisions taken by the IMGs to become general practitioners rather than any other type of medical specialist.

4.4.1 General Practice as an Attractive Option

General practice was seen as an attractive option or an alternative to the hospital-based medical work that many of the IMGs were doing at the time (Table 5). It was seen as offering the ability to work closely with the communities. It also

allowed for more freedom, variety and greater challenges. General practice was deemed to be more rewarding than their work in hospitals.

Table 5: Motivation to Become a General Practitioner in New Zealand

Participants	Year of Migration	Why general practice? The motivators					
		General Practice was an attractive option	Issues with working in hospitals	Better work and life balance	Prior Training in general practice (incl. Overseas work experiences)	Personal GP a role model	Information about general practice
Dr Jon (SL)	60s	◆◆+	♣				I-
Dr Manu (SL)	70s	◆+◆++	♣	♥			I+
Dr Lou (AUST)	70s	◆◆++			♣		I+
Dr Jean (CAN)	80s				♣		I+
Dr Ras (IND)	80s	◆+++ ◆++++ ♥+					I+
Dr Deborah (UK)	80s	◆++++					I+
Dr Christa (GER)	80s then 90s	◆+++	♣	♥			I+
Dr Nathan (UK)	90s	◆			♣		I+
Dr Michael (UK)	90s				♣	♣+	I+
Dr Tina (GER)	90s	◆+++	♣	♥			I+
Dr Alyssa (PHIL)	90s		♣	♥			I+
Dr Tily (SL)	90s		♣	♥			I-
Dr Rogers (UK)	80s then 90s	◆+		♥	♣++		I+
Dr Henri (GER)	90s			♥			I+
Dr Phil (UK)	2000s			♥	♣		I-
Dr Charles (ZIM)	2000s	◆+++ ◆++++					I-
Dr James (UK)	2000s				♣++	♣+	I+

◆ = wanted/liked to work in community	♥+ = more satisfaction
◆+ = wanted more freedom,	♣ = prior training/experience in general practice
◆++ = more variety, more challenges	♣+ = personal experience of own GP
◆+++ = more continuity of care	♣++ = overseas medical work experience
♣ = issues/tensions in hospital settings	I- = little information on general practice opportunities
♥ = better life style options - flexibility	I+ = enough information on general practice opportunities

Dr. Nathan, who went straight into general practice, mentioned that he “*loved people*”, and that was one of the key motivators for him becoming a GP in the first place.

Dr. Jon, while still working in the hospital, realised that he liked working in the community. He wanted to be there for his patients which he could not do as a doctor in the hospital.

“General practice was such that that’s where I learned a good lesson...the patients who came in wanted accessibility, availability and affordability.”
(Dr. Jon - FTF)

Dr. Lou also wanted to work with people, and do a variety of work. As a student back in Australia, he had the opportunity to do a short stint in a rural general practice which informed his choice later on.

“I had experience of general practice in a rural setting in Australia as a medical student for 3 weeks, in 5th year. I wanted to do a wide range of work, and help people.” (Dr. Lou - EI)

General practice was also attractive because it provided freedom and flexibility. Through his work as a GP, Dr. Jon was also able to do other types of work with organisations including different ethnic councils and various NGOs. He noted that a career in hospitals may not have afforded him those opportunities.

Dr. Manu had already spent a few years working in different hospitals, and was looking for change. He wanted more freedom to do what he wanted.

“I was getting a little bit tired of living in the hospital. I was alone, and it was just too difficult to think of... I was offered the position of another senior registrar job to continue my studies [in paediatrics], but by that time, I was emotionally not ready to continue being, you know, in a one-room hospital thing for another four, five years. So I decided that I should go somewhere where I’m free to do what I like. And so I started doing some locums, and the jobs were offered as a result of my work as a locum. Many of the places I worked, they contacted me, and said, “Would you like to join us as long-term locum?”(Dr. Manu - FTF).

Similarly, Dr. Rogers, who was working in a hospital back in the UK, chose to do general practice because he wanted more flexibility. Like Drs. Jon and Manu, Dr. Rogers was able to do other things such as teaching while also doing general practice.

“Before I went to Africa, I had done a couple of paediatric jobs, and I thought I might do paediatrics. And then when I came back from Africa, I did quite a lot of emergency department, ED medicine. And I liked that. And I could have carried on in that, but the career pathway then was to becoming a consultant. I was still fairly kind of rootless at that point, and

it didn't happen. So general practice then seemed to be the place where, no matter what you were doing, you had a lot of flexibility to do what you were doing, so general practice kind of fitted itself. And then the move into academic practice was kind of similarly bizarre, really." (Dr. Rogers - FTF)

Another reason why general practice was seen as an attractive option was due to the variety of medical work one could do and therefore, the challenges it offered. Drs. Manu, Ras, Christa, Tina and Charles all stated this as a key motivator in becoming a GP. Additionally, very closely related to the above reasons was the fact that general practice was about the continuity of care that GPs were able to afford their patients, something that is often lacking when practising in hospitals. For example, Dr. Ras succinctly stated that he found the variety of work, the challenges it provided, and the continuity of care, as the most interesting and attractive things about general practice. These aspects of general practice were also expressed by the other aforementioned participants.

"In general practice, there is a continuity of care, there is that association with the individual and also their family; and it is a trust that you build up over several number of years. So one is the variety, second is the satisfaction, and the third is the challenge. Because in general practice, the patient comes with a variety of symptoms, which then you have to analyse, as to which one is important, which one is not important. As compared to a specialty: if someone has a heart attack, you know you only have to deal with the heart. Someone has already made the diagnosis, and you basically have to fix them. Whereas in general practice, you are the person who is doing the - what shall I say - the investigations and making the diagnosis. And often you can fix it yourself. If you can't fix it yourself, that is when you refer them to the specialist. Yes. So it was the challenge. I think it was those three things: one is the variety, the challenge, and the continuity of care." (Dr. Ras - FTF)

Six of the participants mentioned that one of the key reasons for choosing general practice was to get away from issues they were facing in the hospital settings. The next section elaborates on these issues.

4.4.2 Issues with Working in Hospitals

The reasons stated for choosing general practice can be viewed in the context of push-pull factors (Table 5). The issues that IMGs faced when working in hospitals can be seen to have 'pushed' them into general practice. IMGs stated a variety of issues they faced in hospitals such as being alone, not doing well in certain exams, disliking the hours of work, being overlooked for promotions, and being undermined.

Dr. Jon did not hesitate in affirming that his lack of success in one of the speciality exams caused him to reconsider his hospital career. This, combined

with his desire to work within communities, and to have more freedom to do other things, 'pushed' as well as 'pulled' him into general practice. He also mentioned that his wife did not like where they were living so he took up an opportunity in a general practice in Auckland.

"Yes, in the sense that I came to [provincial] hospital and I worked as a registrar. Then I decided to sit for exam, the membership exam. And I came down in that exam. And I thought...that's the time, I thought, I would go into general practice. So it was not a case of I knew much of general practice as such, but it was again a case of I was a person who liked the community a lot. So I worked with the community then, so I thought this was a good opening for me, and that's really when I came into general practice...it was quite a good task for me to carry on my other work also...and my wife didn't like [town] so much. I thought, I loved it." (Dr. Jon - FTF)

Dr. Manu had other types of difficulties in the hospital. He got promoted to a senior position and started having problems with one of his colleagues. This made him rethink his work in the hospital. He recalled it as a racist encounter.

"And then about ten...nine months later, a vacancy came as a medical registrar. And I didn't apply for it or anything. Next thing, my name comes as, "Dr. So-and-so has been appointed the medical registrar." When that happened, there was a reaction from one of the house surgeons, who called me to a side. He and I were same vintage, same age, same...just same. He said, "I don't want your nose in my work. If you are a registrar, keep out of my work." So I was quite upset. And then he gave me a hard time, and he would, like, not ring me, but ring the consultants, and say, "I don't know what to do. Registrar is not available." All this sort of crap. That time, I was so upset. So that's one of the reasons I left that hospital, and so forth. Because I didn't want to tell the boss that I have this problem with this guy. So that is the only time...he made a remark about...the racist remarks. I don't want those coloured fellows coming in." (Dr. Manu - FTF)

He was supported by other colleagues and some senior consultants but that was not enough to keep him in the hospital setting. Dr. Christa was in somewhat of an opposite situation to Dr. Manu but also felt aggrieved. She had applied for a senior role but was turned down in favour of someone she thought was less qualified than her but who happened to be a New Zealander.

"My application to the medical stream, whilst still working in hospital system was declined despite superior academic application to other applicants (i.e. M.D. in hepatology) and I believe it was because it was a 'closed shop' stream to overseas applicants." (Dr. Christa - FTF)

Drs. Tina, Alyssa, and Tily, who were all young mothers at the time, found working in hospitals challenging due to the odd hours of work, and the on-call duties. They were finding it difficult to juggle their work commitments with the needs of their young families. It should be noted that this 'push' factor is also a 'pull' factor in terms of having a 'better work and life balance', for the sake of family.

"My husband's got a very demanding job, and to do the full training into another specialty...and then I've spoken to different specialists, and I mean, it's very difficult to actually combine postgrad work in the hospital with family. And I mean, by that time, in [CNIT] I had another child. And it's so just most flexible to do general practice...it's really been those practical considerations that made me choose general practice. I'd never dreamt of doing general practice. I've always wanted to do a surgical subject, and my Ph. D. was in surgical subject as well...but it would have meant, many years of training, and then actually being hospital-based, and doing on-calls and weekend work, which is not very family-friendly." (Dr. Tina - FTF)

"I went back after my daughter was born. It was getting difficult. I worked at ED, and I was working night-time - night shift. And she, the daughter, got sick. And I had to get someone to look after her while I worked. And my husband also did shift work, so that was sort of more a lifestyle choice. You know, I would have liked to have done internal medicine, if I had a choice. But I didn't regret that now, because I'm quite happy where I am, what I'm doing." (Dr. Alyssa - FTF)

"And then, I think I had a chance to get into anaesthetic practice, but my daughter was little, and it was really hard, as a woman, housewife, to do that job. So I thought general practice...you can choose your hours, part-time work, and also, hospital medicine is really tough, I think. Night duties, and...it's not really pleasant." (Dr. Tily - FTF)

It is interesting to note that all three of them enjoyed their hospital specialties but the work scheduling, and the demand on their family time, meant that general practice was a better choice. The following section further elaborates on the reasons why general practice was seen to offer better work and life balance for the participants.

4.4.3 Better Work and Life Balance

In addition to the flexibility that general practice offered IMGs such as Drs. Tina, Alyssa, and Tily to better cater for the needs of their families, as well as fulfil their own career aspirations, other IMGs also stated similar reasons for choosing general practice. Dr. Phil was a GP by training and had experience from the UK.

He too noted that the flexibility in general practice afforded him time to be with his family and so he pursued it when he came to New Zealand.

“General practice certainly provided flexibility for being there for children while my wife settled into a very busy job but general practice became an obvious choice as it was my background.” (Dr. Phil - EI)

Dr. Christa “enjoyed the flexibility of being a locum” after having experienced work life in hospitals.

Dr Henri wanted some stability in his life, and found that a career in general practice would provide that. He was candid with his observations of the situation with his previous wife, who was also a doctor.

“Wife threw toys out of the cot every few years, so better to get something under my belt. Not my first choice...yep, my spouse was useless in accepting anyone’s career, so every time I got onto the surgical bandwagon she pulled the plug on the country. When the writing was on the wall in the UK I rather quickly finished a fellowship- the fastest was GP.” (Dr. Henri - EI)

In terms of lifestyle choices, New Zealand offered good options for outdoor activities. Dr. Manu wanted to practise in a rural setting where he could also enjoy the great outdoors. His choice of practice location meant that he was able to connect with others from his own ethnic community.

“I was offered jobs in Auckland as well as in rural areas. But I like the rural area, [CNIT], because it is close to the ski fields and the mountains and the rivers. And things like the lifestyle is extremely good there as well. And I had some Sri Lankan friends. One of them was working in the hospital there as well. So we mix as a small community, we felt more comfortable there as well.” (Dr. Manu - FTF)

Prior training and work experiences were other reasons that some IMGs chose to join general practice. The following section elaborates on these motivators.

4.4.4 Prior Training and Experience in General Practice

With the exception of Dr. Deborah, all the other IMGs from the UK (Drs. Nathan, Michael, Rogers, Phil, and James) had prior training in general practice. For these IMGs, becoming a general practitioner in New Zealand was an obvious choice. Dr. Jean, from Canada, also had prior training in general practice but she initially worked in hospitals in New Zealand before pursuing general practice.

Dr. James initially did not have any general practice training but had worked in general practice type settings in Africa. He always wanted to do general practice but upon his return to the UK he was unable to get into it. As noted earlier,

having the opportunity to do general practice was one of the reasons he chose to come to New Zealand.

“And I remember, when I went overseas, and I went to work in Africa, I came back, I’d made a decision that it was...I was 27, so this was quite young...I was either going into general practice, or I was just going to have a good time for a few years, until I had to go into general practice. Because I was trying to get an academic job, and my new focus, after medical school, was to become a general physician. And that was at the time in the UK when general physicians were being phased out for specialists. And when I went to interviews, they’d say “What do you want to be?” I’d say that I wanted to be a general physician, and they’d all laugh, and say, “Oh well, nobody’s a general physician any more, it’s all going to be in general practice. And so somewhere in the process, I got into a place where I knew what I wanted to do, but nobody wanted me to be that. And yet I had some fantastic teachers in general medicine. They were...even to this day, were superb doctors. And I guess we see those people in general practice now.”(Dr. James - FTF)

For two of the IMGs from the UK, their personal experiences with their own GPs were influential in their decision to become one themselves.

4.4.5 Personal General Practitioner as a Role Model

Drs. Michael and James recalled how they liked their own GPs, and how that influenced them in later years. Dr. Michael stated that he *“always fancied it, mainly due to a like for his family GP”*. Dr. James provided more insights into his experiences as a child being influenced by his family GP.

“I suppose, when I was a kid, I came from a non-medical family, and the most important person in my introduction to general practice was my local GP. I remember him well. He was a lovely old man, who used to wear a wing collar, and cycle round on a bicycle. So it was long ago. And they came to your house, and you had a rash, and he’d sit on the bed, and he’d give you some pills, and he’d say, “He’ll be alright tomorrow.” And you thought that was wonderful. And he didn’t really do anything, but that wasn’t the point. It seemed such a sort of lovely job to do. And my mother thought it was a good idea. And from the age of four, I wanted to be a GP, see. So it wasn’t like I woke up at eighteen and wanted to be a GP: I wanted to be a GP when I was a baby, you know.” (Dr. James - FTF)

In summary, the IMGs in this study gave a variety of reasons for choosing general practice as a career. For those who started their medical careers in hospitals, the flexibility and ability to do other things were key motivators to join general practice. For others certain lifestyle choices played an important role in choosing general practice. Some IMGs came with prior training and experiences

so general practice was a natural choice. For the majority of the participants, there was more than one reason or motivator that made them become GPs.

A key factor in any decision-making process is the amount and value of the information available to facilitate the desired outcome. It is important to understand what the sources of information about general practice were, and how useful it was for the IMGs, regardless of whether it affected their final decision.

4.4.6 Information about General Practice

The IMGs reported having many different sources of information about general practice. As noted in earlier discussions, the majority of IMGs initially worked in hospitals, and for them, information came through the various hospital channels. For others, their prior travels to New Zealand gave them opportunities to investigate what general practice had to offer. Some did their own homework using information technology and personal contacts.

Dr. Jon, who came in the late 1960s, noted that he had very little information on the opportunities in general practice, and observed that *“general practice was a very well-knit closed shop”* (Table 5). Dr. Phil, who came in the early 2000s, also noted having very little information of value despite having spoken to contacts in a department of general practice, and an after-hours service provider. Similarly, Dr. Charles, who came soon after Dr. Phil, also noted that the information was *“poor”* and of *“limited”* value. His main sources were other doctors and the DHB he was working for. Dr. Tily, who was working in a hospital, also noted having little information about general practice.

Some IMGs did note that the information on general practice they received was useful. Drs. Lou, Christa, and Tina got information from hospital boards and fellow colleagues in the hospital; Dr. Ras heard about general practice through a new training programme that was being introduced specifically for IMGs – the Family Medicine Training Programme (FMTP); Dr. Deborah got information from local GPs while working in a local hospital; Dr. Alyssa attended a session run by a GP in her hospital that provided her with the necessary information.

Drs. Nathan, Michael, Rogers and James, who went straight into general practice, had a lot of information on opportunities in general practice, from New Zealand medical magazines, international journals and local contacts. Like many of the early arrivals, Dr. Henri saw employment opportunities advertised in international journals but he recalled being a bit more hands-on by contacting local GPs as well.

“Rang up practices, decided to live in South Island and got number of the biggest medical centre from tourist information, then badgered the GPs with daily phone calls until they gave me a 2 month locum job. Persistence always wins.” (Dr. Henri - EI)

With the exception of a few of the IMGs, the rest had enough information to decide that they wanted to do general practice. The information included the employment opportunities and the additional training requirements. The next section explains the various training pathways that the IMGs took to achieve independent practitioner and specialty status within general practice. The key outcome of the training was the achievement of the Fellowship of the RNZCGP, and vocational registration with the MCNZ.

4.5 Training to Become a General Practitioner in New Zealand

Specialty training is mandatory for all medical fields regardless of whether a doctor is an IMG or a local. One of the key selection criteria for this study was that IMGs had fulfilled and achieved the Fellowship of the RNZCGP – FRNZCGP. The main reason for having such a criterion was to understand the complete journey of IMGs coming to New Zealand and becoming independent, specialist GPs. Formal training can also be an important milestone for highly skilled migrants in new countries. The continuing medical education aspect of doctors' ongoing professional development is also mandatory for the upkeep of their practising certificate; however this will be discussed in a later section.

The GP training programme is prescriptive in the sense that new medical graduates have to do the registrar training programme which gives them Membership of the College – MRNZCGP, and then the vocational training that leads to the FRNZCGP. For IMGs, the training pathway to FRNZCGP is dependent upon their prior medical qualifications, their prior medical work experience and their country of origin. These factors determine how much further training will be necessary for them to achieve the standards of the FRNZCGP and thereby become specialist GPs.

4.5.1 Specialist Training to Become a General Practitioner

The majority of the IMGs in this study reported doing some training on their way to the FRNZCGP (Table 6). It is important to note that all the IMGs were working in general practice during their GP training period. For the early IMGs such as Drs. Jon and Manu, there were no particular restrictions at the time to practise as GPs. Their hospital-based experiences were enough to get them into general practice. Another reason was that the RNZCGP was only established in the late - 1970s; however, GPs were already in existence before then (RNZCGP website – History of the RNZCGP, 2014).

Dr. Nathan, who came in 1990 from the UK, was the only participant to state that he was not required to do any further training to get the FRNZCGP. Dr. Michael, who had also come from the UK a couple of years after Dr. Nathan, reported that initially he was not required to do any further training because he had the *“Joint*

Certificate of Equivalence which was enough in the pre-Bottrill²⁰ days” but later on had to complete the FRNZCGP training.

The training requirements were not introduced until much later. When the requirements were introduced, both were only asked to complete the vocational training for FRNZCGP but not the registrar programme.

“At that time, even the College was not in existence, in 1970. But my work in the hospitals, which covered paediatrics, medicine, surgery, everything, opened the direction of general practice. I came to understand...as a registrar you were involved with communicating with general practitioners writing letters. So I had a reasonably good idea. Then I did the locums, which gave me another bit of experience.” (Dr. Manu - FTF)

“We had the MBBS. But I had to do the Fellowship of the Royal College of New Zealand General Practitioners, FRNZCGP. And I completed that.” (Dr. Jon - FTF)

Drs. Jean and Ras were also working in general practice but took the time to complete the training needed to practise independently. Dr. Jean mentioned that she did the Primary Medical Examination (Primex) that GP registrars do at the end of the Stage 1 training programme, even though she was not in the training programme itself. She liked doing exams so just went and did it when it was held. Soon after, she completed the Stage 2 vocational training and achieved the FRNZCGP.

“Well Primex...when I say I did Primex, I did the exam. There was really just an exam, there was an essay, and then maybe, somewhere I had to do videos [the videos are part of the Stage 2 vocational training]. So it wasn't really a programme. I enjoyed doing exams. I know that's a bit bizarre. That was quite fun, doing the exam...they just sort of...I sent in the money, and they said, “The exam date is the 10th of November. Show up at nine o'clock.” (Dr. Jean - FTF)

²⁰ Dr. Bottrill was a UK trained pathologist working in Gisborne when he was accused of medical negligence when interpreting cervical smear tests of many patients. He was found guilty of the negligence by the Privy Council in 2002 and the Medical Council of New Zealand. This incident led to changes in the way IMGs' prior qualifications were assessed and thereby, what further training was necessary for them to practise in New Zealand. Arguably this was a turning point in medical registration policies that affected many IMGs at the time and those who came later on. (Gisborne Cervical Screening Inquiry - <http://www.csi.org.nz/>).

Table 6: Training to Become a General Practitioner in New Zealand

Participants	Year of Migration	Specialist training to become GPs	Training in cultural competence	Relevance of training	Challenges	Support important for training
Dr Jon (SL)	60s	F	♣ ♦ ♠	♪ ♪		T FMTP R+ GP+ IM-
Dr Manu (SL)	70s	F	♣ ♦ ♠	♪ ♪		T CR HS GP+
Dr Lou (AUST)	70s	NA	NA	NA	NA	NA
Dr Jean (CAN)	80s	F O	♣	♪		I+T
Dr Ras (IND)	80s	FMTP O F	♥ ♥+	♪ ♪	X X+	FMTP Q+ B+ C+ IM-
Dr Deborah (UK)	80s	GP-S F	♥	♪ ♪	XX XXX	GP-S GP-R
Dr Christa (GER)	80s then 90s	GP-S F	♣ ♦	♪ ♪	X	M+
Dr Nathan (UK)	90s	NR	♥ ♥+	NR		NA
Dr Michael (UK)	90s	F	♣ ♦	NR		M+
Dr Tina (GER)	90s	O GP-S F	♥ ♥+ ♠	♪ ♪	XXX	M+ Q+
Dr Alyssa (PHIL)	90s	O GP-R F	♥ ♥+ ♠	♪ ♪	XXX X++	M+ S+ C+ ♥+
Dr Tily (SL)	90s	GP-R F	♥ ♥+	♪	XXX	GP-R
Dr Rogers (UK)	80s then 90s	F	♣ ♦ ♠	♪ ♪	X+ XM	Q+ I+T CR IM-
Dr Henri (GER)	90s	F	♣ ♦	♪	XX	M+ Q+
Dr Phil (UK)	2000s	F	♣ ♦	♪ ♪	XI	M+ I+ HS
Dr Charles (ZIM)	2000s	GP-R F	♥ ♥+ ♠	♪	XI X XX	C+
Dr James (UK)	2000s	GP-S F	♥ ♥+	♪ ♪	XW X++	GP-S

F = completed Fellowship (FRNZCGP)	XW = workload
FMTP = Family Med Training Programme	R+ = more support for refugee docs
GP-S = GP seminar programme	GP+ = improve image of general practices as a specialist
GP-R = GP registrar programme	IM- = reduce mismatch between immigration & professional authorities
O = other qualifications	HS = awareness of NZ's health systems
♣ = No formal training cultural competence (CC)	I+ = more information about training requirements
♦ = self-learned CC	Q+ = better recognition of qualifications and experiences
♥ = Formal training in CC	B+ = better understand IMGs immediate needs
♥+ = CC training was useful	C+ = support with cost of training
♠ = visited a Marae	M+ = good mentoring from experienced GPs
♪ = training was useful and relevant	S+ = encourage socialisation among IMG trainees
♫ = training could be improved	T = became a GP teacher
NR = Training not required	CR = rep on a RNZCGP Committee
XI = lack of information on training requirements	NA = responses not available due to technical issues
X = new learning environment	
X+ = mode of learning/training	
X++ = quality of teaching	
X (√) = saw other IMGs struggle	
XX = financial	
XXX = family	
XM = ongoing MCNZ issues	

At about the same time, Dr. Ras made a deliberate choice to do all the training necessary to become a GP. He considered himself fortunate to be selected for the Family Medicine Training Programme (FMTP) that was the main training programme on offer from the RNZCGP. The FMTP offered Dr. Ras a great opportunity to learn about general practice. He also provided great insights into what the programme was about. After completing the FMTP, he did the vocational training and achieved the FRNZCGP in 2001.

“The Family Medicine Training Programme was the precursor for this, and I did that programme up north in Whangarei. And when I finished with my hospital programme, then I said, OK, if I want to go into general practice, let me see if there is any formal training scheme or a training programme. And I was fortunate enough to be selected for that nine-month training programme. And for that, I did four months in [rural Northland town], attached to a practice there, three months in [another rural Northland town], and three months in Whangarei Hospital. So that was working both in the rural practice, plus also I did three months in paediatrics at Whangarei Hospital, which was to prepare me to deal with children in general practice. So it was working out in the community under supervision, learning the tricks, learning all the things that need to

be done, and also working in a semi-rural or a rural practice, where you get to do a lot more. As compared to working in an urban practice, where there are a lot of people to do a lot of things who are more senior to you, so you don't get to do much. So I went through that nine months of family medicine training programme, which was to prepare me as to what type of cases which I would be seeing in general practice, how to deal with those cases, time-management issues, certain aspects of running a business, as to how to look for a practice, how to do locum work, and how to look for a practice for yourself, how to build up your practice. So a very useful kind of a package that was done.” (Dr. Ras - FTF)

Dr. Ras also spoke about the ‘Bridging Programme’ that was introduced and funded by the government in the 1990s to assist IMGs who were having difficulties with the recognition of their qualifications. At that time, there was a mismatch between the information Immigration New Zealand (INZ) was providing to IMGs, and the expectations of the Medical Council of New Zealand (MCNZ), in regard to medical qualifications. The situation became difficult because INZ recognised the IMGs’ qualifications as sufficient to work in New Zealand whereas the MCNZ said they could not. So the Bridging Programme was seen as a solution to get the affected IMGs to the expected standards of the MCNZ.

“I could work straightaway on my existing experience and qualification in a health board or hospital under supervision, for a period of two years. Whereas I think from early 1990s, or late 1980s, if someone migrated to this country, because their qualifications were recognised on the points system, they coped with migration, but their degree was not recognised by the Medical Council. So you had this kind of situation where the immigration had said, ‘Yes, your degree is alright to come and work here’, but then the organisation which was approving that license, which is the Medical Council, said ‘sorry, your degree is not recognised’. So there was probably about quite a few hundred doctors who came under that kind of a scheme, and they were in a kind of a limbo. So that is when they started the bridging programme, to prepare these doctors for an assessment exam. The bridging programme is just, I think, a solution to overcome that situation, which had arisen because of the mismatch between the immigration service and the Medical Council.” (Dr. Ras - FTF)

In the late 1980s, the RNZCGP introduced the more structured General Practice Education Programme (GPEP) as the successor to the FMTP. The GPEP was in two stages when most of the participants in this study completed it to gain the FRNZCGP. The first stage (GPEP 1) was a fulltime, one year training programme and the second stage (GPEP 2) was practice-based, 12-18 month training under the supervision of an experienced GP. Furthermore, in its original format, GPEP 1

was fully-funded through a bursary system but it emerged that there were not enough training places for all the graduates who wanted to do the training. As a compromise to cater for the demand, the RNZCGP introduced a variation to the original format known as the GPEP 'seminar programme'. The seminar programme was not funded except for some financial support for travel, and it was not a fulltime training programme but the final assessment process was the same as the original format – both cohorts of trainees had to do the PRIMEX to advance to the next stage. The seminar programme provided regular day-long seminars on the same topics as those covered by the fulltime registrars. The programme was popular among the IMGs who had prior medical experience. It allowed them to be in paid general practice employment while studying towards their FRNZCGP. When the government increased funding for the training programme in 2006-7, the seminar programme was terminated.

Drs. Deborah, Christa, Tina and James all successfully completed the GPEP seminar programme (GP-S), and then went onto completing the advanced vocational training/education (AVE as it was known then). For Dr. Christa, the seminar programme was a way of learning more about general practice while doing locums. Dr. Deborah liked the flexibility the seminar programme allowed her in terms of having the opportunity to work, study and raise her family (Table 6). She had a supportive host GP who encouraged her to train.

"The training course was very flexible in allowing part time attendance at seminars and training once our child was born. I appreciated being able to train and work in the area we had chosen to live in – we stayed there for a total of 14 years. The local community were supportive in terms of offering help – child care especially and accommodation for the on-call. Finally if it hadn't been for my host GP's suggestion I might not have done the training at all." (Dr. Deborah - EI)

Similarly, Dr. Tina found the support of an experienced GP teacher a key factor in her positive experience during the GP seminar and the AVE programmes.

"At that time, I was in Palmerston North. That was an ex-trainer, ex College-trainer, and he was in the practice, and I had a very close relationship, and we had almost daily meetings initially. Because as I said, I worked as a seminar attender. So I worked as a general practitioner in the practice, but just attended those seminars once a week. But I mean, he was a great help. Our practice was really supportive, and we had a great teacher and a really good team. I mean, I had a positive experience all the way round for that year. And even afterwards, I mean, the AVE programme is pretty simple, very easy to pass, and so to become fellow, I found." (Dr. Tina - FTF)

Dr. James was reluctant to undertake the GP seminar training because he had many years of medical experience, and thought that he should not have to

retrain, especially when he was already working in general practice. He did however enjoy the experience of being a student again, and learning with young doctors who had far less experience than he did.

"I reluctantly did it, to be honest. Especially reluctantly paid for it. But actually, I really enjoyed it. I thought it was a wonderful...it was the one thing that really made me feel more comfortable with general practice because I suddenly realised we were all at a very similar stage, and asking similar questions. And the young people were just the same as me in a way: they were just getting the same insecurities, and asking the same sorts of questions. So I felt really quite young. It made me feel like I was a student again, but I had the benefit of life's experience. So I was less anxious, maybe, than they were. I'd fallen in more holes in my life than they had, so they were probably more anxious than me. But I learned a lot in that course." (Dr. James - FTF)

Drs. Alyssa, Tily, and Charles were accepted into the fully funded, fulltime registrar programme (GP-R). Dr. Charles, who had many years of medical experience prior to coming to New Zealand, got a rural placement training (RPL) post that he used to complete his registrar training and the AVE training. He also received good mentoring which he found valuable.

"Having a mentor: I was assigned Dr. B, an experienced NZ trained Dr. as my support person not a supervisor. This was very valuable and we still keep in contact." (Dr. Charles - EI)

Similarly, Dr. Tily liked the support she received especially from the RNZCGP during the training period. The support helped her complete what was required to achieve the FRNZCGP.

"The College was really good. I didn't find anything particularly difficult, because it's one of those things that you just go through, and do it. You know, as long as you understand the culture, and the people around, and where to get the resources, then you are alright. Yes, the general practice training programme was really good. My teachers were very helpful. And you know, it was a very good training programme, actually." (Dr. Tily - FTF)

While Dr Alyssa also liked the registrar training programme, she mentioned facing some problems with a particular teacher, when she was doing an experiential stint. She felt the male GP teacher was undermining her ability to practise because she was a woman, and an IMG. She tried doing something about it but was unsure what came of it.

"I don't see it as a difficulty, but there's still that notion among New Zealand - trained people that IMG's are not really up to it. And there was, during my registrar year, there were some problems there that I had to go

and see my GP for. Because he wasn't really doing his job as a teacher, sort of. I brought it up with my GP, because there were also practices that I didn't agree with...and he sort of pointed out to me that I had to think about bringing this up with the College: because first, I'm a woman, I'm a lady doctor; second, I'm an international graduate, you know, he sort of implied that I'm a second-class doctor. That didn't put me off. Anyway, I dropped it, because I thought, well, I'm not going to be there any more in a few weeks' time, and I'll just have to practise the way I'm taught to practise, by the true correct way of practising, rather than do what he does. I drafted a letter, but I didn't send it. And then it turned out, a few months after, he got into trouble, and I showed it [letter] to the lawyer. And I don't know what they did, because the lawyer said that they were going to bring it up with the Medical Council. I haven't heard anything about it, so."
(Dr. Alyssa - FTF)

Drs. Rogers, Henri and Phil, who all had qualifications and work experience from the UK, only had to do the AVE training programme to gain the FRNZCGP. While it sounds straightforward, it was anything but that for them. The problems that were faced by the IMGs during their training years are discussed in a later section focused on the challenges of training.

In addition to the formal GP training programme, some of the IMGs had previously completed other qualifications to support their work as GPs. Drs. Jean, Ras, Tina and Alyssa had completed Diplomas in Obstetrics and Gynaecology (O&G) because prior to 2003, GPs were the lead providers of maternity care in New Zealand. A very high percentage of the GP workforce at the time was qualified to provide maternity care. Dr. Tina also reported that she had done a Diploma in Paediatrics prior to joining general practice.

The next section presents the findings regarding the level of cultural competence training that the IMGs received. Since 2006, cultural competence has become a requirement of all doctors who wish to practise in New Zealand. This requirement is part of the overall list of competencies that doctors need to demonstrate to get registration with the MCNZ.

4.5.2 Training in Cultural Competence

Cultural competence means having the ability, knowledge, and skills, to deal with patients from a diverse range of backgrounds in terms of their ethnicity, disabilities, religious, and sexual orientations (MCNZ, 2006). The majority of participants in this study trained and worked at a time when cultural competence was not really a formal part of any training programme, especially for those who did not do the GPEP Stage 1. Those IMGs who went directly into the AVE pathway reported not having done any formal training in cultural competence (Table 6). However, this is not to say that they were not aware of the cultural

issues, especially from the perspective of ethnic culture. These IMGs reported taking the initiative to teach themselves through participation in their communities, attending conferences, talking and observing behaviour, and visiting maraes²¹, to participate in Māori gatherings when the opportunity presented.

Informal Training in Cultural Competence

Drs. Jon and Manu stated that when they first started out there was no training at all in cultural competence, not even about Māori culture. Through their own initiatives they learnt about the diversity present in New Zealand and what was appropriate when dealing with different people. Dr. Jon participated in various non-governmental organisations (NGOs), and ethnic councils, and found these experiences to be very useful.

Similarly, Dr. Manu can be considered to be a sort of pioneer in the articulation of culturally appropriate behaviours for institutions, especially those regarding Māori. As a service doctor for a while, he helped devise policy documents on protocols to be followed when dealing with culturally sensitive issues relating to Māori. At that time, he was a GP working in a predominantly Māori community, and understood and appreciated the importance of being culturally appropriate. He also mentioned having written papers for RNZCGP publications and presented ideas in community settings. His contribution was not limited to Māori culture but also extended to articulating appropriate behaviours when dealing with mentally ill patients. It is difficult to report everything he shared regarding these contributions but some extracts of his narratives are presented below.

“Well, one of the things is that I’ve been involved quite a lot in the cultural things, and working in [CNIT] exposed me to a lot of Māori people. And the extended family system, among, for instance, the Māori patients is similar in Sri Lanka, India, and most of these countries. There was a big controversy going on a few years ago about post-mortems, and removal of body parts. And I had discussions with the Māori as well as the police, and said, “Look, I’ll put forward a proposal. Why don’t you have a look at it: where there are any sudden deaths for instance, and the cultural appropriateness of how to handle that. Now this was taken up by the police on a trial basis, both in [CNIT] and in one of the South Island towns. And

²¹ A marae is a sacred courtyard for the gathering of Māori and guests to celebrate Māoridom. It also includes the physical buildings within the courtyard. Māori cultural practices and protocols are embedded into any visit to a marae. A marae is often used to celebrate and observe all significant occasions that affect Māori and their cultural being. It is also used as a place to educate and create awareness about Māori culture, for those who are interested.

(<http://www.awataha.co.nz/About+Us/What+is+a+Marae.html>)

the Māori people took this to Parliament, and presented it as a future thing. The other one paper I wrote was the transfer of patients who are mentally disturbed from rural areas to the cities, and rather than having physical restraint, to use appropriate medical restraint with drugs, is much safer than tying them up. I was fortunate when I came to [CNIT], some of the Māori nurses sort of took over me, as a brother, and there were two Samoan nurses called me brother again. They did used to come and actually clean my house and I sort of didn't know why they were doing it. They said, "Oh, you our big brother." So like that. And one should get involved with them. Now from there, then when I left, I was probably one of the first Asian doctors to be given the Māori cloak by the three tribes of [CNIT]. You know, they had a ceremony, and I was given the feathered cloak. And so that's sort of, I thought, the highlight of my career, because they accepted me as one of their leaders." (Dr. Manu - FTF)

Dr. Christa, as a GP trainee worked in a kohanga reo²², where she had first-hand experiences of health issues in a Māori setting. This experience was complemented by her self-directed learning. However, she found that the knowledge she had gained was more theoretical, and not related to the real health needs of Māori. Dr. Michael, who also did not have any formal training in cultural issues, had found dealing with Māori patients "fairly challenging". Like Dr. Christa, he did a lot of self-directed learning, and dealt with the challenging cultural situations in the work place as they arose. He stated that he would have benefited from cultural competence training at that time. Dr. Phil also noted that he learnt while establishing himself in general practice but would have liked some cultural training early on in his career as a GP in New Zealand.

Dr. Rogers did not receive any formal training in cultural competence either, but as an educator, was privileged to experience aspects of the Māori culture through the cultural immersion training programme for undergraduate medical students. He found the experiences practical and useful. Additionally, as an educator, all medical research and education in New Zealand has an ethnic and cultural component to it so awareness of the prevalent cultural issues were very important.

"I was very fortunate from 1999 to have been part of an undergraduate experience where we took medical students up to the East Coast, and they had a cultural immersion week where we went and stayed on a marae on the East Coast for a week. So that was hugely practical, kind of having to do cultural competence, and being hugely privileged to work with people like [the late Dr.] Pat Ngata. So from that point of view, and then also here

²² Te **Kōhanga Reo** is a total immersion Māori language family programme for young children from birth to six years of age. (<http://www.kohanga.ac.nz/>)

within the medical school, ethnicity is a big strand of what has happened from the kind of research point of view. So I've been exposed to lots and lots of it, and in fact taken part in training sessions and so on. But I haven't had a block of cultural competency. And in fact, that was certainly never suggested. I mean certainly not in the 1980s, but even when I came back in 1997, as part of any induction into professional or New Zealand life, was not suggested. I think that probably would be now, but it wasn't then." (Dr. Rogers - FTF)

Dr. Henri stated that respect for people regardless of who they are is important to understand even if one has not received any formal training to appreciate cultural diversity. He did however get some exposure to the cultural issues when doing RNZCGP's Aim for Excellence Practice Accreditation Programme.

"We did the whole spiel as a practice during Aim for Excellence [Cornerstone Accreditation Programme]. Was quite amusing but in my opinion you respect anybody for what he/she represents, no matter if they are white, brown or little green men." (Dr. Henri - EI)

Formal Training in Cultural Competence

Those IMGs who had formal training in cultural competence found it to be useful, however the emphasis was more on the Māori culture. The formal component included awareness programmes for those who worked in hospitals, sessions in the GP training programme, visits to a marae, and conference sessions.

"When I was in the hospital board, there was emphasis on the Māori culture, and the indigenous way of doing things, and the respect that we have to provide to the first people of this country. So the main focus, both at the hospital, and also when I was going through the College training programme, there was significant degree of emphasis on the Māori culture, the Treaty of Waitangi, and the things associated with that. And since I was working in Northland, the emphasis was even more. And I think that is a good thing, because it is important for all of us to know about the indigenous people, and to provide them with culturally appropriate medical care, or at least be aware from what angle they are coming, and as to what their needs are, and how do we address them. And also certain peculiar things, or certain things that are done differently in that culture. And every culture is different, so since we are in their country, so we have to pick up some of those things." (Dr. Ras - FTF)

Dr. Tina liked the training she received but was well aware of some of the broader cultural issues through her travels. She was also part of a diverse group of trainees so had the opportunity to learn from them as well. In terms of the Māori culture, she would have liked to learn a few more words that patients

commonly used when they sought help. Other IMGs also expressed similar sentiments.

“Oh, we had a lecture on the Treaty of Waitangi, we had a marae stay visit - we had an overnight stay. That was pretty much it. I mean, because we were quite a diverse group ourselves, from different ethnic backgrounds, we always had good discussions, I think that prepared you quite well...as I say, I worked in different countries as well, so I mean I had a bit of a background; I travelled a lot...so I think I’ve got a reasonably good understanding of cultural diversity anyway. The only thing which...but probably particularly for my kind of work is probably learn a few more words. Because patients do use them, and I mean it would increase...yes, trust, and empathy in terms of knowing a few words for body parts, a few greetings. That would be helpful.” (Dr. Tina - FTF)

Dr. Alyssa, who worked in Auckland, was well aware of the Māori cultural protocols and practices, and mentioned being comfortable with her Māori patients but not so confident with some of the other minority groups. She was unsure how feasible it would be get training programmes developed regarding minority cultures given their small presence, for example the Iraqis.

“I think you get pockets of other minority cultures that are not represented really, like if I had an Iraqi patient come in, I wouldn’t know how to deal with them, in terms of you know, being culturally sensitive. You know, like the other ones, the other Asians, or the other Middle Eastern people. I wouldn’t know how to deal with them...Probably other minor cultures, but then again, it’s probably not feasible, you know, because the other minorities, they’re very minor.” (Dr. Alyssa - FTF)

Dr. Ras was also of the opinion that there should be some cultural training to better understand the Europeans as well. This would be really helpful for those IMGs from non-Western countries. He also suggested that training should include other cultures that are common to this part of the world such as those of the Pacific Islanders.

“There was no specific programme which was available, or designed, or that we were specifically taught, about how to deal with the Europeans. I think the Europeans were taken as the standard, and then the Māori were considered to be different in their perception of health, and in their health needs, and especially in relation to smoking, diabetes, obesity, and other social issues, that had to be addressed specifically by knowing about the culture. There should be a package especially for people coming from other countries. And if we can have a package that, when you come to a new country, especially in dealing with things like health, it would be extremely helpful...and most people from overseas countries would not have much knowledge of dealing with the specific needs of the Māori or the Pacific

Island people. So that's taken care of. But there's not much for the majority population. It's totally lacking." (Dr. Ras - FTF)

Dr. Rogers, as an educator and practitioner, made an interesting observation regarding a conflict between the Māori cultural protocols and the practical needs of doctors when treating patients. He noted that the head is considered 'tapu' or sacred among Māori and many Pacific cultures, and should never be touched. However, the dictates of medical practice sometimes make it necessary to examine the head. He posed the dilemma as a question needing practical consideration that should a doctor seek permission all the time if they have to examine the head or should the patient already expect that it will be done anyway because they are in pain? Additionally, he saw this predicament as a result of Māori being seen as a homogenous group when all members may not have the same attributes, beliefs and values.

"One of the things which I have never been clear about - and this is now despite almost being part of training packages in cultural competence - is the degree to which, if you talk about cultural responsiveness to Māori, how different or otherwise it actually is than what people would do intuitively and inherently. Because in fact increasingly talking about Māori as a homogenous group, I think certainly does Māori a disservice, but becomes less and less robust, in the same way as talking about Asian culture as a single homogenous thing is pretty fatuous and simplistic. And to some extent I think we're locked into that. So I think in terms of trying to adapt to the official world view, and then the reality can sometimes be quite different, and a bit disorientating, really." (Dr. Rogers - FTF)

Regardless of whether the participants had formal cultural training or not, they agreed that it is useful to know about the culturally appropriate practices and protocols of Māori as the indigenous people of New Zealand. Many would still like the formal training to acknowledge the other cultures in New Zealand including possibly some awareness on the majority Europeans as well.

The next section discusses the relevance and importance of the formal training programme to the IMGs' occupational adaptation to New Zealand. This aspect is essential to consider, given that many of the IMGs had completed their basic medical education and had significant work experience prior to coming to New Zealand.

4.5.3 Relevance of the Training in General Practice

All the IMGs who did some or the entire GP training programme found it relevant to and useful in their subsequent work (Table 6). The training gave them a better understanding of the primary health care environment they were working in, the different types of patients they were dealing with, the socio-economic factors that were affecting their patient populations, the standards of

practice that were expected of them, a level of self-confidence in a new practice environment, and gave them the recognition of being specialists and professionals.

Dr. Jon noted that it was through the AVE programme he realised that in general practice the “*patient comes first*”, and that despite the socio-economic factors affecting the practice itself, the provision of care to patients was paramount whether they were rich or poor. However, he did note that at times, it can be difficult to achieve uniformity across the board in the context of a general practice in a wealthy area versus one in a deprived area. He also found the training useful because the primary care environment was changing with the introduction of Primary Healthcare Organisations (PHOs), and it was important to understand their impact. Similarly, Dr. Tily noted that the training was important for understanding the different systems of doing things.

“Because when you come from another country, you should actually get to know about the system there. I think that was the main thing. I mean, medicine is same, but you’ve got to know the system, and especially, general practice training was really good, because when I did the hospital medicine that was different. And general practice community set-up is different. So how you manage your patients, that’s completely different, because you can order X-rays, and bloods on every patient, like we do it in a hospital. So that training was really good.” (Dr. Tily - FTF)

Another aspect that Dr. Tily liked was that it made her aware of the different cultural groups that were in New Zealand, and to know enough about them to practice well. Dr. Christa also noted that knowing about Māori and Pacific Island patients was very useful.

“I thought the weekly GP registrar seminars were very useful, up to date, practical and these provided more practical information for the interaction with Māori and Pacific Island patients than any written material, previously read as part of the exam curriculum.” (Dr. Christa - EI)

One of the main aspects of the training programme that was very useful for most of the IMGs was its inherent structure and flexibility. Dr. Ras, who did the FMTP, summed it up well when he noted the various aspects of the training programme delivered in a practical setting. The current programme (GPEP) was possibly built on the FMTP as some of the key features that Dr. Ras mentioned also exist in the current format.

“I think the programme is very well-designed. It is flexible, it is open-ended, there’s enough time for a practitioner to settle into a practice. The most important thing is it is practical. It is all around what you do on a day-to-day basis in a practice. So there’s not that you go to a classroom and study there, so it is mainly what you do in your day-to-day work, and

learning from your mistakes. And then have someone like a peer who comes and audits, or examines you, and in a very non-threatening manner lists out the problems which need to be addressed. Simple things like, on the practice management side, do we have a board outside which says when do we close. What is our opening hours, what is our closing hours, what is our after-hours arrangements...and the things which we do in the consultation...what sort of questions you ask, how you ask them, how to open a consultation, how to close a consultation. You cannot keep on going on for hours in a consultation, so you have to have certain skills as to when to close the conversation, and that's where the continuity of care comes in. Because you can't solve the patients problem in one 15-minute consultation. So you prioritise. Those are some of the skills that you learn."
(Dr. Ras - FTF)

Drs. Alyssa and Tily, who did the GPEP training, also made similar observations.

"Before the formal lectures, we did small groups, and we did role-plays. So I think that one for me was pretty good, and we get to sort of experience what the other doctor, what our colleagues have experienced from their practices." (Dr. Alyssa - FTF)

"The whole time was good. Because every year it was different: you go through the registrar programme, and then you have these AVE assessments and you work with doctors – seniors and so it's every day we learn something new. Even after training is same...you learn something new every day in medicine." (Dr. Tily - FTF).

Even the IMGs who did the seminar training programme, such as Drs. Deborah, Christa, Tina and James, found the structure and flexibility very relevant and important. In addition, having good teachers and mentors was an important factor for nearly all the IMGs. Some exceptions to good teaching were noted earlier such as those experienced by Dr. Alyssa. However the training programme itself exposes trainees to a number of teachers, both in classrooms and in actual practices.

"Oh, I think it was very important, but as I said, a small part was the seminar, but the major part was the experience. Actually working as a GP, and having that support from one of my colleagues. We had a very good teacher. We had a small group, we had a lot of open discussions, and really good seminars, which I believe is not always the case...we had a couple of trips to Wellington to meet with the bigger group. We had a very good communication workshop. And I think that was really worthwhile. For general practice, it's very relevant, and I certainly learned a lot there."
(Dr. Tina - FTF)

Another key component in the vocational pathway is the video analysis of consultations by the assessors to better understand the competence of the trainees. The videos are used to provide feedback on the deficiencies of the consultation process as well as commend good practices. Dr. Rogers had to do these like the other IMGs, and found them useful even though he was not keen on doing them. As a medical educator, he reflected on the importance of video recording consultations for learning purposes.

“If you look at the kind of the video analysis side of things, then although I don’t like it, I think that there is a value in actually being observed, either with someone sitting in the corner, which happens as part of the accreditation pathway, or having your videos kind of reviewed. I mean I have to believe that that is helpful. It’s what we do a lot of at the undergraduate level, and in research terms. And I think you can learn a huge amount from it. Peer group is clearly hugely important. I think my own situation is somewhat unusual, in that I get a lot of additional medical educational input as part of the job, rather than the clinical training. I think if I was just doing general practice, clinical, then getting that peer support would be hugely important.” (Dr. Rogers - FTF)

Similarly, Dr. Manu found the external peer review process very important in understanding his own practice habits and to learn from them.

Well, the thing was, you get a practice assessment done. Sometimes when you work, a few years in practice, you don’t know how you’re seen from outside. So you think, “You are on average, OK, I’m doing all right.” So it’s very good for someone else to come, and look at, and sit with you...so it is good to see how you are perceived by the others as a practitioner. And I think that is the important thing, that is, to always look back on yourself or get someone else in. That’s why, I suppose, this idea of peer review and things, because you’re looking at other peers and saying, ‘Hey, what do you do, how do you do this?’ or whatever, and just talk among themselves.” (Dr. Manu - FTF)

Dr. Henri noted that the only relevance of the training to him was to fulfil the bureaucratic requirements rather than to do any actual learning. For Dr. Phil, the only relevance of the training was that it gave him self-confidence that he could meet the standards of the RNZCGP, and be recognised as a professional.

“I don’t think it was important to the way I work as a GP although AVE is relevant to work in general practice, but it did my self-confidence good to achieve FRNZCGP – it was a recognition that what I was doing was professional and acceptable in the eyes of the College.” (Dr. Phil - EI)

Some of the participants faced a few challenges while completing the training. The following section elaborates on them, and mentions improvements that can be made, according to the participants.

4.5.4 Challenges Faced when Completing the Training Programme

The key challenges faced by the IMGs during the training period, for some also comprising the MCNZ's examinations, included not having clear information on what was required, adjusting to the modes of learning, managing family and financial needs, and coping with workloads (Table 6). The IMGs that did the MCNZ registration training and the GP training reflected on the challenges of doing both. These challenges were not about the health system or the cultural challenges or the minor language issues, but more about the training programme itself and its various aspects.

Issues with the Training Programme

As noted earlier, having the right information at the right time is important to the decision-making process; however, this was not the case for some of the IMGs. Dr. Charles was doing the rural placement training programme, and reported being isolated, without adequate information, and not knowing where to find what he needed to know. Dr. Phil, who had initiated his information gathering process while still in the UK, could not get what he needed either. For him, it became a step-by-step process which he considered to be less than satisfactory.

“Getting a clear idea and information regarding the stages of the process – it seemed to be a series of hoops and the next hoop only became evident after passing through the previous one.” (Dr. Phil - EI)

“Isolation working in a rural area, lack of information specific enough for me, knowing where to access info...College was great in advising on right pathway to follow and who to ask for assistance, I needed that more specific info...the blind leading the blind - lots of misinformation nothing specific enough, confusion over AMPA [Accident Medical Practitioners Association].” (Dr. Charles - EI)

While one of the key aspects of the training was its practical nature, it also presented some challenges to IMGs who were not used to that mode of learning. Dr. Ras noted that the mode of learning was not overwhelming but something they had to learn to cope with. Dr. Christa mentioned that while she did not have too much difficulty during the training, she saw many other IMGs struggle with the mode of learning and assessments, especially those who had left medical school a long time ago.

“Most struggled more, as they had spent more time out of medical school and found exams as assimilation to the NZ system more difficult.” (Dr. Christa - EI)

Drs. Alyssa and Tily also made similar observations about other IMGs they trained with, especially those that were doing the seminar programme. For some of these IMGs, the level of English language competence required for the training programme was too high, especially for those who might not have done their basic training in English. The language issue coupled with the new environment and mode of training saw many IMGs fail to complete the training.

Even Dr. Rogers, an experienced medical educator and GP, found some of the requirements of the training stressful and questionable. However, he did complete it and noted that he was better for it.

“I don’t think anything was difficult. I think some of the requirements, even though they weren’t onerous, seemed onerous. But whether or not that was just my own workload, or whether they really are onerous. So I’d be talking there largely about the College. Requirements around going through whatever it was, the accelerated pathway, the AVE thing. So you know, the patient satisfaction surveys, the [assessor] visit and the videoing, I guess I didn’t find it particularly stressful, but I mean, in terms of personality and temperament, I think I found it stressful. In terms of the fact that I’d done quite a lot of it, because we do video work here, and I’ve done it for ages and ages, and I’d done it in the UK. It was OK. I think the challenge, towards the end, was this whole weariness with the thing about...you know, I’ve been a doctor for thirty years, whether I’d ever be allowed to be acknowledged to be one. So it was kind of an interesting psychological experience, which I’m sure was character-building.” (Dr. Rogers - FTF)

Additionally, Dr. Rogers was having continuing issues with his MCNZ registration status, which was probably more challenging than the GP training itself. He was being told that if he did not do what the MCNZ wanted then he would not be allowed to practise or that he would have to meet some other compliance arrangements. To make matters more interesting, Dr. Rogers was also involved in the RNZCGP in his academic capacity where he provided advice on the necessary training requirements of his fellow colleagues, while he was in the same situation as them. The irony of the situation was not lost on him.

“I was in this slightly bizarre situation where I was running/contributing to the registrar training programme, and the IMG bridging programme, so I was having lots of opportunity to be with IMGs, was on the College reviewing people who weren’t going through AVE, while at the same time, I wasn’t going through AVE. [laughs] So I really enjoyed that sort of surreal experience. And I think it was interesting, in that we would be

talking about doctors almost invariably who were either brown or yellow, or you know, it wasn't working for them, and they weren't getting through this pathway, and they were not working appropriately. And having even a vague insight of being on the outer was actually quite helpful, in sometimes being able to articulate their [IMGs'] view, and say, 'Well look, I can actually see how this person would have come into that situation, and they haven't progressed here, and they haven't done this, so it must feel to them like there's no way they can get out of that situation.'
(Dr. Rogers - FTF)

Dr. James was very complimentary about the teaching he received from the RNZCGP, but he had issues at the practice level, and the peer group level. He found the attitude of some senior doctors to be counterproductive to a good learning experience.

"In a practice, not all colleagues are very sensitive. They can be quite cruel, and they can crush people. And I can see some of my colleagues being very inept with juniors, by being cleverer. Being clever is not my idea of the way to do things. And at the same time, if you've got good ideas, they're not really accepted, because they like to be clever. So there's a pecking order here, that if you're a real GP, you know it all, and nobody offers any more information. But as long as they're telling the juniors, or the locums, then that's right, but if the locums start to tell the fully-fledged doctors which way is up, then that's less well appreciated. The College is different. I'll be honest with you, because a good teacher is a good learner, because there's nothing wrong with knowledge. Yes. So it's to do with a mindset."
(Dr. James - FTF)

Like Dr. Alyssa had mentioned earlier, he found that some of the New Zealand-trained doctors did not feel that IMGs had what it took to be doctors. He thought that if he could be treated so badly, being from the UK, he could not imagine what it must be like for those from elsewhere.

"But it's that sort of thing, is that there are people that are knowledgeable, and people that aren't, and if you're a locum, or a student, you can't have any knowledge. You know, you're learning. And that to me is a very strange thing, because people come from overseas with often a lot of knowledge, and they're quite senior, and they're treated as juniors. And if I can get treated that way, coming from the UK, which is the mother country, can you imagine what it's like coming from Pakistan or Indonesia. You could be the Professor of Medicine in Indonesia, and come to be a GP here, and they'd treat you like dirt." (Dr. James - FTF)

He strongly believes that the RNZCGP has to ensure that IMGs should not have to go through this type of learning experiences, and should articulate the roles and responsibilities of GPs as educators. Dr. James would also have liked some

training to deal with difficult patients because he had not encountered such patients when working in hospitals.

“When you said you were coming to talk to me, it’s sort of an unusual one, but you can imagine, if you happened to have coloured skin, just how badly some of them would treat you. Because it wasn’t the Māori patients, it wasn’t the Pacific Island patients, it was the hard-on, lower-middle-class white patients and sometimes the middle-class patients, who believed you were just there for their purpose, and nothing else. And they had this funny idea that you weren’t a person, you were just the guy you went to get a chit from, or a sick-note, or you know, it was that sort of attitudinal stuff which I needed help with: dealing with aggressive, unpleasant, socially inept, rude patients, who sometimes had a reason for that. Sometimes they had been traumatised, sometimes they were treated badly. But I hadn’t been ready for that stuff. That was real general practice.”
(Dr. James - FTF)

Dr. Phil felt he was completely on his own during the AVE training period despite the programme being practice-based. Dr Henri recalled that the practice he was working at during the vocational training required him to project manage the development of their new clinic as opposed to looking after patients. He found the supervision he received while training to be very limited.

“None [supervision during training] - only supervisee in our practice. To be honest, that really amounted to zippo. However - working in a large group practice and not being backwards in coming forwards helped. They probably thought I was real crap and asked me to project manage our new medical centre a year after starting - I was safer with the builders than the patients.” (Dr. Henri - EI)

At the time of the interview, Dr. Tina had heard from the recent GP trainees that the training programme was not so good, mainly due to the poor quality of teaching. Dr Deborah would like to see that the trainees are exposed to more than one GP teacher. Dr Alyssa noted that she would like to see the training programme cover advancements in medical practice in its curriculum. She found this to be lacking.

Dr. Manu wanted the IMG trainees themselves to improve their attitude and complete what was being asked of them. He considered that some of the IMGs, who complained, had perceived themselves to have failed without even attempting to try the training programme.

Dr. Jon, who came in late 1960s, stated that the GP trainees that he assisted in the early years told him that there was a lack of uniformity in the assessments across the different training centres in New Zealand. He noted that trainees from Auckland and Hamilton were going to Christchurch to do the exams because

“there, the exams are much better...examiners were better...they used to get through exams easily”. It is difficult to determine how real the variations in assessments were, and how relevant it is today, but the RNZCGP continues to do assessments in various centres and in the practices where doctors are training. This may need further investigation within the context of Dr. Jon’s statement.

Some IMGs had faced other circumstantial challenges such as issues of catering for family needs and coping with the financial strain of doing the GP training.

Circumstantial Issues when Doing the Training Programme

The pursuit of the GP training programme presented other circumstantial challenges for some of the IMGs, such as travelling to the training venues, making arrangements for child care, and coping with financial constraints. Dr. Deborah trained while working in a rural practice, and faced certain challenges that the city based IMGs did not have, such as having to travel long distances, dealing with bad weather that affected her travel, and needing to arrange child care while away for the seminars. The training programme was able to cover some of the costs of the training but she had to depend on friends to look after her child when she was away from home. Where she lived there was no cell phone or phone connections which meant that she had to stay very close to the practice when on-call.

“I was based in a small town and had to travel to the afternoon course seminars on a weekly basis. Travel time was approx. 4 ½ hours one way so I used to stay the night. During the following year we had our first child and fortunately the programme refunded travel costs/air fares to enable attendance at the seminars on a fortnightly basis. Travel was an issue as weather frequently affected roads/made flying unpredictable. We lived rurally – no phone or cell phone initially so for my on-call times I had to come into the small town to stay (with friends) we did finally get the phone connected. Child care was also a concern as we had no family nearby. The course was flexible to allow part-time work and we found (again) friends who were able to do child care once I came back from maternity leave. I appreciated being able to train and work in the area we had chosen to live in – we stayed there for a total of 14 years. The local community were supportive in terms of offering help – child care especially and accommodation for the on call.” (Dr. Deborah - EI)

Drs. Henri and Charles faced some financial constraints while training. However, Dr. Charles was able to secure some funding from the DHB he was working for. Dr. Henri did not have any such support. Dr. James trained while working fulltime, and reported that it was difficult at times.

“I think the main thing was just how busy I was. I was flat out. I was doing ten sessions in general practice as somebody who’d never done it

before. Including after-hours with no support. And some of that was scary. And then I had to do all the Primex on top of it, and plus all the studying as well. So it was for the first year here, if I hadn't been determined, I would have given up. I was so determined I wasn't going to be fazed, because I wanted to do general practice so much, and I'd been prevented from doing it, really, in the UK. I was determined I was going to get a qualification, because that was one of the things that triggered me to New Zealand." (Dr. James - FTF)

Despite the many challenges the IMGs faced, all were successful in completing the training programme to become independent, specialist GPs. In understanding their educational experiences it was also important to explore what they thought would benefit future IMGs who wanted to become GPs. The following section outlines their suggestions.

4.5.5 Support for IMGs to Complete the Different Training Programmes

The participants suggested many things that could be done to support new IMGs with the MCNZ and the RNZCGP training programmes. The key was good support including having adequate information on the training requirements upfront, awareness of New Zealand's health system, better recognition of the qualifications that IMGs bring with them, better understanding of IMGs' immediate needs, financial support for some of the training requirements, and more importantly, good mentoring when the IMGs are engaged in the training programme. The support mechanisms can be categorised into two distinct groups – support with the GP training programme, and support with institutional requirements.

Before going further, it should be noted that some of the IMGs, such as Drs. Jon, Manu, Jean, and Rogers, had extensive experience with other IMGs, in their capacity as ambassadors for their ethnic groups, and as GP teachers, either in a formal or an informal capacity. Dr. Jon provided educational support to some IMGs of his own volition in his practice on weekends. Drs. Manu, Jean and Rogers were employed as GP teachers, the former within the context of the RNZCGP training programme, and the latter two in an academic capacity within a university setting. Additionally, Drs. Manu and Rogers were on various RNZCGP committees, advising on issues related to the training programme, and on other related matters. They all provided valuable insights into what types of support IMGs ought to receive when they come to New Zealand.

Support with the General Practice Training Programme

Dr. Jon noted that the bridging programme that was offered for a period of time in the 1990s had really benefited many IMGs, as it had prepared them well for examinations, and subsequently for the GP training programme. Dr. Ras, who

had done the fully-funded FMTP, was also of the opinion that all IMGs should do this type of training programme. One of the key features of the FMTP was the good level of mentoring that was provided to IMGs. The majority of the IMGs, such as Drs. Deborah, Christa, Michael, Tina, Alyssa, Tily, Henri, Phil and James, who had done the formal GP training, all mentioned that good mentoring from experienced teachers was essential for IMGs.

"I think that one-to-one mentoring is the most important one. That you really have somebody with an open door, right next to you working, that you can approach at any time, so you can really ask any question. And general practice is about experience...you can't learn it from books, so you actually have to do it. And this mentoring programme should really be at least a year. At least...I think that's the most important thing." (Dr. Tina - FTF)

"You find that in general, everyone's helpful, as long as you ask for help. You know, that the teachers I had at the other practice were very good, and in fact I went back to them, and asked for advice after, when I got into trouble with the other fellow." (Dr. Alyssa - FTF)

"Close relationship with a functioning practice, ideally some personal relationship within that practice...living the dream is much better than learning about it!" (Dr. Henri - EI)

A good understanding of New Zealand's health system is also very important for new IMGs. Drs. Manu and Phil, who came in different decades, emphasised the fact that the unique accident compensation scheme (ACC), and the bulk funding of pharmaceuticals through PHARMAC, affected how doctors practised and therefore, should be well understood by IMGs. They noted many other distinctive features about New Zealand that IMGs should know about such as the ethnic mix, English language variations, and the amount of paperwork involved in normal general practice.

"I think, whatever their experiences overseas are, and however much qualifications they have got, they've got to get used to the New Zealand system. Each country has their own system, and each country's medical system, general practitioner system, are different. I mentioned about the language, about the attitudes, the way we do things, all are different. We have ACC: some of these countries would never know about it. And I think it is very important that at least one or two years of training is given, to understand. It is now looking back. I came at a time, I was protected because I was in a hospital environment to start with. We didn't have all this paperwork now. It is the paperwork nightmare. And to know that, and to go through it, and be confident." (Dr. Manu - FTF)

Dr Alyssa mentioned that IMGs need to be acculturated into the diversity that exists in New Zealand. She observed that the IMGs in her study group did not “*mix and mingle*” with other ethnic groups as she did. She found that getting to know people from other ethnic backgrounds made it easier for her during the training period. Likewise, Dr. Rogers, in his experience as an academic, was of the view that acculturation into New Zealand’s uniqueness should be required for all IMGs, even if they come from the UK, which has many similarities to New Zealand.

“Where I think there is an opportunity is actually in the acclimatisation, acculturation. And it doesn’t take a lot, but you do need a couple of exploratory sessions with people where they can be exposed to the quite significant differences between New Zealand as a place and identity - small Pacific nation versus being a rich part of Europe, and also an introduction to the New Zealand health system, and the implications of that. Particularly in terms of user pays and the general poverty of the system. So I mean I think we should be offering that to everybody.” (Dr. Rogers - FTF)

The cost of re-training can be a major barrier for many IMGs who may have limited funds when they migrate. Dr. Charles noted that the lack of financial support can be the difference between success and failure for many IMGs. Dr. Ras mentioned that he knew of an IMG, who had done the NZREX a couple of times, but was unsuccessful, and was scared of failing a third time as the costs associated with doing the exams were significant. Additionally, he noted that he knew of IMGs who looked at the costs of the exams and decided not to pursue their medical careers in New Zealand.

“There are quite a few IMGs who were unsuccessful in the registration exam. It’s about three-and-a-half to four thousand dollars [for the exams each time]. And some of the IMGs do not have those resources, when they’ve moved into a new country. I’ve got at present a patient who is an IMG, and she took the exam about two years ago, and she was not successful, and she basically is very scared to take the exam, and she does not want that to be a financial issue: that she takes the exam again, spends that amount of money, and if she’s again unsuccessful, she will feel guilty, because she’s got a young family. So yes, the cost of the exam is also a barrier. So quite a few of the IMGs have come in, got their residency, looked at the exam, and not done it. And whether it’s the system or whether it’s the individual I don’t know, probably both. Because as you said, most of the IMGs are middle-aged, and you obviously reach certain seniority in your profession. And then to start all over from scratch, it’s not very - what should I say - palatable to most people.” (Dr. Ras - FTF)

IMGs also need support with dealing with various institutions in New Zealand such as the MCNZ, Immigration New Zealand, and the RNZCGP. Each of these institutions presents their own challenges.

Support with Institutional Requirements

Right at the beginning of an IMG's journey are two crucial New Zealand agencies that significantly affect their future. First is Immigration New Zealand (INZ), and secondly MCNZ, as the medical registration authority. It was noted by some of the participants that there was a mismatch between what INZ was telling IMGs, and what the MCNZ was expecting of the IMGs once they got here. Drs. Jon and Ras both noted that INZ approved work and residence applications on the premise that the IMGs would have no issues with working as doctors whereas the MCNZ has very strict guidelines about who can work in New Zealand. They both observed that many IMGs left for Australia because New Zealand was unwilling to accommodate them in relation to their medical careers. Those that did not move to Australia took up non-medical work in New Zealand because their options were limited. Dr. Ras saw this as an unnecessary waste of resources.

"I think there has to be a better kind of interaction between the immigration service and the licensing authorities. I don't know whether they've changed it now or not, but there has to be a better understanding and a better working relationship between those two organisations. No point in approving someone, that their qualification is recognised, but not registered. And that's when you have the situation when the neurosurgeons and the cardiologists are driving taxis, which is a waste of resource. Wastage of a human being. And probably having impact on their respective families. Creates unhappiness, the country gets a bad name, and then these people go to Australia. And they don't mind working in the middle of the desert, but they're still happy there, because they've got a job that they want to do. And I've got numerous instances where that is exactly what has happened. So New Zealand has lost out, because of the supposedly strict regulatory environment." (Dr. Ras - FTF)

In addition to the above, some IMGs are very senior in their fields prior to coming to New Zealand, and they are asked to start all over again. This is a significant barrier. Drs. Tina, Rogers, and Henri were frustrated that New Zealand could be so difficult for IMGs who come with significant work experience, and with relevant qualifications. They thought the registration and the subsequent training programme requirements could be significantly improved to better meet the needs of the diverse group of IMGs that come to New Zealand.

"Well firstly, I guess they have to take a deep breath, and accept that this country's pretty arrogant in many ways, in thinking that it runs the best

thing in the world, and that people, no matter what they've done before, have just got to knuckle down and go back to starting at square one, or square two, or wherever it is. Beyond that, I think that it would be helpful for people to get as much support as they can in a single point of support, who would be able to honestly say to them, "Look, you've got this, this and this; the minimum pain route for you is to do this." I genuinely believe this, that the UK training is as good as the New Zealand training. And in some ways is better. I mean it's better supported. So from that point of view, you'd still almost be looking for a pretty easy, tick-the-box approach to this. And I think we're about to enter a new phase of this now, with the kind of emphasis on quality and safety and accreditation, and the kind of post-Shipman and post-Bristol enquiries...the UK's kind of led the world in that. So if people have managed to keep up with their MOPS and TOPS and this and that, and then pretty much I would say at the technical level, they should be allowed to slip very easily into New Zealand general practice and primary care." (Dr. Rogers - FTF)

Dr. Henri also mentioned the difficulty he was having with the MCNZ in getting a highly qualified friend registered in New Zealand.

"I am trying to get a friend, a world-class ophthalmic surgeon (no joke) registered in New Zealand. A right pain as the minimum working requirements are too inflexible." (Dr. Henri - EI)

The above issues with the MCNZ are exacerbated with the lack of information about the training requirements, both for registration and the subsequent GP specialty training. Dr. Jean, in her experience as an academic, commented that IMGs should know as much as possible about the seminar programme. While the seminar programme no longer exists, her concerns were valid in that many IMGs chose to do that programme without fully understanding what was required of them.

"I guess just more information about what was involved. But again, maybe that's now what's happened through the seminar programme, and maybe if everybody's encouraged to participate in the seminar programme, and then the support is done in that way." (Dr. Jean - FTF)

Dr. Jon brought a unique perspective from his experiences among the refugees. He came across some refugees who claimed to be doctors back home but due to the circumstances of their escape, they were unable bring any documents to support those claims. He was of the opinion that these refugee doctors ought to be provided with opportunities to prove themselves under supervised and well-mentored training programmes. The main challenge these refugees faced was that they could not even get through the door of the current registration system, let alone do any form of training. Again the registration system was seen as inflexible to deal with situations that were unusual.

Dr. Ras was of the opinion that the relevant authorities should be able to do a 'gap analysis' to better understand the diverse groups of IMGs that come to New Zealand and thereby, tailor the support to better meet their needs. He was not suggesting individually tailored support but programmes of support that are generic enough to meet the needs of compatible IMGs. The age of the IMG at the time of registration should be an important consideration.

"You can't obviously design an individual programme for everyone. The needs for an IMG who's coming, say, from Europe is going to be a lot different as compared to an IMG coming say from Asia...So probably a gap analysis. And then design a programme depending on the results that you get. How much baggage they are carrying...The baggage being their family...Now, some of the doctors that are coming from overseas are highly skilled. I would say over-skilled for what we need. Some are cardiac surgeons, some are neurosurgeons. But then the age becomes a problem. Where do they start? As a junior doctor? Or as a consultant? So it's a very complex issue. Now what that help will be will be determined by the quality of the people coming in, and the age. Generally the younger the person, it's easier for them to adapt. The older the person, it becomes more difficult. I'm not saying impossible, but it becomes more difficult...that the younger the person, they find it much more easier to adapt. But then the older the person gets, then you get a more experienced person. But then sometimes they are not being used by the system for their experience." (Dr. Ras - FTF)

Finally, specifically in terms of making general practice attractive to IMGs, Drs. Jon and Manu would like to see general practice promoted as a proper medical specialty. As Dr. Ras had noted, the age of an IMG can also have an impact on their outlook on general practice as a viable option. Dr. Manu, who was a GP teacher, was strongly of the opinion that the onus is on the IMGs to adjust and complete whatever is needed to work as doctors in New Zealand. He succinctly observed how highly qualified and experienced doctors from many countries viewed general practice as the last option because in their home countries general practice was not a specialty area. Many IMGs, based on their existing specialist qualifications, wanted to be able to do general practice without any further training. Dr. Manu was not supportive of this stance.

"Now, I had doctors working under supervision with me, when I was in [CNIT], and we had this programme. I said, 'I know you, but this is nothing to do with knowing you. Every morning, come and tell me what your yesterday's problems are. We discuss that.' Now, I have had approaches from doctors, saying, 'Look, I'm working 200km. away in a town. Can you just keep an eye, and sign this paper, saying that I'm alright?' And I refuse. And it causes unpleasantness. I said, 'Hey, the

intent of that clause, by the Medical Council, is to make sure you're safe to practice. You want to be a good doctor, you want to be accepted by the peers, as well as accepted by your patients. To do that, you can't take that short cut.' It is really awkward if you are a fifty-year-old doctor who has done twenty years of practice in another country, to work in that level. It may be even humiliating. But that is what you want, then do it properly, and not half, saying 'I was a big man in my own country, therefore you shouldn't ask me any questions. I should be able to practise.' Because you invariably get into trouble. General practice now is another specialty, vocational registration. If you're not prepared to do that, then you should get into some other field, like administration, or public health, or whatever." (Dr. Manu - FTF)

The next Results chapter – Part II, documents the work experiences of the IMGs, and their adaptation to the inherent challenges of general practice in New Zealand.

4.6 Summary

- The participants in this study were from all the major source countries for New Zealand's IMG workforce except for South Africa.
- The arrival timeframe of the participants ranged from the late 1960s to the mid-2000s – covering approximately five decades of IMG stories.
- All except for one participant was aged under 50 when they first came to New Zealand. Just under half were in their twenties, five were in their thirties, and four were in their forties.
- The main reasons for migration included having job offers, wanting to travel and see the world, raising a family, wanting a change in their lives and wanting to escape political turmoil in their home nations. Some of the participants had New Zealand-born partners, and reported that being a reason for migrating.
- The participants found information about New Zealand from a variety of sources such as family and friends, word-of-mouth, through their prior travels to New Zealand, from libraries, through media, and via the Internet. The sources of information have a historical context where the early arrivals reported having limited knowledge of New Zealand.
- The majority of the participants initially settled where they had employment.
- Some of the challenges faced by the IMGs when they first came here included adjusting to their new work environments, understanding the spoken language including the colloquialisms, getting their qualifications recognised, settling into the mode of life in New Zealand, adjusting to the

poor public infrastructure, and dealing with family related issues such as schooling for children.

- For the participants, the process of getting registration varied depending on when they came to New Zealand, their qualifications, their prior work experience, and their English language competency. The early arrivals, despite their countries of origin, mentioned having very little difficulty in getting registration compared to those who came in the 1990s and 2000s. Nearly all the IMGs who came after the 1990s mentioned having issues with getting registered.
- Except for one participant, all the IMGs had done their training in English.
- The majority of participants were from countries that were preferred under the Commonwealth education system or under the current preferred countries for medical registration in New Zealand.
- The majority of the participants had job offers prior to coming to New Zealand. The majority of the early ones worked in hospitals while the later arrivals went into general practice.
- The majority of the participants had prior medical work experience in either hospital settings and/or general practice. Just under half of the IMGs had worked in another country other than their home nations.
- The participants chose general practice because it was seen as an attractive option due to its community-based orientation, the freedom it offered, the variety and challenge of the medical work it encompassed, and the continuity of care it afforded them and their patients.
- Participants who initially worked in hospitals chose general practice because of the type of work they were doing, the hours they were working, and the challenges they faced with some hospital colleagues. All the female participants who joined general practice noted that it offered them the freedom to choose the hours they wanted to work while raising their young families. Many of the participants mentioned that general practice provided them with a better work/life balance.
- At the time of joining general practice, nearly all the participants reported having enough information about what the work would involve.
- Nearly all the IMGs mentioned that they had to do some form of training to achieve their Fellowship of the RNZCGP. Some just did the fellowship component while the others did the full General Practice Education Programme (GPEP).
- Just over half of the participants reported doing some form of formal training in cultural competence but noted that the training was of little relevance to the way they were expected to treat their patients. The

majority of the training was focused on Māori culture and the Treaty of Waitangi but not on any other ethnic groups or on competencies needed to treat patients from different cultures. They all felt that cultural training that is more relevant to treating patients would be useful.

- The GP training programme had been relevant and useful. Just over half thought that the current programme could be improved in terms of better mentoring and support for the trainees, especially IMGs.
- While in training, some of the participants mentioned being challenged by the mode and quality of the teaching/learning, and by issues relating to finances, family, registration and workloads.
- The participants, based on their own experiences, reported that IMGs wanting to join general practice or other medical specialties ought to have the right information about the registration and further training requirements upfront.
- Other types of support that would assist future IMGs included having a good awareness of New Zealand's health system, having their qualifications and prior experience better recognised by the relevant authorities, financial support for those who need it in order to complete the requirements for training and registration, and having good mentoring when in training.

5.0 Results Part Two: Working as a General Practitioner and Adapting to New Zealand

5.1 Working and Continuing in General Practice in New Zealand

The IMG participants, as fully-fledged GPs, are the key focus of this thesis within the context of occupational adaptation to New Zealand. The previous sections looked at why they came to New Zealand, and what they did in order to practise as GPs. This section focuses on the key aspects of occupational adaptation including their current practice setting, their patient population, the impact of their cultural background on their patients and their peers, and how different they have found working in New Zealand when compared to their home nations. In addition to the occupational adaptation, this chapter ends with the presentation of results on their social adaptation to New Zealand.

Participants provided considerable insights into general practice that had to be split into two comprehensive tables: Tables 7 and 8 focuses on the 'current' practice environment, and Tables 9 and 10 focuses on the key features of general practice in New Zealand, and also provides a comparison between general practice in New Zealand and the IMGs' home nations. Finally, Tables 10 and 11 documents their social adaptation to New Zealand.

5.1.1 Current Practice Environment

Practice Environment

At the time of the interviews, the majority of the IMGs were working in urban centres among populations considered to be in the middle to upper deciles.²³ The data analysis in this study shows that the patient population in the middle and upper decile areas are mostly New Zealand Europeans whereas the lower decile areas are mostly multicultural (Table 7). Two participants, Drs. Michael and Henri, worked in rural centres but with contrasting populations with the former working among a high needs, predominantly Māori population, and the latter in a low needs, predominantly New Zealand European population.

²³ New Zealand's socio-economic deciles are calculated on household income, occupation, household crowding, educational qualifications, and is used by government and other institutions to provide additional support to the most deprived areas (Ministry of Education).

Table 7: Current General Practice Environment in New Zealand

Participants	Year of migration	Current Practice	
		Current practice environment & Continuity	Ongoing Challenges
Dr Jon (SL)	60s	U- (√)	◆ CME
Dr Manu (SL)	70s	U- (√)	◆+++
Dr Lou (AUST)	70s	SR (√)	B
Dr Jean (CAN)	80s	U+ (√)	FFS
Dr Ras (IND)	80s	U- (√)	B PS-
Dr Deborah (UK)	80s	SR (√)	♣ AN CME WK
Dr Christa (GER)	80s then 90s	U+ (√)	
Dr Nathan (UK)	90s	U+ (√)	OP
Dr Michael (UK)	90s	RU (√)	PE GV
Dr Tina (GER)	90s	U- (√+)	B
Dr Alyssa (PHIL)	90s	U+/- (√+)	GE PS- H- B
Dr Tily (SL)	90s	U+ (√)	B
Dr Rogers (UK)	80s then 90s	U+ (√+)	IC WK PE SE FFS B
Dr Henri (GER)	90s	RU+ (√+)	PE H-
Dr Phil (UK)	2000s	U+ (√)	P ACC FFS DP
Dr Charles (ZIM)	2000s	U+ (√)	WK IS I- CME FM
Dr James (UK)	2000s	U+/- (√)	OP ◆+++

<p>U- = urban practice (low decile – high needs) U+ = urban practice (middle-upper decile) SR = semi-rural practice RU- = rural practice (high needs) RU+ = rural practice (low needs) (√) = will continue in general practice (√+) = will continue but has reservations ◆ = converting hospital practice to general practice ◆+++ = profiteering/business focus B = running own business WK = workload AN = lack of anonymity OP = opposition from GPs/unprofessional</p>	<p>PE = personal challenges GV = lack of govt respect in scope of practice GE = gender bias IC = providing individualised care DP = diverse patient popu. IS = isolation FM = needs of family I- = lack of health information for the communities PS- = poor primary/secondary link H- = hospitals uncooperative ♣ = accessibility issues CME = continuing medical education P = pharmaceuticals ACC = ACC Scheme FFS = fee for service SE = different social environment</p>
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Additionally, two other IMGs, Drs. Lou and Deborah, were working in semi-rural areas with the former working among a predominantly New Zealand European population, and the latter among a mixed population. Coincidentally, the distribution of IMGs in this study is representative of the way New Zealand's population is distributed, with approximately 86% being urban-based (The Social Report – Ministry for Social Development, 2010). This report also noted that while there is no difference between how New Zealand Europeans and Māori are distributed (84% in urban areas), there was a significant difference when it came to other races (Pacific peoples, Asians and others) with the majority of them (96-98%) being urban dwellers. Four IMGs, Drs. Jon, Manu, Ras and Alyssa, all working in the largest urban centre, Auckland, noted having either a predominantly multicultural or an Asian patient base.

5.1.2 Challenges Faced in the Current Practice Environment and Continuity

The IMGs reported several different types of challenges that they continued to face despite having worked as GPs for a number of years. Some of the challenges related to being in general practice itself while others focused on challenges faced when dealing with patients.

The challenges included financial issues, coping with increased workload, professional antagonism, poor links between primary and secondary care, and certain personal ones. The other more individual challenges are also briefly discussed.

Financial Issues

Drs. Manu and James noted the public/private funding mix in general practice could be the reason for an ever-increasing focus on profiteering and saw this as detrimental to patient care.

"I don't see why a doctor should choose what his salary is, necessarily. I think if there's a shortage, the salary goes up, and if there's too many doctors, the salary goes down. But you see, doctors today, their biggest focus is on how much holiday they get, and how much money they earn when they're not at the practice. If I can do six sessions, and earn the same amount as ten sessions, then I'm being very good, and I get a locum to do the other work. And I think the whole focus is about, 'How can I do other things, and earn the same amount of money?' And I have a problem with that, as a concept. It seems to me that that's basically a business thing, and I don't like doctors to have that sort of mentality, because you know, if you want to do medicine, you may only want to do six sessions. But I don't see why you should be paid for ten, if you only do six." (Dr. James - FTF)

While not quite contrary to Dr. James's beliefs, Drs. Lou, Ras, and Tina started or took over general practices that needed a lot of work to make them financially viable. A lot of hard work and sacrifice went into building successful practices.

"Oh huge. A lot of challenges, it's just like setting up a new business. So there's all those anxieties as to whether it will succeed, or it will not succeed, what are the patients expecting, what services you should provide, what times you should be open, what fees you should be charging, how much staff you should have, whether you should have a nurse; so there were issues regarding the economics of running a practice, and there were issues of providing a good service. And sometimes when you are young, you take these challenges without thinking too much, which is sometimes a blessing. So the challenges were mainly on those two sides: on the economic side, whether the practice will succeed - yes, we had to put in a lot of hard work, long hours, which was sometimes at the cost of personal time. And I remember we used to work about 70, 75 hours a week, we'd do some other medical work, to supplement the income. Do the after-hours work. And then try to provide good service to the patients in the practice also. But gradually, as the practice built up, then you give up all the other distractions, and concentrate just on the main work." (Dr. Ras - FTF)

Dr Tily stated that while she saw mostly working people, and they paid the necessary fees, her practice had a viability problem because she was not able to access capitation due to the nature of her practice.

*"I think, in terms of income, it's not really great in New Zealand, because we are not getting any subsidy. Like in the UK and Australia, the GPs, they get sum of money from government. But here, it's not that great, so we still depend on our patients' fees that they pay every day. So it can be quite difficult, because the prices, the fuel prices, and expenses are going up, higher and higher. And I think the patients will find it difficult to pay the doctors' fees. **[Do you get capitation here?]** Not in this practice. No, because the other doctor, he does musculoskeletal work, so I am trying to get into the PHO. But that's another problem, because the PHO I spoke to, they don't want to come and do it just for me. They want a whole practice to be part of PHO. But the other doctor is sports medicine doctor. He doesn't need that. So it's a challenge. So I'm still working on that." (Dr. Tily - FTF)*

In particular for IMGs from other western countries such as the UK and Canada, the 'fee-for-service' model needed some getting used to as primary health care in those countries was free. Drs. Jean, Rogers, and Phil all reported that they were not used to this but mentioned that the fee-for-service model provided certain advantages that were absent in their home countries. For example, patients seem to value the service more and GPs had the opportunity for longer consultations.

“I don’t know what happens in other countries for people coming in, but it was a big change for me to have to start charging patients money to see me as a doctor. And because medicine is a helping profession, having to ask people to pay to be helped was quite a challenge at the beginning. I’m actually very adamant now that it’s a really important thing actually, because it helps people see value in the interaction. And that if something is free of charge, it’s often not considered valuable. And that’s certainly what I saw when I went back and worked that seven months in Canada, that people did not see value in the advice or care that they were getting from general practice, just because they weren’t paying out of pocket for it. But that’s a big adjustment, a big psychological shift.” (Dr. Jean - FTF)

Dr. Phil’s memoirs include some observations that he shared in this study regarding general practice consultations:

“So, having started work what did Dr Alien find difficult and different? Initially he luxuriated in the 15 minute appointment as he came from a culture where his fellow aliens barely had time to sit down before their consultation was over. It soon became apparent, however, that the New Zealand nature was to ‘get their money’s worth’ and so as he battled with a speculum in one hand, a flu shot in the other, the sphygmo in one foot, the peakflow meter in the other, throat swab balanced gently in his teeth while reading the student’s latest download from some obscure health website, the 15 minutes soon passed and he still hadn’t issued the prescriptions, printed the medical certificate and lab forms, let alone written anything up on the computerised record or decided what Read code would best suit ‘concern re familial tendency to ingrowing toenails in people with borderline iron saturation but not homozygous for hereditary haemochromatosis’. How he longed that New Zealand practice nursing was not so much more advanced to that which he was used to. Only recently were the roles of alien nurses being developed to complement doctors rather than to be their handmaids but at least they concentrated on ‘nursy’ things and would be there to do the injections and swabs and dressings.” (Dr. Phil - EI)

Workload

Some of the IMGs, such as Drs. Deborah, Rogers, and Charles, reported that the workload of GPs can also be challenging, especially when dealing with a complex and transient patient population.

“High transient population i.e. currently 10% of the population to rise to 33% approx. in the next 5 year period according to DHB stats. These people are essentially not funded for at least ½ of their stay under the current enrolment system. There has not yet been developed an effective

way of handling this though various strategies are being investigated.” (Dr. Deborah - EI)

“I think, now the fact that relatively few people do fulltime New Zealand clinical general practice shows that it’s a hard job to do fulltime. I know I don’t do anything like that but I certainly make up the hours on the other side. I can understand what an overloaded work week can feel like. And I think that is a challenge, and is certainly a challenge to people who might be working in areas where there are greater disparities and inequities, and that you’re really being challenged both by the complexity of the clinical problems, but also by the socio-economic status of the population. I’ve been told recently by a whole bunch of people that I’m working too hard. Now that’s partly, I think, the split workload that I’ve got, with the academic stuff and the clinical stuff. I think the people who do eight, nine-tenths of New Zealand general practice work too hard. So I think overall workload and work/life balance is a challenge.” (Dr. Rogers - FTF)

Professional Antagonism

Drs. Nathan and James, both from the UK, mentioned experiencing opposition and professional antagonism, mainly from New Zealand-trained doctors. Dr. James, the most recent arrival, expressed frustration at how he was being treated by his New Zealand colleagues when he made suggestions for improvements or took initiative.

“And so that’s why at Christmas I’m moving from my practice: because I think, after four years, even though the patients have been lovely, I can’t stay in an environment which is restricting my development, and I’m only using one percent of what I can do at the moment. Not because I’m clever, but because I feel very suppressed. Usually, academics have got the ability to change, because if you show them the evidence, they’ll say, ‘OK, it’s good evidence.’ But general practice is not that sort of environment. It’s like, if you show them evidence that undermines their view, you’re a difficult person. There is a disadvantage, and I did mention the word ‘parochial’. The parochialness is that Kiwis like to be running everything, and they like to have people...they don’t mind you, as long as you’re not running anything. Well, they wouldn’t say, ‘Would you like to be chairman’ or ‘Would you like to be our representative on this committee?’ I’m actually on three committees, which I’ve actually been asked to join them. And my practice, on one occasion, tried to object, because they hadn’t sent me. I said, ‘Well, it doesn’t matter. Somebody asked me to join, and I accepted.’ And they resented the fact I’d gone to join a palliative care committee, or a skin surgery committee. I wanted to be in the committee, not because I wanted to tell somebody what to do, but because I wanted to

know what was right, and what was wrong, what the experience was. And the palliative care committee, because...well, there's a reason behind...my father died in a very awful way, and I became very involved in palliative care as a result. And so I wanted to get involved in those things." (Dr. James - FTF)

Dr. Alyssa also felt undermined by New Zealand-trained GPs because of her gender. She felt that male GPs looked down on women GPs.

"From men GPs, who think they're more superior than the lady...the women GPs." (Dr. Alyssa - FTF)

Link between Primary and Secondary Care

Due to the way the New Zealand health system works, there is a need for good links between primary and secondary care. For some IMGs, these links are poor mainly due to secondary care policies and practices. Drs. Ras, Alyssa, and Henri all reported that they found it difficult to work with secondary care, and with particular hospitals when trying to access timely care for their patients.

"The secondary care is not sometimes up to speed in providing the follow-ups that we want done. Somebody comes with tummy pain, I want an ultrasound scan done, the hospital will take about a month. OK, they've done the ultrasound scan, and found gallstones, they need to have the gall bladder out. That will take probably about two months. So those are the challenges. Acute services are good, I wouldn't say excellent. Acute services are good. I'm just talking about the Auckland area now. The outpatient clinics can be improved upon, and there are some new systems that they're putting in place." (Dr. Ras - FTF)

"Oh, it's the usual thing, you know, that for number one, is that as a GP you have to refer patients to the public system. For example, I have a patient who had a skin cancer that I could not take out because it's over here, quite close to the artery. So I referred him. Three months down the track, he hasn't been seen, and it has been cancelled. So the frustration's really with dealing with the secondary system, the hospital, being seen in the clinic, and all that sort of stuff...But ringing through to the hospital, you get this registrar who screens all the calls, and if he had his way, everyone would be treated in general practice. But he always has this catch, at the end of his long, long thing that, 'Of course if you're really worried, you can send him in here.' Those are the frustrations. For us, especially for me, it's the time. It's a time constraint. And it's really so frustrating too, because you see the patient getting worse and worse, and you've sent so many letters already. You don't know who to talk to, because there isn't any one they say that is in charge of this." (Dr. Alyssa - FTF)

Dr. Phil highlighted the issues he faced when dealing with the Accident Compensation Corporation (ACC), and PHARMAC. He found the links between primary care and the private injury rehabilitation providers such as physiotherapists to be very unusual. In relation to PHARMAC, he found it hard to believe that in a free country a government body could restrict what drugs can or cannot be prescribed. Excerpts from Dr Phil's memoirs:

"Pharmac is an interesting institution to Dr. Alien. He finds it hard to believe that in a free country one government agency can at a whim, it seems, make certain groups of drugs unavailable for the general public, even if they are already being prescribed them, and that this decision can be implemented and reversed with no prior consultation with those at the coalface almost overnight." (Dr. Phil - EI)

Personal Circumstances

Three of the IMGs, Drs. Michael, Rogers, and Henri, shared some of their personal challenges while working and adapting to New Zealand. Their personal experiences were beyond the scope of this study but were very valuable in providing insights into their decision-making processes.

Dr Michael reported having no money and no car to help with his work arrangements. Dr. Henri had just started moving on from a broken marriage when he started working in New Zealand. Dr. Rogers felt that being a migrant in New Zealand is not easy given the identity issues that emerge every so often. The fact that New Zealand is isolated from the rest of the world also has an impact on keeping up with family and friends. As a migrant, Dr. Roger also made some personal observations about New Zealand like a lack of proper infrastructure, and some cultural subtleties that affected him.

"So my dad died five years ago now, and that was huge. He died at a good age, but the distance, and the fact that for periods of my life, I'd been away from the family, and you know, my mum's gently kind of dementing over in the UK now, and it's a long way away. And so when I'm here, people still do say, you know, 'Well you're from England,' or 'You're not a New Zealander,' or 'You're not this', or 'You're not that,' So if you didn't have some kind of personal identity which wasn't related to ethnicity, and wasn't related to the country you were working in, then I think it's often quite challenging. And I think a lot of people, particularly as they get older, do get a bit spooked about the fact that they don't have roots. And if you're a first generation here, the other challenge is that this is not an easy country. I mean people say that it is, and it is in some regards, but there are kind of cultural subtleties which are quite difficult. You know it's a new country, it's a raw country, it's not tamed. There's bugger-all here. There's virtually no infrastructure. That we could do with double the

population, and a whole bunch more wealth and a whole bunch of other things. And so I think it's often easy for migrants to either feel exposed or to uncover the exposed nature of the country. And we thought it was paradise, and in many ways it is. But when it isn't, then I think the links or the security within the country is not anything like people might wish it to be." (Dr. Rogers - FTF)

Other Individual Challenges

Some other challenges faced by the IMGs included:

- Converting hospital practice to general practice (Dr. Jon)
- A lack of access to facilities, and little anonymity when working in a small rural community (Dr. Deborah)
- A lack of respect from government when they limit the type of diagnostic tests GPs can request. For example GPs cannot order CT scans or echocardiograms (Dr. Michael)
- The responsibility GPs take on to provide high quality individualised care such as mental health care when resources are scarce (Dr. Rogers)
- The need to understand and respond to the diverse social and cultural environment when providing health care (Drs. Rogers and Phil)
- Meeting the needs of the family, especially children as they grew up (Dr. Charles)

Continuing in General Practice

At the time of the interviews, participants were asked if they would continue in general practice despite the challenges they faced (Table 7). All the participants were planning on continuing in general practice, however Drs. Tina, Alyssa, Rogers, and Henri expressed that their continuing was conditional on their workload decreasing, fulfilling the CME requirements, the schooling requirements of their children, the options as they get older, on winning Lotto or how New Zealand treats them.

"Well, I mean, work certainly becomes more stressful, because we have less GPs; or GPs don't increase, but all the health service do increase. Demands increase: people are getting older, getting sicker...so I mean, if work pressure increases too much, that would certainly be a reason for looking for some alternative, yes. In terms of country and location, at the moment I'm very happy in New Zealand, and certainly want to stay in New Zealand until my children are well through school. Don't want to say that I'm staying in New Zealand forever. I mean, I love travelling, and once the kids are out of the house, I might, you know, work somewhere else

again. It really depends how well New Zealand treats me.” (Dr. Tina - FTF)

Drs. Jon, Deborah, and Charles reported that one of the main issues they faced that could affect their continuing in general practice was the time it took to complete the CME requirements, especially for Dr Jon who was in his early 70s. Dr. Deborah worked in a rural practice and noted that the distance she needed to travel to access CME was an issue. Similarly, Dr. Charles noted the isolation he faced when doing CME, while based in a rural practice.

5.1.3 Patient Diversity and the Disease Burden

Patient Population and Disease Burden

IMGs such as Drs. Lou, Jean, Christa, Nathan, Tily, and Phil, who worked among a predominantly New Zealand European patient population, in middle to upper decile areas, reported not having encountered any particular trends in disease burden among their patients (Table 8). Dr Tily worked in an atypical general practice which was right in the middle of a city centre. She noted that her patient population included younger people, the working class, and those who needed some emergency care.

“It’s a very wealthy area, because we see all working people here. We see all young people, working crowd, and sometimes they are enrolled in another practice, but they just pop in here for any emergency stuff. And there’s no challenge as such, but you don’t see a lot of families, like children, and elderly, like a typical general practice. We don’t see a lot of them because it’s in the City.” (Dr. Tily – FTF)

However, IMGs such as Drs. Alyssa, Rogers, Henri, Charles and James, who had significant numbers of European patients, as well as patients from other ethnic groups, reported having higher than average prevalence of certain diseases/conditions. For example, patients of Drs. Alyssa, Charles and James had a high prevalence of chronic conditions. Additionally, Dr. Charles had many elderly patients who had mental health issues, lifestyle problems, and lacked support structures such as social/family networks when they needed it.

Dr. Rogers also reported that some of his patients had mental health issues. Dr. Henri, who worked in a rural but affluent New Zealand European community, reported seeing a higher than usual prevalence of fractures, given that adventure tourism was one of the key attractions in his community.

Table 8: Patient Diversity, Disease Burden and Challenges

Participants	Year of migration	Patient Population		Impact of IMGs own cultural background	
		Patient diversity & Disease burden	Challenges	On patients	On Colleagues
Dr Jon (SL)	60s	MC ♠♠+	♦+ ♠♠+ ♠++	NI ♥♥+	NI
Dr Manu (SL)	70s	MC ♠♠++	♠++ CC	NI ♥♥+	NI ♦++
Dr Lou (AUST)	70s	NZer	♠♠++ CC	NI (♥)	NI
Dr Jean (CAN)	80s	NZer	♠++ CC	SI (♥) ♥+	SI
Dr Ras (IND)	80s	AS ♠♠++	PCC CC	NI ♥	NI
Dr Deborah (UK)	80s	MC ♠	♠++ CC	♥ ♥+ SI CU	SI CU
Dr Christa (GER)	80s then 90s	NZer	♠++ CC	♥ ♥+ SI	SI
Dr Nathan (UK)	90s	NZer	♠++ CC	NI	NI
Dr Michael (UK)	90s	M ♠♠+++	♠++ CC SH TP	NI	NI
Dr Tina (GER)	90s	M ♠♠+ ♠++ ♠+++	♠+ ♠++	SI ♥- ♥♥+	SI CU ♥++
Dr Alyssa (PHIL)	90s	NZer AS ♠	♠+ ♠++ CC	SI ♥	SI CU
Dr Tily (SL)	90s	NZer YO	♠♠++ SH WH CC	NI YO (♥)	NI
Dr Rogers (UK)	80s then 90s	NZer ♠+	♠++ CC	SI ♥ (♥) ♥+	SI CU
Dr Henri (GER)	90s	NZer TO FC	♠++ PCC CC	SI ♥♥+	SI ♥++ CU
Dr Phil (UK)	2000s	NZer	♦+ ♠++ PCC CC	SI	SI CU B
Dr Charles (ZIM)	2000s	NZer ♠♠+ ♠++	♠++ CC	SI ♥♥+	IMGs
Dr James (UK)	2000s	NZer/M ♠	♠+ PCC DF CC	SI ♥+	SI ♥++ OP CS

MC = multicultural	♣++ = language issues
NZer = mainly NZ European	SH = sexual health issues
AS = mainly Asian	WH = women health issues
M = mainly Maori	TP = teenage pregnancy
YO = mainly youth	NI = no particular impact noted
TO = tourists	SI = some impact
♣ = Chronic conditions	CC = need to be culturally competent
♣+ = mental health issues	CU = personal cultural impact
♣++ = lifestyle issues/support structures	IMGs = too many IMGs
♣+++ = domestic violence/sexual abuse	♥ = saw patients from own culture
FC = fractures	(♥) = aware of patients going to GPs of same culture
♦+ = giving bad news to relatives	♥+ = good interactions with Maori/other patients
♦++ = providing support outside of G.P.	♥++ = good interactions with colleagues
B = running own business	♥- = unable to influence behaviour change
OP = opposition from GPs/unprofessional	PCC = patient centred care/patient expectations/patient choice
DF = difficult patients	CS = good College structures
♣ = accessibility issues	
♣+ = compliance with medical advise	

In contrast, Drs. Jon, Manu, Ras, Deborah, Michael, and Tina worked with a predominantly Māori or multicultural patient population that had a higher than average prevalence of chronic conditions, mental health issues, lifestyle problems, sexual health issues, and domestic violence problems. Drs. Michael and Tina reported all of the above conditions as widespread in their communities.

“[Among my patient population there is] domestic violence, diabetes, heart disease, STD’s, highest teenage pregnancy rate in the country.” (Dr. Michael - EI)

“Very high needs. I mean, just to get a picture of our clientele, we do have Māori mental health service next to us...we share most of those patients. We do get a lot of referrals from WINZ, from Alcohol and Drug, from youth services. They’re all quite ‘difficult to treat and manage’ patients. And also we do have a very high percentage of high needs chronic disability, so a much higher percentage of diabetes, of heart disease, of the usual chronic diseases: asthma. Yes, certainly a challenging population. Not just the medical challenges, it’s the social background. I mean, drug

use, smoking status, alcohol use, violence and sexual abuse are just so much higher than in the general population. So you're not just facing medical problems." (Dr. Tina - FTF)

Drs. Jon, Manu, and Ras, had a multicultural patient base, with significant portions of Asians that also had a high prevalence of all the above mentioned diseases. Dr Jon also mentioned that he had patients from war-stricken countries like Kosovo. He and Dr Manu noted that compliance with medical treatment, and understanding how the New Zealand health system worked, was problematic for some of their patients.

"Certain cultural things, you know, they've got their cultural aspects...certain people come from a war-stricken country. So they've got their own issues and problems. The concerns of each community differ a lot. So some of them medically...some form of resistance to a drug. Say for example a diabetic fellow. Well, someone has told him, you must take all your tablets, and go. You'll never get medication in New Zealand. So like that, I think the medication needs a lot of explanation." (Dr. Jon - FTF)

"Well, the number one challenge is, because when you have so many new immigrants, who (A) are not used to the New Zealand, or Western type of medical system, who also have not been exposed to the level of care we are offering, you find they still go back to practising, or making their lifestyle choices as they have done in their own home towns. And this happens in Asians. One of my pet things is, 'Don't eat rice and curry, eat curry and a little bit of rice.' But that is the number one problem with Asians. We are not big-made people. I'm fighting to get that [BMI chart]: that chart is not for Asians. That chart is for Pacific islanders. And I'm pressurising the government to say, 'Hey, in ten years' time, you need lots more money if you ignore this, because you will have the complications of this.' And it is for Pacific Islanders, it's already happening. And I think unfortunately, these are areas which are not very up-market." (Dr. Manu - FTF)

Overall, the majority of the IMGs reported that their patient populations were affected by one or more types of diseases/conditions, and these are higher among lower decile and rural-based populations.

5.1.4 Challenges Faced when Dealing with Patients

Within the context of occupational adaptation, patients are the key people that GPs interact with. This study explored the challenges that the participants faced when dealing and caring for their patient populations. These challenges affected both the IMGs and their patients, and included issues with accessibility to care, compliance with medical advice, language problems, and a higher than usual prevalence of particular conditions (Table 8). The IMGs noted that they were challenged to provide culturally appropriate care and be culturally competent, to

provide patient-centred care and to learn to deal with difficult patients. In addition to the above, IMGs were asked about their interactions and experiences with Māori patients.

Language Issues

Nearly all the IMGs mentioned that language was a barrier when treating some patients, mainly due to patients not knowing English very well. Language problems often led to other issues such as patients not understanding their treatment regimes. Often patients with little English would bring in another family member such as children or siblings. For some GPs, the involvement of family in the consultations created issues, especially where children were involved. Dr. Jon noted that a Cambodian father (patient) possibly restricted his daughter (interpreter) from disclosing some information important for making a proper diagnosis. Dr. Manu recalled children as interpreters were uninterested in what he was saying about their elderly family members.

“Some of the Samoan and Tongan people, older people don’t speak English. So it is a bit of a barrier. And it is difficult to get through about diet, and all the other things, when the knowledge of English [is lacking]. Unfortunately, when no interpreters, they bring from the family, the young teenager or somebody, and half the time they’re not interested. They’re texting while I’m talking to them. So that is a problem and I think there is a real negative thing to improve the health status just through communication.” (Dr. Manu - FTF)

While finding interpreters can be a problem, most of the participants agreed that having some form of interpretation was better than nothing. Some of the IMGs had used the government-contracted ‘Language Line’; however there were issues with its use. The first was that the ‘Language Line’ was hosted out of Melbourne, Australia, and may not be conducive to understanding the New Zealand context. The second issue was that it was over the phone, and this was not ideal for face-to-face consultations with patients. The nature of interpretation makes consultations longer than usual and thereby, affects GPs’ workloads. The IMGs thought that the above issues made the use of the ‘Language Line’ impractical. Dr. Nathan reported that on occasion he had used online translation programmes but did not elaborate what these were. He found them to be useful.

In some instances, like the practice that Dr. Manu worked in, practice staff were often available to translate. This made it easier because at one stage the practice owners wanted Dr Manu to learn the predominant language among the patient population. He refused, saying that the onus was on the patients to learn English and not the other way round.

The majority of GPs also noted that they attracted patients from their own ethnicity or knew that it was happening, mainly because it facilitated

communication. Some of the IMGs found this useful for the sake of their patients while others were of the view that patients ought to make an effort to learn English because that was the main language in New Zealand.

“Because they always say, ‘Oh, it’s better to be able to explain...you know, without having to think about what to say.’ That’s what they always say. [So you communicate in...] In our language, yes. And Philippines, there’s so many dialects, in the Philippines. I understand most of them anyway. So they can still say things in their dialect, and I still understand it. It’s a bonus for them.” (Dr. Alyssa - FTF)

“Yep I have. Refused to speak bloody German, that sorted that out. Didn’t come to New Zealand to collect all the buggers from back home. Happy to help as long as they behave like Kiwis.” (Dr. Henri - EI)

“But I know my colleagues, like sometimes women, Sri Lankan women will go to a Sri Lankan woman doctor. That is understandable. Sometimes women doctors will see women patients. Otherwise language itself...yes, I can speak the Sri Lankan language. But it’s the people. I say, ‘Hey, you want to learn English, talk to me in English as well.’ I have no problem whether it’s Sinhalese or English, but they are the ones who should get used to the system here. What happens when I’m not there, and they end up in hospital? So I think it is really encouragement.” (Dr. Manu - FTF)

While this is not so much of a problem, IMGs from the UK and Canada noted that New Zealanders were able to distinguish them as migrants based on their accent. However, patients with English as a second language could not tell the difference.

“In fact, people from other cultures...perhaps it’s people who have English as a second language often don’t identify that I’m not a New Zealander, and they’ve often been surprised when I’ve said something like, to a patient, ‘Oh well, I’ll be away in July when you want to come in again.’ And they say, ‘Oh, where are you going?’ And I say, ‘Oh, I’m going to Canada.’ ‘Oh, why would you be going to Canada?’ And I say, ‘Oh, well my family’s there.’ ‘Oh! Are you from Canada? I thought you were from New Zealand.’ So it’s people who maybe are not so well attuned to English accents don’t pick that I’m not a New Zealander.” (Dr. Jean - FTF)

Compliance with Medical Advice

A result of poor English language skills among patients is sometimes seen in their lack of compliance with medical advice. Together with non-compliance, the IMGs noted that patients were taking alternative medicines, sometimes without notifying them. While some of the IMGs were not against complementary medicines, they insisted that what they prescribed was adhered to. Drs. Jon,

Manu, Ras, Alyssa, Rogers, and James all noted that compliance was an issue for both immigrants and New Zealand-born patients.

“Then the Pacific Island one is very different, because there, people are very easy to manage. But they don’t listen to anything you say, and they do exactly what they want, and they manage their health so poorly. And the problem is they may fail to get any care. So your challenges are very different. If you get care at all, it’s quite fulfilling. So you come away saying, ‘Gosh, you know, that guy actually listened to what I said last time,’ and that’s amazing, because nobody else did.” (Dr. James - FTF)

“I had a patient this morning who has got diabetes with chronic renal failure, who’s on dialysis. And he’s improving. And he said that there is some magician overseas, who tells him to take this powder, and his kidneys will get better. And stop all his medicines. And he came to us, and ‘Should he do that?’ I said, ‘This is what the science tells us. This is what happens in kidney failure. These are the medicines which are helping you. What that powder, what that medicine this person is telling you to take, what it does, I don’t know. He is the best person to tell you. What is his guarantee, what is his reputation, how many such patients he has treated?’ So I told him, ‘What I’m saying is, you take that powder, but don’t stop these medicines also.’ So culture becomes important, that yes, you need to have some basic understanding as to where the other person is coming from, as to what their beliefs are. We have to basically go on evidence base. That is the basis on of Western medicine...I’m not saying the others are wrong, but the proof is not there.” (Dr. Ras - FTF)

Accessibility to Care

Some of the IMGs, such as Drs. Jon, Lou, and Tily stated that their patients had experienced accessibility issues for various reasons. For Dr. Tily, her city-based practice created parking issues, and this made some patients late for their appointments. Drs. Jon and Lou noted that their high needs patients were mostly poor, and could not afford to access all the care they needed. Both doctors worked in Auckland where travel costs can be substantial due to the distances involved.

Dr. Jon also reported that some of his patients such as refugees and those from war-torn countries were not used to a GP type of model of care, as their first point of call, and often insisted on being treated in hospital settings. It took a lot of educating to turn such perceptions around.

Cultural Competence

While the majority of the IMGs had received some form of cultural awareness and competence training at some stage during their training or thereafter (Table

6), they still felt that more awareness of cultural competency issues within the medical context would be helpful. The IMGs reported that they liked learning about the Treaty of Waitangi, and other aspects of the Māori culture, but found it difficult to convert that into clinical practice. Additionally, the cultural awareness should be extended to cover other cultures as well.

“Not very as Māori were the only group covered and as my patients are a mixed bunch this was of partial use only. Also the reality of dealing with Māori patients was not really covered – just Treaty issue.” (Dr. Deborah - EI)

IMGs such as Drs. Jon, Manu, and Henri questioned whether people can become culturally competent just through training. These IMGs took the initiative to learn more about the different cultures through interactions at work, and social settings, and stated that all patients regardless of their ethnic background or other differentiating factors should be treated with humility and respect.

“Going out with a Māori family for dinner would work much better than ‘training’. Taking an interest in culture and history helps to develop good relationships with most all cultures.” (Dr. Henri - EI)

“One of the things that I guess appeals to me more and more, the longer that I practise medicine, is almost the kind of universality of culture being greater than the differences between them. And again, [Late Dr.] Pat Ngata’s said to the students once, and has said to me on a number of occasions, in terms of working with Māori, what is it that he would want, should they do? Well, you should actually treat people in the way that you would want to be treated. And that’s universal, so it’s not at all unique to working with Māori. It’s the same with any culture. And yet it’s hard to do, and to do it well and to do it with integrity.” (Dr. Rogers - FTF)

“I think if you deal with any patient with humility, professionalism, respect, no matter what the background of the individual is, you should not have any problems.” (Dr. Ras - FTF)

Patient-Centred Care

While the IMGs understand the need for and value of patient-centred care, it can be challenging because of an ageing population, and the different chronic conditions they suffer from. The lack of financial support for providing better patient-centred care to those who need it can be a barrier. Drs. Ras and Rogers observed the above among their patient populations.

“I think that the overall responsibility that New Zealand GPs take for clinical care is high, and I think to be able to respond to that at the level of the individual is hard. Well, it’s not hard, but it’s the job...that’s what you do. I think money is an issue. And so people who, for example, in the UK

you know you would want to see frequently, and you don't have to charge them there and then, very quickly it becomes an issue of either they continue to pay the full rate and it's hurting them, or if they don't, then it's hurting you. Hurting me. Financially. That's particularly so say in areas like mental health, where the expectation is that you'd have long consultation times anyway. And I think that is a challenge, and is certainly a challenge to people who might be working in areas where there are greater disparities and inequities, and that you're really being challenged both by the complexity of the clinical problems, but also by the socio-economic status of the population.” (Dr. Rogers - FTF)

“With the capitation system, there is certainly less pressure to push the patient through the door. So we can spend a bit more time with the patient. But having said that, because I've got patients who've been with me for fifteen, eighteen years, their problems are getting more complex, and their problems are getting multiple. So obviously, fifteen, twenty, twenty-five minutes sometimes is not enough. I think the main issue is the time.” (Dr. Ras - FTF)

Drs. Henri and James noted that some patients can be demanding and aggressive, and dealing with them can be very challenging.

“The Pakeha practice, the challenges are based on the fact that it's an urban practice, where the patients are more aggressive, they're less socially deferring, they think they know it all, they're a little bit aggressive. They think they can walk down to the Boulcott Hospital and get their appendix done, and all they need is a postman's letter. So they're quite dismissing of your skills. Just a bit insulting, really. And some will come in and say, 'I want to see a real doctor'... 'I want to see a paediatrician, my kid's got diarrhea, I don't want to see a general practitioner.' Which is like, well, hang on - how many paediatricians see kids with diarrhea? Ridiculous. So there's that type of thing that I find the most difficult in a typical urban practice with the patients. That's the one thing I think is hardest. I have a very strong thing about managing as much as I can, within my own competence. So philosophically we have some difficult situations, where I never quite know how to handle it, because I don't think it's a justifiable thing to refer to a specialist. And so I have some difficulties knowing what my role is in that situation, because I have a professional one, and I have a people one.” (Dr. James - FTF)

Other Individual Challenges

Some other challenges faced by the IMGs when dealing with patients included:

- Giving bad news (Dr. Jon experienced this when he started as a GP)

- Higher than usual prevalence of sexual health issues and teenage pregnancies (Dr. Michael who works in a rural practice)
- Higher than usual prevalence of sexual health and women's health issues (Dr. Tily who works in an inner city practice with a predominantly younger patient population).

Despite the issues and challenges, all the participants were positive about continuing in general practice. The next section focuses on the impact of IMGs' own cultures on their patients and colleagues.

5.1.5 Impact of IMGs' Cultural Background on Patients and Colleagues

The participants were asked whether their own cultural/ethnic backgrounds had an impact on their patients and colleagues. The IMGs found this a bit difficult to answer because impact of culture is difficult to judge, and often, it's the personality of a person that is more influential than possibly their cultural background.

Just under half of them said that their cultural backgrounds had no impact on their patients or colleagues. Those that said 'yes' reported that it seemed to be mostly positive because they could relate to their patients better given their own struggles as immigrants to New Zealand, they attracted patients from their own cultural backgrounds because it assisted with communication, the IMGs' accents created some fascination among patients in relation to why they were in New Zealand and whether they liked it here, and most felt that they were able to influence their patients to achieve better health outcomes by relating to them in a way that they appreciated.

Among colleagues, most of the IMGs mentioned that they found New Zealanders to be very laid back and in contrast they possibly brought a stronger work ethic and more discipline in the way they did things. For some of the IMGs this had a positive effect while for others it was seen as being problematic.

Cultural Impact on Patients

Drs. Jean, Deborah, Christa, Tina, Alyssa, Rogers, Henri, Phil, Charles, and James, all mentioned that their cultural backgrounds did have an impact on their patients mostly in a positive way.

"I try to not presume what my patients may require of me with respect to their cultural background. I invite my patients to correct me (for instance pronouncing their names), I double check, whether my suggestion/recommendation for treatment is a) understood and b) acceptable. If I feel I tread on sensitive grounds I admit to my uncertainties and ask for enlightenment...I truly believe that respect and goodwill bridge barriers."
(Dr. Christa - EI)

“Well, we certainly have a few examples where, yes, I mean, you made a difference, and a positive impact on the patient. They’re rare, but I mean, yes they do happen, and it’s good to see. Negative...I mean, touch wood, I never had any complaints or anything. But, sometimes it’s very frustrating, that some patients I have a lot of impact, and not just from me, or input not just from me, but from the nurses, and other health agencies; and there’s no change, and that can be very frustrating. But, you’ll find that wherever you go. If they don’t want to change, you can’t do it for them.” (Dr. Tina - FTF)

Dr James mentioned a few examples where the personalities of some patients, more than their cultural backgrounds, seemed to cause issues. He did however note that his problem patients were mostly from one cultural/ethnic group – New Zealand Europeans. His way of dealing with such patients had got him into trouble but he was determined not to be undermined by them.

“It would be wrong to say no. I mean, I can’t recall more than the odd incident where I’d say there had been a cultural problem. I’ve had more difficult situations with the Pakeha patients, but that’s to do with personality types. It’s not an ethnicity issue. So I’ve had difficult patients, who I’ve had to say, ‘I’m sorry, I’m not prepared to go there, I’m not prepared to be spoken to like that. I think you should come back.’ So I have gone that far with white patients. But I tend to be more worse with the Kiwis than I do with the ethnic minorities, because they don’t give me bad stuff. They treat me with respect, and they’re a little bit deferring, actually, on the whole. It’s the aggressive, know-it-all, poorly-educated Kiwi that gets me, and it’s probably those are the guys that probably get everybody. They... you know... disrespectful.” (Dr. James - FTF)

The majority of the IMGs, regardless of whether they thought that their own cultural backgrounds had an impact on patients, reported having very good interactions with all their patients including Māori patients. Most also thought that they had achieved good health outcomes for their patients even though it can be difficult to measure.

“Feedback yes, because I specifically asked some people, when I was working on the Māori health plan for our practice. I specifically spoke to some of my Māori patients, and asked them if they felt we were dealing with their needs, and very specifically they fed back ‘yes’. So I’m fairly confident about that. Health outcomes is a whole different thing, and I don’t think that that’s something that you can really be able to ask, or get an answer. I don’t even know if the Ministry of Health knows if health outcomes are better once people have had cultural training.” (Dr. Jean - FTF)

Cultural Impact on Colleagues

IMGs, such as Drs. Jean, Deborah, Christa, Tina, Alyssa, Rogers, Henri, Phil, Charles, and James, mentioned having an impact on their colleagues. Most of them found New Zealanders to be easy going to the extent that they often lacked structure to how they did or ran things. The German and other non-UK IMGs were quite particular about how they were more structured and disciplined when managing their practices and their communication with peers.

“My staff feel that I am ‘personified German efficiency’....[Among peers] Not really, though they mumble similar comments as my staff and they at times comment, that my style is ‘Germanic and outspoken’.” (Dr. Christa - EI)

“Yes, they all are [in relation to colleagues being New Zealanders]. And they all need a kick in the backside, yes. [laughs] No, but I mean, they’ve come on board really well.” (Dr. Tina - FTF)

“[Perceptions his colleagues have of him] Gruff bastard and nonsense...Yep, I get things done.” (Dr. Henri - EI)

“I tend to be quite up front about things, and just if I think something’s not going right, I’ll just say it, and I don’t know whether that’s cultural, or whether that’s me. And that’s something that my peers in my practice have commented on, and find it quite useful, that they say, ‘Oh, I felt too worried to say this to this family,’ or ‘too concerned to be...I didn’t know how to approach telling someone, so-and-so, this. What would you say?’ And I’ll say what I would say, and they can use that as a tool. So that I don’t know whether that’s culture, or that it’s me. I don’t know. Some people might say that North Americans are a bit more brash, or up-front, or whatever.” (Dr. Jean - FTF)

Dr. Rogers has tried hard to acculturate, and mentioned that often IMGs from the UK can come across as polite and reserved, and sometimes New Zealand doctors pick on these attributes, mostly in a positive, humorous way.

“OK, well it does. It’s certainly part of quite a strong New Zealand culture response is that bloody Poms...the Brits are here, look round this room now, none of us are kind of New Zealanders except, whoever’s speaking, and one other person. Well I mean it does happen a lot, because in health there’s a lot of IMGs. And I think it’s nearly always, I think, said in good humour. To start with, there was definitely a difference in kind of cultural bluntness. I mean, the English kind of being reserved and quite polite...and New Zealanders are reasonably polite as well, say compared to Australians or whatever. But that is a difference. So it takes a little while to get up to speed on that. I don’t think it’s a significant issue on a day-to-day basis, but as I was saying before, I’ve worked quite hard at the acculturation

thing. And I can do the chameleon bit. If I try I can do a pretty reasonable, sustainable Kiwi accent as well. There may be an issue, which is that in order to acculturate well, I leave behind my own ethnicity, or my own ethnic identity from the country of origin, if I ever thought it was important.” (Dr. Rogers - FTF)

Dr. Charles believed that his cultural background had made his practice a better place but was concerned that there were too many IMGs from one single place.

“[It] has made the place richer...richness in diversity...lots of fun interacting with them [staff]. [However] too many foreign doctors...dominant immigrant community; too many IMGs from one area” (Dr. Charles - EI)

Overall, the IMGs mentioned that they enjoyed the work they did even with the challenges they faced. As mentioned earlier, they all planned on continuing to practice as GPs in New Zealand.

The following section looks at the perceptions the IMGs had of general practice in New Zealand in comparison to their home nations. Also discussed below are the key features and the ‘likes’ and ‘dislikes’ of general practice in New Zealand, as mentioned by the participants.

5.1.6 General Practice in Comparison to Home Nations

Some of the participants had never worked as GPs in their home nations but were still able to reflect on the similarities and differences based on their prior knowledge.

IMGs from Canada and the UK noted that general practice in New Zealand was quite similar to their home countries. They also noted some differences which were also picked up by IMGs from very different health systems to that of New Zealand.

Similarities

All the IMGs from the UK (Drs. Deborah, Nathan, Michael, Rogers, Phil, and James), and one from Canada (Dr. Jean), noted that general practice in New Zealand was very similar to their home nations (Table 9). Dr. Charles, who had trained and worked in Zimbabwe, also noted the similarities of general practice to that of his home nation. The similarities that the above IMGs mentioned relate to how general practice is structured and acts as the gatekeeper to the health system. In the abovementioned nations, general practice is usually the first port of call of most patients. In addition to the above similarities, Drs. Michael, Phil, and Charles reported that the disease burden is quite similar as well. Dr. Phil also mentioned that the information technology used in general practice was also similar to what was used in the UK.

Differences

First, IMGs such as Drs. Jean, Deborah, Nathan, Michael, Rogers, Phil, Charles, and James, from comparable health systems, mentioned that there were many differences regarding general practice in New Zealand.

Table 9: General Practice in Comparison to Home Nations

Participants	Year of Migration	General practice in comparison with home nations	
		Similarities	Differences
Dr Jon (SL)	60s		P LGP
Dr Manu (SL)	70s		IGP CME PS-
Dr Lou (AUST)	70s	-	-
Dr Jean (CAN)	80s	SN	FFS
Dr Ras (IND)	80s		GK RS
Dr Deborah (UK)	80s	SN	FFS PCC P SE
Dr Christa (GER)	80s then 90s		LGP
Dr Nathan (UK)	90s	SN	FFS PCC
Dr Michael (UK)	90s	DB	SC
Dr Tina (GER)	90s		SC GK
Dr Alyssa (PHIL)	90s		LGP GPS
Dr Tily (SL)	90s		LGP FFS SC
Dr Rogers (UK)	80s then 90s	SN	ACC TS
Dr Henri (GER)	90s		LGP/SN
Dr Phil (UK)	2000s	SN DB IT	FFS ACC P ♣+++
Dr Charles (ZIM)	2000s	SN DB	FFS SC
Dr James (UK)	2000s	SN	SC P ACC SE WK ♦+++

<ul style="list-style-type: none"> ♣+++ = funding issues ♦+++ = profiteering/business focus ACC = ACC Scheme CME = continuing medical education DB = disease burden FFS = fee for service GK = gatekeeper, quality health professionals GPS = recognise G.P. as specialty IGP = general practice independent of govt. IT = good IT 	<ul style="list-style-type: none"> LGP = little general practice/different scopes of practice P = regulation of pharmaceuticals PCC = patient centred care/patient expectations/patient choice PS- = poor primary/secondary link RS = good r/ship with peers/providers SC = bigger scope of practice SE = different social environment SN = similar to home nation TS = lack of support for trainees WK = workload
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These differences included the fee-for-service model, the focus on patient-centred care, the higher patient expectations, the regulation of pharmaceuticals, the different social environment, the accident compensation scheme (ACC), the funding issues that face New Zealand's health system, the broader scope of practice that GPs can perform, the larger workloads, and the business-like focus of general practices.

"Well, general practice is definitely the primary care part of people's care. Pretty well everyone has a GP that they would identify as being their doctor. People come in for appointments, make appointments, and come in with problems. So things are similar in that way. Differences would be that in Canada, people don't pay at all to see a doctor, so often will come in with much more trivial complaints. And here, because people pay, the expectation is often a little bit higher for quality of care." (Dr. Jean - FTF)

"Fee for service – not free, longer consultations, more treatments available by GPs without having to refer on, different social environment, Pharmac affecting prescribing here, patients can choose their GP – not determined solely by geographic area." (Dr. Deborah - EI)

"Patients much more likely to wish to take some responsibility for their health. They also demand a higher standard." (Dr. Nathan - EI)

Among those IMGs from dissimilar health systems, such as Drs. Jon, Manu, Ras, Christa, Tina, Alyssa, Tily and Henri, the key differences noted between New Zealand and their home were the regulation of pharmaceuticals or the lack of separate pharmacies in Sri Lanka (Dr. Jon), the independence of general practice from government interventions in Sri Lanka (Dr. Manu), the need for CME in New Zealand (Dr. Manu), the links between primary and secondary care are poor in Sri Lanka (Dr. Manu), the scope of practice is broader in New Zealand compared to Sri Lanka and Germany (Drs. Tily and Tina), general practice in New Zealand acts like the gatekeeper to the rest of health system which is not the case in India and Germany (Drs. Ras and Tina), and peers and health providers in New Zealand seem to have better relationships with each other than you might see in India (Dr. Ras).

"It is a very good system [NZ], where the people, the providers, and the funders have some say in each other's management of patients. At least in Sri Lanka, it didn't happen. You can be a GP for years and years, without going to any seminar, and you just continue by habit, or whatever, and that's what happens. There is no-one to give you positive feedback, there's no-one to help you with your education. You do it on your own. I think this primary, secondary interface with the providers and the funders, everything being in one packet deal, really helps everyone [in NZ]." (Dr. Manu - FTF)

“It’s the gatekeeper role that the GP has in the country, but to be able to do that, you also have to have a system, which we have in New Zealand, where you have to be registered with a GP. Which is not the system in the majority of other countries. So having that system, you obviously have the continuity of care, one person responsible, or one practice responsible for the patient’s health care.” (Dr. Ras - FTF)

“It’s a bit difficult. But things do change now. Because they’ve noticed that the system they [Germany] had previously is becoming a bit too accepted. So I mean, let’s say you need a smear: you go to the gynaecologist. You have a child, you go to the paediatrician. So you didn’t actually see the general practitioner. So their skills were very limited. That’s why I would never have chosen that kind of specialty in Germany. But they’re changing that now as well, so that general practitioners becoming more gate-keepers, so that people actually have to go for a first opinion to a GP. And hopefully over time, they’ll pick up the skills, and be able to do more things again.” (Dr. Tina - FTF)

5.1.7 Key Features of General Practice in New Zealand

Leading on from the above discussion on similarities and differences, this section notes the key features of general practice as expressed by the IMGs. Many of these have already been mentioned above as things that the participants’ noticed about general practice in New Zealand, and therefore are briefly presented here (Table 10).

Key Features

The key features of general practice included:

- The fee-for-service model (Drs. Jean, Deborah, Nathan, Tily, Henri, Phil and Charles).
- The focus on high quality, patient-centred care (Drs. Jon, Jean, Deborah, Nathan and James).
- The close links with the community/family and the continuity of care over a long period of time (Drs. Ras, Christa, and Tily).
- Good access to health care. Some IMGs thought that New Zealanders have very good access to health care that is fair to all and of a high quality (Dr. Jon, Manu, Jean, Christa, Tily, Rogers, and Henri).
- More time to consult and a broader scope of practice (Drs. Christa, Michael, Tina, Tily, Rogers, Charles and James).

Table 10: Key Features of General Practice in New Zealand

Participants	Year of Migration	Key features of general practice in New Zealand		General practice in New Zealand	
		Key Features	Income	Likes	Dislikes
Dr Jon (SL)	60s	PCC GA PR PI	IN-	C+ PHO	I-
Dr Manu (SL)	70s	FP H-	IN+	FP C+	H- WK WL
Dr Lou (AUST)	70s	-	IN-	-	-
Dr Jean (CAN)	80s	FA FFS PCC AD		GA FA	AD
Dr Ras (IND)	80s	C+ RC RS	IN+	C+ RC	FFS WF GPT
Dr Deborah (UK)	80s	FFS PCC P SE	IN-	GPT	FFS P AD
Dr Christa (GER)	80s then 90s	SC GK C+ ACC	IN-	SC GK C+ ACC	WT ♣+++ AD SE
Dr Nathan (UK)	90s	FFS PCC	IN-	PA FFS	FFS QL
Dr Michael (UK)	90s	SC	IN-	SC	AD SP GV
Dr Tina (GER)	90s	SC	IN+/-	SC	GPS H- PS-
Dr Alyssa (PHIL)	90s	♣+++	IN+	WK C+	♣+++ FFS SC
Dr Tily (SL)	90s	FFS C+ GK SC FP	IN-	RS WK WL	♣+++ FFS
Dr Rogers (UK)	80s then 90s	GPT GA WL IT CS	IN-	GPT GA WL IT CS	PF
Dr Henri (GER)	90s	FFS GK RS	IN+/-	FFS RS	H- PS- OS AD DHB
Dr Phil (UK)	2000s	IT FFS	IN+/-	C+ B IT ACC P RS	FFS GVP ACC PHO DHB
Dr Charles (ZIM)	2000s	FFS SC	IN-	SC	AD
Dr James (UK)	2000s	SC PCC EM	IN-	ED CS SC	P ACC SE DF WK OP ♦+++

I- = lack of health information for the communities	GVP = govt pressure
♣+++ = funding issues	H- = hospitals uncooperative
♦+++ = profiteering/business focus	IN- = inadequate income in G.P
ACC = ACC Scheme	IN+ = adequate income
AD = more administration/paperwork/compliance	IT = good IT
B = running own business	OP = opposition from GPs/unprofessional
C+ = attachment to community/continuity	OS = obsession with safety
CS = good College structures	P = regulation of pharmaceuticals
DF = difficult patients	PA = professional autonomy
DHB = role of DHB	PCC = patient centred care/patient expectations/patient choice
ED = G.P. as an educational environment	PF = personality influences
EM = empowering	PHO = role of PHOs
FA = more fairness	PI = no need for private insurance
FFS = fee for service	PR = patient registration system
FP = good funder/provider link	PS- = poor primary/secondary link
GA = good access to quality health care	QL = lack of quality standards
GK = gatekeeper, quality health professionals	RC = good records
GPS = recognise G.P. as specialty	RS = good r/ship with peers/providers
GPT = more time for GPs to consult	SC = bigger scope of practice
GV = lack of govt respect in scope of practice	SE = different social environment
	SP = no superannuation
	WF = workforce
	WK = workload
	WL = work/life balance
	WT = waiting lists

- Some other infrequently noted features by the participants, including negative ones, were:
 - The patient registration system used in primary and secondary care is a good feature (Dr. Jon).
 - The easy access to most health care means that there is no real need for private medical insurance (Dr. Jon).
 - The extensive use of IT assists with keeping good records (Drs. Ras and Rogers).
 - The general practice work allows flexibility and adaptability which is a good thing to maintain a work/life balance (Dr. Rogers).
 - The RNZCGP has good structures to support a strong ethos around family medicine, general practice and primary health care (Dr. Rogers).

- General practice is an empowering and rewarding profession (Dr. James, who was not allowed to train and work as a GP in the UK).
- The regulation of pharmaceuticals through PHARMAC is unique (Dr. Deborah).
- The accident compensation scheme (ACC) is also unique to New Zealand (Dr. Christa).
- The social environment in New Zealand is different given the diverse communities present. It is also different in the sense that it is home to a large Pacific community (Dr. Deborah).
- The uncooperativeness of hospitals when dealing with GPs can be problematic for patients (Dr. Manu).
- The need for paperwork to meet administrative and compliance requirements can be excessive (Dr. Jean).
- The dependence on government funding and sometimes the funding is race-based as opposed to needs-based. Dr. Alyssa noted having poor, white patients for whom there was no extra funding available unlike for Māori and Pasifika patients (Dr. Alyssa).

“It is still a fee-for-service environment, despite capitation, it’s people still, in general, pay a fee for each time they come in. And therefore it’s almost general practitioners are there to serve patients, on a fee-for-service basis. And so I think that actually means that does have an impact on the quality of care - for the good. And the overall concept of fairness is very embedded here but may not be seen so much, I think, in other countries. That fairness and trying to support people with higher needs, or higher health needs, or higher economic needs, in an even stronger way than the general population.” (Dr. Jean - FTF)

“I am good at and capable of a wide range of medical skills, I am the first port of call for my patients for many health/counselling needs. I am truly a family doctor spanning care for several generations of a family. I like the no-fault ACC system, allowing us to practice with less concern for medico-legal issues.” (Dr. Christa - EI)

“Being dependent on the government for funding. And it’s a struggle, because I believe that the ones that need help are not really the ones that are getting help. Yes, we may have European patients here, but are high-needs, rather than some of our Māori patients here. You know, half the Māori patients have their own business, and drive flash cars. But yet the New Zealand system classes them as high-needs. Whereas I’ve got patients who don’t have a house, don’t have transport; because they’re white, they don’t

have high needs. So I'd say that it should really be based on [need] rather than race." (Dr. Alyssa - FTF)

"I think that it is high quality and committed. And I think some of the things like the relatively long consultation times, the emphasis on being flexible and adaptable, and evolving quickly, which I think is what New Zealand does well. So you've got high uptake of IT, and still being reasonably well attuned for that. I do think that the structures and the College, and the ethos that it provides around family medicine, general practice, and the transition that it's made to primary health care and what that means, have been very successful. So New Zealand general practice, I think, still punches way above its weight." (Dr. Rogers - FTF)

"Well trained doctors, usually well trained nurses (at least the ones we employ) and a great collegial relationship between doctors, and doctors and nurses. In all honesty, the Kiwis are not that different to the POMs. Biggest problem was adjusting to the fee for service environment (love it!) and being able to sort things out by picking up a phone. I feel we are losing that ability slowly. Shame." (Dr. Henri - EI)

Income

The majority of the participants noted that income from general practice has been relatively low when compared to other countries such as the UK and other western nations. They did report that it was improving because of the capitation system, and their ability to charge a co-payment. Additionally, the lack of higher income was compensated for by other factors such as being able to achieve better work/life balance, and better job satisfaction. However, there is concern that some New Zealand doctors may not have the same level of financial security as their overseas counterparts, and this may have an impact on their retirement.

"Comparison is, you can't, not in dollar terms, but if you look at incomes there [Sri Lanka], general practitioners have very comfortable lives. But they work longer hours sometimes, because they're independent. Here, I think if you have a lifestyle balance, which I didn't have initially - I didn't know, you see - now, I have a bit more balance. The income is adequate, it's more than adequate if you're careful and knowledgeable. Some of the doctors who came in the seventies, my vintage, they didn't have any business training, and things like that. And so now you get a lot of advice on what to do. And so if you do it wisely, and prepare for retirement, the New Zealand income is quite adequate." (Dr. Manu - FTF)

"See, I think most of us never go into the general practice just for the income, although income is an important part of life. You can't ignore it. Since the capitation system, there has been an improvement in the income over the last two or three years. But the risk is that if the capitation is not

inflation-adjusted, then there can be real drop-off in the income. And in the situation where the fees are capped, we cannot increase the fees. Something has to give.” (Dr. Ras - FTF)

“What I would say, being semi-serious, and I don't want to think about it, is that in terms of security, it's not insecure for international medical graduates, [and] comparatively, doctors tend to be reasonably well-off. But you know there will be doctors who can't afford to retire. And that would be pretty unusual in many countries. [And you can see that happening in New Zealand?] Yeah, I can. The provisions for a secure, comfortable lifestyle in old age...it's very, very patchy.” (Dr. Rogers - FTF)

Expanding on what has been mentioned above the next section will discuss the 'likes' and 'dislikes' of the participants in regards to general practice in New Zealand.

5.1.8 The Likes and Dislikes about General Practice in New Zealand

Interestingly, some of the key features mentioned above are the same things that some participants either liked or disliked (Table 10). For example, the fee-for-service model is a key feature of New Zealand general practice but was disliked by three of the participants. Others did not like the pressure that PHARMAC, ACC, DHBs and PHOs put on GPs.

The Likes about General Practice

Without repeating in detail the key features, the IMGs mentioned that they liked:

- The link between general practice and the community it operated in. General practice was the gatekeeper to the health system and in most cases the first place patients go to be seen. The care provided by GPs can be comprehensive due to the broader scope of general practice in New Zealand. The capitated funding enabled good access for the patients. Additionally, capitation allowed GPs to have longer consultations which may be resulting in better outcomes for their patients (Dr. Jon, Manu, Jean, Ras, Deborah, Christa, Michael, Tina, Alyssa, Rogers, Phil, Charles, and James).
- Dr. Phil liked the small business model that could link up with secondary care to achieve continuity of care for his patients.
- The relationships they have with their peers and the funders. The roles that ACC, PHARMAC, DHBs, PHOs and the government play is liked because it creates awareness of the necessary services in the community, funding of free care for the under sixes, and four paid visits per year for senior citizens. Drs. Christa and Phil liked the ACC scheme because it reduced medico-legal issues, and therefore, GPs could concentrate on

treating patients. Dr. Phil also liked the fact that medicines were being regulated on a national level.

- The use of IT systems for good record keeping. Having timely access to records is important for providing quality care to patients.
- The flexibility to manage their workload and achieve a better work/life balance. Drs. Alyssa, Tily and Rogers mentioned that general practice allowed GPs to choose their work hours so that they could also pursue other activities. In particular, Drs. Alyssa, Tily and Tina reported specifically choosing to do general practice so that they could have time to raise their children.
- The professional autonomy that general practice allowed. Dr. Nathan liked the higher level of professional autonomy, and this was partially due to being able to charge patients for the services provided. The fee-for-service also meant that a higher quality of service was expected by the patients.
- The support structures of the RNZCGP. Drs. Rogers and James liked how the College was supporting general practitioners. Dr. James in particular liked the educational environment that existed in general practices, and how the College was instrumental in enhancing the learning experience.

“Being able to go home in an afternoon, and not work weekends. It’s always mainly I think you become a part of the family. And you become friends with the patients, and you don’t really want to be, like that, but it’s sort of a good feeling, to be able to help them, and sort of a have a long-term sort of relationship with your patients. You don’t get that much from the hospital system.” (Dr. Alyssa - FTF)

“I like it because you can choose the hours in general practice, and you don’t get a lot of stress, dealing with [patients] like in ICU kind of situations. You don’t need to deal with many emergencies, like in the hospital system. So it’s less stressful, and you can choose your hours. And we deal with more preventive health, so. I mean, the hospital work is really stressful, I think, because most of the time, they see the acute patients, with illnesses. Here, we deal with the preventive side of it.” (Dr. Tily - FTF)

“It’s educationally very stimulating. And I’m constantly wide-eyed about what I’m learning every day. And when I stop doing that, it will worry me. It will worry me when I stop learning, because I start to get bored, then. But I feel that I can’t get enough education, really. That’s one of the things I love about it.” (Dr. James - FTF)

The Dislikes about General Practice

Some of the 'likes' about general practice were also noted as 'dislikes', and these were:

- The fee-for-service model because it meant some patients could not afford to see their GPs or that the GPs cannot charge what they consider to be a fair cost for their services. The adequacy of the current funding allocations is also debatable as some people are still missing out on health care (Dr. Ras, Deborah, Christa, Nathan, Tily, Alyssa and Phil).
- The intrusion of DHBs, PHOs, ACC, PHARMAC and government into general practice. These organisations have supposedly increased the bureaucracy and paperwork requirements within general practice. One of the key dislikes in general practice was the amount of paperwork that GPs had to complete in order to be compliant and to access appropriate care for their patients. The above requirements added to the already large workload for many of the GPs (Drs. Jean, Deborah, Christa, Michael, Henri, Phil, and James).
- The poor links between general practice and secondary care, especially with hospitals often meant the IMGs were unable to get timely treatments for their patients (Drs. Manu, Tina, and Henri).

In addition to the above, the IMGs mentioned the following dislikes that affected them individually:

- While Dr. Jon liked how PHOs were making communities aware of the service available to them, he was still concerned that some communities were not getting the necessary information about health care.
- Dr. Manu disliked the heavy workload and would have liked to have a better work/life balance. In hindsight his workload had affected his health and his family life. Dr. James alluded to the poor relationships he had with some of his New Zealand colleagues which affected him greatly.
- Dr Ras mentioned that despite having the opportunity for longer consultations he was often constrained by demanding patients and by the needs of running his own practice. The shortage of GPs at the time was affecting his practice.
- Dr. Christa disliked the long waiting lists that hindered patients from getting timely treatment in hospitals. She also did not like "*the climate of need for political correctness.*"
- Dr. Nathan disliked the government's lack of recognition of quality standards. Dr. Henri thought that the government was too obsessed with safety, and this led to increased bureaucracy.

- On a similar note, Drs. Michael and Tina thought that the government was not showing them enough respect by not recognising general practice as a medical specialty.
- Dr. Michael also disliked the fact that there was no superannuation however he might have been meaning something else because New Zealand has had a superannuation scheme for a long time. It is possible that he was referring to a compulsory saving scheme that only came into being in 2008.
- Dr. Rogers observed that general practice in New Zealand had a small number of personalities influencing everything. He thought that this was quite typical of New Zealand, and was not in favour of such practices as they stifled progress.
- Dr. James, the most recent arrival among the participants, mentioned that he disliked difficult patients, and the opposition he faced from fellow GPs.

“I think there’s a huge amount of compliance, quite a lot of compliance...forms, and really, the number of funding streams for patients is a pain. The fact that here we have to have a practice manager just to help make sure that we get all the money to which we’re entitled is a pain. Whereas that difference in Canada: there’s only one way to get money. It’s all government-driven. Yes, you do have to put in your fee-for-service things, but you just do it. It’s not a bit for ACC, or a bit for someone else, or bill the DHB for this, or send something to a PHO for that. It’s just one bulk thing that goes in weekly, and you get paid, and that’s it. And there’s no mucking around. And so it means that the admin support required in general practice in Canada is way less than here.” (Dr. Jean - FTF)

“Where it stands at the moment, in terms of perception in the general population and with specialists alike: I think it should be level with other specialties. And at the moment, it doesn’t get that recognition. Yes. You are the specialist, you’re standing high as God; you’re a GP, you’re quite a bit lower. And that really has to change. They’ve [College-RNZCGP] left it for too long, really. It’s difficult to change that view...because otherwise nobody wants to become a GP anymore. And also, specialists, they need to change their attitude. If a GP rings the hospital because they have a concern, they need to be talking to an equal partner. And if that GP’s concerned, they usually have lots of experience, and that needs to be taken as seriously as when another specialist rings. Probably even more seriously, because the other specialist probably doesn’t know about that field as much, you know? But so that needs to improve.” (Dr. Tina - FTF)

“At times I think it’s [general practice] still quite backward-looking, and resistant to some appropriate change, heavily influenced by small numbers

of personalities. But then that's New Zealand for you all over." (Dr. Rogers - FTF)

"One here is this issue of passive aggression is a very, very Kiwi way of dealing with people...if you want to really blow somebody out, you don't talk to them, you don't answer them. For example, I never get my e-mails answered because they don't want to answer me, and that's what I call passive aggression. And it's a well-known thing in management circles, and that is something which has been probably most hard to deal with. Is the 'I don't exist' thing. And the other thing that they do is, if you're insecure, some people jump on you and make you feel more insecure. And they're people with problems. But unfortunately, if you're insecure, you don't know that." (Dr. James - FTF)

The IMGs in this study shared their work experiences, stories about their patient populations, the challenges they faced being a GP and their perceptions of what general practice is like in New Zealand. Despite their issues, challenges, likes, and dislikes, they all wanted to continue to practise as GPs in New Zealand. This is because general practice in New Zealand has many features that make it unique, and highly valued by the practitioners and the patients.

This study also explored the social adaptation experiences of the IMG participants. The next and final section of this chapter will explore the impressions, challenges and experiences of the IMGs in their adaptation to New Zealand's social environment. This aspect of the study completes the journey the IMGs have been through from their desire to be GPs in New Zealand to them supposedly becoming New Zealanders.

5.2 Social Adaptation to New Zealand

While there are overlaps between the occupational and social adaptation processes that the IMGs went through, given the nature of their work, this section specifically looks at experiences outside of their need to become GPs in New Zealand.

This section presents the first impressions the participants and their families had when they arrived in New Zealand, their experiences of interacting with the locals outside of the context of work, their perceptions of how New Zealand is different from their home nations, the challenges they faced, their advice to future migrants, and whether they consider themselves to be New Zealanders.

5.2.1 First Impressions of New Zealand

The IMGs reported quite different first impressions and experiences of New Zealand. These ranged from having good experiences and liking the beautiful environment, to being frightened and feeling isolated. On the whole, the majority of the participants had very good initial impressions of New Zealand (Table 11).

Table 11: Impressions of New Zealand

Participants	Year of Migration	First Impressions		Communicating with locals
		Personal	Family	
Dr Jon (SL)	60s	F IW	G R	LM A CO
Dr Manu (SL)	70s	G IW	S	NI A
Dr Lou (AUST)	70s	G W		
Dr Jean (CAN)	80s	G W	S K R	NI
Dr Ras (IND)	80s	IW C	S	A CO
Dr Deborah (UK)	80s	W O FP	S R	A CO
Dr Christa (GER)	80s then 90s	B P	S K R	NI A
Dr Nathan (UK)	90s	FP	MF	NI
Dr Michael (UK)	90s	Q	S R	NI
Dr Tina (GER)	90s	G P F CC	K	NI
Dr Alyssa (PHIL)	90s	Q D G	S K	CS
Dr Tily (SL)	90s	L I D	G Q GC	NI LM
Dr Rogers (UK)	80s then 90s	G O C	FP D CC K R	NI LM
Dr Henri (GER)	90s	G Q P	G K	NI
Dr Phil (UK)	2000s	G	SC MF	NI CO
Dr Charles (ZIM)	2000s	Q	SC MF PI R	NI CO
Dr James (UK)	2000s	M	G R	NI

A = Accent	L = Lonely
B = Backward	LM = Limited contact
C = Clean, Orderly, Fresh	M = Mixed feelings
CC = Cultural Change	MF = Making Friends
CO = Colloquialism	NI = No issues
CS = Culture Shock	O = Open spaces/Outdoors
D = Different values/priorities	P = Provincial, Laid back
F = Frightening	PI = Personal Issues
FP = Friendly people	Q = Quiet, Empty, Peaceful
G = Good/Positive/Beautiful	R = Returning
GC = Good for Children	S = Single
I = Isolated	SC = Schooling
IW = Started work immediately	W = Good weather
K = Kiwi partner	

Personal First Impressions

The majority of the IMGs reported positive first impressions of New Zealand. Drs. Manu, Lou, Jean, Tina, Alyssa, Rogers, Henri, and Phil mentioned that they found New Zealand to be good for various reasons. Dr. Manu said he felt good because there were other Sri Lankan doctors in Wellington; Drs. Lou, Jean and Deborah said they liked the weather; Drs. Alyssa, Michael, Henri and Charles said they found New Zealand to be quiet; Drs. Ras and Rogers mentioned it being clean, orderly, and fresh; Drs. Deborah and Rogers liked the open spaces, and the outdoors; and Drs. Deborah and Nathan mentioned that the people were really friendly.

Drs. Jon, Manu, and Ras reported starting work immediately upon arrival, and it took them a while to familiarise themselves with New Zealand.

“Oh, it was quite good, friendly. There were about five or six other Sri Lankan doctors at that time in New Zealand, whom I didn’t know, but the hospital I came to was Wanganui, and they contacted most of these doctors, who were in Wellington. And they were at the airport to meet me. And they went out of their way to make sure that I was comfortable and welcome, yes. They were very, very good.” (Dr. Manu - FTF)

“Difficult to describe, mainly. I don’t think I paid much attention to what the first impression was. It was mainly to get into the work, do the work that I was appointed for. So what my first impression was: it was clean, everything was orderly, things seemed to work. But it wasn’t a shock, coming from UK, where I’d been for about six months. So I’d been exposed to some of these things, but had I come straight from India, probably it was the same shock that I got when I went to the UK, at that stage, in the mid-1980s.” (Dr. Ras - FTF)

“Sunny, clear winter skies, interesting biosecurity procedures at Auckland airport. Wide open Christchurch streets, single storey houses, joggers in Hagley Park. First people I met seemed to be all ex-UK, very friendly.” (Dr. Deborah - EI)

Not all the IMGs had good impressions of New Zealand on arrival. Dr. Jon, who came in the late 1960s, said it was a frightening experience because there were no instructions for him, and he had to find his own way. He also found that most of the important buildings were made of red bricks, which did not give him a good impression.

“But on this side of Australia - I came to Australia, it was all in transit - but when I flew from Sydney to New Zealand, Auckland, I remember it was just over the sea, you know? And I thought, ‘Where am I going?’ And then I came up...the worst was when I got down at the Wellington Airport, it was a red brick. And ‘Where did I come to?’ And then I took a taxi to

Wellington hospital. And when I was there, I saw red brick at the entrance. Then I thought, 'Oh.' Then anyway, then I was showed that the quarters were there, for doctors' quarters. So first impression was really frightening for me, in that where I'd come to. There were no instructions at that time for migrants, or like what we are doing now. So at that time, it was a case of breaking in." (Dr. Jon - FTF)

Dr. Tina came with her New Zealander husband, and noted liking New Zealand but had some apprehensions when she first moved to a town in central North Island. As noted earlier, they got lost on their way while driving through what she considered a no-man's land. She also noted that New Zealand has been through a cultural change and therefore, immigrants are able to access certain things such as good coffee and ethnic cuisine that were not available before.

"Many things do change in New Zealand, even though the last ten years, New Zealand has changed a lot. It's opened up much more, you get more foreigners, more tourists, coffee-shops are opening everywhere. Cultural upheaval has been huge over the last ten years. Now you can even get places where you can buy decent bread. Not many, not in [CNIT] yet. But I mean, food-wise it's always really important for a culture...some decent sausages, things like that...get different cheeses; you know, ten, twenty years ago you couldn't get that. So it is much easier for immigrants, I think, to live here now, though still continue a little bit with your own culture." (Dr. Tina - FTF)

Dr. James also had mixed feelings when he first came, questioning whether he had made the right decision. He found that being met at the airport by someone who knew New Zealand was really helpful.

"We landed: we were jet-lagged, we were worn out, it was chucking down with rain, and we thought, 'Oh gosh, have we done the right thing?' And we were stuck in the middle of Wellington. And we were met by the agency, who was an Indian chap actually, he was very nice. And he basically looked after us for a few hours, while we got a car, and told us where to go. I think he'd arranged some hotel for us to stay in. So from there on we moved off and did our own thing. But he was really helpful. And that was really important, because that meeting off the plane was probably the most important thing that happened, I think, in that initiation. Just somebody being there, and saying, 'I'm here'." (Dr. James - FTF)

Dr. Christa, who first came in the 1980s to do research, returned home to complete her studies before coming back in the 1990s. She did not have a favourable first impression of New Zealand. She had initially found NZ to be *'backward and provincial and a place not to live permanently but to explore as a tourist'*. However, she married a New Zealander and continued to live here. Dr. Henri was also married to a New Zealander, and while he found New Zealand to be laid back and somewhat lazy, he was positive about the prospects it presented to him.

"Love it. Empty, no Germans! People are cool and a little bit of effort gets you a long way as everyone else is so laid back (read lazy)!" (Dr. Henri - EI)

Dr. Tily came to New Zealand from Sri Lanka via the UK, and felt lonely and isolated. This was due to not knowing anyone in New Zealand. While she was expecting New Zealand to be like the UK, she noted that it was quite different, due to the different values and priorities of New Zealanders – she did not elaborate on what these were.

Families' First Impressions

Just under half of the participants were single when they first came to New Zealand (Table 9). Three of them, Drs. Jean, Christa, and Alyssa, married New Zealanders later on. Of those who came with families or came as couples, three were married to New Zealanders. Drs. Tina, Rogers, and Henri all met their New Zealand partners while overseas.

Among the early arrivals, Dr. Jon was the only one who was married. Initially he had come alone but was followed by his wife shortly after. He later had two children, both born in New Zealand. His wife had adapted well to New Zealand, and soon after arrival was able to secure employment with the Ministry of Health. One thing he did note was that landlords were reluctant to rent him a place until they had met his wife. It was not a major challenge though because he still had hospital-based accommodation before his wife arrived.

Drs. Tily, Henri, and James came with young families and mentioned that they all felt good about being in New Zealand. Dr. Tily thought that New Zealand was *"a peaceful and beautiful country and it's good for children, to bring up children"*. It should be noted that Dr. Tily was from Sri Lanka, and in the 1990s and 2000s, there was political turmoil there. Dr. James also agreed that New Zealand was good for raising children.

Drs. Nathan, Phil, and Charles noted that making friends was a bit challenging for some of their family members. In addition, Drs. Phil and Charles needed to arrange schooling for their children.

“Teenage daughter had a bit of difficulty being accepted by her peers at school and in working out where she was on the education front because of the different educational systems. General practice certainly provided flexibility for being there for children while my wife settled into a very busy job but general practice became an obvious choice as it was my background.” (Dr. Phil - EI)

Dr. Rogers liked New Zealand, but from the context of his family and the need to adapt, he noted that things were not what they seemed initially. He found that the friends he had initially made were too busy, like him, to really socialise. He found the infrastructure to be fragile and susceptible to damage by natural events such as storms. He also agreed that New Zealand had been through a cultural change since his first visit in the 1980s. There are still some persistent characteristics about New Zealand that are difficult for him to deal with, and he thinks this is because New Zealand is a very new country still finding its way.

“And so you know, you arrive, people say, ‘Oh come round for a barbie,’ and then you come round for a barbie, and so on. Beyond the first few months, you realise that the differences are there, and some of that is different, certainly, to the UK. A lot of the relationships can quite easily be superficial, in that they start off being very relaxed, and everybody’s very friendly, but then after that, people say, ‘Oh we must get together sometime,’ and three years later you know, ‘We must still get together sometime.’ And it doesn’t happen. I mean they’re thinly stretched...there are only four million of us to run the whole bloody place. And you kind of look around New Zealand, and on a bad day the airports are shut, there’s a slip on the road which has washed out State Highway 1, the power’s gone down. And that’s not a reason to go back. I think that loss of identity...there is something there about an identity and roots that is appealing. There are things that New Zealand just doesn’t get. I think there’s an anti-science culture in New Zealand, there’s an anti-intellectual culture. Sometimes there’s even an anti-culture culture, which is quite hard. Having said that, New Zealand punches above its weight in literature and the arts, but it’s always done in a kind of ‘Mmm, there they go, another bloody you know... film director,’ or another this. They celebrate it, but it’s not proper New Zealand stuff. And I think particularly for kids growing up, there’s that kind of harshness. You know, you’ve got to be tough, you’ve got to play sport, you’ve got to do this, you’ve got to do that. It’s not a very cultured place. In the broadest sense of the word. And part of that is just the newness.” (Dr. Rogers - FTF)

Just over half of the participants had considered returning to their home countries or migrating to another country. This was mainly due to the initial anxieties and challenges, which they overcame to remain here.

Communicating with Locals

The majority of the participants said that they did not have any difficulties communicating with locals. However, a few of them such as Drs. Jon, Manu, Ras, Deborah, Christa, Phil, and Charles, had to adapt to the accent and the colloquialisms. Drs. Jon, Tily, and Rogers noted that outside of work they had limited contact with locals when they initially came, mainly because New Zealanders 'disappeared' during the weekends and reappeared on Monday mornings.

"It's good, but I think it's the nature of Kiwi, is that they tend to disappear in the weekends. They mind their own things, so. Otherwise, it's alright, yes. Yes, communicating with them is good, but I think overall, New Zealand is a small country, and it's very isolated, so it's not like living in London or New York, it's different." (Dr. Tily - FTF)

Dr. Alyssa felt bit of a culture shock due to the informality that existed in New Zealand when people communicated with each other. She had to adapt to this level of informality.

"And the thing that was a culture shock for me was the professors, the senior clinicians, would want to be called in the first name basis. I couldn't get over that. Probably I was still doing Dr. So-and-so until I was well into two years as a house-surgeon. I had to stop, because one of the [doctors] he's not even that senior, but he called me back as Dr. So-and-so. So I said, 'No, you call me [Alyssa].' He said, 'I'll call you [Alyssa] if you call me so-and-so.' [laughs] (Dr. Alyssa - FTF)

Some other participants noted the informality and perceived equality with the first name basis style of communicating as a key feature of New Zealand.

5.2.2 Key Features of New Zealand

The participants mentioned a number of key features that they believed make New Zealand unique (Table 12). These included New Zealand having different values and priorities, a diverse ethnic population, equality, freedom, green image, open spaces, good outdoors and good weather. Participants believed that New Zealand had a cultural focus, liked sports, was wealthy, and afforded a comfortable lifestyle, was small but happy, was less class conscious, and had open-minded people with integrity who were helpful.

Table 12: Key Features of New Zealand and Becoming a New Zealander

Participants	Year of Migration	Key Features about NZ	Social Challenges	Advice for Migrants	Becoming a NZer
Dr Jon (SL)	60s	FR EC	HU SC EF	DS H	NZer+
Dr Manu (SL)	70s	OM SP ST	SE FS TV I BWL EC	RC CF OM	NZer
Dr Lou (AUST)	70s				
Dr Jean (CAN)	80s	CF EQ	NI CC (EQ)	CF H	NZer
Dr Ras (IND)	80s	IG CM	NI SB	LA HS	NZer
Dr Deborah (UK)	80s	SM FP O W IG CF	FS	LA W H GI	NZer+
Dr Christa (GER)	80s then 90s	ID OM IN	NI	LA AC	NZer
Dr Nathan (UK)	90s	P FP OM	MF	AC	NZer+
Dr Michael (UK)	90s	C GR HP	NI	CF HS	NZer
Dr Tina (GER)	90s	P DC O (GR)	NI	LA AS	NZer+
Dr Alyssa (PHIL)	90s	WL LR HP OM	RA	CF AS	NZer-
Dr Tily (SL)	90s	FP IG SM	SO (W) I TV	W AS TR I	NZer
Dr Rogers (UK)	80s then 90s	(FP) SP P V D W O G	(GC) (AS) IS (SM)	(GC) TR	NZer-
Dr Henri (GER)	90s	P OM IN	NI EF	AS RX	NZer
Dr Phil (UK)	2000s	HL LR IN	NI	PC CF SM	NZer
Dr Charles (ZIM)	2000s	CF I	NI SC MF PI	()	NZer
Dr James (UK)	2000s	SM LE O G SP GC (SC)	MF	EM	NZer-

() = Exceptions	LA = Language
AC = Accept Change	LE = Lack of Expose
AS = Associate/Integrate	LM = Limited contact
BWL = Balancing work/life	LR = Less Religious
C = Clean, Orderly, Fresh	MF = Making Friends
CC = Cultural Change	NI = No issues
CF = Cultural Focus	NZer- = Feels like a NZer on occasion
CM = Comfortable/Easy Living	NZer = New Zealander
D = Different values/priorities	NZer+ = New Zealander but with own identity intact
DC = Drinking Culture	O = Open spaces/Outdoors
DS = Democratic Structure	OM = Open Minded
EC = Ethnic Community	P = Provincial, Laid back
EF = Ethnic foods	PC = Political Correctness
EM = Employment Contract	PI = Personal Issues
EQ = Equality	PV = Poverty
FP = Friendly people	RA = Racism
FR = Freedom	RC = Reasons for Coming
FS = Family/Friend Support	RX = Relax/Enjoy Life
G = Good/Positive/Beautiful	SB = Sabbatical
GC = Good for Children	SC = Schooling
GI = General Information	SE = Spouse's Employment
GR = Green	SM = Small country/population
H = History	SO = Starting over again
HL = Lack of History	SP = Sports
HP = Happy	ST = Stereotyping
HS = Health System	TR = Training Requirements
HU = Housing	TV = Travelling
I = Isolated	W = Good weather
ID = Individualistic	WL = Wealthy
IG = Integrity/Helpful	
IN = Innovative	
IS = Identity Issues	

New Zealand society was seen as being more individualistic, and rather innovative.

"[New Zealand provided a] platform where people can talk about their culture, their language, their land and that is acceptable. [In Sri Lanka this was] completely taboo...you'd be taken to task immediately." (Dr. Jon - FTF)

"I found one of the things with New Zealanders is, if you are a good footballer, they are happy with that, yes. They don't care where you come from. Look at the All Blacks. They are from all over. If you are a good doctor, you are a good lawyer, a lot of people in various jobs. Good businessman, good tradesman. That's why they go out and bring these people there. I think that's one fantastic thing." (Dr. Manu - FTF)

"I think still there is a little bit more equality, a little bit more feeling of equality in New Zealand." (Dr. Jean - FTF)

"I think it's the...what shall I say...the honesty of the people. The trustworthiness of the people. The less corrupt institutions, the fact that things work, and people do, in the majority of the cases, as they promise." (Dr. Ras - FTF)

"Small population – generally small cities, so people easily know each other. Friendly helpful to strangers. People with a lot of commonsense, ingenious, lateral thinkers, practical – then I have lived in rural areas. Outside lifestyle, good climate especially the summers, lots of outdoor activities in uncrowded spaces. Unique plant and animal life. Māori and Pacific culture and outlook on life. Lively arts scene, alternative culture." (Dr. Deborah - EI)

"Emphasis is placed on individualism. There isn't the same emphasis on 'sticking to the rules/conventions' as there is in Germany. Innovative or common sense alternatives to traditional settings are more likely to be given an opportunity." (Dr. Christa - EI)

While there were many good features about New Zealand there were also challenging aspects reported by the participants. This included the drinking culture, the smallness and provincial demeanour, the laid back attitude of some, the over-emphasis on sports especially the All Blacks, the level of stereotyping of individuals based on ethnicity or race, and the relative poverty that exists in New Zealand. In addition while some participants reported the 'green image' as being an essential part of New Zealand, others reported that it was not what it was made out to be. Similarly, while New Zealand is a good place to bring up children, it was noted as having some of the worst records of child and family abuse.

"I mean they're much more laid-back. They much more put a priority on enjoying themselves, having a good time. Sometimes too much, sometimes it just means getting drunk, which I find very disturbing. That recent study I found interesting, and I probably agree with it, is that Kiwis think, or they uphold the image of being really environmentally friendly, and being so open about it. I mean, coming from Germany, where things are very tidy, where people are very environmentally conscious, I find it still

shocking that New Zealand is so dirty, actually. Cars are puffing out stuff that's unbelievable, they're noisy as. There are people just throwing their rubbish away. They can just get away with it, because there are only four million people in New Zealand. But otherwise, this would be a very dirty country...and people come from overseas, from Germany, coming here and think, well New Zealand is so fantastic, but it's actually much dirtier than their own country. And Germany hasn't got that image of being really clean. So yes, image and reality are very different, actually." (Dr. Tina - FTF)

"There is poverty in New Zealand that it's hard to find now in the UK. Yeah, real poverty. It's relative still. I mean it's not like Africa or wherever. But you know, kids without a decent pair of shoes, kids doing this, that. And you can track that through...although the differences are not huge, the drinking culture here is subtly different. It's harsher. There are differences in terms of a reluctance to debate certain issues. There's areas that- and I'm not saying that anywhere debates them reasonably well, but you know- the marijuana debate. The fact that there's still such a strong kind of libertarian, legalise it...when we've got a huge drugs problem, and it's growing- and the medical evidence is growing and growing- and yet the debate hasn't even got going. So there's that kind of...it's the 'you can't knock New Zealand'. You're seen as a wrecker if you moan and whinge. And there's a sort of mini-blindness, I think." (Dr. Rogers - FTF)

"I think that they're very small-minded, as a culture. I think they're parochial. A lot of people believe they know the world, and they don't. They make assumptions about you which are untrue. So they come with their own mentality, and they see somebody, and reflect their own stuff onto you, and then you're everything...they believe they know you. And that's where I imagine foreign doctors, who are classified as a typical foreign doctor, who may not come from the UK, will have the biggest problem, to my mind...is that you come from a poor country, where they don't have real doctors, and they all live in straw huts, and 'what could you possibly tell me to do?'...I'm much more into arts and things. And not many New Zealanders are very into arts. But you do have to connect on a sports level. I've got a calendar on my wall with the All Blacks on, and the number of people who say, 'Oh, it's the All Blacks', 'great team, oh Jesus.' I actually have to manufacture that in me. I couldn't care a toss whether the All Blacks have won or not, to be honest. But I have to find out what the score is before a Monday morning clinic, so that I can go in and say, 'Yes, that was a great game'." (Dr. James - FTF)

Despite certain misgivings, they all had very good things to say, and noted that

New Zealand was a great place to be.

“And some of the other differences are that on a good day, this is by far a better place. You can walk out, the sun shines, you’re within twenty minutes of getting lost in the bush. You’re an hour away from whatever it is you want to be, and you can still get a decent cup of coffee. I mean it’s magic. And I think there’s also a celebration of that by New Zealanders. So by and large, people can be optimistic here, and positive, in a way that’s not in the UK way of being is to be kind of understated. Whereas here, ‘How’s it going?’ ‘Great, thanks.’, ‘Good, thanks.’ You’re supposed to be positive.” (Dr. Rogers - FTF)

5.2.3 Adaptation Challenges and Advice to Potential Migrants

Social Adaptation Challenges

Just under half of the participants said they did not face any particular challenges other than those in their initial days in New Zealand. Those that did, reported being challenged by the cultural change, being isolated, starting all over again, achieving work/life balance, finding suitable housing, accessing ethnic foods, making friends, racism, finding employment for spouses, and dealing with the travelling distances between New Zealand and home nations. The majority of these were overcome through adaptation and understanding of the peculiarities of New Zealand. Some challenges still persisted for the participants at the time of the interview.

“Main challenge was just being away from family and friends in a rather isolated part of the country. Though as a house surgeon it was easy to make contact with others in a similar position and the social isolation soon eased.” (Dr. Deborah - EI)

“In general, I think as a migrant, it’s not everywhere, it’s not across the board, but you do get treated differently. Especially if you have a different colour. But I don’t see that as a barrier. It’s their problem, not mine.” (Dr. Alyssa - FTF)

“It was difficult, because as an immigrant, it’s all from A to Z, you know, starting from the scratch. But other than that, I think it’s just get to know people, and adjust to the climate and weather. It’s very cold. That’s the main problem.” (Dr. Tily - FTF)

“Well, I think it’s [cultural change] to do with economic structure, that some people are paid very large amounts of money, and some people are not. And so there’s more inequality. There’s much more poverty, there’s much more people who are really struggling now. Whereas my perception...now, again, this is only my perception then was that people were much more equal. So that when I came, and I was a doctor, and one of my good friends was the receptionist who answered the phone at the

hospital. We could interact equally socially, and we would do things: we'd go to movies, we'd go out for meals, and it wasn't I as a doctor had lots of money, and could afford to do that, and my friend, who was a receptionist, couldn't afford to do that. We interacted equally in that way. Whereas I would perceive now someone that was working even as a house surgeon...their earning power would be so much greater than the receptionist that they wouldn't be able to interact in the same way." (Dr. Jean - FTF)

"I think there's a lot of myths about New Zealand, some of which, and the realities, are very ugly. So people go on about what a great place this was to bring up children, and I felt I could see through the hypocrisy of that fairly early on. And this is a shit place for lots and lots of kids. And we've had a bit of trouble trying to get that agenda out into the open...there's a kind of easy 'she'll be right' view which sometimes even extends to let's say child-rearing. It's not an engaged culture, in the way that, you know, my fantasy, let's say, of Italian culture is. Where everybody's, the kids and the adults are sat round the same table, and they're all integrated. And it's really important that the kids are there and they're modelling [that]. Whereas in New Zealand, it's likely to be there's the adults, [and then] there's the kids off doing their thing. But I've kind of pointed this out to New Zealanders on a number of occasions, and they go, 'Oh, that's bollocks.' Or they go, 'Oh, actually, you've maybe got a point there. OK a barbie might be like that'. So some of those ingrained cultural laws are challenging. I'm not even necessarily saying they're inappropriate, but they're challenging." (Dr. Rogers - FTF)

Advice to Potential Immigrants

The participants provided a variety of advice for potential migrants who may wish to come to New Zealand to pursue their careers or otherwise. The main pieces of advice for immigrants are to know the language, understand the cultural aspects including the history, work towards associating and integrating into New Zealand society, and be ready to accept change. They should also understand that New Zealand is a small country that at times can seem isolated from the rest of the world. The people are often open-minded but can be 'politically correct' about some issues. New Zealand offers opportunities to have a relaxed lifestyle through engagement with the local communities but some immigrants tend to segregate themselves which is not conducive to integration. Dr. Charles mentioned, possibly tongue-in-cheek, that if immigrants knew too much about New Zealand then they possibly would not come to New Zealand. However, he did reiterate that immigrants ought to mix and integrate into New Zealand society.

“But you know when you come here, to understand tangata whenua, they’re not asking anything else, just to be recognised. And you’re the people of the land, they respect the water, all this sort of thing. The thing is, have an open mind.” (Dr. Manu - FTF)

“I think it’s still very high up in the political agenda, in health agenda, the disparities between Māori, Pacific, and other. That’s how everything is done. And so I think an understanding of that...because if one just looked at population statistics, you’d say, oh well, population-wise, then Māori deserve 17% of the attention to things. But really, politically, and health-wise, and trying to address disparities, there’s a huge, much more focus. Understanding that context would be really important.” (Dr. Jean - FTF)

“The need for political-correctness and a bit about Māori culture; the fact that NZ is however a multicultural society with a large Chinese/Asian community; that it has a small population and in a lot of ways has the characteristics of a developing country.” (Dr. Phil - EI)

“Their English needs to be understood and they need to be flexible in adapting to how NZers live whilst maintaining their immigrant identity.” (Dr. Christa - EI)

“[Immigrants should have] knowledge of ACC and the medical system [and] a bit of knowledge of the Māori ways.” (Dr. Michael - EI)

“I think what would make it easier would be to mix and mingle, really. That’s what I see was where my colleagues were having difficulty. In terms of knowledge, in terms of intelligence, they were quite good. But they kept to their own, they never mixed and mingled and they wouldn’t, even in the hospital, they would just sit by themselves. So I think that they should just mix and mingle.” (Dr. Alyssa - FTF)

“Relax, enjoy life and life with the locals, not in your own ‘cultural community’. In my opinion the self-segregation of immigrants is half the problem of Kiwis not accepting them.” (Dr. Henri - EI)

5.2.4 Becoming a New Zealander

To understand the extent to which the participants had acculturated to general practice and New Zealand as a whole, they were asked whether they considered themselves to be New Zealanders. Arguably, feeling like a New Zealander, calling New Zealand their home, can be a positive indicator of cross-cultural adaptation. However, this measure remains crude as other factors do come into play such as having citizenship, the movement of children as they grow, the ongoing impact of ‘looking and sounding different’, and the preference to retire in one’s own country of birth.

Despite the participants having personal feelings about being New Zealanders, some did mention that it is a difficult concept to articulate because how they felt was often questioned by the public, intentionally or otherwise.

The majority of the participants considered themselves to be New Zealanders but at the same time they wanted to maintain their own cultural and ethnic identities. Drs. Manu, Jean, Ras, Christa, Michael, Tily, Henri, and Phil said that they considered themselves to be New Zealanders despite being frequently questioned about their country of origin, even after having spent the majority of their lives here.

“Where are you from?’ And I said, ‘When do I become a New Zealand doctor? When I become that fifty years later, saying,’ ‘Bah! I’m a New Zealand doctor!’ You know, here I’m teaching medical students, my children are grown, they still say, ‘Well, when are you going home?’ Or some people think that I’m from Fiji. They say, ‘Are you going back to the Islands?’ But those things don’t upset me, but some of them put it in sort of [a negative way]. Only time that I got a lot of problems was during the Springbok tour, which I opposed, and the fact that I opposed the hard-core thing for rugby was not taken very well in a small town...who everybody knew who supported that, and I was one of the handful of people. But I took a stand, and I lived with it, and those things passed.” (Dr. Manu - FTF)

“Well, it was when everybody started to have to write down their ethnicity. And when the Department of Foreign Affairs put big fees on returning residents. I had New Zealand residency for years and years, but if I went out of the country, I had to pay \$300 to come back in, because I needed to get a returning residents’ visa, and so I got really annoyed with that. And so I just applied and got New Zealand citizenship. So probably around then, yes [became a New Zealander]. So it was when I got my passport.” (Dr. Jean - FTF)

“Well, I already do that. Yes. It’s mainly a question of how you feel, as to how much you are part of this society. Because if you always look at yourself as different from where you are living, then no matter for how long you have been in a country, you will always be an outsider. So I think it’s also an individual’s acceptance, as to how well they integrate with the local society. Yes, well I’ve been here long enough.” (Dr. Ras - FTF)

Some of the other IMGs, such as Drs. Jon, Deborah, Nathan, and Tina, did say that New Zealand was their home, and did consider themselves to be New Zealanders. However, they also acknowledged that their own ethnic identities would be difficult to ignore, and that they had a preference to maintain those identities. Certain GPs from the UK mentioned that being far away from family was stressful which could have an impact on their decision to stay and thereby still be New Zealanders.

“Well, I still strongly have the connections, back home in my own country. But I am a New Zealander, number one. Number two is my own language. I am New Zealander...so I can call myself New Zealand Tamil.” (Dr. Jon - FTF)

“I will never lose my accent. People can tell straightaway that I’m not a New Zealander. But otherwise, I think I’m well integrated, I’ve got enough friends and acquaintances...so I feel well integrated. But yes, I’m not a total New Zealander...where you have grown up is always where your roots are.” (Dr. Tina - FTF)

“Currently I am ~ 50:50 i.e. lived ~ ½ my life here and ½ in England. Possibly the balance will shift in the next 10 years. However, where you grow up has a huge influence on this belying the length of time spent in places. Yes as I have enjoyed it very much here and can’t imagine settling back in the UK...the main negative is the distance from family which is a major factor in deciding whether settlement here is viable.” (Dr. Deborah - EI)

[He feels like a NZer and sees NZ as his home now but also noted that he felt] “stresses of separation from family and friends in the ‘old country.” (Dr. Nathan - EI)

Drs. Alyssa, Rogers, and James all mentioned that to a certain extent they could never be New Zealanders because either they will always be seen as foreigners or they have their roots and identity too grounded elsewhere to really let go.

“I don’t think so [on being a NZer]. You know, probably, it just depends on who you meet, the other people. Because there was a time I bumped into someone, crashed her car...she came out, and I don’t wear makeup, and she sort of straightaway said to me, ‘Do you have insurance?’ I almost said, ‘Look woman, just because I’m brown and I don’t wear makeup, doesn’t mean that I can’t pay insurance.’ I almost said that. I had it in my mind. But I didn’t say that to her. You know, you will always be seen as a foreigner, I would say. But how you deal with that depends on you. Entirely different: depends on you.” (Dr. Alyssa - FTF)

“It’s come as much as it’s going to. And I think there’ll be a slight winding back. Which is an age thing, as much as anything else. I’m very suspicious when people start to get interested in genealogy. But there’s almost this inevitable pull of well, you know, sort of where did you come from, what did you leave behind, and what did that mean, and would you want to go back there, and what would you want for your kids. And I mean that’s a biggie for me. Do I hope my son and daughter stay in New Zealand? I’m not really sure that I do. And that’s quite big, really.” (Dr. Rogers - FTF)

“I don’t think I’ll ever become...I mean, I may get citizenship next year, but I don’t think I’ll ever be a New Zealander, no. My kids will be, if they stay. My wife will never be a New Zealander. We are foreigners, and we’ll always be foreigners here, and that’s because we will never quite get into the culture, because there is a sort of...they’re quite conservative as people, New Zealanders. They don’t invite you to their homes much. They’re not as open as I would like, but I can’t change that culture. It’s the way it is. And so I guess it’s...so no, I don’t think I would ever become a Kiwi, no.”
(Dr. James - FTF)

The above concludes the Results chapter. The following summarises the key points about the journey of the participants from their post-training days to their adaptation to general practice, and to New Zealand in general.

5.3 Summary

- At the time of the study, the majority of the participants (13) were working in urban practices; nine were in populations considered to be in the middle to upper deciles.
- Two participants worked in rural settings but with contrasting patient populations, with one working among Māori in a high needs area, and the other among predominantly New Zealand Europeans in a low needs area.
- Additionally, two participants worked in semi-rural settings with one in a predominantly New Zealand European population and the other in a mixed population.
- Some of the IMGs who were working among middle to upper decile New Zealand European populations did not report any particular disease burdens or trends among their patient groups. However, others working among similar population groups reported seeing high levels of chronic conditions, mental health issues, and problems related to lifestyle issues.
- Those IMGs who worked in predominantly Māori or mixed populations noted higher prevalence of chronic conditions, mental health issues, lifestyle related problems, sexual health issues and domestic violence problems. These populations were predominantly in the lower deciles.
- The IMGs noted several ongoing challenges when working in general practice including the focus on profiteering based on the public/private business model, the need to make their practice financially viable, the requirements necessary for accessing capitation funding for patients, the fee-for-service model that can have an impact on accessibility issues for patients, the management of their workload when dealing with patients with complex conditions, the professional antagonism faced when dealing

with New Zealand-trained colleagues, and the lack of adequate links between primary and secondary care systems including the issues with ACC and PHARMAC.

- Additionally, when dealing with patients, the participants reported ongoing language issues, patients' non-compliance with medical advice, patients' lack of access to timely care, and at times, providing culturally appropriate care due to a lack of adequate cultural competence training within the medical context.
- Despite the challenges they faced, all the IMGs mentioned that they planned on continuing in general practice for the foreseeable future. However, some of the participants stated that their continuing will be conditional on their workload decreasing, fulfilling the CME requirements, the schooling requirements of their children, the options they have as they get older, and on how New Zealand treats them.
- Some of the participants did mention that their own cultural backgrounds did have an impact on their patients, mostly in a positive way. Some of the participants also thought they were able to achieve good health outcomes for their patients, including Māori patients.
- One of the more recent participants from the UK noted that he had some difficulties with New Zealand European patients who he thought had personality issues rather than cultural. He was a bit uncertain on how to deal with such patients.
- Additionally, the majority of participants reported that their cultural background and more so their personalities did have an impact on their colleagues. For the most part, the IMGs reported being more organised and efficient in the way they managed their practice when compared to their New Zealand counterparts.
- Some of the participants had never worked as GPs in their home nations but were still able to reflect on the similarities and differences when compared to New Zealand. The IMGs from Canada, UK and Zimbabwe generally noted that general practice in their home nations was very similar to New Zealand in terms of how it was structured and its role as the gatekeeper to the health system.
- In terms of differences, the IMGs from the UK and Canada noted that the key differences included the fee-for-service model, the focus on patient-centred care, the higher levels of patient expectations, the regulation of pharmaceuticals, the different social environment, the compensation scheme for accident-related injuries (ACC), the funding issues of New Zealand's health system, the broader scope of practice that GPs can

perform, the heavier workload, and the business-like focus of general practices in New Zealand.

- The IMGs from dissimilar health systems (Sri Lanka, India, Germany, and Philippines), reported that the key differences included the lack of regulation of pharmaceuticals (PHARMAC role), the lack of separate pharmacies within their health system, the independence of general practice from government interventions in home nations, the need for CME in New Zealand when compared to their home nations, the links between primary and secondary care being poor in home nations, the scope of general practice being broader in New Zealand, general practice not being the gatekeeper to the rest of health system, and the better relationships between peers and health providers in New Zealand.
- Furthermore, the participants noted that the key features of general practice in New Zealand included the fee-for-service model, the focus on patient-centred care, the close links with the community/family and the continuity of care, the good access to health care for people given the gatekeeper role of GPs, longer consultation times, and the broader scope of practice.
- Other, less noted features of general practice and the overall health system in New Zealand included the patient registration system, no real need for private medical insurance, in some cases the lack of cooperation between general practice and secondary care, the excessive paperwork requirements, the extensive use of IT for record keeping, the regulation of pharmaceuticals, the ACC scheme, the dependence on government funding including race-based funding, the diverse socio-cultural environment, the flexible work environment within general practice that allows for better work/life balance, the role and purpose of the RNZCGP in supporting a strong ethos around family medicine, and that general practice in New Zealand can be an empowering and rewarding profession.
- Nearly all the key features mentioned above by the participants were also what they liked about general practice in New Zealand.
- The main aspects that some IMGs disliked about general practice included the fee-for-service model because it caused access issues for some patients; the intrusion of medical organisations (DHBs, PHOs, ACC, PHARMAC) and government into general practice because it increased bureaucracy and paperwork; and the poor links between primary and secondary care because it resulted in delayed care for patients.

- Other, less noted aspects IMGs disliked about general practice and the overall health system included the lack of information about health care targeted at communities; the heavy workload that made it difficult to achieve a work/life balance; the poor relationships some IMGs had with their locally-trained colleagues; the time commitment demanded by patients with complex conditions complicating the need to run a viable practice; the long waiting lists for hospital care; the need for political correctness; a lack of government recognition of quality standards; the influence of a small number of personalities in general practice; and the difficult local patients that they have to deal with.
- The majority of the participants reported that the income from general practice in New Zealand has been relatively low when compared to their home nations even for those from dissimilar health systems. However, the introduction of capitation and the co-payments had improved income levels in recent times.
- In terms of social adaptation, the majority of the participants reported having positive first impressions of New Zealand. They had found New Zealand to be quiet, empty, clean, orderly and fresh with open spaces, good weather and friendly people. A few of them felt apprehension, isolation, and fear, mainly because they did not know anyone, and were going to live and work in places smaller than they were used to. Some felt that New Zealand was still a very young country finding its place. They observed that the infrastructure was fragile and susceptible to damage by natural events such as storms.
- Some of the IMGs who had been in New Zealand longer than others noted how it had changed since the time they came. They observed that in the 1970s and 1980s, New Zealand would shut down on Friday evenings and reopen on Monday mornings – people disappeared on weekends to do their thing and the majority of shops would be closed.
- In addition to the above, until the early 2000s many of the IMGs from the Asian subcontinent, and Europe, noted not being able to find ethnic foods, good coffee and a variety of different breads.
- In terms of communicating with the locals, the participants did not report any major issues other than needing to learn some of the local lingua and colloquialisms.
- The participants mentioned that the key features that make New Zealand unique included it having different values and priorities, a diverse ethnic population, equality, freedom, green image, open spaces, good outdoors, good weather, a cultural focus, being sports oriented, being wealthy and affording a comfortable lifestyle, small but happy, less class conscious,

with open-minded people with integrity who were helpful. New Zealand society was said to be more individualistic and rather innovative.

- The participants also reported some challenging aspects about New Zealand including the drinking culture among many of the people, the smallness and provincial demeanour, the laid back attitude of some, the over-emphasis on sports especially the All Blacks, the level of stereotyping of individuals based on ethnicity or race, and the relative poverty that exists in the population. In addition, while some participants reported the 'green image' as being an essential part of New Zealand, others reported that it was not what it seemed. Similarly while New Zealand was deemed to be a good place to bring up children, it was difficult for them to ignore that it had some of the worst records of child and family abuse.
- The participants noted that immigrants to New Zealand would do well by knowing English as all business is done in this language, and learning about the cultural focus and the history of contemporary New Zealand, the democratic structures that govern the institutions of authority, the organisation of the health system, and other general information. Those immigrants who want to pursue their careers in medicine should be aware of the training requirements that are necessary to achieve registration.
- Additionally, the participants reported that potential immigrants need to understand that New Zealand is a small country that at times can seem isolated from the rest of the world. The people are often open-minded but can be 'politically correct' about some issues. New Zealand offers opportunities to have a relaxed lifestyle through engagement with the local communities but some immigrants tend to segregate themselves which is not conducive to integration.
- The majority of the participants considered themselves to be New Zealanders but at the same time they wanted to maintain their own cultural and ethnic identities. Just over half of the IMGs said that they considered themselves to be New Zealanders despite being frequently questioned about their country of origin. Three of the participants said that to a certain extent they could never be New Zealanders because either they will always be seen as foreigners or they have their roots and identity too grounded elsewhere to really let go.

6.0 Results Part Three: Institutional Perspectives

6.1 Introduction

As part of this study, formal input was sought from key institutions such as the Medical Council of New Zealand (MCNZ), the Royal New Zealand College of General Practitioners (RNZCGP), and the government-contracted medical recruitment agency (NZLocums), on current policy directions regarding registration of IMGs, the targeted recruitment to reduce doctor shortages in certain parts of New Zealand, and the training requirements for IMGs wanting to become general practitioners. All were asked about the types of support and assistance they provided to IMGs in their respective organisational roles (refer to Appendix E for interview schedule).

Representatives from the three institutions were interviewed; however the RNZCGP withdrew its interview contribution subsequently, citing that their representative's responses were inconsistent with the College's stated objectives, processes, and procedures. It should be noted that while the RNZCGP had verbally agreed for their representative to be interviewed, they refused to provide formal consent because they disapproved of a small portion of what was going to be documented about them. Ironically, what they disapproved of was reiterated by one of the other institutional interviewees.

The other two institutional representatives had formally consented to their interviews being used for the purposes of this research, and that they could be identified by their work titles.

Thankfully, the RNZCGP later agreed to re-engage; however, a senior manager indicated that there was not a single person who could respond to all the questions and therefore, several people within the RNZCGP would need to be interviewed. Upon reflection, it was decided that the majority of the information needed could be obtained from the RNZCGP website, and that any in-depth real experiences regarding IMGs were unlikely to be forthcoming given their initial contentions. Also, the task of interviewing several people to get an official view of the RNZCGP was deemed to be too resource-intensive, without any perceived added value. However, the College was still approached and they agreed to respond via email to the list of questions used for the initial interview. A contact person within RNZCGP coordinated the responses from several people and forwarded it when completed. As anticipated, the responses to the questions were limited in nature, and did not add anything new to what was known from the RNZCGP website.

In summary, the following personnel were interviewed from their respective institutions: the Business Services Manager of the MCNZ, and the General Manager for Recruitment from NZLocums. These two interviews were conducted in July 2013. There were several different respondents from the RNZCGP, mainly staff who looked after the general practitioner (GP) training programmes – GPEP Year 1, 2 & 3, and their Medical Director. The RNZCGP provided their feedback in April 2014.

The structure of this chapter will follow that of the preceding results chapters that mapped the participants' journey of coming to New Zealand, achieving registration, doing the necessary training to become GPs, and finally working as independent specialist GPs.

6.1.1 Recruitment

While the majority of the IMGs come to New Zealand of their own volition, NZLocums was specifically set up in 2000, through funding from government, to recruit IMGs to fill vacancies in rural areas that have staffing issues. NZLocums comes under the umbrella of the Rural General Practitioner Network (RGPN), which had initially lobbied the government to provide assistance with recruiting medical personnel (doctors and nurse practitioners) for rural communities facing critical workforce shortages. The recruitment of doctors has been NZLocums' main focus, mainly due to the bureaucratic difficulties of recruiting and placing nurse practitioners within New Zealand (GM Recruitment – NZLocums).

Essentially, NZLocums has a two-fold mandate with a clear focus on supporting rural communities; the first is to find IMGs who wish to work for short periods as locum support, and the second is to find IMGs who are needed or wish to work for longer periods or who may want to become permanent. They recruit from countries on the MCNZ's list of countries with comparable health systems to New Zealand²⁴, due to the straightforward registration process for such recruits, and the confidence the MCNZ has in the training the IMGs have received in their respective countries. It should be noted that there are many other recruitment agencies operating in New Zealand with a similar focus to NZLocums.

Within the context of the current global medical workforce, the GM for Recruitment at NZLocums noted that it was a challenge for New Zealand to attract IMGs given the competition from the other big recruiters – the USA,

²⁴ The current list of comparable countries includes Australia, Austria, Belgium, Canada, Czech Republic, Denmark, Finland, France, Germany, Greece, Iceland, Israel, Italy, Norway, Republic of Ireland, Singapore, Spain, Sweden, Switzerland, the Netherlands, United Kingdom and United States of America. This list is reviewed regularly and some countries could be excluded and new countries added (MCNZ – List of Comparable Health Systems, 2012).

Canada, UK and Australia. New Zealand is unable to compete on remuneration with any of these countries so has to promote other pertinent aspects that may be attractive to IMGs who are less interested in money than lifestyle, and to experience the way medicine is practised in New Zealand. The changes occurring in home countries was also noted as a 'push' factor for some IMGs coming for short-term or limited-period working contracts.

"Extremely. It is very difficult. We're competing on the world market against the big five. So Canada, USA, Australia, New Zealand, and South Africa used to be the big five...and the UK. South Africa's dropped off. In any one of those countries, other than New Zealand, they pay more. So if anyone's going for money, New Zealand lucks out completely. So where New Zealand comes into its own is that we sell the lifestyle. People come to New Zealand for its lifestyle. Thanks to that very successful campaign of New Zealand, the one hundred percent pure. It's put New Zealand on to many people's bucket lists. They want to come down and experience and see New Zealand. Also, with all the movies that have been shot down here, it's a massive attraction. And it's seen as a very clean destination to come out and have some really good fun. So we maximise on that. And people come from different countries for different reasons. So our Dutch doctors for example, they come because of the scenery and the hills. So they come to New Zealand for the space, for the more relaxed general practice atmosphere of the 15-minute appointments rather than 10, and they come for the scenery and the Americans come so they don't get sued. They don't have that absolute fear. The UK docs....okay, so NHS is having a massive revamp at the moment, and has been for the last 18 months, 24 months. So there's a lot of dissension in the ranks. They don't like the way things are going at the moment, so they are coming for those reasons. So it depends on the country." (GM Recruitment, NZLocums)

Even with such attractions, the Recruitment Manager reported that the great distances between New Zealand and some of the preferred countries was still a barrier for recruitment.

You can generally pick why people are coming out to New Zealand. But it is quite a challenge. It's a hell of a long way from anywhere. If they're family-orientated, their family are back in their home country, so you're asking a huge ask of these people to leave everything that they know, and all their friends and their family, to come into a country that they've never been to before, and set up shop permanently. But we are a lot more relaxed in our general practice, in our hospitals, so they do have the opportunity to have a life outside of work. So that is very attractive, and works in our favour." (GM Recruitment, NZLocums)

While added incentives do not seem to be the norm for most recruits, sometimes NZLocums have to negotiate with practices, PHOs or DHBs to increase remuneration levels and other benefits to make certain hard-to-fill positions more attractive. Some added benefits could include the ability to do roving medical work in two or more practices within a given area, support for families with employment and schooling, and extended holidays. The Recruitment Manager noted that there was a need for work flexibility in some parts of New Zealand.

6.1.2 Support for IMGs

Once the IMGs get to New Zealand, NZLocums provides arguably the best support any IMG could ever ask for. While this study cannot directly corroborate the support given because none of the IMG participants in this study had come through NZLocums, there is still an opportunity to compare what the participants recommended for new IMGs with what the NZLocums provides to its recruits.

NZLocums has relationship managers who assist with MCNZ registration, immigration matters, settling into the new work environments and to a certain extent, they support accompanying family members with work and/or schooling needs. The level of support and assistance provided reduces the stress and the time it takes for the IMGs to start working.

“Our service is end-to-end, so we take the doctor from the lead, from the first enquiry, right through to being in practice and working. So we undertake the interviews, we do the reference checking, et cetera, before we actually even set them up with a potential role. If they’re coming in for a longer term, then they need to have a job offer before they can go through Medical Council process anyway. So we don’t want to put any doctor that we don’t believe is, (A) going to make Medical Council registration, and (B) has got anything questionable in their past. So we do lots of searches on the doctor online, make sure that we’re happy to put that person forward and represent them. So before they get here, their application and everything is done for them. And then when they arrive, they all attend orientation here in our offices. So we meet every single one of them. We help them with their immigration before they get through. So I’m licensed, and I’ve got two newly-licensed staff members that are going to assist me. And then the RMs, we call them the relationship managers - these are the guys that are handling the doctors - will stay in contact with those doctors. If they’re roving, we’re in contact with them every week. When the doc’s in, if he’s brought his family, so then the partner, if they need a job at the outset, we will try and put them in touch with commercial recruiters that work in the area that they’re in. Also with the schooling, we find out what ages are the children and whether the partner’s actually going to work or be a stay-at-home parent. So we work with them in that regard. We can

put them in touch with the community, with groups that are interested in the same hobbies, or things that they're interested in." (GM Recruitment, NZLocums)

Much like the IMGs who come on their own and decide to practise in New Zealand, the NZLocums recruits have to work under supervision during their tenure here, the exception being Australian IMGs.²⁵ Additionally, the induction and orientation programmes of NZLocums and the MCNZ educate the IMGs on New Zealand's unique health system. The NZLocums orientation programme is CME accredited by the RNZCGP.

Overall, NZLocums works very closely with the MCNZ, the RNZCGP, Immigration New Zealand (INZ), PHOs and DHBs, individual general practices and other support organisations to assist their recruits to settle into work, and have a positive experience while here.

6.1.3 Challenges Faced by IMGs

The challenges faced by the NZLocums recruits, as reported by the Recruitment Manager, were very similar to those faced by the participant IMGs in this study. These included learning about New Zealand's health system, the specific challenges of rural practice including the on-call work, the need for skills to deal with emergencies and trauma cases, cultural and social etiquette especially in relation to Māori and Pasifika patients, adjusting to New Zealand's laid back attitude, and language issues especially among families from European countries. Most of the challenges are overcome through the assistance and support provided by the various institutions and through interacting with the community and the patients.

The Recruitment Manager also reported having challenges with delays in the MCNZ registration process, due to the need to cite original, paper-based 'Certificates of Good Standing' when, in their opinion, electronic copies could well have sufficed. Additionally, they stated that given the MCNZ and the INZ are very policy driven, dealing with them can cause unnecessary delays, and at

²⁵ Excerpt from the NZLocums website: "Whether you are a junior doctor or a consultant, supervision is a requirement of the MCNZ for all new registrants, (the exception is Australian graduates), and is an excellent way to integrate and familiarise yourself with practicing in New Zealand. The role of the supervisor is to assist the Council in determining that you have the required skills, knowledge and attitudes to practise safely in New Zealand to a standard comparable to your peers in this country".

times, the policies do not seem to keep up with the times and technological advancements.

“The amount of paperwork these docs have to do is scary, to be honest. It’s absolutely scary. And some of it, I think, is just red tape. I think back in the seventies, we weren’t so aware of fraud, and people being what they’re not. I think we do now, because the internet - everything is instantaneous. I also think that some of our processes are still looking at a system where there was no internet. So still very much paper-based, or focused on ‘I need a pen signature original,’ or ‘I need a certified copy.’ Whereas hey, why can’t an email from that body directly to you suffice. And sometimes my docs are prevented from starting work, because they’ve asked their registration body for their certificate of good standing, it has to come by snail-mail because Med Council needs the original; and I’m going, ‘Why can’t they just send you an email?’ It always gets lost in the post, it’s not been received, and my docs can’t start until that’s been received. So I do think that there is a lot of technology out there that we could and should be moving towards. I know Med Council can turn it round in a day. And I know Immigration can turn around a request in a day. So the fact that they take 20 working days, and Immigration will take three, four weeks on a temp visa, and if you apply for permanent residency in this country, a year...a year? Come on. That’s absolutely...and it leaves the person feeling betwixt and between.” (GM Recruitment, NZLocums)

To curb some of the processing delays, as noted above, the MCNZ Business Services Manager reported that since 2011, they have started issuing ‘Letters of Eligibility’ to potential IMGs while they are still in their home countries. The MCNZ does a preliminary check of all the necessary documentation in the initial application, and assesses candidates’ fitness to register in New Zealand. Thereafter, they issue a ‘Letter of Eligibility’ to those deemed suitable. The letter outlines the next steps that the candidate has to take in order to get registered in New Zealand. According to the MCNZ, the ‘Letter of Eligibility’ is accepted by INZ for granting visas. Approximately 1,500 of these letters are issued every year.

“The doctors are the only profession where Immigration will grant you your visa simply on the letter of eligibility, rather than having the practising certificate in your hand. Every other registered medical practitioner, they have to have their practising certificate before Immigration will give them a visa. In our case, if we give them the letter of eligibility, then they have six months before they get their practising certificate. Immigration will give them their visa based just on that letter. And that is because they’ve audited our processes, and they know that we’ve done our due diligence. So that means the doctor can apply for the

visa without having to be here. So they don't have to do that bridging time, where they have to come to New Zealand, set up a family, apply for immigration, and then only start working. I guess that makes it a little bit simpler. So Immigration knows, if it's a locum tenens, it's a maximum of a year, so they won't issue them with a visa for more than a year. But the work to residence programme, if the doctor's intending to stay, and they're staying for (x number of years)...because work to residence is two years. We can sort that out pretty quickly." (Business Services Manager – MCNZ)

The following section elaborates on the current MCNZ registration process, highlighting the options that could potentially reduce issues that IMGs face.

6.2 Registering to Work in New Zealand

Chapter One provided the historical context within which the MCNZ's mandate was created to regulate medical practitioners (Jones, 2002). This historical context adds to the longitudinal nature of the primary data collected in this study. The chapter also detailed the current pathways to registration and to re-cap, there are essentially three overarching pathways: the Vocational Pathway for specialists; the General Pathway for all other doctors who are not specialists or wish to practise as specialists; and the Special Purpose pathway for short-term locum tenens and doctors coming to work as experts, to do research and training, work in emergency/pandemic situations or work in teleradiology. IMGs who want to practise in New Zealand for a longer period need to register either under the vocational scope or the general scope. Each of these broad pathways have more specific pathways that take into account an IMG's country of origin in terms of qualifications and work experience. The different pathways were created to better meet the needs of the different types of IMGs wanting to practise in New Zealand. IMGs from comparable countries to New Zealand should experience a straightforward registration process, whereas those from other countries may be required to do further training, and work under supervision until such time that they are deemed capable of working independently.

6.2.1 Comparable Health Systems and Registration Requirements

According to the Business Manager – MCNZ and the MCNZ website, there are currently 22 countries²⁴ whose health systems are considered comparable to New Zealand's based on public health, practice environment and registration indicators. IMGs from these countries can easily get registered in New Zealand by proving that they:

- hold a primary medical degree from a university medical school listed in the Avicenna World Directory of Medical Schools;

- have worked in a comparable health system for a minimum of 30 hours per week for at least 33 out of the last 48 weeks;
- hold full or general registration in the comparable health system in which they meet New Zealand's active clinical practice requirement, OR be satisfactorily participating in a training programme recognised by the American specialty boards or Canadian colleges, or be registered by the Irish Medical Council as a specialist trainee;
- have proposed employment in New Zealand in the same or a similar area of medicine and at a similar level of responsibility to the work they had been doing in a comparable health system for the last 33 out of 48 months;
- satisfy English language policy requirements; and
- satisfy section 16 (Fitness to Registration) of the Health Practitioners Competence Assurance Act.

Among the comparable countries is a sub-group of 'competent authorities' such as the General Medical Council (UK) and the Irish Medical Council. IMGs from Australia are considered to be the equivalents of New Zealand medical graduates. Graduates from any of the comparable countries have a simpler pathway to medical registration.

Additionally, IMGs with qualifications from countries outside of the comparable countries but who have worked fulltime for up to five years in one of the comparable countries may be considered under the 'comparable country' pathway. However, like all IMGs, they too will need to have their qualifications and work experience assessed before the appropriate registration pathway is recommended.

The Business Services Manager for the MCNZ reported that approximately six percent of all applicants, in a given year, may be asked to go down the New Zealand Registration Examination Pathway (NZREX). The NZREX is an examination-based training programme, and is the only option for IMGs who do not qualify for registration under any of the other pathways. It is the most difficult registration pathway in terms of training, formal assessments, and costs. Additionally, IMGs that are deemed to not have sufficient English language competence have to complete an accredited English exam before they can do the NZREX. As noted earlier, five of the IMGs in this study had to do the NZREX and they were from Sri Lanka, Philippines and Germany. They all came in the mid-nineties and three had medical registration in the UK but were still required to go down the NZREX pathway.

In determining the most appropriate pathway for specialists, the MCNZ often seeks an assessment of the IMG's qualifications and prior work experience from various professional bodies such as the RNZCGP. The professional bodies' advise the MCNZ on the most appropriate course of action to facilitate

registration. The involvement of professional bodies is seen as a critical part of the process because the MCNZ itself is unable to do a thorough assessment given its expertise and resources.

“If the doctor wants to practise as a specialist GP, then they have to apply down the vocational registration pathway. We involve the College of GPs in that process. They assess the application, and they tell us whether they think the doctor’s qualifications, training, and experience are equivalent to, or nearly equivalent to [NZ specialists]. If they’re equivalent to- and generally those tend to be the ones who have qualifications from the UK, then they will be simply under supervision. If they’re down what we call the assessment pathway, then they’ll need something else to happen besides supervision. With the College of GPs, they all tend to be assessment, because nobody else does the practice visits like we do here. So as a part of the Fellowship requirements for GPs in New Zealand, they have to have a practice visit at the end of their training, where other vocationally registered doctors or Fellows go and observe their practice, and confirm that they’re at the standard they need to be. And then their Fellowship is conferred. So for anyone coming from outside, unless they have a Fellowship, there’s a process. They still have to undertake that process here.” (Business Services Manager – MCNZ)

According to the Business Services Manager for MCNZ, the above registration pathways and processes have been the same for many years now but the time required for completing the registration process has become a bit shorter for those IMGs who have proven their ability to practise independently. Additionally, locum tenens who come for short stints are given 12 month registrations as opposed to the previous six month duration.

“What has changed is the time that the doctor needs to be under supervision before they can move from their provisional registration period to their full registration period. It used to be twelve to eighteen months, and it’s now between six and eighteen months, again depending on what the doctor’s qualifications, training, and experience is, and how the College assesses them. So because the vocational process, application process, can take four to six months to complete, sometimes when we get to the point of saying ‘You’re good now,’ almost straight away they go into vocational registration, because they’ve been here and working under their supervision arrangement prior to that. We had quite a bit of feedback that six months was too short for the doctors who genuinely wanted to do a locum, so we’ve extended that to twelve months. So now we have a clearer differentiation between the doctors who genuinely want to do locum, short-term thing, and the ones who want to pursue vocational registration.” (Business Services Manager – MCNZ)

The MCNZ Business Manager and the NZLocums Recruitment Manager alluded to the fact that IMGs from comparable countries or with comparable medical training, who have job offers, may be allowed to work while their qualifications and prior work experience are fully assessed to determine the appropriate pathway to full vocational registration.

“And what used to happen with that is, someone who wanted to apply for vocational registration, because it takes four to six months for that to be approved, they would apply for locum tenens first, and then while they were on that - and it was limited to six months - the vocational process could happen. And there was nothing wrong with that. Because we want people to be vocationally registered. And if they’re here to start work quickly, then locum tenens gave them an option. Locum tenens, though, is limited to people with a very specific qualification.” (Business Services Manager – MCNZ)

It would seem that some of the IMGs in this study were given this type of opportunity, such as Drs. Rogers, Michael, Ras, Jean, Jon, Manu, and James. There is evidence from a participant in this study, Dr. Phil from the UK, who could not take up a job offer because of the delays in processing his registration status. He possibly could have benefited from the locum tenens option.

The Business Services Manager also noted that they were reviewing their reference-checking policy to become a bit more flexible, especially for those IMGs who have been working in isolation overseas, and who may have difficulty in meeting the current standards. However, the levels of competence and confidence in skills and knowledge still apply.

“There is a reference policy that says we need three references. They need to be from people that have observed the doctor’s practice for at least six months in the last two to three years. And we also need one from the most recent employer. That’s short-term. For general practice, especially people who have been working quite rurally - I think about Canada for example - that is quite difficult, because they might be working in isolation but closely with radiology, and maybe accident and medical centre, or a general surgeon, or an emergency medicine specialist. They might not be working very closely with other GPs. And we ask for the referees to be from the same area of medicine. So we tend to be a bit more flexible in our approach. But it’s case by case. And what we want is to know that we’ve got some references from someone, from people who’ve actually worked alongside the doctor, and can tell us with some degree of authority or confidence that they think the doctor’s practice is at a safe level, competent level, at least. And then of course we back that up with other pieces of information, like the certificate of good standing from the authority.” (Business Services Manager – MCNZ)

Overall, the registration policy and processes have changed significantly since the early 1970s when some of the participants in this study first came to New Zealand to work. In those years the registration process was simple and straightforward because it was based mostly on the qualifications the IMGs had gained. However, the current policy goes beyond just qualifications and looks at an IMG's fitness to practise. Fitness to practice includes having sufficient language skills, professional standing, and integrity.

“The shortest timeframe [for registration] might be two weeks. And that’s if we put a rush on the applications. If they’re from the UK or Ireland, if they’ve done their primary qualification there, and they’ve completed their internship there and they’ve worked only there in the last little while, it’s a pretty straightforward application. But there’s no guarantee any more, like there used to be, because the way the legislation was framed then, it was all about the qualifications you have. Now it’s the qualification, but even before that, it’s about fitness to practise. It’s about your language skills, and it’s about your professional standing, your integrity. So there are some questions around that that have to be answered first. And even if you have the right qualifications and training, if you don’t meet those fitness questions, then you cannot proceed.” (Business Services Manager – MCNZ)

6.2.2 Supervision

The supervision of IMGs is a key component of the pathways to medical registration in New Zealand. The aims of any supervision plan are to familiarise IMGs with New Zealand's health system, and with the expected standards of medical practice (MCNZ website - supervision, 2011). Every IMG has to have a job and a supervision plan to be on any one of the registration pathways except for the NZREX pathway. General practices that would like to supervise IMGs need to be accredited by the MCNZ so that they have all the necessary systems and processes in place to support IMGs. Having a practice accredited for supervision also negates the need to link one supervisor to one IMG. However, the individual one-on-one supervision is still an option. The MCNZ Business Services Manager stated that they are quite particular about the supervision aspect of registration, and always try to place IMGs in the best possible practices during their provisional registration period.

“We do specific supervision workshops now. We have for I think about the last 18 months, where we train supervisors of IMGs to be good supervisors of IMGs, and to focus not only on things clinical, but the general support, and with induction orientation, and just generally being a good person, or a good buddy, a good mentor. Making themselves available. And they’re all people who supervise international medical graduates, or intend to, or have at some time, and intend to in the future. And something else that’s

happened in the last twelve months is approved practice settings. So in the past, the only way that a doctor could be supervised was by an individual one-on-one supervision relationship. They can now apply for a practice setting to be approved, so that they don't have to submit to our supervision plans every time that a new doctor starts. They get the setting accredited, where we've gone in and we've audited them, and we've said 'You've got all of the systems and processes in place. We know that if an IMG comes here, and it's specific to IMG supervision, if an IMG comes to your practice, they will be properly supported and looked after.' So primary care's responded best to this option to go for the setting, rather than the individual one." (Business Services Manager – MCNZ)

6.2.3 Support

The MCNZ supports IMGs indirectly by ensuring that they have appropriate support while working towards full registration, and by providing written guidelines that would assist towards their training and acculturation to medical practice in New Zealand. As noted earlier, they run workshops for doctors who wish to supervise and train IMGs. They have also started accrediting practices that want to supervise IMGs. They have developed web-based resources for doctors such as Guidance on good practice, Medical care, Good prescribing practice, Communication and informed consent, Cultural competence, Management, Professionalism, Cole's medical practice in New Zealand, and Guidelines for patients.

In addition to the above, they have a self-assessment tool to assist potential IMGs to work out their fitness to register in New Zealand. While this is not direct support, it provides IMGs with an idea about medical work in New Zealand.

6.2.4 Challenges Faced by IMGs

There are various challenges, as noted earlier, that IMGs face when trying to register. The MCNZ tries to make it easier for IMGs to register if possible. For example, after getting feedback from various stakeholders including IMGs working in New Zealand, the MCNZ has simplified forms and other paper-based requirements. They have become more flexible when checking for references. They have created different pathways to better meet the needs the difference types of IMGs, and they have emphasised the need for good supervision during the crucial adaptation period to New Zealand's work environment. They have developed a more intuitive website that provides excellent information to doctors wanting to come here. They continue to strive to make it easy and simple for IMGs to register without compromising on their core role of 'promoting and protecting public health and safety in New Zealand' (St George, 2013)

“We’ve had KPMG doing audits of our internal processes, and case management is obviously part of that. And they’ve reviewed vocational registration, they’ve reviewed our health systems, and they’re reviewing performance...the sort of professional standards area soon. And they make certain recommendations for us as well, and it’s all about trying to improve the way that we do things.” (Business Services Manager – MCNZ)

6.3 Training to Become a General Practitioner in New Zealand

The RNZCGP is a professional body that provides training and professional development for GPs and rural hospital generalists. ‘The College’ also sets standards for general practices through its Cornerstone General Practice Accreditation programme. As noted earlier, a College representative was initially interviewed; however, their contribution was not approved for use. The subsequent email-based feedback from the College was limited, so the majority of the information about the GP training programme is from the RNZCGP website.

6.3.1 Current Training Programme

The RNZCGP is the only provider of specialist general practice training in New Zealand for doctors who want to be GPs. The RNZCGP works closely with the MCNZ, RGPN, and Health Workforce New Zealand (HWNZ), in developing and delivering general practice training appropriate for New Zealand settings.

The College recently made some significant changes to its training programme syllabus and requirements, with input from the various stakeholders such as HWNZ. It should be noted that these changes did not affect the participants in this study. The GP Education Programme (GPEP) is in two stages comprising 36 months of training. The terminology has changed where Stage 1 is Year 1 and Stage 2 is Years 2 and 3. The first year (GPEP 1) comprises 12 months of training, providing GP registrars with fulltime, general practice-based learning, under the guidance of experienced GP teachers. This year of training includes regular, formal educational sessions that all registrars must attend. At the end of year one, all GP registrars have to sit an examination – PRIMEX (Primary Medical Examination) that has a written and a clinical component. The successful completion of GPEP 1 leads to registrars becoming Members of the College - MRNZCGP.

The second and third years (GPEP 2) take between 18–24 months, and are also practice-based but with more hands-on experiential learning with qualified GPs. In total, GP trainees have to spend approximately 18 months in a general practice before they would be considered prepared for the fellowship assessments. The

GPEP 2 has its own assessments including an in-practice audit of medical practice, and an in-practice visit by a medical educator to observe clinical practice. The successful completion of GPEP 2 leads to GP trainees becoming Fellows of the College - FRNZCGP and thereby achieving vocational registration with the MCNZ.

Previously, doctors could complete GPEP 1 and pursue careers in general practice without really needing to do GPEP 2. However, many such doctors did complete GPEP 2 but at a time of their own choosing. The time spent in general practice, or in some cases other medical specialties, often counted towards trainees' GPEP 2 time requirements.

Since 2011-12, under the new regulations, any time spent in general practice that is not under a training programme is not counted towards the time requirements of the GPEP training programme. In addition, there was a proposal for trainees to do six months of training in another vocational scope; however the status of this proposal remains unclear. The main reasons for these changes seem to be the recognition of the importance of GP training in the wider context of robust specialist training, and to have confidence that GP trainees have covered all necessary aspects of the GP training programme. Arguably, the previous system did not allow for a proper assessment of what doctors did while working without being under a specific training programme.

6.3.2 Recognition of Prior Learning or Training

IMGs from countries with comparable health systems and training can get their prior training and work experience recognised as equivalent to New Zealand's requirements, and thereby they get full or partial exemption from the GPEP. Australian graduates have automatic recognition of their training and work experience in New Zealand as part of a reciprocity agreement between their respective GP colleges. IMGs still need to apply to the RNZCGP's Branch Advisory Board (BAB) for an assessment of their training and work experience if they qualify under the 'prior learning' pathway. In turn the BAB advises the MCNZ on what it considers to be the appropriate registration status for any given IMG. BAB would also recommend any additional training that IMGs may need to complete in order to meet New Zealand's vocational registration requirements. As noted by the MCNZ Business Services Manager, some doctors may need to wait between four to six months before knowing the outcome of their vocational assessment.

6.3.3 General Practice Seminar Programme

Previously, the RNZCGP had the GP seminar training pathway as well as the other pathways. The seminar pathway was offered when the government decided in the early 1990s to reduce the number of fully-funded registrar

placements by nearly half. The College still had demand for training places that it could not meet so they decided to offer the seminar option. Under this option, trainees were expected to work under the mentorship of experienced GPs, and attend regular seminars that were organised by the College. This option was taken up mostly by IMGs because it allowed them the opportunity to earn a living while also completing the training. In terms of the approach to training, the seminar programme relied on the GP trainees to be self-directed learners, and to take the initiative to bridge the experiential learning gap between the fulltime registrar programme and the part-time seminar programme. Both streams of trainees had led to the PRIMEX examination at the end of their respective programmes. There was a significant difference in the pass rates for both streams, with the seminar programme trainees faring much worse than their registrar counterparts (Email correspondence with RNZCGP Medical Director, 2014). While the College was aware of this problem, it felt obligated to provide some form of training to those who wanted to become GPs but could not be part of the registrar programme.

In the mid-2000s, the College successfully lobbied the government to increase registrar places to meet the demand for training and to help alleviate the workforce shortage that was emerging as a major concern. The seminar programme was stopped immediately.²⁶

6.3.4 Support for IMGs

According to the responses from the College, there are no particular support systems specifically for IMGs. They are provided the same types of support and assistance as those afforded to other GP trainees, including advice on pathways to fellowship and vocational registration, other training options for those who have not completed GPEP 1, guidance on training and working in general practice in New Zealand, and referral to organisations who may be able to assist with specific issues.

They acknowledge that the College could provide a 'mentor/buddying system' that would be beneficial to IMGs. They also stated that IMGs ought to know about patient-centred care, the New Zealand conditions, systems and style of practice, and possibly try to get experience of the primary/secondary interface.

²⁶ I was an employee of the College at this time.

6.4 Summary

- While the majority of IMGs come to New Zealand of their own volition, NZLocums has been established to recruit IMGs from comparable countries to staff areas with critical workforce shortages.
- NZLocums attest to providing their IMG recruits with end-to-end support, from before they leave their home nations through to assisting accompanying family members with their needs.
- NZLocums' Recruitment Manager noted that IMGs do face challenges, similar to those noted by the participants in this study. The Recruitment Manager also noted that the key institutions such as the MCNZ and INZ were not using technology to facilitate their bureaucratic processes to the extent that they could. This lack of technological competence caused unnecessary delays and copious amounts of paperwork for both the IMGs and NZLocums staff.
- The MCNZ Business Manager noted that they try to make the registration process as simple and straightforward as possible for the IMGs; however, first and foremost their core role is protect the public of New Zealand from unsafe practitioners. This core role underlies everything they do.
- In comparison to previous registration policies, many things have changed to support MCNZ's core role. They provide a number of different pathways that IMGs can take to register, depending on where they got their primary medical qualification from, where they have worked, and how long they intend to stay in New Zealand. Often the MCNZ would work with professional bodies such as the RNZCGP to determine the most appropriate registration pathway for IMGs.
- The RNZCGP is the only provider of specialist general practice training in New Zealand for doctors who want to be GPs. The RNZCGP works closely with the MCNZ, RGPN, and Health Workforce New Zealand (HWNZ), in developing and delivering general practice training appropriate for New Zealand settings.
- While the RNZCGP does not have any specific support systems for IMGs, they feel that they could provide a mentor/buddying system. At present they have no such assistance other than what is provided as part of their training programme to all trainees.

7.0 Discussion

7.1 Introduction

The central theme of this thesis is that occupation adaptation is a key predictor of overall acculturation of migrants to host nations, especially for those who are highly skilled such as international medical graduates (IMGs). This study has enhanced the understanding of the experiences of immigrants in three distinct areas of discourse. The first contribution is towards a hybrid model for studying and understanding the experiences of highly skilled migrants within the context of cross-cultural adaptation internationally – the Integrative Framework for Acculturative Research (IFAR). The second is towards a better understanding of IMGs who came to New Zealand and were successful in forging a career in general practice as seen through the IFAR. This contribution describes the acculturation process of a cohort of IMGs into general practice in New Zealand through a series of historically linked narratives. The longitudinal nature of the findings from the narratives has emerged as a key strength of this study. The research was not originally designed as a longitudinal study. However the experiences of the participants, spanning nearly five decades, made the insights much more valuable and therefore a historical comparison across certain aspects of the lived experience was possible. These insights have added to the discourse of this thesis. The third theme is focused on the use of e-interviews within the context of ethnography and mixed methods study design, especially in predominantly qualitative research. The following discussion will demonstrate these contributions explicitly.

7.1.1 The Integrative Framework for Acculturative Research

The Integrative Framework for Acculturative Research (IFAR) takes a multidisciplinary approach to the study of migrants whose main purpose for migration was to pursue their occupations in host nations (Figure 6). This framework proposes a concise approach for researching and understanding the experiences of migrants within the context of intercultural communication and cross-cultural adaptation but also takes the key learnings on migrant experiences from the disciplines of sociology, anthropology, economics and migration policy development. The integrative nature of the IFAR is argued to be a key strength of the model. It is important to note that a data analysis framework (Figure 5) was first developed to organise and categorise the primary data prior to the development of the IFAR. The analysis framework is the complementary data analysis model to the IFAR, and was informed by several existing models created to study the adaptation of different types of migrants, using different schools of thought. While there are several existing models of acculturation and cross-cultural adaptation, most are rather complex, rooted in psychological processes

and not focused on occupational adaptation as the key to acculturative success. John Berry, a psychologist, has made significant contributions to the understanding of migrants' psychological acculturation to host nations (1997, 2002, 2005, & 2006). His (1997) framework for acculturation research took a psychological approach to understanding the experiences of migrants and is often used for studying migrants in new environments. His framework proposed that certain group and individual level variables are universal when explaining the acculturation experiences of migrants (refer to Figure 3). Some of the universal variables such as attitudes towards migrants in host nations may be beyond the influence of migrants, but would have an impact on the adaptation process.

Bourhis and colleagues (1997), using a similar approach to that of Berry (1997), outlined the adaptation strategies that migrants are likely to use when confronted with different situations in host societies (refer to Figure 4). The four key strategies that Bourhis et al. (1997) proposed included integration, assimilation, segregation and exclusion or marginalisation. Berry (1997) also used the four adaptation strategies to explain the outcomes of the interplay between the universal variables that immigrants experience. These four strategies are still relevant when determining the adaptation status of migrants, where integration is the most preferred option and exclusion or marginalisation the least (Berry, 1997; Schwartz, et al., 2011).

Colleen Ward, another prominent psychologist based in New Zealand, and Associates, have published numerous articles looking at various aspects of the migrant experience, both nationally and internationally. Ward (2010) also subscribes to the acculturative framework as suggested by Berry (1997), and has published mainly within the domain of social and cultural psychology, focusing on migrant factors such as identity, discrimination, development, ethnicity, culture, psychological and social adaptation, and acculturation. In a recent study, Ward (2013) asserted that research shows that integration and adaptation occur better in multicultural societies, and that behaviours are more powerful predictors of psychological and socio-cultural adaptation than are attitudes.

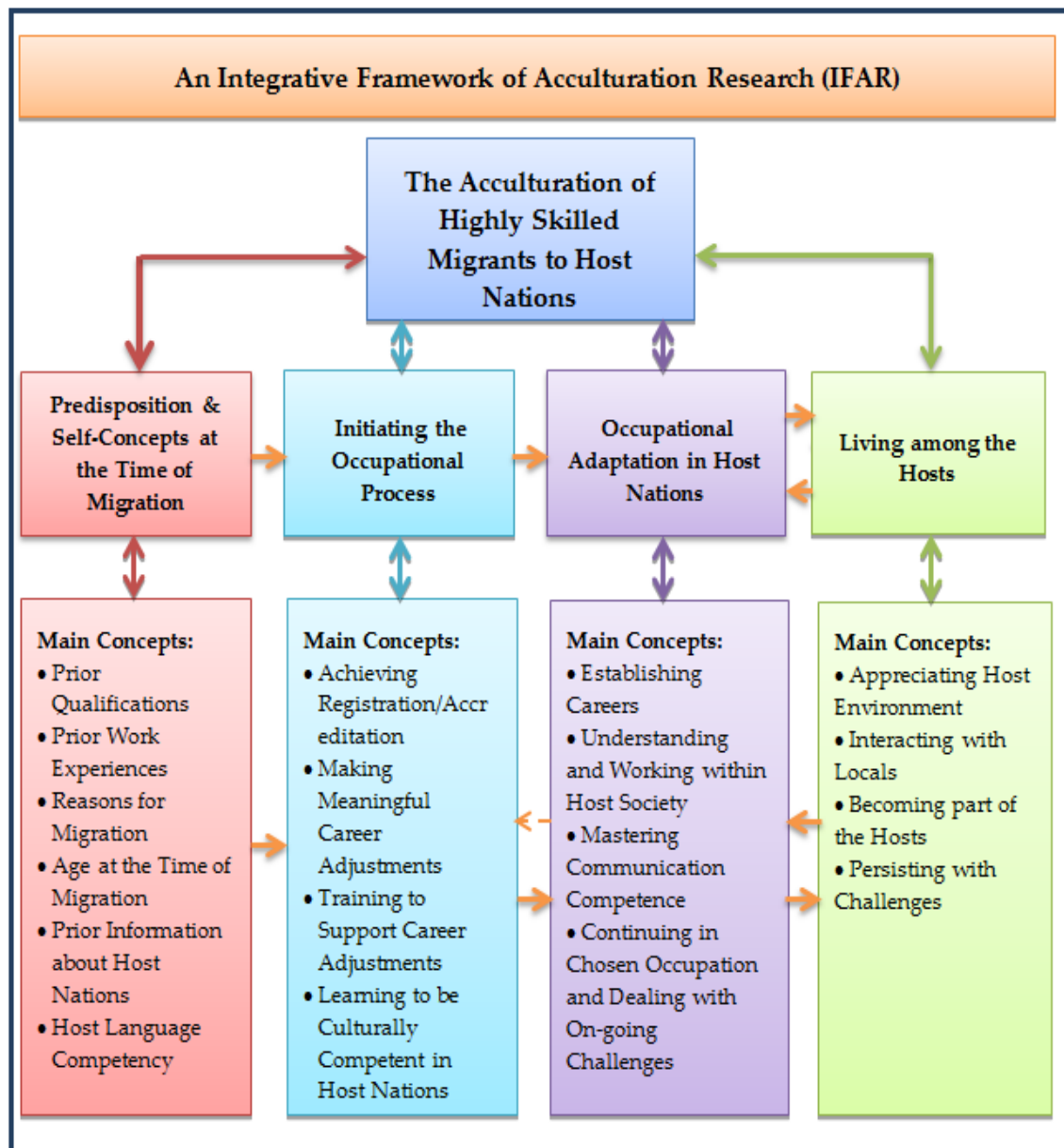
Kim (1998, 2001), a scholar in intercultural communication, took an integrative open systems approach that linked the migrants and their surrounding environment into a single large framework. Her model is in the context of intercultural communication where the higher level interactions between the migrants and the hosts matter the most (refer to Figure 1). Gudykunst (2005), another scholar in intercultural communication, focused on the need for migrants to manage their anxiety and reduce their uncertainty in the host environment as a way of acculturating (refer to Figure 2). The less anxiety migrants felt and the less uncertainty there was in host environments, the better their chances of cross-cultural adaptation success in host societies.

The key difference between the acculturative models as proposed by Berry and Bourhis, and Kim and Gudykunst, is that the former undertook their work within the context of psychological acculturation whereas the latter studies were based within the context of intercultural communication. Both approaches are valid given the complexity of studying the migration phenomena. Additionally, the two approaches are very similar and as Berry (1997) noted, *“it is often difficult in practice to distinguish the research done, or the conclusions drawn from the two approaches”* (p. 8). However, studying the complete migration experience under the two approaches is rather complex given the lack of emphasis on any particular motivation for the instigation of the migration process in the first instance. Both approaches also looked at migrants in general, usually focusing on those who have considerable difficulties in host nations. It is here that the proposed IFAR model in this thesis adds value, by grounding the migration experience in the need for occupational adaptation, as the key motivator for the highly skilled. The outcomes of occupational adaptation are the key predictors to the social, psychological and cultural adaptation of the highly skilled to host nations.

The IFAR (Figure 6) borrows from the above scholars in an effort to simplify the way migration can be understood for those who are highly skilled and for whom the main motivation is to pursue a career that started before their migration to another country began. Some of the key concepts of the IFAR are present in Berry’s model, such as the importance of the pre-migration demographics, whereas others are from Kim and Gudykunst’s models, such as those involving host communication competences. The amalgamation of these concepts in the IFAR is specifically designed, and purposefully ordered, for understanding the journey to occupation adaptation, as the basis for acculturation into host nations. In drawing together the key concepts into the IFAR, literature was sourced from sociology, anthropology, economics, and intercultural communication studies. Many scholars have called for an integrative approach to studying migration; however, this has proven to be more complex than originally anticipated, mainly due to them mostly working within their own disciplines (Brettell & Hollifield, 2008). Many existing acculturation models and migration theories have been criticised for a lack of integration (Favell, 2008). The IFAR is an attempt to integrate some of the main approaches of the above disciplines to address the criticisms of existing models of acculturation and theory.

The experiences of IMGs who came to New Zealand to pursue their medical careers are used to support the IFAR as a valid approach for understanding the acculturation of highly skilled migrants. The four main components of the IFAR relate to migrants’ predispositions at the time of migration, their initiation of the occupational process, their occupational adaptation, and their overall social and cultural adaptation to host nations.

Figure 6: An Integrative Framework of Acculturative Research



The main concepts under each of the four components are not mutually exclusive, and can affect the outcome of the other main concepts. For example, the age at the time of migration can influence the uptake of training opportunities when initiating careers or when deciding to remain in host nations for longer periods. Some of the key concepts are influenced more by the migrants rather the hosts and vice versa. For example, the need for accreditation before migrants can work in their chosen careers is influenced by hosts more than migrants, whereas once accredited, migrants may be able to choose where they work without any influence from the hosts, especially in the New Zealand context. In contrast, Australia has for a long time required IMGs to work in hard-to-staff areas, for up to 10 years prior to being allowed to live and work anywhere they wished (Hawthorne, 2012).

Prior to discussing the IFAR approach in the context of IMGs working in New Zealand, the following section discusses the lessons learnt from this study, when using e-interviews within an ethnographic framework.

7.1.2 Qualitative Research and Ethnography of Communication

Ethnography of communication was the guiding qualitative methodological framework used to inform the primary data collection for this study. The rationale for choosing a qualitative approach using ethnography was to get a deep and rich understanding of the experiences of the IMGs in New Zealand. In practice, both these methodological frameworks allow for an intimate research experience where participants share important aspects of their lived experience with the researcher in the traditional face-to-face setting (Fetterman, 1989) and through the use of e-interviews (Murthy, 2008; Hine, 2000). The narratives were ideal for understanding, and momentarily experiencing, the journey that the IMGs took from their homes to New Zealand. From the perspective of the aims of this thesis, the IMG story could only be told well using qualitative methods such as those afforded by ethnography (Hall & White, 2005; Hall, 2014).

While participant observation has been a mainstay of the traditional ethnographic approach, there have been discussions and commentaries on whether studies can be considered ethnographic without explicitly doing participant observation. Atkinson and Hammersley (1994) provide a compelling critique of how ethnographic research has developed since it was first used in the late nineteenth and early twentieth century, to how it advanced in the modern and postmodern era. They concluded that *“it is noteworthy that in none of these disciplinary areas [social and cultural anthropology, sociology, human geography, organization studies, educational research, cultural studies] is there a single philosophical or theoretical orientation that can lay unique claim to a rationale for ethnography and participant observation. Across the spectrum of the social sciences, the use and justification of ethnography is marked by diversity rather than consensus. On that basis, it is arguable that it is futile to try to identify different types of ‘qualitative research’. Rather, one has to recognize different theoretical or epistemological positions, each of which may endorse a version of ethnographic work”* (p. 257). Furthermore, it is only in the last two decades that ethnographic research has been impacted by the emergence of social media and other technology-based communication advancements. The context of understanding the acculturation of IMGs to New Zealand in this thesis has used an adapted version of traditional ethnography to suit the modern context where the research participants’ social/work environments are no longer ‘alien’ anymore through the extensive exposure of those environments in mass media. Participant observation was often done to understand how a person and/or community interacted within a particular social setting, where the understanding of the social setting was just as interesting as how its members interacted in them (Hall 2014; Leeds-Hurwitz, 2014; Jackson II,

2014). In the context of this thesis, both the work and the social environments were familiar, albeit, through the researcher's personal experiences as immigrant to New Zealand, as a former researcher at the Royal New Zealand College of General Practitioners (RNZCGP), as a patient attending general practices for treatment, and through previously documented literature and mass media. These experiences do imply an 'insider-outsider' characteristic in the context of qualitative and ethnographic research. As Dwyer and Buckle (2009) stated "*the process of qualitative research is very different from that of quantitative research...we are firmly in all aspects of the research process and essential to it. The stories of participants are immediate and real to us; individual voices are not lost in a pool of numbers...the intimacy of qualitative research no longer allows us to remain true outsiders to the experiences under study and, because of our role as researchers, it does not qualify us as complete insiders. We now occupy the space between, with the costs and benefits this status affords*" (p.61). The use of a variation of ethnography allows for the insider-outsider research stance and therefore, set this study apart from others in the field of IMG acculturation where quantitative methods were predominantly used to understand aspects of the acculturation of IMGs and other highly skilled migrants.

Some researchers have used quantitative methods such as surveys to gather their primary data on aspects of the acculturative experiences of IMGs and other migrant groups (Groutsis & Arnold, 2012; Falcone, et al., 2013; Young & Schartner, 2014; Brown & Connell, 2004). The sample size in these studies ranged from 60 to over 500. These studies provided good insights into various aspects of the acculturative process; however, the themes and discussions were usually based on percentages and statistics, and at times lacked the participant voice needed to capture the experiences of acculturation. Some studies did present verbatim comments from the participants and these were insightful. Young Yun Kim, whose model of cross-cultural adaptation has influenced the development of the IFAR, began her study of migrants using the survey method (Kim, 1977). As the discipline of intercultural communication emerged and separated from traditional anthropology in the 1960s-70s, quantitative methods came into favour among communication scholars to the extent that the majority of the early studies in intercultural communication used only quantitative methods such as surveys, interaction-based content analysis, and a variety of experimental methods (Leeds-Hurwitz, 2014; Jackson II, 2014). While the initial studies in the new discipline had very low sample sizes in relation to most quantitative studies, Porter's 1974 study of African-Americans and Kim's 1977 study of Korean migrants in the USA involved approximately 400 participants each – this was seen as significantly raising the bar within intercultural communication research. It was only in the 1990s and beyond that qualitative methods re-emerged as valid options within the new discipline (Jackson II, 2014). While the primary data in this study was qualitative, most of the secondary data was quantitative, such as

the medical workforce statistics that are published by the MCNZ. Overall the mixed methods approach used in this study was guided as much as possible by the ethnography of communication.

Furthermore, email-based interviews (e-interviews) were trialled as an alternative to face-to-face interviews in this study. The reasons for this approach were many including, first and foremost, to see whether technology could be used within the context of ethnography to collect qualitative data that would be comparable in quality to that collected through the traditional personal interviews. Secondly, e-interviews provided an option for potential participants who may have found it difficult to allocate time to do personal interviews, and therefore would not have participated at all. Thirdly, the experiment would add to emerging literature on emails as a research tool. The reasons listed above are well documented in previous and emerging literature (Garcia, et al., 2009; Markham, 2004, 2008; McCoyd & Kerson, 2006; Murthy, 2008). In total eight of the 17 participants voluntarily chose to do e-interviews.

In addition to the primary data from the IMGs, this study also sought the views of the key institutions related to the vocation of general practice, to provide a comprehensive picture. Two personal interviews were done with key informants from the Medical Council of New Zealand (MCNZ), and the NZLocum Recruitment Agency (NZLocums), while the Royal New Zealand College of General Practitioners (RNZCGP) provided written responses to an interview schedule similar to that used for the personal interviews with the other key stakeholders. This approach was very similar to the e-interviews used for the IMG participants.

It should be noted that when this study was being planned, telephone-based interviews were considered as an option. However, the facilities to record telephone interviews, in order to generate transcripts, were not readily available for personal use. Therefore, the telephone interview option was not pursued even though it was a legitimate approach for qualitative and ethnographic studies (Hine, 2000).

7.1.3 E-Interviews as an Ethnographic Tool

Understanding the use of e-interviews as an ethnographic tool for collecting primary data from a cohort of participants is one of the key contributions of this study. The strengths and opportunities that information technology presented at the initiation of this study made e-interviews a viable methodological option to explore (McCoyd & Kerson, 2006). At the time of designing this study, there were very few studies on the effectiveness of e-interviews as a data collection tool, and so it was decided that this study could make a contribution to existing literature. Since then, a number of studies have been published to support not only the use

of e-interviews in qualitative research but also in ethnographic studies (Bjerke, 2010; Garcia, et al., 2009; Markham, 2008; Murthy, 2008; Hine, 2007).

Ethnographic Setting

Within the context of ethnography, e-interviews, as supported by some studies, do not entirely capture the essence of this particular IMG study. Some recent studies that are ethnographic in nature (Gibson, 2010; Hine, 2008; Androutsopoulos, 2008), have treated the virtual world as the ethnographic setting rather than the social reality that underpins that virtual reality. In this study of IMGs, the ethnographic setting was general practice, and New Zealand's social and cultural environment. The fact that e-interviews were used did not at any time make the mode of data collection the ethnographic setting itself. However, in the abovementioned studies, the interactions with participants over the Internet about worldly issues made the virtual world the ethnographic setting. This is not entirely inappropriate as most recent studies have said that the choice of e-interviews or other technologies ought to be considered once the subject matter under investigation is clear. *“Rather than deciding in advance to conduct an ethnography of an online site or community, the ethnographer should first choose their topic of interest, and then define the field in terms of whether and how that topic involves different modes of communication or technological locations”* (Garcia, et al., 2010: p. 56). In this study, documenting the experience of IMGs working in general practice was the primary aim of the study. The gold standard face-to-face method was the first choice, because it has been shown to be efficient, effective, informational, motivational, and persuasive, as a communication mode – it engages more human senses than other methods (Nardi & Whittaker, 2002). E-interviews were only considered as an option when it was realised that many GPs were using emails in their daily work. Therefore, e-interviews became a viable option, which was pursued among potential IMG participants.

Participant Experienter

Participant observation is a key component of ethnography research that is usually impossible when using e-interviews (Gibson, 2010; Murthy, 2008; Bjerke, 2010). To address this shortcoming of online-based studies in ethnography, Walstrom (2004a), coined the term 'participant experienter' when studying online support groups. This is arguable similar to the insider-outsider stance in qualitative research (Dwyer & Buckle, 2009). Participant experiencers are meant to have some prior understanding and personal experience of the central problem being investigated. This term and its meaning fit well with how I perceived my role as an ethnographer in this study. First, I am an immigrant to New Zealand. Second, I have spent the majority of my professional career in different types of health settings despite not having any formal medical training. Third, my role as a Research Fellow at the RNZCGP (2005-2010) provided me

with valuable insights into the workings of general practice in New Zealand. These personal and professional experiences allowed me to fulfil the criteria of being a 'participant experiencer' as proposed by Walstrom, and legitimise my use of e-interviews within the context of ethnographic and qualitative research. Having such attributes can assist participant experiencers in understanding and interpreting the comments within the context in which they were made, without actually having to be there – a shortcoming of online research methods. For example, when e-interviewees spoke of language issues, disease burdens, social challenges among their patient populations, and adjusting to general practice in New Zealand, it was not difficult to contextualise their responses given my background, and the fact that these emerged as rather common experiences for most other participants. The responses from e-interviewees were not different to those from the face-to-face interviewees, and so made the participant experiencer role less challenging.

Mixed Methods

Several studies that used e-interviews also used face-to-face interviews; however, in most studies (Bjerke, 2010; Gibson, 2010; Murthy, 2008), the e-interviews preceded the personal interviews. For example, Murthy (2008), in his study on the Asian electronic music scene in the USA, found it difficult to recruit participants for personal interviews in a nightclub. However, he still managed to collect enough email addresses for online research. Later, Murthy was able to convince some of the e-interviewees to take part in personal interviews. Bjerke (2010) also used a similar approach when studying participants in Alcoholics Anonymous (AA) programmes. Interestingly, Bjerke found that online communications had created certain physical and cognitive constructs about participants that did not match the reality when conducting personal interviews. She reported feeling almost let down by the face-to-face interviews. Upon reflection, in this study of IMGs, it almost seemed inevitable to do the same based on 'participant experiencer' history, stereotypes of GPs, and the demographics of the IMG participants. It felt from the researcher's perspective that the e-interviewees ought to have a face to identify them by. While I knew three of the eight e-interviewees before the study, the rest remained physically unknown to me. Furthermore, Bjerke reported that her face-to-face interview with one of the participants had the roles reversed, where the participant had become the researcher and she became the researched. At no stage did this occur with the IMG participants, possibly because I had declared who I was and what I was aiming to achieve through this study. I was also very visible to both sets of participants as an employee of the RNZCGP, which Bjerke was not.

Key Lessons

Overall, the information gathered through the e-interviews varied in quantity when compared to face-to-face interviews but not in actual quality. Some recent studies have argued that the asynchronicity of e-interviews allows participants to provide in-depth and rich data that is sometimes better than those collected through personal interviews (Gibson, 2010; Murthy, 2008; James & Busher, 2006). The e-interview participants in this study provided succinct responses that averaged about a paragraph with approximately four to five sentences. All the e-interview responses were at an intelligible level and therefore, were valid and very useful (Gibson, 2010). Researchers have mentioned that if technology and online methods can adapt conventional qualitative approaches of data collection to the medium of communication, then credibility and authenticity can be achieved (James & Busher, 2006). In this study, the e-interviews were primarily based on the same structure and questions that were used for the face-to-face interviews – considered the gold standard in ethnographic research (Fetterman, 1989). Murthy (2008) found that using “*the two methods in tandem provided a more powerful approach*” (p. 842) because sometimes one of the two could provide unique data that the other would not, thereby enhancing the quality of insights. As seen in this study, one of the e-interviewees shared their memoirs, which provided unique insights. Schaefer and Dillman (1998) observed that using a combination of e-interviews and face-to-face interviews increased response rates, which was also experienced in this study.

Additionally, the responses were generally similar for both data collection methods, thereby supporting the credibility, reliability and authenticity argument above, and those in the Methodology chapter. For example, the following responses, as coded for use in the thesis, demonstrate the quality aspects mentioned above:

Q. What forms of training did you receive to acknowledge and appreciate the special status of Māori in NZ?

“Written material initially for self-learning. Whilst working as a GP locum during my GP training year (attending the weekly seminars) I covered the clinics at the Kohanga Reo under my GP’s supervision. That was when I learned ‘hands on’ about some of the aspects of Māori understanding of health issues.” (E-Interviewee)

“Oh, I can...again, probably over the last five to ten years, I’ve been to seminars, I’ve been to...I’ve done reading, I’ve read cultural competence guidelines, I’ve worked on Māori health plans.” (Personal Interviewee)

From experience in this study, a drawback of the face-to-face interviews is that there can be too much transcribed data to sieve through to identify the appropriate quotes to use (Huberman & Miles, 2002). One of the longest personal

interviews was just under two hours, which yielded a 37 page transcript. On average, the face-to-face interview transcripts were 26 pages long. By the time the data was coded and ready to be used, the individual outlines for each of the participants averaged approximately 10 pages; the coding exercise rendered much of the personal interview data redundant whereas the majority of the e-interview data was useful (Gibson, 2010; Murthy, 2008). In addition to this particular advantage, there were many others that were noticed. These advantages reinforce that e-interviews can be a stand-alone method for data collection or be used in conjunction with other methods (Gibson, 2010; Bjerke, 2010; Murthy, 2008, Bampton & Cowton, 2002; Illingworth, 2001; Hines, 2000; Mann & Stewart, 2000). Further to the value of asynchronicity and the quality of the e-responses, some other advantages included:

- Providing access to rural GPs. Personal interviews would have incurred substantial research expenses if rural participants had opted for them. Also, there is no way of knowing what the impact on participant recruitment would have been if face-to-face interviews were the only option.
- Initiating and maintaining credibility. This is critical especially if researchers want to maintain anonymity in online research (Garcia, et al., 2010). In this study, there was no such need to remain anonymous because recruiting participants could have proven difficult. Additionally, it was important to demonstrate credibility to the participants and therefore, my role at the RNZCGP was important to disclose to the participants, both for the e-interviews and the personal interviews. Once e-interviews had been initiated, maintaining good rapport was important. Mannerisms in online exchanges are displayed in text form rather than through any verbal or non-verbal cues that personal interviews benefit from, and therefore careful attention ought to be given to written communications (Hine, 2000; Gibson, 2010; Garcia, 2010). In this study, diplomacy and polite persistence were important to keep the e-interviewees engaged. The end result of this approach was that all e-interviewees completed the e-interview process, even though there was a glitch with responses from one participant.
- Providing adequate response time. Gibson (2010) noted that participants in her study were allowed up to one month to respond to a particular question; however, in this study participants were encouraged to respond within a few weeks to maintain the flow of the interviews. In total, there were approximately 60 main questions with several follow-on questions, and therefore, there was a need to keep the e-participants engaged without overextending the data collection period.
- Managing the e-interview process. For the e-interviews, the personal interview schedule was divided into five distinct parts and was

administered over a six to nine week period. The e-interview participants were sent one set of questions at a time, and upon the completion, another set of questions was sent until all the five sets were completed. Some of the participants were sent follow-up questions seeking clarification of their previous responses. This approach has been supported by other similar studies using e-interviews (Bjerke, 2010; Gibson, 2010; Garcia, et al., 2009).

- Getting consent online. The consent process was done via email which is supported by other studies (Garcia, et al., 2009). Interestingly, the recruitment of participants for both types of interviews was done via email. Theoretically, it would have been possible to do all the interviews via email if all the participants had chosen that option.
- Preparing feedback for analysis. One aspect that was slightly different to what has been noted in the literature was that in this study, interview schedules were emailed to the participants in Microsoft Word documents as opposed to writing the questions straight into the emails. None of the literature cited spoke of this approach. One of the key advantages of this was that the Word documents incorporating responses were more convenient to use and more easy to securely store than the email exchanges themselves. Also, some old emails stored in folders can be very difficult to open in new technological platforms so a word-processed interview schedule and responses can be more secure and readily available for future use.
- Managing confidentiality. Some of the participants shared very sensitive information about their private lives which could have been difficult to share in face-to-face interviews (Bjerke, 2010). One participant shared their personal memoirs that included very detailed observations of New Zealand and general practice. These contributions were very valuable. Additionally, it is possible that one of the personal interview participants, who later withdrew, would have benefited from the e-interview approach. After the interview, she felt very uncomfortable about the possibility of being identified through her insightful responses. In hindsight, she might have felt more secure in an e-interview environment.
- Managing technology. One challenge that was experienced in this study, in relation to e-interviews, was the loss of data. One participant had said they had sent through responses to two parts of the e-interview schedule; however, they were not received at my end. Unfortunately the participant could not find the responses on their computer either. While a bit disappointing, the other responses they had provided were valuable and therefore, to ensure their ongoing participation, the matter of the lost data was not pursued further. The secure transfer and storage of participant feedback is a key requirement of e-interviews (Hine, 2000; Gibson, 2010).

Finally, this research supports the use of e-interviews in ethnographic studies but only with certain criteria being met (Garcia, et al., 2010; Murthy, 2008; Androutsopoulos, 2008; Hine, 2007; Rutter & Smith, 2005). First, it would be helpful for the researcher to have some understanding and personal experience of the background and context within which the interviews are occurring, to facilitate the participant experienter role. Secondly, the researcher will need to clearly demonstrate why e-interviews would be better than any other form of data collection. This is crucial to maintain the relevance and validity of the research methodology. Thirdly, the e-interviews would benefit from being short and specific to certain areas of inquiry. However, well-structured long interviews, administered over an extended period, can also achieve good results as shown through this study. Fourthly, the use of good IT systems is essential so that data is not lost and can be recovered if systems fail for any reason. Good IT and appropriate software would also help with collating and analysing all the data. Some of the risks of IT failure can be mitigated by using Word documents for collecting data, attached to emails, as opposed to direct responses in email format. Fifthly, good rapport is needed to maintain the participants' interest, especially in comprehensive studies such as this one. Diplomacy through written communication is an essential skill in maintaining rapport through emails. Sixthly, demonstrating credibility to online participants could enhance the quality of the responses, as seen in this study where participants shared very personal experiences that may not have been forthcoming otherwise. Lastly, given the extensive use of communication technology in most countries, all types of immigrant groups across national and international boundaries could be accessed for a study such as this.

The following sections discuss the contributions made to further the discourse on IMGs in New Zealand, and put the findings into the proposed model for studying the cross-cultural adaptation of highly skilled migrants – the IFAR (Figure 6).

7.2 Predisposition and Self-Concepts at the Time of Migration

The first key component of the IFAR covers the predispositions and self-concepts that migrants bring with them at the time of migration. Predisposing factors and self-concepts are seen as enablers for migration, and the subsequent adaptation process (Kim, 2001; Gudykunst, 2005; Yakushko, et al., 2008). Additionally, Kim (2001) stated that *“predispositional conditions serve as a kind of blueprint for what follows in the new environment”* (p. 82). Yakushko (2008) stated that both the positive factors and stressors of immigration play a significant role in how migrants can approach their career development in host nations.

The main predispositional factors and self-concepts, as noted in the IFAR in terms of occupational adaptation, include the migrants' prior medical

qualifications, their prior work experience, their reasons for migration, their age at the time of migration, the amount of prior information available regarding the hosts, and their host communication competencies in terms of language skills. In addition to the above factors being included in major psychological and intercultural acculturative theories (Berry, 1997; Kim, 2001; Gudykunst, 2005), some studies have framed the same factors in the context of human capital and economic determinants of socio-cultural integration (Bourdieu, 1986; Tharmaseelan, et al., 2010; Fokkema & de Haas, 2011), and within the social cognitive career theories (Yakushko, 2008). They all infer the importance of predisposing factors in the outcomes of the adaptation process in host nations. The IFAR proposes to add to this existing literature by using the examples from IMGs who came to New Zealand to pursue medical careers.

7.2.1 Prior Qualifications

According to studies on highly skilled migrants, the higher the level of pre-migration formal education, the better the chances of acculturating into host societies (Fokkema & de Haas, 2011; Tharmaseelan, et al., 2010; Hercog, 2008). Additionally, the Human Capital Migration Model asserts that migrants with good education and well-paying jobs in home nations will have a better chance of being selected for migration, and also have the necessary resources to migrate (Chiswick, 2008). All the IMGs in this study had gained their basic medical degree prior to coming to New Zealand. Some had postgraduate qualifications including one that had a PhD in surgery. These qualifications had predisposed the IMGs to achieving their career aspirations in New Zealand. The Longitudinal Immigration Survey of New Zealand – LisNZ (2004-2009) observed that just under two thirds of immigrants had 14 years or more of education, with just under half having advanced vocational or university degrees (Department of Labour – New Faces, New Futures, 2009).

However, for some IMGs, such as those in Mpofo and Hocking's (2013) study, their medical qualifications did not adequately predispose them to medical work in New Zealand because of the criteria of the MCNZ. For example, the refugee IMGs could not adequately prove their prior medical qualifications. Those IMGs that were able to do so could not overcome the first hurdles of accreditation and registration. Therefore, just having the appropriate qualifications may not be enough to continue pre-migration careers in new environments; other pre-migration criteria such as the ability to meet host institutional requirements also need to be fulfilled. The impact of professional protectionism on the accreditation of medical professionals has also been cited as a barrier however, there have been convincing arguments on the need for certain standards to protect the public from incompetent practitioners (Arrow, 1963; Bourgeault & Grignon, 2013; Hawthorne, 2013, 2015). The suggestion for having a more global recognition system for certain highly skilled professionals could potentially alleviate the

wastage of valuable skills that some migrants bring with them (Hawthorne, 2013).

7.2.2 Prior Work Experience

Overseas work experience can be considered to be valuable human capital that would assist highly skilled migrants to get a head start in new environments, when compared to other types of migrants (Wickramasekara, 2008). Fokkema and de Haas (2011) found that prior work experience, especially in other countries, was a good predictor of occupational and settlement success. In contrast, some scholars have argued that immigrants who show a tendency for frequent travel and changes in work destinations become transnationals, and do not necessarily belong to one country or another. This can have an impact on their settlement and integration into one or more nations (Brettell & Hollifield, 2008). The LisNZ study found that over half of all immigrants had 10 or more years of paid work experience prior to coming to New Zealand; about a quarter had more than 20 years of work experience (Department of Labour – New Faces, New Futures, 2009)

The majority of the participants in this study had prior medical work experience in either hospital settings and/or general practice. Just under half of the IMGs mentioned having worked in a country other than their home nations, prior to coming to New Zealand. Some of the IMGs from non-English speaking countries such as India, Sri Lanka and Germany had spent short periods in the UK prior to coming here. Kim (2001) and Gudykunst (2005) asserted that immigrants with experience in countries similar to host nations are better equipped to acculturate. Over half of the participants had done their basic medical training in a country considered to have a comparable health system to New Zealand. Additionally, two of the earliest arrivals had done their medical degrees in Commonwealth accredited universities in developing countries whose training was considered to be of an acceptable standard, comparable to developed Commonwealth countries such as New Zealand. Of the 17 participants, 15 had work experiences in the UK prior to coming to New Zealand. Given the similarities between most participants' prior work experience and those experienced in New Zealand, the occupational adaptation became less stressful and positive (Yakushko, et al., 2008).

7.2.3 Reasons for Migrating

A few studies on health workers have alluded to prior job offers as a prelude to migration (David & Cherti, 2006; Troy, et al., 2007; Harvey, 2011; Batnitzky & McDowell, 2013). The majority of the IMGs in this study reported having job offers in New Zealand prior to migration. Additionally, two participants were accompanying their partners who had job offers. This scenario is rather different to what other types of migrants would experience, as seen in some of the

sociological and anthropological studies where the majority seem to seek employment post-migration (Brettell & Hollifield, 2008). In New Zealand, recent changes to the immigration policies and the selection system favour those with relevant skills, prior jobs experiences or job offers (Ministry of Business, Innovation & Employment – MBIE, 2012). Additionally, New Zealand is focused on attracting students from non-OECD countries with the intention of progressing them towards work experiences that may eventually result in permanent residency. The aim of such policies is to meet future labour market needs in critical sectors important to New Zealand.

In the discussions of the push and pull factors, migrants often leave their home nations for better opportunities and security, either due to unfavourable home conditions or in pursuit of livelihoods considered to be much better outside of their home (Ravenstein, 1885; Lee, 1966; Manning, 2006; Zikic, et al., 2010). The IMGs in this study were no different, and while many had job offers in New Zealand, they were also influenced by other reasons such as the desire to raise a family, support spouses' careers, to travel, to specialise in a medical speciality, to do research, for greener pastures, and for change. Two participants were married to New Zealand women, and they did mention that it was a reason for them coming to New Zealand. The above reasons are well supported by previous studies on IMGs and other highly skilled migrants (Brettell & Hollifield, 2008; Fokkema & de Haas, 2011; Tharmaseelan, et al., 2010). The LisNZ also noted that the main reasons/motives stated by immigrants for coming to New Zealand, in order of frequency of the top five, were 'relaxed pace of life or lifestyle'; 'climate or the clean green environment'; 'a better future for my children'; 'employment opportunities' and 'friendly people' (Department of Labour – New Faces, New Futures, 2009).

Neither Kim nor Gudykunst directly addressed the importance of the various reasons for migration in the success of acculturation but did state that "*voluntary, long-term immigrants are likely to make a greater effort to prepare themselves for relocation before they enter the host environment than those who are reluctant immigrants or those who are forced by circumstances to leave their home countries*" (Kim, 2001: p. 83). Even those who voluntarily move can face barriers to adaptation despite being well prepared, as seen among the non-EU IMGs in Ireland who somewhat regretted their move (Humphries, et al., 2013). Furthermore, refugee 'doctors' in New Zealand showed that despite their lack of preparedness, they made great efforts in host communities to compensate for it (Mpfu & Hocking, 2013). One participant in this thesis was a 'reluctant' immigrant due to conflicts in her home country but she had moved voluntarily, and was prepared to adapt to new environments. Interestingly, Hovey and Magana (2003), in their study of Mexican immigrants to the USA, found that high levels of education combined with a lack of choice regarding migration were predictors of negative functioning in host nations. This negative functioning is

further supported by Mpofu and Hocking's (2013) study of refugee and struggling IMGs in New Zealand, where the participants reported having mental health issues due to not being able to pursue their medical careers.

7.2.4 Age at the Time of Migration

The age at the time of migration is considered to be a key predictor of settlement and acculturation – the younger the migrant, the better chances of their settlement into a new environment (Fokkema & de Haas, 2011; Hercog, 2008). The New Zealand immigrant selection system also favours younger immigrants by offering extra points to those between 20 and 44 years of age ((Ministry of Business, Innovation & Employment – MBIE, 2012). A cohort of health professionals drawn for the LisNZ showed that the majority (86%) were between 25-44 years old (Department of Labour – New Faces, New Futures, 2009). All participants except for one were aged under 50 when they first came to New Zealand. Just under half were in their twenties, five were in their thirties, and four were in their forties. At the time of the interviews, the majority of the participants had spent, on average, 18 years or more in New Zealand, with the earliest participant having spent nearly 40 years and the latest only five years.

According to Kim (2001), *“the rate of adaptation is inversely associated with advancing age...age, however, is not considered a logical and viable ‘cause’ of greater or lesser adaptation in and of itself. Rather, age is a significant factor in cross-cultural adaptation because of its close linkage to openness to change”* (p. 175). This notion is supported by the experiences of the younger IMGs in this study who felt they were free to do what they wanted. Many were still single when they arrived, and they mentioned that overcoming challenges was not difficult. Additionally, three of the participants, all females, found their future partners in New Zealand and got married. This directly added to their acculturation experiences.

Another major impact of age on the participants was seen in the GP training phase. Many of the participants made the general observation that because they were young, and not too long out of medical school, they were able to cope better with the demands of further training to get registered in New Zealand or to complete the Fellowship programme of the RNZCGP. This is supported by Kim (2001) who asserted through the earlier quote that younger migrants are more likely to be open to change and therefore, are better geared for adaptation to host nations. The IMGs in this study had observed that some of the older IMGs in their training cohorts were struggling in the MCNZ and RNZCGP programmes required for registration and specialist accreditation, respectively. Even one of the more experienced participants dreaded the thought of having to prove his ability through extensive re-training, despite having been educated in a comparable health system to New Zealand, and having extensive overseas work experience.

Tharmaseelan and Associates (2010) found that there was a positive correlation between the length of stay and social integration into host nations, especially in the context of career success. Some of the male doctors in this study, who came when they were young and single, mentioned that overcoming challenges both in the workplace and social settings was not difficult. They were willing to do whatever it took to advance their careers, and most of them started working in rural or semi-rural settings which presented their own challenges.

Finally, another important factor related to age and acculturation was the flexibility that general practice afforded the female participants who wanted to start and raise their families (Allen, 2005). The female participants in this study, like some of the male participants, started their careers in New Zealand hospitals but later joined general practice for the flexibility it afforded them. Many studies have shown that female medical graduates are likely to choose general practice when considering raising families (Pande & Stenson, 2008; Fretter & Pande, 2008; Allen, 2005).

7.2.5 Prior Information about Host Nations

Fokkema and de Haas (2011) found through their work that the sources of information can be an important determinant of occupational and acculturative success. Benson-Rea and Rawlinson (2003) also noted within the New Zealand context that highly skilled IT migrants could not find sufficiently detailed information prior to migration and therefore, there was a gap between the expectations of the migrants and the reality when they arrived. A few of the participants noted that the information they received or gathered themselves was of limited use when they arrived in New Zealand. There is a historical perspective to be seen through this study where the IMGs who came in the earlier years (1960s-1980s) found little information about New Zealand, and this was mostly second-hand, from acquaintances and through the knowledge of iconic New Zealanders such as Sir Edmund Hillary, Sir Richard Hadlee, and the All Blacks brand. Interestingly, some of the more recent IMGs also noted that the information they had was of little value once in New Zealand.

In terms of medical career prospects in New Zealand, the Medical Council of New Zealand (MCNZ) and the RNZCGP have made an effort to provide as much information as possible to potential IMGs because in the last decade or so there was a persistent valid criticism that there was a mismatch between what Immigration New Zealand (INZ) was telling IMGs, and what the MCNZ was expecting of them when they got here (Jones, 2002; Mpofu & Hocking, 2013). Therefore, as Benson-Rea and Rawlinson (2003) noted, accurate and timely information is valuable for potential migrants, possibly more so for the highly skilled, who have much to lose if they cannot pursue their careers in host nations. One participant mentioned that they had lost the job they had secured pre-migration because the MCNZ had not been forthcoming with all the necessary

requirements for registration. Kim (2001; 2005) and Gudykunst (2005) indirectly discussed the importance of information about host societies but in slightly different contexts.

Kim (2001) argued that migrants need enough information whether before or immediately after migration to improve their host communication competencies, while Gudykunst (2005) argued that having some understanding of hosts would reduce the 'anxiety and uncertainty' that immigrants feel in host societies. A few of the IMGs in this study expressed feeling lost and anxious during their first few days in New Zealand. They questioned whether they had made the right decision in coming to New Zealand. However, the longer they stayed, and the more they interacted with the locals, the more comfortable they started to feel.

7.2.6 Host Communication Competence

Studies on migrants within sociology, anthropology and economics all suggested that language competence and knowledge of the hosts' socio-cultural practices, beliefs, and values can make acculturation less stressful and more productive when compared to those who do not have these predispositions (Brettell & Hollifield, 2008; Berry, 1997; Hawthorne, 2013; Masgoret, et al., 2012). Kim (2001; 2005) and Gudykunst (2005), and placed great emphasis on the need for host communication competence because, by far, it is the most direct and significant facilitator of cross-cultural adaptation. Studies have also shown that host language skills were very important for occupational adaptation, and good mental health among migrants (Yakushko, et al., 2008). In relation to future migrants, nearly all the participants noted that immigrants would do well by: knowing English as all business is done in this language; learning about the cultural focus that New Zealand has adopted due to Māori being 'tangata whenua'²⁷; understanding the history of contemporary New Zealand; understanding the democratic structures that govern the institutions of authority; learning about the organisation of the health system; and gaining other general information. These requirements are supported by previous studies on migrants to New Zealand (Benson-Rea, 2003; Durie, 2004; Wilson & Cunningham, 2013). Immigrants who want to pursue their careers in medicine ought to be aware of the training requirements that are necessary to achieve registration.

Additionally, while not quite supported by any literature cited in this study, many of the participants noted that potential immigrants need to understand that New Zealand is a small country that at times can seem isolated from the rest of the world. New Zealand offers opportunities to have a relaxed lifestyle through engagement with the local communities but some immigrants tend to segregate

²⁷ Tangata whenua literally means 'people of the land' and in this case, Māori are the indigenous people of New Zealand. (Michael King, 2003).

themselves which is not conducive to integration. In support of previous findings, the participants reiterated that immigrants ought to mix with hosts to facilitate integration into their new environment (Berry, 1997; Kim, 2001; Gudykunst, 2005). Also having such prior understanding of hosts would add to migrants' human and cultural capital pre- and post-migration and thereby, increase their chances of successful integration and acculturation (Fokkema & de Haas, 2011; Hercog, 2008; Hatzidimitriadou & Psoinos, 2014). In a New Zealand study partly based on the findings of the LisNZ, Ward and Associates (2011) noted that *"greater concentration of immigrants afford opportunities for more intercultural contact, resulting in more favourable perceptions and greater liking of immigrants"* (p.24). This study also noted that when immigrants felt that the hosts supported integration, then the immigrants were more likely to report higher levels of satisfaction with life in host nations.

7.3 Initiating the Occupational Process

Within the IFAR, 'Initiating the Occupational Process' is the second key component for the acculturation of highly skilled migrants. This is an early predictor for the subsequent acculturation of immigrants. This is the phase where pre-migration factors are tested to gauge how the occupational journey for newcomers is likely to turn out in host nations. By far, for many IMGs, the process from arrival to registration to starting work can be considered the most challenging as has been seen in numerous studies in different global settings (Hatzidimitriadou & Psoinos, 2014; Mpofu & Hocking, 2013; Humphries, et al., 2013; Laird, et al., 2013; Neiterman & Bourgeault, 2012; Harvey, 2011; Wong & Lohfeld, 2008). For some migrant types, there is no need for accreditation or registration to initiate careers. However, medicine is one of the vocations where both locally-trained and overseas-trained health professionals working in both the public and the private sector have to fulfil the requirements of a regulatory authority prior to being allowed to practise (Hawthorne, 2013, 2007; Bourgeault & Grignon, 2015; Ariss, 2010; Wong & Lohfeld, 2008; Riberio, 2008; Ineson, 2009). Some other professions known to be regulated include architecture, accountancy, engineering, social work, and teaching (Hawthorne, 2013; Ariss, 2010). For some health workers, the pre-registration process may require further formal training and/or employment under professional supervision. In some situations, training and working can overlap as medical practitioners need to demonstrate their skills and knowledge in real work environments.

The main concepts that define the occupational initiation phase according to the IFAR include achieving registration or accreditation, making meaningful career transitions, training to support career transitions, and learning to be culturally competent in host nations.

7.3.1 Achieving Registration or Accreditation

The role of a medical authority such as the MCNZ is to protect the general public from incompetent practitioners, to set the minimum standards and competencies for the profession, to maintain the professionalism of practitioners over a long period, and to annually recertify them as fit to practise (St George, 2013). The MCNZ may also review a professionals' work practice should there be concerns from patients or peers. Together with registering all doctors, the MCNZ's primary function is to keep the general public safe from incompetent practitioners (St George, 2013; Personal interview MCNZ Business Manager, 2013)

In this study, the participants experienced different processes for getting MCNZ registration, depending on when they came to New Zealand, what qualifications they had, the source of those qualifications, their prior work experience and their English language competency. The early arrivals, from the 1960s-1980s, mentioned having very little difficulty in getting registration when compared to those who came in the 1990s and 2000s. For some of the early arrivals, their registration had been arranged prior to their arrival or immediately after arrival in New Zealand as most of them started working straight away. For these IMGs, their hospital board employers had arranged their instantaneous registration. This was unique in many ways and demonstrated a different registration policy compared to that of years to come (Jones, 2002; Personal interview MCNZ Business Manager, 2013).

Nearly all the IMGs who came after the 1990s mentioned having issues with getting registered. Some of these IMGs had to do the MCNZ registration examination (NZREX) and an English examination to demonstrate their language skills. A few of the IMGs from the UK, a country with a comparable health system to New Zealand, also faced difficulties and delays with their registration, despite having the necessary qualifications and experience.

The MCNZ's established checks and balances throughout the registration process have been criticised as being difficult, lacking in courtesy with long delays, and sometimes leaving doctors with partial registration that meant they could not work at the top of their scopes of practice (Ineson, 2009; Fletcher & Dickson, 2008). The MCNZ has worked through these concerns to make the process as transparent and straightforward as possible. However, there can still be significant delays which are often caused by professional colleges who work with the MCNZ to assess the qualifications and work experience of IMGs, and determine a suitable registration pathway (Personal interview MCNZ Business Manager, 2013). A review in 2008-2009 recommended that the MCNZ work with the Colleges in fine-tuning the assessment processes or develop new ways of completing the assessment process (Fletcher & Dickson, 2008; Ineson, 2009). At the time of this study, this recommendation was still being considered.

Additionally, there is evidence of IMGs who fail at the first hurdle in the registration process and thereby, incur significant costs when re-attempting the registration examinations (Mpofu & Hocking, 2013). Some participants noted knowing such people, and mentioned that the financial and emotional toll on these IMGs was significant. Apparently, there are very few support systems for these types of IMGs. Most of the participants in this study would like to see a better mentoring system for new IMGs. However, it remains unclear as to whose responsibility it is to provide these types of support. The RNZCGP has indicated that is something that they could possibly do that is currently lacking (RNZCGP e-interview responses, 2014). There is an overseas doctors Facebook page that tries to support IMGs who are struggling to register and practise in New Zealand. Such support systems are informal in nature, and can be equated to the ethnic and professional enclaves that developed in many societies to assist those who were having difficulties (Brettell & Hollifield, 2008; Neiterman & Bourgeault, 2012). The efficacy of these informal support systems and networks in New Zealand is unknown.

Another issue that has recently surfaced is the lack of employment for IMGs who have completed the registration process (Brown, 2014). This is partly due to the recent increase in the number of local graduates and the stagnation in the number of positions within the health system especially in secondary care (MoH – Senior Doctors in New Zealand, 2009). It would appear that New Zealand faces a dilemma in terms of matching the workforce supply and demand between locally-trained and IMG doctors. Some IMGs, not part of this study cohort, have lodged a complaint with the Human Rights Commission in New Zealand because they feel that employers are discriminating against them in preference for locally-trained doctors. It is possible that New Zealand will have to place restrictions on the number of IMGs that are allowed into the country, as ‘brain waste’ of highly skilled migrants is becoming a global concern (Daugeliene & Marcinkeviciene, 2009; Hawthorne, 2013). The World Health Organisation (WHO) has proposed a non-binding code of practice that would reduce the ‘brain waste’, and allow for better management of migrant health workers in host nations (Mercay, 2013). Given global shortages, the WHO expects receiving countries to improve their recruitment, management and retention policies governing migrant health professionals.

Interestingly but not surprisingly, a very recent survey of graduating medical students showed that general practice was so unpopular a career choice that it would negatively affect the future GP workforce (Boyle, et al., 2014). The authors noted that this was partly due to negative role models but were unsure if they were from inside or outside of primary care. Another recent study by Parker and Associates (2014) found that GPs can greatly influence the decision of final year medical students during their general practice attachments by involving them in positive experiences such as allowing students to carry out procedures under

supervision, making them part of the practice team and involving them in consultations.

Some IMGs in this study noted that the RNZCGP and other institutions had left it too late to properly promote general practice as a specialty, and therefore, other specialties often looked down upon GPs. Among others, Boyle and Associates (2014) recommended that postgraduate general practice placements should be more readily available, so that it figures in medical graduates' initial career choices as opposed to an afterthought, having tried other specialties. Additionally, given that the GP workforce appears to remain in crisis mode (NZMA, 2003; 2004), efforts could be made to provide opportunities in general practice to those IMGs who are registered but cannot find work in hospitals, such as to those who have lodged a complaint with the Human Rights Commissioner. As seen in this study, many participants started in hospital settings but made successful career transitions into general practice.

7.3.2 Making Meaningful Career Adjustments

In the IFAR, making meaningful career adjustments is one of the means to occupational success. It refers to having the right reasons for choosing and pursuing an occupation in host nations. Migrants with higher levels of human capital are more likely to succeed in transitioning into occupations of their choice while others may struggle (Fokkema & de Haas, 2011; Yakushko, et al., 2008; 2010). Sometimes, as seen in this study, migrants have the opportunity to assess their initial occupations in host nations, and then make transitions to new careers that better meet their aspirations. Participants who started off working in hospitals chose general practice because of concerns with the type of work they were doing, the hours they were working, and the issues they were facing with colleagues. All the female participants who started off in hospitals, joined general practice because it offered them the freedom to choose the hours they wanted to work while raising their young families (Allen, 2005). Many of the participants mentioned that general practice was an attractive option because it provided them with the opportunity to work in community settings and thereby, achieve greater occupational satisfaction and a better work/life balance.

These values and beliefs relate directly to Kim's (2001) and Gudykunst's (2005) assertions that immigrants' attraction to hosts can be a motivational factor in enhancing their interactions and adaptation to host societies. Wilson and Cunningham (2013) in 'Being a Doctor' commented that *"attending to relationship issues is not an optional activity in medical practice. Awareness of feelings and of the need for emotional intelligence is just as important as the biomedical imperative for accurate diagnosis and management of disease. The doctor-patient relationship affects not only the care that the patient receives, but also the satisfaction and sense of meaning that doctors derive from their work"* (p. 83). All the participants mentioned that general practice was what they had always wanted to do or it became the best option for

finding that fulfilment as medical practitioners because general practice provided higher levels of contact with the hosts that increased their occupational satisfaction. A significant majority of the health professional cohort within the LisNZ (92%) reported being either satisfied or very satisfied with their main job (Department of Labour – New Faces, New Futures, 2009). This arguably indicates that most migrant health professionals do ultimately make that transition to the career they came to pursue in New Zealand.

Some studies on IMGs in the UK, Canada, and Portugal have shown that despite their interactions with hosts within the doctor-patient paradigm, the IMGs lacked job satisfaction due to other occupational factors such as limited opportunities for training and career progression (Hatzidimitriadou & Psinos, 2014; Humphries, et al., 2013; Ribeiro, 2008; Neiterman & Bourgeault, 2012). Interestingly, the majority of the participants in these studies worked in hospitals. There is evidence that general practitioners have higher levels of satisfaction and morale than their hospital-based counterparts, however, the issues that cause dissatisfaction and low morale are the same for both groups, including excessive paperwork, increased workloads and the bureaucracy of the health system (Wilson & Cunningham, 2013; Harris, 2013; Grant, 2004; Dowell, et al., 2002; Edwards, et al., 2002).

Additionally, in a study comparing the career satisfaction of IMGs to US graduates working in primary care, Peggy Chen and Associates (2011) found that IMGs had slightly lower career satisfaction when compared to their local counterparts. One could interpret their results as being rather positive for primary care, and possibly general practice, because nearly 76% of IMGs reported career satisfaction compared to 82% of US graduates. Solutions deemed important to improving satisfaction and morale among medical practitioners generally can be achieved through increased engagement with the regulatory authorities and the organisations they work for, so that they feel heard, respected and seen as adding value (Edwards, et al., 2002; Roberts, 2008; Grant, 2004; Dowell, et al., 2002).

7.3.3 Training to Support Career Adjustments

Making career adjustments is often inevitable for migrants, given the need to adapt to new environments (Yakushko, et al., 2008; Tharmaseelan, et al., 2010). While the biomedical practices of modern medicine are relatively uniform the world over, there are subtle differences in the way it is organised and delivered in different countries (Tovey, 2000, Wilson & Cunningham, 2013). Most studies have discussed the need for IMGs to undertake some form of training in host nations, to familiarise themselves with certain unique aspects that would be unknown to them such as the way the health system is structured, the referral pathways from primary to secondary care, and the links between public and private health systems (Hatzidimitriadou & Psinos, 2014; Mpofo & Hocking,

2013; Harris, 2013; Humphries, et al., 2013; Laird, et al., 2013; Neiterman & Bourgeault, 2012; Harvey, 2011; Prescott & Nichter, 2014; Groutsis & Arnold, 2012; Toader, 2012).

In the case of New Zealand, there are some significant differences between its health system and other countries', even those with comparable health systems. The main differences among many others include the regulation of pharmaceuticals through PHARMAC, the role of the Accident Compensation Scheme (ACC), and the disciplinary system through the Office of the Health and Disability Commissioner (HDC) that patients can use to highlight their dissatisfaction with the quality of health care they received. These are some of the things that IMGs have to learn about regarding medical practice in New Zealand.

The specialty training in general practice in New Zealand has evolved into a more structured and comprehensive programme than it was several years ago (RNZCGP Annual Report, 2014). For more than a decade, the RNZCGP offered an alternative GP seminar programme to the fulltime government-funded GP registrar programme (GPEP 1). The former was designed to meet the excess demand for the funded GP registrar programme. The seminar programme was stopped when the fulltime registrar training places were significantly increased to meet the demand. While there has not been a formal evaluation of the GP seminar programme, there was evidence in the outcome measures to suggest that it was not as robust as the formal, fulltime registrar programme. The GP seminar programme attendees were doctors who worked and studied at the same time, and were expected to meet the same standards and training outcomes as the fulltime GP registrars. Many IMGs opted for the seminar option because they could not get into the registrar programme due to limited places, and because they needed to work to support themselves while training to become a GP. The success rates of the seminar programme were lower than the registrar programme, and were even more pronounced among IMG participants (RNZCGP E-responses – Medical Director, 2014).

Nearly all the IMGs in this study mentioned that they had to do some form of training to achieve their Fellowship of the RNZCGP (FRNZCGP). One of the keys to their success in completing the training programme was the level and quality of mentorship they received. Many of the IMGs considered this to be the single most important factor that assisted them, and they recommended that mentoring becomes a standardised, high-quality feature of the entire training programme. Berry (1997), Kim (2001), and Gudykunst (2005) all stated that this type of host support system is important to the acculturation process for migrants. This is also supported by studies on highly skilled migrants, including IMGs, who had to retrain to develop new credentials in host societies (Zikic, et al., 2010; Fokkema & de Haas, 2011; Terry, et al., 2011, 2014). A recent study among new international students and local mentors in certain Australian universities found that

structured mentoring programmes can help build ongoing cross-cultural friendships between mentee and mentor, and thereby, assist new students with overcoming adaptation challenges (Woods, et al., 2013). Terry and Associates (2011, 2013, 2014), in their study of IMGs in Australia's Tasmanian community, noted that IMGs exposed to favourable host environments would be able to better utilise their social capital to acculturate. Favourable host environments should have support system policies and possibly legislation that are beneficial to migrants. Kim (2001) stated that interpersonal networks in workplaces that facilitate intercultural communication are crucial to the acculturation of new migrants.

7.3.4 Cultural Competency in Host Nations

An important focus of all medical training is cultural competence. This part of the training is to familiarise and instil certain behavioural expectations in doctors when treating patients from different cultural backgrounds. Wilson and Cunningham (2013) noted that *"GPs often think of themselves as 'cultural brokers', negotiating between the world of the patient (background, ideas, personal culture) and the world of biomedicine (understanding disease, requirements for surgery or medication, and so on)"* (p. 167). In today's context, the definition of culture has expanded from the traditional views held within ethnic discussions to those that encompass sub-cultural definitions based on sexuality, youth, class, and minority groups (Asante, et al., 2014). Furthermore, all doctors are expected to recognise and appropriately react to these cultural expectations when patients present with them and/or when these cultural nuances are likely to have an impact on the health outcomes for the patients (Wilson & Cunningham, 2013).

In this study, just over half of the participants reported doing some formal training in cultural competence, but noted that the training was of little relevance to the way that they were expected to treat their patients. New Zealand's strong emphasis on biculturalism within a multicultural setting is unique given the place of Māori as tangata whenua. Therefore, the majority of cultural training is often focused on Māori and the Treaty of Waitangi but not on competencies needed to treat patients from different ethnic or sub-cultural groups. The IMGs in this study all felt that cultural training that is more relevant to treating their patients would be useful. An interesting study in the UK showed that postgraduate international students who received cross-cultural communication education upfront did much better academically, and also adjusted better to their environment (Young & Schartner, 2014). Similarly, another study of IMGs in residency programmes in the USA (Falcone, et al., 2014) found that *"training programs focusing on the celebration of diversity in communities may further enhance adaptation and acculturation to life in the USA"* (p. 229). These findings support other studies on the post-migration success of highly skilled migrants in their acculturation to host societies (Zikic, et al., 2010; Fokkema & de Haas, 2011).

From an occupational adaptation perspective, cultural competence training should enhance immigrants' ability to succeed in their work environments, as noted by the participants in this research.

Finally, the training that the IMGs received to become GPs was considered to be relevant and useful. Based on the current pathways to MCNZ's vocational registration, an IMG could be in New Zealand for at least four years if they did all the necessary training. For many participants in this study, the time spent on achieving vocational registration was considerably longer, with one participant in particular, from the UK, having to wait over a decade before their prior work experience and qualifications were satisfactorily recognised. Berry (1997) stated that the length of time an immigrant spends in a country may also indicate positive acculturation even though there can be periods of stress and challenges.

In terms of cross-cultural adaptation, the retraining and accreditation phase can be the most challenging for highly skilled migrants including IMGs. However, the training needs to be fit for purpose, and add value to the human and cultural capital that the highly skilled bring with them. This is a noted difference between highly skilled migrants who come to pursue their careers compared to those migrants who come with an open mind about occupational opportunities (Hercog, 2008). Furthermore, when highly skilled migrants such as IMGs do not succeed, then they are known to suffer mental illnesses and reconsider their stay in host nations (Mpofu & Hocking, 2013; Humphries, et al., 2013; Ineson, 2009).

The next section discusses the third component of the IFAR – Occupation Adaptation to Host Nations. This phase of the acculturative journey is critical because migrants have overcome the hurdles of initiating their occupations but still need to acculturate to their work environments as bona fide members of their chosen occupations, and the host societies. This is where work satisfaction and career progression can make immigrants more comfortable in the host environment and thereby, further facilitate acculturation.

7.4 Occupational Adaptation in Host Nations

Migrants' participation in host economies is a measure of successful migration (Castes, et al., 2014; Borjas, 2004, 2005; Masgoret, et al., 2012; Hawthorne, 2011; Voicu & Vlase, 2014). During economic downturns in host societies, highly skilled migrants are likely to be exposed to fewer risks because of their employment, and be better prepared than hosts to cope with economic distress (Chiswick, 2008; Voicu & Vlase, 2014). Kim (2001), Gudykunst (2005), and Berry (1997) did not discuss the impact of occupational success on the subsequent acculturative success in host nations in any detail. However, more recent literature on highly skilled migrants has shown that such success is very important when evaluating career outcomes within the context of existential

satisfaction in host communities (Tharmaseelan, et al., 2010; Fokkema & de Haas, 2011; Zikic, et al., 2010). In studies on IMGs in the UK and USA, it was found that career satisfaction was low among the study participants and therefore, many were considering moving to other countries where they may get better opportunities to succeed (Humphries, et al., 2013; Healy & Oikelome, 2011). These studies support the earlier notion that the establishment of successful careers in host nations can lead to better acculturative outcomes for migrants, and possibly the hosts. The findings of this study also support this concept and the following sections discuss the key issues and challenges faced when achieving occupational success and career satisfaction.

Within the proposed IFAR, the 'Occupational Adaptation to Host Nations' has four main factors that underpin occupational adaptation. These include the establishing of careers after training and accreditation, understanding and working within the unique features of the host nation's occupational environment, mastering occupational communication competence, and continuing in chosen occupation and dealing with ongoing challenges.

7.4.1 Establishing Careers

All the participants in this study had made a conscious decision to join general practice because that is what they always wanted to do or because their hospital work was not providing them with the career satisfaction that they desired (Humphries, et al., 2013; Healy & Oikelome, 2011). Most stated that general practice was the type of environment they wanted to practise medicine in (Allen, 2005; Edwards, et al., 2002).

General practice, within the context of primary care, is very different to that of hospital practice (Dowell & Neal, 2000; Wilson & Cunningham, 2013). In their analysis of the inherent differences, Wilson and Cunningham stated that "*many hospital doctors feel quite intimidated by clinical practice in community settings, where patient problems are less well defined, there are no immediate laboratory or radiology facilities, and one is expected to know about a wide range of diseases and presentations. There is a shift in emphasis from a largely episodic, disease-based model to one of continuous, person-based care, where individuals and social factors have a greater impact on disease*" (p. 227). These observations are well supported by the findings of this study where participants with hospital-based experience appreciated the opportunities and challenges of general practice.

First, as GPs, the participants noted that the variety of medical problems that they got to see was much broader than that seen by specialists in hospitals. The comprehensiveness of care is one of the main attractions of general practice (Wilson & Cunningham, 2013). Secondly, some of the participants worked in different communities with higher than usual deprivation and where the patients' health status was affected by their socio-cultural environments. For

example, the IMGs who were servicing poor populations noted higher burdens of chronic diseases such as diabetes, high blood pressure and cardiovascular conditions. In addition, a few of the participants reported that their predominantly Māori and mixed patient populations, who were living in relative deprivation, had higher rates of drug abuse, domestic violence, teenage pregnancy and mental health issues. While the above social issues are quite widespread in New Zealand, the participants noted these issues were more pronounced in patient populations that were poorer than the rest of the country (Howard-Chapman & Tobias, 2000). IMGs who worked among middle to upper decile European populations reported not seeing the widespread prevalence of the health and social issues stated above (Howard-Chapman & Tobias, 2000; Wilson & Cunningham, 2013).

The participants also noted that providing patient-centred care can be challenging when there are many health issues and social conditions that affect their patients. Wilson and Cunningham (2013) noted that *“the determinants of health will be outside the GP’s control, but awareness of the impact of behaviour, income and psychological coherence allows careful consideration of how the doctor might intervene, or at least assist”* (p. 235). For example, with an ageing population, many patients presented with multiple chronic conditions where 15 minute consultations seemed inadequate. Similarly, patients with mental health issues may need regular follow-ups; however the participants reported that the fee-for-service model requires them to balance the absolute need to see patients regularly and the need to not increase the financial burden on such patients. Immigrant patients who had not experienced receiving care through a general practice model often did not understand the need to see their GPs first before being referred to hospitals if needed. The user-pays model of general practice also affected such patients as they would rather turn up to a hospital for free care than pay a co-payment to see their GPs. Participants noted that as a result of the user-pays model, patients were more demanding and expected high quality care (Wilson & Cunningham, 2013; Arblaster & Hastings, 2000).

Many of the participants also had to adjust to the poor links between primary and secondary care in New Zealand. Wilson and Cunningham (2013) noted that GPs, in their role as primary health care providers and coordinators of care, ought to have access to hospitals and specialists. Some patients who were being referred to secondary care by the participants were not getting access to timely diagnostics and essential treatment. This was leading to poorer outcomes for the patients, causing a lot of frustration for the IMGs. Availability and accessibility are key characteristics of good primary and secondary care models (Wilson & Cunningham, 2013). For the participants, understanding the challenges of primary and secondary care assisted with providing patient-centred care, to the best of their ability and available resources.

In addition to the above, there are other important occupational features that migrants ought to know about and understand to facilitate their participation and acculturation into the host's workforce. These are discussed next.

7.4.2 Understanding and Appreciating Unique Occupational Features

Wilson and Cunningham (2013) noted that *"in particular, medicine has long attempted to portray itself as having 'no culture', as being somehow removed from the usual social forces and structures that apply to other sectors of society"* (p. 163). An important aspect of the IFAR is for highly skilled migrants to understand and appreciate the uniqueness of their host's occupational environment. While neither Kim (2001) nor Gudykunst (2005) explicitly discussed the importance of institutions in occupational adaptation, they do note that migrants ought to familiarise themselves with such host structures if they wanted to acculturate. Kim (2001) stated that *"strangers in a new environment are confronted with situations in which their mental and behavioral habits are called into question, and they are forced to suspend or even abandon their cultural identification with the cultural patterns that have symbolized who they are and what they are. Such inner conflicts, in turn, makes individuals susceptible to external influence and compel them to learn the new cultural system. This activity of learning is the very essence of acculturation"* (p. 50). As mentioned above, migrants may need to relearn or adapt their predispositions in order to function effectively within host societies. The IMGs in this study were asked to identify the similarities and differences in the medical set-up and practices in New Zealand, and compare them to their own countries of origin.

It can be argued that on a number of levels these comparisons are important for the acculturative process. First it could lead migrants to value what they have gained in the host society that was absent at home. Kim (2001) called this the personality trait of 'openness', where migrants as strangers examine themselves and the environment they are in to genuinely transform themselves in order to incorporate new learning and new experiences. Secondly, such comparisons could lead to social and political activism to improve things in the host nation if certain things were better in home nations. However, migrants ought to be careful with such ideas as they could be perceived to be ethnocentric, which could hinder adaptation rather than facilitate it (Asante, et al., 2014). Thirdly, such comparisons could lead migrants to better understand whether they belong in the host nation, and if so, then to what extent. This is supported by the four key adaptation outcomes: assimilation, integration, separation and marginalisation (Berry, 1997).

In countries where primary health care models do not dominate the makeup of the health system, the health care service can be specialist-driven, over-used and undervalued, without significant health gains such as increases in life expectancy over time (Wilson & Cunningham, 2013; Arblaster & Hastings, 2000). Nearly all the key occupational features mentioned by the participants were what they liked

about general practice in New Zealand. They liked the user-pays model even though it created some challenges for certain patients. The focus on patient-centred care, the close links with the community/family and the continuity of care, and the good access to health care for people were things they liked. Given the gatekeeper role of GPs, these features made general practice a satisfying career for the participants. The longer consultation times, the broader scope of practice, the patient registration system, the limited need for private medical insurance, the ACC scheme for accident cover, and the extensive use of IT for record keeping gave the participants the ability to be efficient and effective. The diverse socio-cultural environment, the flexible work environment that allowed for better work/life balance, the role and purpose of the RNZCGP in supporting a strong ethos around family medicine, meant general practice in New Zealand empowered them, and made general practice a rewarding profession. These are well supported by other studies on New Zealand's health system (Wilson & Cunningham, 2013; Roberts, 2008; Grant, 2004). A comparison of New Zealand's and other countries' (Australia, Canada, Germany, Netherlands, the UK and the USA) front lines of care, found that the above noted features are indicators of a good quality health system (Schoen, et al., 2006). Despite New Zealand having the lowest per capita spending on health among those countries, it was achieving similar or better health outcomes than others (Schoen, et al., 2009).

Other less noted features of general practice and the overall health system in New Zealand and in some other OECD countries that could be improved included the lack of cooperation between general practice and secondary care, the excessive paperwork requirements, the regulation of pharmaceuticals, and the dependence on government funding including race-based funding which was creating funding inequities for poor patients from other ethnic groups. Some of the above challenges have been noted in previous studies done on general practice in New Zealand and internationally (Roberts, 2008; Schoen, et al., 2006; Morris, 1987; RNZCGP Workforce Series Reports 2006-2014; Pande, 2009; Pande & Stenson, 2008; Ineson, 2009).

The IMGs from dissimilar health systems to that of New Zealand (Sri Lanka, India, Germany, and Philippines) reported that within their health systems there was no separation of pharmacies from the rest of the health system, the general practice set-up was independent from government interventions, that general practice was not the gatekeeper to the rest of the health system, there was little need for CME, the links between primary and secondary care were poor, and the relationships between peers and health providers were not as good as in New Zealand, and in the other countries as investigated by Schoen and Associates (2006, 2009).

The economic returns from new careers in host nations can also be a motivator for acculturation if they are better than home countries (Tharmaseelan, et al.,

2010; Hercog, 2008; Ariss, 2010). In the LisNZ, immigrants from UK/Ireland, North America and South Africa earned more than their counterparts from Asia and other nations (Masgoret, et al., 2012). However, the overall gap in income for these different groups narrowed over time. The majority of the participants in this study reported that the income from general practice in New Zealand was low when compared to their home nations, even for those from dissimilar health systems. However, the introduction of capitation, new funding for the care of vulnerable populations, and the co-payments had improved income levels in recent times. Additionally, the IMGs mentioned that the lack of high incomes was compensated for by the opportunity to achieve better work/life balance, and gain more job satisfaction (Grant, 2004). One IMG commented that the low income levels in New Zealand could have an impact on their long-term financial security, and thereby, GPs' ability to retire. It could mean that GPs may choose to retire outside of New Zealand or return home to work prior to retirement to become more financially stable. This observation supports the notion that income could affect long-term acculturation and retention of migrants (Edwards, et al., 2002).

There was a time when newly trained local medical graduates were going overseas so that they could pay off their student loans faster than would be possible if they remained in New Zealand (Moore, et al., 2006). However, the government has persuaded such graduates to remain in New Zealand by agreeing to 'wipe out' portions of their student loans for every year they spend working in hard-to-staff areas – mainly in rural areas (MoH – Voluntary Bonding Scheme, 2009). Additionally, more local graduates are seeking employment within hospitals, which indicates an intention to remain in New Zealand, at least in the short term (MoH – Senior Doctors, 2009). Voicu and Vlase (2014), in their study of highly skilled international migrants (HSIM) in troubled economies within Europe, mentioned that it may be difficult for 'highly skilled natives' to return and cope in their own countries during times of economic distress, and that while HSIM may lose some quality of life, they are likely to cope better and continue to make contributions towards the host's economic recovery. Therefore, in times of economic difficulty, policy and strategy should not try to disadvantage HSIMs over natives; however, in positive economic environments, HSIMs and other migrant types may need special attention to retain them (Voicu & Vlase, 2014). Again, this would indicate that New Zealand may consider strategies to retain IMGs who have managed to acquire accreditation to work but who cannot find suitable employment. A study in New Zealand suggests that skilled immigrants are most at risk of leaving at two years post-permanent residency (Krassoi-Peach, 2013). These migrants are likely to be 30 years or younger, single, former students and migrants from Asia but excluding India. This study suggests that the migrant point selection system may consider favouring slightly older migrants instead of the younger cohort (20-29).

7.4.3 Mastering Communication Competence

By far, all the models of acculturation state that host communication competency is the single most important factor in cross-cultural adaptation (Berry, 1997; Kim, 2001; Gudykunst, 2005, Boski, 2008; Ward, 2008). This is a critical factor in the IFAR as well, as highly skilled migrants need to master their communication competence in order to achieve occupational success in host nations. This requirement is often necessary to demonstrate fitness to practise medicine or to pursue high-level careers that affect host societies (Wilson & Cunningham, 2013; Brettell & Hollifield, 2008; Zikic, et al., 2010; Tharmaseelan, et al., 2010; Fokkema & de Haas, 2011). The participants in this study all had good English language skills despite a few of them being asked to validate this skill by taking the MCNZ English exam. Nearly all the participants had minor communication issues when they initially arrived, mostly due to the accent and the colloquialisms in New Zealand speech. It did not take them long to learn the local terminology that assisted with their interactions with patients and the community in general. In terms of selection for migration and subsequent acculturation, English language competence is a key predictor of success in both (Masgoret, et al., 2012; Hawthorne, 2013).

Interacting with Patients

Among IMGs, the nature of their work compels them to purposively interact with hosts as patients who come seeking various types and levels of health care. Some work on IMGs in Australia (Durey, et al., 2008) and the USA (Laird et al., 2013) found that interacting with locals as patients is a negotiated relationship that can have far reaching impacts. In their study of Muslim IMGs in the USA, Laird and Associates (2013) found that the participants used their interactions with patients and others to project a better image of Islam, post 9/11. Both Kim (2001) and Gudykunst (2005) noted that certain behaviours apply to all types of immigrants such as having the ability to communicate with hosts, understanding the hosts' receptivity and conformity pressures, understanding the place of ethnic communities such as Diaspora within host societies, and most importantly, the ethical considerations that migrants ought to show in their communication with hosts as critical for adaptation. Gudykunst referred to ethical interactions as the basis of such interaction that should be built on respect, dignity and moral inclusion that migrants should show towards their hosts. In medicine, listening to patients and being respectful towards them are the cornerstones of good clinical practice (Wilson & Cunningham, 2013; Tovey, 2000).

In this study, the participants agreed that while medical practice itself can be universal, there are subtle differences that need to be considered when treating individuals. Patients' cultural backgrounds can have as great an impact as the cultural and personal backgrounds of doctors on the provision and

understanding of the health care being delivered. It is important to note that IMGs in the occupational context are no longer immigrants but fully-fledged doctors and therefore, the challenges that patients present with are no different than those faced by locally-trained doctors. This is where IMGs become part of the medical profession and face similar challenges to their host colleagues.

Some of the participants mentioned that their own cultural backgrounds did have an impact on their patients, mostly in a positive way. Some of the IMGs had attracted patients from their own cultural backgrounds or knew of other IMGs that had done so mainly because patients felt they could communicate better with them. Other IMGs said that as immigrants they were perceived to have a better understanding of other immigrant patients in New Zealand. This supports the assertions by Kim (2001) and Gudykunst (2005) that host communication competencies have far reaching influences on both migrants and hosts, and these should be managed to achieve positive outcomes for both groups.

Wilson and Cunningham (2013) noted that a key aspect of good doctor-patient relationships is the level of 'emotional intelligence' (EQ) a doctor has with which to handle difficult situations. One of the more recent participants from the UK noted that he had some difficulties with New Zealand European patients, who he thought had personality issues rather than representing a cultural problem. He found such patients to be difficult and disrespectful which he was not prepared to put up with. Most of the IMGs noted that the key to good doctor-patient relationships was to treat all individuals with respect and dignity regardless of the cultural, social, economic, or any other type of background. Patients ought to be treated as doctors themselves would like to be treated. Interestingly, Wilson and Cunningham (2013) found that many doctors who became patients themselves realised how indifferent or disinterested their colleagues were when treating them. It is unclear whether this type of behaviour is demonstrating a level of professionalism or is just poor conduct. It was not patient-centred care as the doctors had envisioned it to be.

Interacting with Colleagues

Overall, the majority of participants reported that their cultural background, and to a greater extent their personalities, did have an impact on their New Zealand-born and foreign colleagues. Kim (2001) stated that *"not only will an affirmative orientation enhance the supportive climate, providing us strangers with a needed environmental 'pull,' it will affect those who come into contact with us. By being positive, we can help natives develop their own communication competence, only this time, interculturally. Through such opportunities, they are able to increase their knowledge and understanding of some of our own cultural communication practices. Experiences of dealing with differences potentially challenge their cultural habits and facilitate their ability to communicate interculturally – just as we strangers become increasingly*

competent in communicating with the natives" (p. 232). For the most part, the IMGs reported being more organised and efficient in the way they managed their practice when compared to their New Zealand counterparts. Some of the IMGs considered their local counterparts to be *'too laid back, bordering on laziness'*.

Additionally, migrants such as IMGs also need to have good interactions with their colleagues in order to facilitate their acculturation into the workplace. Some studies have noted that IMGs had low morale and high dissatisfaction due to a lack of opportunities for career progression and being restricted to a limited scope of practice (Humphries, et al., 2013; Healy & Oikelome, 2011; Terry & Lê, 2013). In these studies, the authors suggested that the IMG participants could not access higher positions because they were being held by locals or by preferred IMGs. Terry and Lê (2013), in their study of IMGs in Tasmania, reported their participants being exposed to racism and discrimination due to them having strong accents and communication challenges. They also reported their cohort being exposed to professional challenges such as having excessive workloads and professional isolation. Interestingly, the Tasmanian IMGs saw themselves as a *'hostage workforce'* in relation to the vulnerabilities they felt within their work environments.

There is a medical hierarchy based on knowledge, skills, and merit, which can cause problems when IMGs feel that they were not considered for higher positions because of their migrant status. Some of the IMGs in this study clearly stated that this was the case, and it hindered their career progression in hospitals. It is not unexpected for IMGs to face prejudice and discrimination in host nations; however, the extent of the problem is very dependent on the type of society: multicultural societies are more accepting of diversity (Terry, et al., 2013; Humphries, et al., 2013; Berry, 1997; Kim, 2001; Ward, 2008). Arguably, multiculturalism in host societies is also reflected within their workplaces.

A few participants in this study from the UK implied that local doctors do not take too kindly to outsiders taking initiative, particularly when IMGs put their hand up for committees and representation on other formal groups. They further implied that New Zealand was very parochial in this sense, and that local doctors wanted to lead everything. This is supported by some of the findings among IMGs in Tasmania (Terry & Lê, 2014). Kim (2001) noted this as host conformity pressures, while Gudykunst (2005) saw this as a power struggle which created tensions, uncertainty, and an unfavourable environment for acculturation. Such attitudes did momentarily have an impact on some of the IMGs' adaptation to their work environments; however the majority of the participants in this study felt that their interactions with colleagues were mostly positive.

7.4.4 Continuing in Chosen Occupation and Dealing with Ongoing Challenges

Within the IFAR model, migrants' pledge of continuity in their chosen occupations in host nations can be a very good indicator of acculturation and integration. This concept of continuity has not been well detailed in most of the work cited except for a few that see continuity in different contexts. Kim (2001) noted that as intercultural transformation occurs, changes take place in migrants as they adapt to their new environment. This is an ongoing process of 'deculturation' and 'acculturation' where migrants forgo some aspects and adopt others to facilitate adaptation. This perspective is rather similar to those espoused by Berry (1997) and Ward (2008), where 'continuity' is framed as 'ethno-cultural continuity'. Ethno-cultural continuity is about the maintenance of core ethnic identities, and the subsequent adoption of host cultural identities. However, the extent to which such a process affects psychological and socio-cultural adaptation remains to be fully understood. Gudykunst (2005) discussed continuity in the context of migrants developing scripts to use when facing different situations in host societies and thereby, reducing anxiety and uncertainty. Migrants also have to be mindful when interacting with hosts, again to manage anxiety and uncertainty, and to foster ethical interactions. Berry (1997) suggested that acculturation strategies such as assimilation and integration are indicators of positive continuity in host nations. The other two strategies of acculturation – separation and marginalisation - may also see strangers remain in host nations but their adaptation may not be optimal. These perspectives do not really capture the moment when an immigrant such as an IMG decides that they have learnt enough and have adapted enough to feel comfortable working and living in host societies. It is this moment when questions on occupational continuity shed light on immigrants' level of acculturation into host societies. In the last wave of the LisNZ research, the cohort of health professionals from the overall study population indicated very high levels of satisfaction with their main jobs and also very high levels of positive settlement outcomes which again can be seen to reinforce the impact of occupational adaptation on positive settlement outcomes (Department of Labour – New Faces, New Futures, 2009). In contrast, Humphries and Associates (2013) found that non-EU IMGs in Ireland were seriously considering moving to other countries or even going back home because they lacked career satisfaction and therefore, did not want to continue working in Ireland. These IMGs were still living and working in Ireland but were likely to be feeling isolated and/or marginalised. Terry and Associates' (2013) study of IMGs in Tasmania also reached similar conclusions, that if IMGs are to be retained for any length of time then career considerations will be paramount.

Therefore, this study of IMGs in general practice in New Zealand is demonstrating that occupational success is a key prerequisite to continuity and long-term integration into host societies. By far, many of the participants had

been in New Zealand for over 18 years, which in itself is a good predictor of occupational success and acculturation. This notion is also supported by studies on other types of highly skilled migrants (Zikic, et al., 2010; Hercog, 2008; Tharmaseelan, et al., 2010). Fokkema and de Haas (2011) stated that *“immigrants who were well-educated and well-informed prior to migration, and who accumulated migration experience at a relatively young age tend to achieve higher levels of socio-cultural integration”* (p. 33). Additionally, Hatzidimitriadou and Psoinos (2014) observed among IMGs in the UK that *“participants with temporary migration status experienced barriers and delays as they tried to develop professionally, whereas those with more permanent status progressed more quickly”* (p. 44). Mahroum (2000), in a study of international migration and human capital, reported that many types of highly skilled migrants such as executives and managers, engineers, scientists and doctors, may stay longer if a host nation’s policies are conducive to enhancing occupational progression. These studies all identify the length of stay as either a good predictor of occupational success and thereby acculturation or point towards host nation policies that could have an impact on the length of stay and thereby enhance the opportunities for acculturation. Kim (2001) summarised more generally that *“immigrants who reside in a new culture for a long, indefinite period are more likely to be committed to adapting than are temporary sojourners”* (p. 17).

Continuity in Occupation

Despite the challenges faced, all the IMGs mentioned that they planned on continuing in general practice for the foreseeable future, in New Zealand. However, some of the participants stated that their continuing will be conditional on reducing their workload, fulfilling the continuing medical education requirements as they got older, meeting the schooling requirements of their children, winning the lottery and on how New Zealand treats them. These aspirations are supported by the abovementioned studies on IMGs. Rather unfortunately, one of the participants died suddenly during the course of writing this thesis. He was still practising as a GP when he passed away.

Ongoing Challenges

Wilson and Cunningham (2013) stated that *“in the twenty-first century doctors are faced with considerable challenges. The demographics of disease and disability have changed significantly in the last hundred years. People in the Western world are living longer, increasing the elderly portion of the population. The incidence of chronic and multiple morbidities is rising. Inequities in health persist both between countries and within countries. Health care is now more costly and complex, yet fails to reach all patients”* (p. 247). These challenges have all been noted by the IMGs in this study, within their respective practice environments.

For some IMGs, the fee-for-service model was affecting their patients' access to timely care. Their heavy workload also meant that dealing with patients with complex conditions was challenging. Resources were scarce when treating patients with mental health issues and other resource intensive health conditions. The lack of adequate links between the primary and secondary care systems including the issues with ACC and PHARMAC meant that some patients were not receiving appropriate levels of care. Additionally, when dealing with patients, the participants reported ongoing challenges with language issues, patients' non-compliance with medical advice, giving bad news to patients, and at times, difficulties with providing culturally appropriate care due to a lack of appropriate competence training within the medical context. Some other more individual challenges that were reported included working in communities that had higher than usual prevalence of sexual health issues, teenage pregnancy, and domestic violence.

In terms of the business of general practice, the public/private mix in the funding model was interpreted by some IMGs as putting the delivery of health care secondary to making money. However, in contrast, certain IMGs saw a need to make their practices financially viable to ensure continuity. The rigid requirements for accessing capitation funding for patients made one GP concerned for the future of her inner-city practice. A few of the participants mentioned that they faced *professional antagonism* when working with New Zealand-trained colleagues. Others were challenged by their personal circumstances such as family considerations and their own identities as immigrants in New Zealand. GPs working in rural settings were challenged by a lack of anonymity, and a lack of access to essential facilities such as banks and adequate shopping centres. There was a perception that the government was being disrespectful by limiting the types of diagnostic tests GPs could prescribe. These noted challenges have support from other studies on IMGs in various countries (Humphries, et al., 2013; Terry, et al., 2013, 2014; Neiterman & Bourgeault, 2012; Chen, et al., 2010, 2011; Durey, 2005; Falcone, et al., 2014). Despite these challenges, the IMGs in this study seemed well acculturated to general practice in New Zealand.

The following section discusses the other predictors of acculturation and adaptation that overlap with occupational adaptation. These are discussed in the context of social adaptation, and refer to situations outside of the work environment that the participants had to deal with. The social adaptation of IMGs completes the picture of their journey to acculturation within New Zealand society. This is the final and equally important component of the IFAR.

7.5 Living among the Hosts

Kim (2001) summarises rather well the tensions of ongoing challenges in host environments when stating that *“this understanding of person-environment interdependence engenders a spirit of cooperation and self-responsibility, as it helps us not to blame the host environment for all our cross-cultural predicaments. Doing so would ultimately be counterproductive to our own adaptive self-interest. We can also better appreciate the fact that all societies and communities assert their sociocultural integrity and justifiably exert some degree of conformity pressure on strangers, subtly or explicitly”* (p. 224). Much of the literature on migrants as discussed in sociology and anthropology focused on these aspects of adaptation (Brettell & Hollifield, 2008). Some recent studies on IMGs or highly skilled migrants discussed the social aspects of adaptation. Neiterman and Bourgeault (2012) saw this as a gap in their study of IMGs who formed professional Diaspora to adapt to Canadian society. Hatzidimitriadou and Psinos (2014) acknowledged that the current models of adaptation are inadequate to fully explain the experiences of doctors and nurses in the UK health system or even internationally. They proposed the ‘Cultural Health Capital’ model for gaining a better understanding of the occupational adaptation of health professionals but like most other studies on IMGs to date, they too did not investigate any of the social aspects of adaptation that are situated outside of the workplace. Terry and Associates (2011, 2013, 2014) also noted in a limited capacity the need for social support for IMGs and their families if they were to be retained in Tasmania.

This study has taken the social adaptation of IMGs a step further by taking a somewhat in-depth look at the perceptions the participants held as members of New Zealand’s society. It was envisioned right at the beginning of this study that a holistic and integrative approach would be taken when examining the adaptation of IMGs to general practice in New Zealand. Wilson and Cunningham (2013) have noted that within general practice, patients’ sociocultural identity and the community they live in are intertwined with their health and wellbeing. The events of illness and disease are often the results of other factors that affect their lives. General practitioners are expected to understand or be aware of these factors so that *“the GP treats disease in the context of the whole person and their supports”* (Wilson & Cunningham, 2013: p. 230). The social experiences of GPs, within their communities and in the broader context, are very important for a greater understanding of their perspectives on life in New Zealand. Arguably occupational adjustment and social adaptation are two sides of the same coin, and therefore, it was valuable to investigate participants’ social adaptation experiences along their journey to occupational acculturation. Within the IFAR model, ‘Living among the Hosts’ is the final key component that provides that holistic perspective that many studies on highly skilled migrants are missing.

7.5.1 Appreciating the Host's Socio-Cultural Environment

Gudykunst (2005) stated that strangers in new environments have four particular needs that have to be satisfied if they are to be motivated to interact with the hosts, and to eliminate any sense of deprivation (Turner, 1988). Additionally, the fulfilment of the four needs will reduce anxiety and uncertainty for migrants. These include migrants': (1) need for a sense of predictability; (2) need for a sense of group inclusion; (3) need to avoid diffuse anxiety; and (4) migrants' need to sustain their self-conceptions (p. 430). Kim (2001) took a more host-orientated perspective, and stated that strangers have to adjust to three environmental conditions to facilitate acculturation. These included understanding (a) the receptivity of hosts towards strangers; (b) the conformity pressures that hosts exert on strangers; and (c) the strength of the strangers' ethnic group within the host environment (p. 147).

Brettell's (2008) anthropological observations suggested that researchers ought to be aware that migrants' views are rooted in their interactions with the structures and agencies of host environments and *"that migrants shape or are shaped by the context (political, economic, social, cultural) within which they operate, whether in the sending society or in the receiving society"* (p. 136). The majority of the participants reported having positive impressions of New Zealand. They had found New Zealand to be quiet, empty, clean, orderly and fresh, with open spaces, good weather, and friendly people. A few of them reported initially feeling some apprehension, isolation and fear mainly because they did not know anyone, and were coming to a country that was much smaller than they were used to. Some felt that New Zealand was still a very young country finding its place when compared to countries like the UK. They observed that the infrastructure was fragile and vulnerable to damage by natural occurrences. Some of the IMGs who had been in New Zealand longer than others noted how it had changed since the time they came. They observed that in the 1970s and 1980s, New Zealand would shut down on Friday evenings and reopen on Monday mornings – *people disappeared on weekends to do their thing and the majority of shops would be closed*. This has changed now with most businesses open seven days a week, throughout the year. Such observations of host environments are not unusual, and serve to demonstrate that migrants have a better grasp of the hosts the longer they stay (Kim, 2001). These observations also serve to make immigrants more comfortable in host nations by increasing predictability and reducing uncertainty (Gudykunst, 2005).

Additionally, until the early 2000s, many of the IMGs from the Asian subcontinent and Europe noted not being able to find ethnic foods, good coffee and a variety of different breads. The earlier IMGs from Asia reported developing links with others from their home nations, and would often take opportunities to partake in homemade ethnic cuisine. The same IMGs developed

those links within the context of formal and informal ethnic networks, and in subsequent years, contributed to them in their professional capacity as doctors and medical educators. These social and ethnic networks are very important to the adaptation process as has been demonstrated in many sociological and anthropological studies (Brettell & Hollifield, 2008). Kim (2001) argued that at times strong ethnic communities can also negatively affect the adaptation process of new comers by impeding the development of host communication competence. Strong ethnic networks can influence the level of prestige, economic and political power its members obtain. However, where members of an ethnic group regularly participate in host environments and acquire host communication competencies, they will over time diminish the overall strength of their given ethnic group. Successful migrants are also likely to further diminish the power of ethnic networks because of the low impact it has on their daily activities in host nations. Interestingly, and somewhat in support of Kim's observations, those IMGs who had strong links to their ethnic communities did so in their role as doctors, and as advocates for the medical system of New Zealand. A number of participants were adamant that if the IMGs of their ethnic communities wanted to succeed then they had to adopt the medical practices and culture of New Zealand. Kim (2001) referred to this as "*identity flexibility or switching*" where strangers accept the identity of the host culture for particular purposes (p. 112). This would be an indicator of acculturation.

Furthermore, Gudykunst (2005) mentioned that in order to reduce anxiety and uncertainty, migrants often place hosts in social categories. This leads to the activation of migrants' cultural identity when engaging in intergroup behaviour with host nationals. The more culture-specific knowledge migrants have about hosts, the more likely their social-cultural adjustment (Ward & Searle, 1991); the less uncertainty and anxiety they experience (Hammer, et al., 1998); the less their tendency to treat hosts negatively (Johnston & Hewstone, 1990); and the more differentiation they experience between their culture and that of the hosts (Linville, et al., 1989). The more knowledge they have of hosts, the more likely migrants are to state their perceptions of hosts in negative or positive terms – each perception affects migrants' overall acculturation into host nations (Gudykunst, 2005). These notions are also supported by Ward (2008) who expanded Berry's (1997) acculturation model to better understand the impact of ethno-cultural continuity as a predictor of psychological and socio-cultural adaptation. This thesis arguably contributes to that psychological understanding despite it not being the focus.

The IMG participants were able to critically appraise New Zealand's socio-cultural features. Their assessment concluded that New Zealand had a different set of values and priorities, a diverse ethnic population, more equality and freedom, an international green image, wonderful physical environments, good weather, a bi-cultural focus, strong sports orientation, a lot of wealth that

afforded a comfortable lifestyle, was small but happy, was less class conscious, and had open-minded people with integrity who were helpful. New Zealand society was said to be more individualistic and rather innovative. As has been noted in international literature, New Zealand is favoured as a key destination for many types of migrants due to the good lifestyle and adventure tourism it offers (Department of Labour – New Faces, New Futures, 2009; IOM, 2009; NZ Herald, 2007).

However, the participants also reported challenging aspects about New Zealand. Kim (2001) stated that *“as individuals become increasingly proficient in two or more languages and cultures and move toward a more inclusive group identity that embraces many groups, they are better able to make rational comparisons among different philosophical and ideological systems, as well as identify with the experiences of parties involved”* (p. 195). The IMGs reported being challenged by the drinking culture among many of the people, the smallness and provincial demeanour, the laid back attitude of some, the over-emphasis on sports especially the All Blacks, the level of stereotyping of individuals based on ethnicity or race, and the relative poverty that exists in the population. In addition, while some participants reported the ‘green image’ as being an essential part of New Zealand, others reported that it was not what it seemed. Similarly, while New Zealand was deemed to be a good place to bring up children, it had some of the worst records of child and family abuse in the developed world. Despite these challenging aspects all the participants reported that this was a good place to live.

7.5.2 Interacting with Locals

Berry (1997), Kim (2001), and Gudykunst (2005) all wrote about the value and importance of developing good communication and relationships with locals if migrants are to successfully adapt. The hosts are also expected to reciprocate these behaviours through individuals and institutions. In Mpofu and Hocking’s (2013) study of IMGs struggling to establish themselves in New Zealand, many of the participants mentioned feeling let down by Immigration New Zealand (INZ), and later the MCNZ. Many felt depressed and discouraged by the negative feedback they received from these institutions, from peers, and from the public in general. The authors referred to such reactions from hosts as ‘occupational apartheid’ that also affected their social relationships with the community at large.

In this study, communicating with the locals did not create any major issues for the participants, other than them needing to learn some of the local terms and colloquialisms. For some of the earlier participants, the locals they socialised with were the same people they worked with in the hospitals. One participant in particular mentioned that the relationships he made in the workplace extended to his social environment where some of the nurses he worked with would come

over and help him with his household chores. In another case, one of the early female participants from Canada noted that her best friend in New Zealand was the receptionist at the hospital she worked at. She observed that such friendships were not unusual in the 1980s but wondered if it would be the same now given the socio-economic disparities between the two occupational groups. Neiterman and Bourgeault (2012) had found the existence of 'professional diaspora' among IMGs in Canada that were used as both occupational and social support systems by their members.

Another recent IMG noted that he found making friends in the professional context quite challenging. His relationship with a colleague went sour when a business deal fell through. He had thought of leaving New Zealand due to all the negative experiences he was encountering. Kim (2001) noted this type of behaviour within the context of overall host receptivity, where at times a willing host could become unwilling if they are under pressure due to political turmoil, high unemployment, and domestic conflicts. Berry (1997) also found that at times hosts may deliberately 'marginalise' immigrants through forceful exclusion. However, for this particular IMG, all was not lost as his school-aged children introduced him to their friends' parents. Again, this is an example of a social network assisting in the acculturative process.

Another participant, from the Philippines, mentioned experiencing a bit of culture shock in relation to the informality with which New Zealanders addressed each other – most communicated on a first-name basis which was surprising to her. Some of the other IMGs, from countries like New Zealand, such as the UK, made similar observations – it took a while to get used to the informality that exists in New Zealand. This can be partially explained by Hofstede's (2010) and Minkov and Hofstede's (2012) original study of culture and organisations in different countries, using their four dimensional value system (power distance, individualism, masculinity, and uncertainty avoidance) – they later added two more dimensions (pragmatism and indulgence). According to these dimensions, New Zealand is low on power distance and pragmatism, relatively balanced on masculinity and uncertainty, and high on individualism and indulgences. Based on these dimensions, the informality that the IMGs encountered is related to the low power distance between people of high status and the others, and the high levels of individualism. In comparison, the Philippines has very high power distance, and very low individualism. In the UK, there is greater power distance and individualism than in New Zealand, and therefore, arguably more formality in the communication between ordinary people and those with high status.

7.5.3 Becoming Part of the Hosts

When immigrants consider and refer to themselves as hosts, then this indicates acculturative success (Kim, 2001; Berry, 1997). Becoming part of the hosts is a defining factor of the IFAR, and this can take on many forms such as those achieved through the legal framework of residency and citizenship, through the occupational framework, through social and cultural integration, through length of stay, and through the growth of the next generation of migrant children. These aspects of becoming part of the hosts are well documented in literature; however the timing of when belonging happens is less well articulated (Brettell & Hollifield, 2008). In fact studies have shown that some migrants can achieve all of the above but still not consider themselves as part of the hosts for various reasons (Gudykunst, 2005; Kim, 2001; Ward, 2008; Humphries, et al., 2013). Therefore, it can be argued that the feeling of belongingness, and considering oneself to be part of the hosts, is far more complex than going through the processes of 'deculturation' and 'acculturation' on an on-going basis, as Kim (2001) and Gudykunst (2005) have alluded to. The process of belonging can be like drawing a line in the sand, where one is comfortable with their individual cultural identity, and at the same time, willing to be considered as part of the host collective, and be referred to as such when the need arises. This moment in an immigrant's journey seems to be less well understood in current acculturative literature (Ward, 2008). It is hoped that this research might provide some insights, and therefore, assert that the moment of belongingness is tied to achieving occupational success, as intended by an immigrant before they migrated to host nations. To support this assertion, all the participants stated that they wanted to continue to work as GPs in New Zealand. In addition to that, some mentioned other reasons for wanting to be considered New Zealanders.

When asked, the majority of IMGs considered themselves to be New Zealanders, but at the same time wanted to maintain their own cultural and ethnic identities. According to literature on acculturation and integration, it is perfectly fine to want to maintain individual identities when belonging to host nations (Brettell & Hollifield, 2008; Kim, 2001; Gudykunst, 2005; Laird, et al., 2013). The diversity in New Zealand allows and encourages migrants this opportunity, despite the negative stereotypes and bad press that some ethnicities get. Berry (1997) asserted that "*the integration strategy can only be pursued in societies that are explicitly multicultural, in which certain psychological pre-conditions are established*" (p. 11). The pre-conditions include the widespread acceptance of cultural diversity, low levels of prejudice, positive mutual attitudes among the diverse cultural groups, and having a sense of attachment to and identification with the larger society by all groups (Kalin & Berry, 1995; Berry, 1997). In New Zealand, by the third wave of LisNZ, approximately 17% of the health professional cohort reported feeling discriminated against, down from approximately a quarter in

the first and second wave follow-ups (Department of Labour – New Faces, New Futures, 2009).

Three of the participants in this study said that to a certain extent they could never be New Zealanders because either they will always be seen as foreigners or they have their roots and identity too grounded elsewhere to really let go. As noted earlier, some immigrants do not wish to be identified using the host identity, and this is also acceptable within the acculturative context. One participant, who took part in the protests during the Springbok tour, recalled that New Zealand as a society was so divided during that period that his stance against the tour had caused him some strife in the small rural community he was working in. As a result he thought that he may never consider himself to be a New Zealander. However, his children were born in New Zealand, his family had lived most of their lives in New Zealand, and he was acknowledged for the contributions he made to general practice, which had changed his mind about considering himself to be a New Zealander.

Many of the other participants had similar inclinations about being New Zealanders due to their marriage to New Zealanders, having their children born or grow up in New Zealand, due to their length of stay, and because New Zealand fulfilled what they were looking for as highly skilled immigrants. Kim (2001) and Berry (1997) both noted the importance of immigrants' psychological health as a determinant and as an outcome of the acculturation process, with the former stating that *"the psychological health of a stranger resides not only in a positive sense of cultural identity but in the integration of the cultural identity with a new, alternative identity that is broader than the individual's ascribed cultural membership. Rigid adherence to the original identity without the ability to transcend it is counterproductive to the stranger's psychological health as long as the stranger lives in a new milieu and is functionally dependent on it"* (p. 199). As seen in Mpofo and Hocking's (2013) study of struggling IMGs in New Zealand, participants' failure to become doctors was significantly affecting their mental health and social wellbeing. Therefore, it can be strongly argued given the evidence in this thesis, that for highly skilled migrants, occupational success is a key predictor of acculturation and belongingness.

7.5.4 Ongoing Challenges

While the majority of the participants did not report any particular ongoing challenges, a few mentioned that New Zealand was very far from their home nations, and at times the distance can be a barrier to family members and friends. One of the IMGs reported that when his father had passed away the logistics and stress of getting home to the UK were challenging, mainly due to the travel distance. Finally, Kim (2001) concluded that *"although the process of becoming intercultural is never complete, each step on this path brings a new formation of life...the*

transformative experiences of intercultural persons around the world bear witness to the remarkable human spirit and capacity for self-renewal beyond the constraints of a single culture. Their struggles, as well as their triumphs, hold wisdom and promise for us as we walk through our own intercultural journeys” (p. 235). The IMGs in this study are likely to encounter challenges as will the rest of the New Zealanders. However, their occupational success means that they are better equipped to cope with challenges than those who are yet to reach that status.

7.6 Conclusion

This chapter has discussed the key themes that emerged from the study of IMGs on their cross-cultural adaptation to general practice in New Zealand. These experiences have been cast within the IFAR model, proposed as being a concise, integrative, and comprehensive approach to the study of highly skilled migrants. The strength of the IFAR lies in the context of migrants putting their motivation to pursue their home-grown careers in host nations as the primary consideration. The IFAR thereby sequentially maps the end-to-end journey that migrants take in achieving that goal by reflecting on their pre-migration careers and human capital, the challenges they face in transitioning into meaningful careers that utilise their human capital, their understanding and appreciation of the nuances of working in their chosen careers in host nations, their mastering of the communication competence necessary to make occupational adaptation a success, and furthermore, reflecting on their life outside of the workplace that makes the overall acculturation to host nations a success. As argued earlier, the IFAR takes a holistic approach to understanding the migration experience and draws from several disciplines, such as sociology, anthropology, economics, migration policy, intercultural communication and cross-cultural adaptation theories, to make the model integrative in nature. The IFAR is supported by a data collection and analysis framework (Figure 5) that could inform a researcher on the different aspects necessary to address when designing a research study on highly-skilled migrants. The longitudinal nature of the data collected made the IFAR and the analysis framework very relevant for historical comparisons across a number of important variables such as the ‘achieving registration’. The IFAR could also be relevant to the study of skilled migrants outside the health sector, such as teachers, lawyers, architects, and social workers.

Overall, the participants in this study considered New Zealand to be their home, where they got the opportunity to ply their trade, and pursue a lifestyle of their choosing. There were several factors that facilitated their stay in New Zealand including the registration process at the time of their arrival, the opportunity to move from hospital-based medicine to general practice, the support received during the training period to become GPs, the variety of medicine they got to practise, the satisfaction they got from being GPs and the links within the

communities that made them feel at home in New Zealand. As highly skilled migrants, they could have gone to any country but chose to remain and forge their medical careers in New Zealand. At the time of the interviews, they continued to make significant contributions to the provision of health care to the people and in return, New Zealand made them feel welcome. They became valued and trusted members of their communities through their professional role as GPs and thereby, have in their own way added to the rich fabric that is New Zealand.

8.0 Conclusion

This study has demonstrated that occupational success is an important factor in the adaptation of highly skilled migrants, as seen through the experiences of the international medical graduates who came to New Zealand and became general practitioners. The central objectives of this thesis include contributions to three distinct discourses on the experiences of migrants. The first contribution is an investigation and critical analysis of the experiences of international medical graduates (IMGs) who came to practise medicine in New Zealand. During the course of analysing the primary data, and relating it to existing literature, it was noted that there was a lack of a precise model that captured the essence of what was emerging. Therefore, the second contribution is the development of a concise integrated framework - the Integrated Framework for Acculturative Research (IFAR) - for the study of highly skilled migrants' acculturation to new environments. The experiences of the IMGs who came to New Zealand as highly skilled migrants were used to develop and discuss the application of the IFAR to cross-cultural adaptation research. There is a historical component to these narratives as the IMGs in this research spanned nearly five decades of acculturation into New Zealand society. The third contribution is in the domain of qualitative research, where email interviews (e-interviews) were used to gather data within the context of ethnography.

Several strategies were used to research the central focus. A literature review was undertaken to assess and appreciate the migration experiences, as seen through the eyes of sociologists, anthropologists, economists, migration policy experts, and intercultural communication and acculturation theory scholars. Additionally, literature on the experiences of highly skilled migrants was also analysed. The primary data were gathered through personal and e-interviews of IMGs who came to New Zealand between the 1960s and the mid-2000s. Key institutional personnel from the Medical Council of New Zealand (MCNZ), New Zealand Locums (NZLocums), and the Royal New Zealand College of General Practitioners were also interviewed. Several research and policy documents of these key institutions were also analysed including the comprehensive historical account on the development of medical registration policies of the MCNZ by Georgina Jones.

8.1 A Study of International Medical Graduates in New Zealand

New Zealand has one of the highest proportions of IMGs when compared to other countries within the OECD, yet very little is known about their lived experiences within the country (OECD, 2008; Dumont & Zurn, 2007; Fletcher & Dickson, 2007). The Results Chapters 4 and 5 provide historical insights into the

experiences of IMGs who came to New Zealand between the 1960s and the mid-2000s. Chapter 6 provides a brief perspective from the key institutions on how their processes and procedures have changed over that period to assist IMGs who wanted to practise medicine in New Zealand. These insights, especially those from the participants, fill an important knowledge gap in New Zealand's understanding of IMGs and their journeys to acculturation (Fletcher & Dickson, 2008; Ineson, 2009). Through this thesis, key findings contribute towards several knowledge gaps, both in the historical and current contexts.

One of the main findings was the change in the registration process since the arrival of the first participants. For many earlier arrivals, the registration with the MCNZ did not seem to be difficult at all. However, over time the perception of 'unsafe' doctors started to emerge locally and internationally, so the MCNZ took a tougher stance in scrutinising the doctors prior to registering them. This was done as a matter of public good because the MCNZ is first and foremost trusted to protect the public from unsafe doctors (St George, 2013). Most of the participants that arrived after the 1990s had to fulfil more stringent criteria for registration. The MCNZ continues to adhere to these levels of checks but has worked towards making their processes less time consuming, more user-friendly, and more sympathetic towards the needs of IMGs, by working with the medical sector to provide appropriate levels of support during training to become independent practitioners. Arguably, this approach has reduced some barriers for IMGs; however the journey to registration can still be time consuming, costly and demoralising for some, especially refugee doctors (Ineson, 2009; Mpofo & Hocking, 2013).

The participants, regardless of when they came to New Zealand, all agreed that good mentoring during the training and initial occupational adaptation years was by far the most important type of support IMGs could get. The MCNZ ensures that all doctors completing their registration processes are placed in safe environments for learning, and has developed standards to measure this. The RNZCGP also ensures this when placing registrars for specialty GP training. While only a few of the participants in this research had experienced this structured approach to mentoring and learning, it would be interesting to investigate what a good model of mentoring IMGs could look like, and when and where is it most appropriately delivered. High quality mentoring can be a good predictor of success and thereby, for occupational adaptation in the long term.

Another important gap in knowledge this research fills is the documentation of the lived experiences of IMGs in their work environment. While some of the IMGs were GPs prior to coming to New Zealand, others were hospital-based trainees, who made a conscious decision to become GPs. Their experiences in both environments provide insights into the challenges faced by doctors new to New Zealand. The majority of those who arrived earlier did hospital work while

the more recent ones did both as a matter of course, before choosing general practice. The reasons expressed for joining general practice by the participants are well supported through the literature (Fletcher & Dickson, 2008; Fretter & Pande, 2008; Hill, et al., 2002). A key contribution of documenting the work experiences highlighted the many challenges and facets of general practice that can be quite different to hospital-based practice (Wilson & Cunningham, 2013). The interactions within a community-based setting, with a relatively stable set of patients, some over many generations, make GPs more aware of the needs and the challenges of that community. The inherent differences between general practice and hospital-based medicine highlight the reasons why doctors choose one over the other. The higher levels of satisfaction derived from working in a chosen medical profession is a predictor of long-term stay in a host environment, otherwise IMGs may consider moving to other types of work or even other countries to find that level of satisfaction (Department of Labour – New Faces, New Futures, 2009; Humphries, et al., 2013; Mpofu & Hocking, 2013; Dowell, et al., 2002).

A critical contribution to the discourse on IMGs takes into account all of the above and places it within the context of retention. It is argued throughout adaptation literature that the longer migrants stay in host nations the more likely they are to acculturate (Hercog, 2008; Kim, 2001; Berry, 1997). It is known that while New Zealand has been an attractive destination for IMGs, the retention rates are abysmal, with only 33% of them remaining two years after registration, and 21% after 12 years post-registration (MCNZ, 2013). Further analysis shows that IMGs from North Africa, the Middle East, and South East Asia, and those who are aged between 30-50 years, and those with 11-20 years of post-qualification experience have higher retention rates (approx. 40%). However, the highest retention rates (66%) are among those who achieve their vocational registration in New Zealand. According to the MCNZ, IMGs aged 20-29 have low retention rates; however this study shows that given the right support and environment, more of the younger IMGs could be retained in New Zealand. In the wider context of having a stable medical workforce, the acculturative experiences of IMGs can be enhanced if the key institutions such as the MCNZ, RNZCGP, and other professional bodies assist IMGs to achieve vocational registration as soon as possible. Vocational registration is part of occupational success and therefore, the sooner this is achieved the better the chances of IMGs adapting to their medical and social environments in host societies.

Finally, in terms of the actual acculturation of the IMGs, the preference has been towards integration rather than assimilation (Berry, 1997; Kuo, 2014). Integration allowed the IMGs to retain important features of their pre-migration socio-cultural identities. At the same time, it allowed them to adopt aspects of the host society that enabled them to effectively function as doctors and as members of New Zealand society. Integration also meant that they could be critical of how

New Zealand progressed without being vilified for doing so – a feature that arguably makes New Zealand a favoured destination for all types of migrants. Overall, the analysis of the experiences of the IMGs who came to work in general practice in New Zealand led to the development of the IFAR model.

8.2 The Integrated Framework for Acculturative Research (IFAR)

The literature review in Chapter 2 summarised the key findings of what is known about migration through the disciplines of sociology, anthropology, economics, and intercultural communication and acculturation theories. The IFAR (Figure 6) has attempted an integrated approach to understanding the experiences of highly skilled migrants such as IMGs – this is a key strength given the model provides the opportunity to combine the key assertions regarding migration from a number of distinct disciplines such as sociology, anthropology, migration policy development, economics, intercultural communication and acculturation theories, as well as migration policy studies. The key gap in the literature that led to the development of the IFAR was the lack of focus on the particular reasons why people migrate, other than the generalisations discussed in the context of ‘push’ and ‘pull’ factors, with reflections based on very broad, ungrounded migration motivations (Brettell & Hollifield, 2008; Gudykunst, 2005; Kim, 2001; Berry, 1997). Arguably, the motivation to migrate has to be reciprocated in host nations if acculturation and integration are to occur. The concept of the IFAR developed as the occupational aspirations of IMGs became a key feature of the research analysis framework (Figure 5). It is reasoned through this research that occupational success is a key predictor of acculturative success. Additionally, a recent synthesis of literature on coping, acculturation, and psychological adaptation noted more gaps in the current understanding of the acculturation process (Kuo, 2014). Some of the limitations of existing literature include the lack of longitudinal studies that measure coping strategies of migrants over time; the lack of examination of critical variables that have an impact on the acculturation process; the lack of a systematic and programmatic effort to study adaptation; and that the majority of empirical studies are in the North American context.

It is among these identified gaps in knowledge that the IFAR and the study of IMGs in New Zealand adds to the current discourse on acculturation and adaptation. First, while the study of IMGs was not longitudinal in nature, the interviews garnered responses on historical events, and recorded the decision-making processes that took place within those contexts. For example, participants were asked about their work experiences prior to migration to New Zealand. They were also asked about their initial experiences in New Zealand, from the time they landed to the day they became qualified GPs. The participants also spoke about critical events during their journey to becoming independent GPs and their acculturation into New Zealand society. These historical experiences

highlighted the challenges they faced and the strategies they used to cope in a new environment.

Secondly, the IFAR has clearly articulated the critical variables, such as predispositions, initiating occupational processes, adapting to occupational environments, and living among hosts, as the most important consideration factors when investigating the adaptation experiences of highly skilled migrants. The identification of the critical variables serves to fill two gaps as identified by Kuo (2014). The first is the impact of the variables on the acculturative process itself. The second is on the development of a systematic and programmatic approach to studying the adaptation of highly skilled migrants, using those variables. It should be noted that most of the critical variables that affect adaptation have been discussed in previous literature. They were not, however, organised in a fashion that made them meaningful within the context of the reasons for migration. This research specifically investigated the adaptation process from the angle of occupational reasons for migration and thereby, structured the critical variables so that it gave meaning to that acculturative process.

To facilitate development, the presentation of the Results chapters was organised in such a manner that it directly informed the critical variables within the IFAR (see Figures 5 & 6; Tables 3-12). The first set of critical variables focuses on the predispositions of the highly skilled migrants including their prior qualifications and work experiences, their reasons for migration, their age at the time of migration, their prior knowledge of the hosts, and their language competencies regarding the host's occupational requirements. The second set of critical variables emphasises the initiation of the occupational process within host societies including the effort needed to get accredited to ply their trade, the career adjustments needed to commence work, the training needed to support any career adjustments, and the need to better understand the socio-cultural environment to facilitate occupational adaptation. The third set of critical variables underlines the additional effort needed to properly adapt and operate in the host environment including the establishment of careers after completing the accreditation and training requirements, gaining a thorough understanding of the uniqueness of the host's occupational environment, mastering the occupational communication competencies, and being able to cope with ongoing challenges as fully fledged members of an occupational group.

The final set of critical variables concentrates on the need for social adaptation that complements migrants' occupational adaptation. Nearly all studies on highly skilled migrants cited in this thesis lacked information on this final stage of acculturation. It is here that the IFAR adds that extra dimension that completes the investigation of the adaptation process of highly skilled migrants. It also pulls together numerous studies done in sociology, anthropology and intercultural

communication that focused on the socio-cultural aspects of the migrant experience. The critical variables for understanding how migrants live among the hosts include their appreciation of the host environment, their competencies when interacting with the hosts in social settings, their understanding of the uniqueness of the hosts in comparison to their own home nations, and their desire to become part of the hosts. Bringing all the critical variables together, within the context of occupational adaptation, makes the IFAR a concise and integrated model for researching the experiences of highly skilled migrants in new environments. While this research focused on highly skilled migrants in the form of IMGs, there is potential for the IFAR to be applied to other types of highly skilled migrants, those with less skill or those who moved for other reasons such as avoiding conflict or for family reunification. It could also be used to study skilled migrants who may not need to endure very strict accreditation regimes in host nations.

This study also addresses the last gap identified by Kuo (2014) by providing empirical evidence from outside of North America. This study includes the investigation of migration experiences in the New Zealand context, the analysis of the experiences of the highly skilled, and finally in the context of medical migration. This last issue can at times be contentious when doctors from poor countries migrate, leaving critical workforce gaps in home nations, and when receiving countries fail to capitalise on the skills of such migrants, causing 'brain waste' (OECD, 2008; Zurn & Dumont, 2008; Daugeliene & Marcinkeviciene, 2009).

The IFAR model provides several enhancements to migration research which lead to potential new insights for the researcher and a reflective experience for the participants in the research. First, for the researcher, it allows the gathering of historical data through the reflections of the migrants, over a period of time. For the migrants, the IFAR approach allows them the ability to recall significant events that shaped their acculturation into host environments. Secondly, both the researcher and the migrants are guided through a structured cycle of critical milestones that have been identified to affect the acculturative process. For example, the interview schedule in this study was designed such that participants had the opportunity to begin their story from the moment they decided to come to New Zealand, through to the period of their journey to occupational success in New Zealand, and finally, to the stage of self-reflection, based on all the significant prior events, to decide whether they belonged in the host environment and to what extent. While the narratives of the participants were gathered at a single point in time, arguably also in the context of e-interviews, their adaptation experiences spanned several decades in New Zealand. This approach can be highly valuable for researchers if they wish to get a comprehensive account of the migrant journey from the beginning to the present, in a relatively short period of time. This approach also allows for in-

depth investigations into critical variables considered important such as the focus on occupational issues in this study. Finally, for migrants, it gives them the opportunity to be heard and thereby, assists host nations to make amends or improvements if migrants express feelings of marginalisation and isolation. One of the most recent participants, who was having a challenging time with work colleagues, noted after the interview that he found the whole process of talking about his experiences in New Zealand to be *therapeutic*.

8.3 Response to the Research Focus

The following specific questions were asked and the answers to these are stated below:

Q1. What are the barriers and enablers faced by IMGs when cross-culturally adapting to general practice work in New Zealand?

- The participants identified several barriers or challenges on their journey to occupational adaptation and success. One of the initial barriers was the inadequate recognition of their prior qualifications and work experience. Most of the participants were required to do further training to receive either their MCNZ registration and/or their Fellowship of the RNZCGP. The participants also had to adjust to the general practice environment in New Zealand. They had to learn about the unique aspects of the health system such as the role of ACC and PHARMAC, and about the public/private funding mix and a fee-for-service model, which was a change in general practice culture for many. They had to deal with the perceived poor links between primary and secondary care, the excessive paperwork requirements, the challenges presented by the diverse patient population and their increasing chronic disease burden. Many of the above noted challenges are present in most OECD and developing countries as reported in the literature. Some of the IMGs had to deal with professional antagonism from local doctors in the workplace and also had to deal with difficult and non-compliant patients. Those who worked in socio-economically deprived areas noted that their patient populations had a greater disease burden, and were facing many social issues when compared to patients in less deprived areas. Additionally, those working in rural areas, which were often small towns, noted having to travel long distances to access training and other essential services.
- The participants also reported being challenged by other socio-cultural factors. Some noted that New Zealand was not as clean and green as was being portrayed internationally. New Zealand was also perceived to be a great place to bring up children; however, it was seen by some to have higher rates of child abuse, family violence and poverty than other developed countries. They saw New Zealand's infrastructure as fragile and susceptible to frequent adverse weather and natural disasters. To a

certain extent, New Zealand was seen as very parochial, possibly due to its isolation and newness as a nation. Some of the above occupational and social issues continued to challenge the participants even after being in New Zealand for many years.

- Despite the barriers, the participants reported that the enablers of their occupational adaptation in New Zealand included their relative young age (between 24-40 years old) and strong desire to become general practitioners (GPs) so that they could work in local communities and deal with a variety of medical conditions that would not have been possible in hospital-based careers. They also noted that general practice provided them with flexibility that allowed for a better work/life balance including the ability for female GPs to raise young families and work as they desired. The participants reported that the support and mentoring they received during their training period enabled them to succeed. They recommended mentoring as the single most important support system for new IMGs who wanted to become doctors in New Zealand. The professional antagonism that some participants reported did not deter them from adapting and working in general practice in New Zealand.
- In regard to their social adaptation to New Zealand, the participants reported being supported by friends, colleagues and members of their ethnic networks, either from within their workplace or from the community in which they worked. Their love for the great outdoors and the lifestyle choices available meant that they liked living and working in New Zealand. Despite the challenges, the majority considered themselves to be New Zealanders. Even those who did not consider themselves to be New Zealanders mentioned that they planned on continuing to work and live here.

Q2. For highly skilled migrants, what is the role of occupational success in their overall acculturation to new environments?

- This research has argued and demonstrated using the narratives of IMGs that occupational success is a key predictor of overall acculturation of highly skilled migrants to new environments. This argument is based on the premise that highly skilled migrants move to new environments to pursue their careers and if they are able to achieve that and get satisfaction from their careers, then they are more likely to acculturate to the host nation. The initiation of the occupational process has to be supported by the key institutions within the host environment so that highly skilled migrants do not face overwhelming challenges. The literature cited in this study and the findings of this research demonstrated that the age and the length of stay in the host nation are important factors in the acculturation process. Younger skilled migrants are more likely to complete training

requirements in order to get accreditation in new environments. Additionally younger skilled migrants who achieve early occupational success may stay for longer in host nations. The MCNZ workforce report (2013) showed that IMGs between 30-49 years old remained in New Zealand for longer. In addition to age and length of stay, the work environment has to be conducive to accommodate the needs and aspirations of the highly skilled migrants so that they do not get disenchanted and leave for better opportunities. From this research, there is evidence that poor work environments can affect IMGs when considering their stay in New Zealand. Therefore, younger skilled migrants who achieve their occupational goals, in a reasonable amount of time with few challenges, and who are well supported in their work environment will most likely remain and acculturate to the host nation.

- Skilled migrants who do not achieve occupational success in host environments will either leave for another country or return home, or work in occupations that do not adequately utilise their skills. While the latter cohort remains in the host nation, their level of acculturation may vary. While this research has not directly shed light on this scenario, there is evidence in literature that such migrants often find it hard to cope with occupational failure and may face mental health issues. It is highly unlikely that such migrants would assimilate or integrate into host societies. They may either isolate themselves or remain within their ethnic enclaves where they may find support systems. Some skilled migrants from developing countries may find that the remuneration they receive from alternative employment in host nations fulfils their expectations and so they decide to stay. Again, their level of acculturation will vary depending on other factors such as host's receptivity and their overall satisfaction regarding their alternative employment and life in general.

Q3. How appropriate are e-interviews, as a research tool, in qualitative and ethnographic research?

- This research supports the use of e-interviews in ethnographic studies but only with certain criteria being met as explored in the Discussion chapter. First, it would be helpful for the researcher to have some understanding and personal experience of the background and context within which the interviews are occurring, to facilitate the participant experience or the insider-outsider role. Secondly, the researcher will need to clearly demonstrate that e-interviews would be better than any other form of data collection. This is crucial to maintain the relevance and validity of the research methodology. Thirdly, the e-interviews would benefit from being short and specific to certain areas of inquiry. Fourthly, the use of good IT systems is essential so that data is not lost and can be recovered if systems

fail for any reason. Additionally, good rapport is needed to maintain the participants' interest, especially in comprehensive studies such as this. Furthermore, demonstrating credibility to online participants could enhance the quality of the responses, as seen in this study where participants shared very personal experiences that may not have been forthcoming otherwise. Lastly, given the extensive use of communication technology in most countries, all types of immigrant groups across national and international boundaries could be accessed for a study such as this.

8.4 Strengths of this Research

In undertaking this research, several milestones were achieved that enabled the completion of this project. These included:

- The originality of the study question, and its current relevance among the involved stakeholders;
- The support for this research from key institutions such as the RNZCGP, the University of Otago, and the New Zealand Health and approval for the study from the Disability Ethics Committee;
- The breadth of literature covered including from sociology, anthropology, economics, migration policy, highly skilled migrants theories and cross-cultural adaptation theories;
- The willingness of the participants to share their stories;
- The relatively straightforward recruitment of enough participants, based on the prescriptive criteria for selection;
- The ability to experiment with different data collection methodologies – the use of face-to-face and e-interviews;
- The characteristics of the participants allowed for comparisons across:
 - Historical timeframes
 - Hospital settings versus general practice settings
 - English-speaking versus Non-English speaking countries of origin
 - Gender and age differences
 - Urban and rural experiences of general practice
 - Different data collection methodologies
- The willingness of key institutions to provide their perspectives; and
- The quality feedback from highly experienced supervisors that enabled critical thinking.

8.5 Limitations of this Research

The limitations of this research include the:

- Focus on IMGs working in general practice rather than including those who work in hospital-based specialties;
- Lack of more recent IMGs in the study;
- Lack of participants who came as IMGs but did not succeed and are still in New Zealand;
- Lack of participants who came as IMGs but left New Zealand for whatever reason;
- Withdrawal of a participant, post-interview, who had provided valuable insights into their experiences of migration to New Zealand; and the
- Generalisability of the findings given its qualitative nature.

8.6 Recommendations for Future Research

The limitations of this thesis also provide opportunities for future research including:

Research on migrants to New Zealand:

- Applying the IFAR model to investigate the acculturative journey of other health professionals and other non-medical highly skilled migrants such as engineers, teachers, and architects. It would be interesting to see to what extent the experiences of the IMGs in this study match those of other highly skilled migrants. An international comparative study would also be possible.
- Adapting the IFAR to a survey-based research approach to capture a larger sample of IMGs, and to validate or contradict the findings of this thesis. This type of research design could be applied across all the medical specialties, and all types of health professionals. Such a study could allow for robust acculturative comparisons, both nationally and internationally.
- Applying the IFAR to highly skilled migrants who were not able to pursue their careers in New Zealand for whatever reasons or who did not remain in New Zealand. This study would provide further insights into the challenges faced by all types of migrants, and identify where improvements can be made by host institutions to better support such migrant cohorts.
- Applying the IFAR to all types of migrants who came for better career opportunities, so that occupational adaptation can be further validated as a good predictor of acculturation and integration.

- Investigate the use of e-interviews as an alternative or as a complement to other data collection methods in any of the above opportunities. This would further validate e-interviews as a qualitative research tool for certain types of research designs, and certain types of study participants.
- Investigate whether New Zealand's immigration policies align with the WHO Global Code of Practice on the International Recruitment of Health Personnel in terms of attracting and approving immigrant health professionals. The aim of the Code is to ensure that all people have the right to the best standards of health care including universal health care, and the right for health professionals to move to any country that wishes to have them as part of their health workforce (Siyam & Poz, 2014). It is important that New Zealand is not benefiting from medical migration to the detriment of poorer countries.
- Continue to investigate the labour market and settlement outcomes for all types of migrants.

8.7 Research to Inform Institutional Policy in New Zealand

The following research recommendations are made in light of the discussion of the literature and results of this thesis. It is aimed at professional institutions such as the RNZCGP, the MCNZ and Health Workforce New Zealand (HWNZ):

- Urgently review the future medical workforce demand and supply, especially in the context of increased number of local graduates and the stagnation of new employment opportunities within the secondary health system. New Zealand should not be seen to be complicit in any 'brain waste' given the shortage of medical professionals in developing nations. There is evidence that 'brain waste' among IMGs in New Zealand is starting to happen. Such a review should in turn inform immigration and recruitment policies in New Zealand, especially in the context of attracting long-term migrants.
- Explore opportunities to attract IMGs into general practice who are already registered to work in New Zealand but cannot find employment in hospitals. The RNZCGP could advocate for recognition and further training to facilitate the career transition of such IMGs. However, it is unclear how many such doctors are in New Zealand. Some anecdotal evidence suggests approximately 40 such doctors are currently looking for medical work. General practice could benefit from any added supply of doctors.
- Review the formal and informal support systems including any current mentoring models, to establish if they are appropriate for assisting IMGs

into medical careers. The IMGs in this study saw the mentoring of new IMGs as critical to occupational adaptation, and the extent to which mentoring is available to all IMGs wanting to practise in New Zealand was unclear from this study. The RNZCGP could explore/develop and test different mentoring models for different situations and different IMGs based on country of origin.

- Investigate mechanisms whereby refugee health professionals could be tested and trained to work in New Zealand. This could become highly relevant with the expected influx of refugees from Syria, some of whom maybe health professions. Again, the RNZCGP could facilitate this discussion in light of the aging GP workforce and future demand.
- Strengthen the links between the MCNZ and various professional bodies to expedite the assessment process regarding the recognition of prior learning. IMGs forgo an economic opportunity while waiting for assessment decisions which can take several months. This experience itself may affect IMGs' length of stay in New Zealand, as there is evidence of excessive paperwork requirements hindering timely decision-making.

Overall, this research has aimed to fill gaps in current knowledge on IMGs in New Zealand, and used this finding to inform a concise and integrative framework for acculturative research on highly skilled migrants. The IFAR model has been designed to capture new elements of the migrant journey, with the main focus being on occupational acculturation and adaptation. The purpose of developing a concise model for studying acculturation was to integrate more of the knowledge gained through prominent disciplines of sociology, anthropology, economics and intercultural communications. This model does not invalidate existing models for acculturative research; rather it makes the IFAR suitable for studying occupational adaptation as a key predictor of overall acculturation of migrants into host societies.

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Appendices

Appendix A: The New Zealand Medical Register

(MCNZ Annual Report, 2014)

Country	Provisional general	General	Provisional vocational	Vocational	Special purpose	Total	Number with practising certificates
England	1,269	1,269	34	1,286	24	3,882	1,904
South Africa	68	245	14	766	12	1,105	734
United States of America	563	101	77	250	111	1,102	357
Scotland	293	365	9	369	3	1,039	512
Australia	10	580	2	352	3	947	391
India	80	245	25	377	16	743	471
Ireland	221	187	7	78	1	494	196
Germany	90	81	23	123	2	319	177
Wales	131	111	-	55	3	300	113
Sri Lanka	9	83	2	180	11	285	140
Canada	132	25	5	67	12	241	72
Iraq	6	72	1	97	1	177	103
Netherlands	88	27	9	38	-	162	83
Pakistan	22	62	3	33	2	122	76
Bangladesh	7	41	1	70	-	119	54
Sweden	65	14	9	14	-	102	11
China	5	39	-	56	-	100	73
Egypt	9	27	2	52	-	90	50
Northern Ireland	36	28	-	25	1	90	41
Fiji	1	17	-	45	14	77	64
Philippines	5	27	3	26	-	61	38
Russia	7	30	1	18	-	56	43
Poland	13	23	2	12	-	50	30
Zimbabwe	2	6	3	33	1	45	37
Yugoslavia; Federal Republic of	3	16	1	24	-	44	26
Nigeria	15	16	2	7	3	43	19
Singapore	8	10		21	1	40	18
Belgium	16	10	2	9	-	37	19
Romania	6	13	1	14	1	35	23
Italy	10	8	3	12	-	33	18
Denmark	15	11	2	5	-	33	9
Austria	19	6	1	1	-	27	9
Myanmar	2	9	-	13	1	25	14
Hungary	6	6	1	11	-	24	16
Czech Republic	7	10	-	5	-	22	14
Switzerland	9	3	1	8	1	22	7

Ukraine	2	14	1	4	-	21	18
Spain	4	4	2	9	1	20	15
Malaysia	2	6	-	7	2	17	14
Croatia	1	6	-	9	1	17	11
France	4	6	2	5	-	17	11
Bulgaria	1	6	-	8	-	15	12
Zambia	1	6	1	5	-	13	9
Finland	6	5	1	1	-	13	8
Iran	1	6	1	4	1	13	7
Mexico	4	1		6	1	12	4
Colombia	1	3	2	3	2	11	7
Sudan	3	5	-	2	-	10	9
Papua New Guinea	1	-	-	9	-	10	8
Norway	2	-	-	8	-	10	7
Brazil	2	4	1	3	-	10	6
Nepal	4	3	-	2	1	10	5
Dominica	7	1	-	-	2	10	4
Israel	1	4	-	2	3	10	4
Other ¹	45	64	4	73	9	195	119
New Zealand	424	4,497	-	5,712	-	10,633	8,141
Total	3,764	8,464	261	10,424	247	23,160	14,381

Appendix B: Ethics Approval



Health and Disability Ethics Committees

1 the Terrace
PO Box 5013
Wellington
0800 4 ETHICS
hdecs@moh.govt.nz

02 May 2014

Mr Madhukar Pande
40 Bassett Rd
Johnsonville
Wellington 6037

Dear Mr Pande

Re:	Ethics ref:	MEC/06/09/107/AM01
	Study title:	The cross-cultural adaptation of international medical graduates (IMG)/overseas-trained doctors (OTDs) to the work culture of general practice in New Zealand

This letter is to confirm approval of the annual progress report for this study, reviewed by the Chairperson of the Northern B Health and Disability Ethics Committee on 30 April 2014. Existing approval remains valid.

Your next progress report is due by 16 October 2014.

Please don't hesitate to contact us for further information.

Yours sincerely,

A handwritten signature in black ink, appearing to read "R. Sporle".

Mrs Raewyn Sporle
Chairperson
Northern B Health and Disability Ethics Committee

Encl: appendix A: documents submitted

Appendix C: Participant Consent Form

PARTICIPANT INFORMATION SHEET

Title: The Cross-cultural adaptation of overseas-trained doctors (OTD) to the work culture of general practice in New Zealand.

Principal Researcher: Mr. Madhukar Mel Pande

Address: Level 3, 88 The Terrace,

Wellington.

Ph. (4) 915 4936

Email: mel.pande@rnzcgp.org.nz

Personal Note: This study contributes towards the achievement of the Doctor of Philosophy degree for the principal researcher.

Introduction:

It is the aim of this research to investigate the challenges faced by OTDs in adapting to working as general practitioners in New Zealand. The findings will be valuable in identifying areas where various stakeholders can channel their resources and expertise to make it easier for OTDs to adapt and provide quality primary health care to the populations.

The three broad categories that will be investigated with regards to OTD GPs in New Zealand will include:

- Positive aspects of general practice
- Negative aspects of general practice
- The Way Forward for general practice

Underlying these three will be sub-categories of:

- Rural and urban differences/similarities
- Lifestyle issues
- Partner/Family issues
- Working conditions including stress factors and morale levels
- Clinical and other training needs
- Opportunities for CME
- Community participation and involvement
- Other significant events and issues.

A copy of the full proposal is available to participants to make an informed consent decision if they wish.

Study Design

This report will be based on data collected from OTDs working in general practice in New Zealand. The primary data will be based on the interviews with selected OTDs. Most the OTDs selected for interviews will be in full time employment. The secondary data will be based on literature concerning OTDs, migrant issues, cross-cultural adaptation, work culture, professional development, and around specific issues as identified by OTDs

The questions asked will mostly be open-ended. The idea behind open-ended questions is to encourage participants to discuss issues rather than just state them. Since this will be a qualitative research project, a relatively small, representative sample will be selected (the sample would be purposively sampled from OTDs in general practice): approximately 20-25 participants will be selected based on:

- They being overseas-trained;
- They being vocationally registered (It is important to have fully experienced the qualifying process);
- They being currently in fulltime general practice (Some GPs in part-time work may be considered only if a fulltime alternative is not available).
- They being willing to participate given the aims and objectives of the study, especially the methodology.

The ethnicity criteria will be used to select half the sample from English speaking countries (UK, Canada, Australia, etc) and the other half from non-English speaking countries (India, Sri Lanka, other Asian countries, etc). Furthermore, the sample plans to include approximately 40% (10) female participants, as this is the same proportion as females in NZ OTD GP workforce. It is also planned that sample will be an approximate representation of the urban/rural spread of GPs; 80% urban, and 20% rural. The sample will also aim to take into account the geography i.e. North and South Island.

It would ideal if the study attracted enough OTDs that fulfilled all of the above criteria. However, since this a qualitative survey, and the initial sample will self-select, this study will be open to certain sample modifications. It would seem that if the sampling criteria were to be ranked then the following would apply to the sample population:

1. 50/50 split between OTDs from English-speaking (where English is the first language) and non-English speaking countries.

2. 70/30 split between urban and rural GPs
3. 70/30 split between male and female GPs
4. 70/30 split between North and South Island GPs.

The tools of ethnographic studies are personal interview, focus groups, participant observation, content analysis, and case studies. It has been suggested that video recording of interviews would be very valuable, thus selected participants would be asked if they would like to be videotaped as part or for all of the interview process. Since the interview process itself can be rather time consuming and expensive (travel distances are great for some areas), alternative or hybrid methods within the qualitative research paradigm can be employed. The use of technological advancements in communication can be used, i.e. emails and Internet.

If the study supervisors and participants agree, email could be used as a complementary data collection tool to face-to-face interviews. This data collection method would work as such: every week for 2-3 months, one open-ended question will be emailed to the participants to answer via the email technology. The way e-interviews would work can be tailored to each individual participant's needs. This form of e-interview allows the participant to consider the question in-depth and answer appropriately, saves the interviewer on interview and travelling costs, and allows for the experimentation of a new form of communication tool for a large qualitative research. I have employed e-interviews for some smaller research, and have found it to be a very useful qualitative research tool. Please note that this tool will not replace face-to-face interviews unless agreed upon by the researcher and the participant. If this method (e-interviews) is acceptable then the face-to-face interview will be used to gather information deemed interesting and encapsulating of the broad experiences of general practice in New Zealand. This face-to-face interview would be ideal for videotaping. Also, if a participant prefers face-to-face interviews, then e-interviews may be appropriate for some follow-up or clarification type questions. In any case, participants will have the final say in the matter.

The data collected will be analysed using the practices and principles of thematic analysis. The computer software *NVivo*® will be used to code/analyse the information gathered. The data will be analysed for recurring themes and important/significant issues. A small but significant amount of statistical data around demography will also be generated and reported. The themes and issues that will be discussed are more important than the statistical significance of the sample size. The literature search and review are also an integral part of this research.

Confidentiality

The principal researcher would like to assure all participants that the information they provide would be kept confidential and secure (In a locked cupboard with access only to the principal researcher). All video-recorded face-to-face interviews will also be kept secure in locked-up facilities at the College. Anonymity is assured to all participants whereby alias or codes will be used to identify participants in the study report. Participants will be given an option to select an 'alias' (eg. 'Tim' instead of their proper name Timothy) to be used to identify them when discussing the results in the study report. It is hoped that having an 'alias' would make representation of participants more meaningful.

All information gathered including video-recordings of interviews would be kept secure and confidential for up-to five years after the completion of the study before being destroyed. Participants will be offered the opportunity to get copies of the information they provide prior to the information being destroyed.

Therefore,

As the **principal researcher**, I promise to:

1. Be transparent and accountable to all participants, supervisors and sponsors with regards to my conduct and progress in this study;
2. Keep all information provided by participants secure and confidential;
3. Allow participants to unconditionally withdraw from this study at any time.

As a **participant in this study**, you agree to:

1. Provide accurate and timely feedback to questions asked for the purpose of this study;
2. Being contacted via email with questions asked for the purpose of this study;
3. Allow video recording of my face-to-face interview (Video-recording of the interview is not compulsory to the participation in this study, but the face-to-face interview or the e-interview is).
4. Review transcripts to demonstrate my clear intent as recorded by the principal researcher.

I, _____ (**Participant Name plus an alias**) have read or listened to the above information and I have decided that I will participate in the study described above. The principal researcher has explained the study to me and answered my questions. I know what will be asked of me. I understand the purpose of the study is to find out more about the challenges

faced by OTD GPs working in New Zealand. I also understand that this study contributes towards the investigator's PhD. If I don't participate there will be no penalty or loss of rights. I can stop participating at any time, even after I have started.

I agree to participate in this study.

I agree to be videotaped at the time of my face-to-face interview (please cross out if you disagree)

Participant's Signature: _____ **Date:** _____

I, **Madhukar Mel Pande**, have explained to the above named individual, the nature and purpose, the potential benefits associated with participating in this study. I have answered any questions that have been raised and I will provide the participant with a copy of this consent form.

Madhukar Mel Pande _____ **Date:** _____

(Principal Researcher)

For any further enquiries please contact the principal researcher on the contact details listed above.

Appendix D: Participant Interview Schedule

Demographics (some of this will be known prior to the interview)

Thank you very much for agreeing to participate in this study. I really appreciate you making time for this. Before getting into the interview proper, I would just like to ask some questions about your current work.

1. Name:
2. Age:
3. Sex:
4. Ethnic identity:
5. Cultural identity (*Your ethnic and cultural identity can be one and the same or it may be slightly different e.g. European and German or vice-versa respectively. Essentially ethnicity is inherited and culture is learnt. So you could be of Indian ethnic background but brought up in a Western society. Therefore your cultural identity may be more complex than your ethnic identity. Please state as clearly as possible what you perceive to be your cultural identity*):
6. What is your current work status?
 - a. Are you self-employed, or salaried, locum or other; part-time or fulltime?
 - b. Where do you currently work in New Zealand?
 - c. Is it in rural or urban NZ (Do you work in an area with <20,000 or does the practice you work in have a rural ranking score?)
 - d. Do you work in a subspecialty area (e.g. dermatology)?
 - e. How many hours per week do you spend in general practice work?

I will first start by asking about your basic medical training and the reasons for migrating to NZ. Then I will ask about any training you undertook when you got here, and how it prepared you for work. I will ask about your work environment and the challenges you had and are still facing. Finally I will briefly ask about your adaptation to NZ as a whole. You are welcome to refuse answering any question if it makes you uncomfortable. You can seek any clarifications about the questions at any time. So just relax and take your time answering the questions as best you can. I will try to make it as painless and enjoyable as possible.

7. In which country did you get your basic medical training?
 - a. The University?
8. When did you arrive in NZ (Year)?
9. How many years of medical practice did you have prior to coming to NZ?
 - a. What type of medical work were you doing?
 - b. How many years of general practice or similar experience did you have prior to coming to NZ?
10. Did you work in another country (other than your country of origin) prior to coming to NZ?
 - a. If yes then please state the country (s):
 - b. Did you work in general practice or in a similar environment?
 - c. How many years did you work in this country (s):

Migration to NZ

11. What were the main reasons for migrating to NZ?
 - a. What category did you migrate under?
12. How did you hear about NZ?
 - a. How much information about NZ did you have prior to migrating?
 - b. What were your sources of information?
 - c. Was the information useful?
13. Did you know anyone in NZ prior to arriving here?
 - a. If yes, then did you request any assistance from them when you first came here?
 - b. Were you accompanied by any family members when you arrived in NZ?
14. What were your first impressions about NZ?
15. What difficulties/challenges did you face when you first arrived here?
 - a. How did you overcome these difficulties/challenges?

Professional adaptation

I would now like to ask you about your professional adaptation; about your training in NZ and subsequently your work in general practice.

General

16. Before going further, why did you choose general practice as opposed to other medical specialties (in NZ)?
17. So generally, how much information did you have about employment opportunities in NZ?
 - a. About general practice employment opportunities?
 - b. What were your sources of information on employment opportunities?
 - c. How useful was this information?
18. Did you have a job offer in medicine or general practice in NZ prior to coming to here?
 - a. If yes, then please describe how you went about securing a job prior to coming to NZ.
 - b. If no, then please state what you planned on doing upon arriving in NZ.
19. Did you have your medical qualifications assessed by NZ authorities prior to or after coming to NZ?

Training

The majority of IMGs/OTDs have to do some form of training prior to being allowed to practice independently.

20. How much further training were you asked/required to do? (Please state the training programmes)
21. What difficulties/challenges did you face while training to become a general practitioner (GP) in NZ?
22. What forms of assistance and support (mentoring, financial) did you get in overcoming the difficulties/challenges you faced while training to become a GP?
23. (If you got no assistance and support): Would some assistance and support been helpful in your training?
 - a. Would it have made a difference to your training experience?

24. What opportunities did you have to train with NZ graduates doing the same training programme as you?
- How was your experience of training with NZ graduates?
 - What about your experience of training with other OTDs/IMGs?

Many IMGs/OTDs, especially from non-English speaking countries need to show their competence with the English language.

25. Did you have to do an English language test?
- If yes then please state which one:
 - If yes, what are your views on the English test in terms of its difficulty and relevance to your subsequent work environment:

If you were not required to do an English test;

26. How difficult/challenging was it to adjust to NZ English (colloquial language)?
27. Did you do any self-training in NZ English to better communicate with your patients, peers, and other health workers?

I would now like to ask about any training you might have received to acknowledge the cultural diversity of the patient population.

28. What training did you receive to address the cultural diversity among patients in NZ?
- What forms of training did you receive to acknowledge and appreciate the special status of Māori in NZ?
 - Overall, how difficult/challenging was the training in cultural diversity?
29. If no cultural training given then would some cultural training have been useful?

Ok, so having completed some general practice training in NZ:

30. Eventually, how long did your training in general practice take before you were able to work independently?
31. What are your views on the relevance and importance of the training you received prior to being allowed to practice independently in NZ?
- What part of the training programme (s) did you like the most?
 - What part of the training programme (s) did you like the least?
 - What changes would you suggest be made to the training programme?
32. What types of support should OTDs/IMGs receive in-order to succeed in the general practice training programmes?
33. Do you know of other OTDs/IMGs who did not succeed in becoming GPs in NZ?
- If yes, do you know what they are doing now?
34. Overall, did the training you received in NZ prepare you adequately for general practice here?
- If no, then what more could have been done?

I would now like to talk about your work experiences.

Work

35. How difficult was it to find a general practice job of your choice (e.g. urban or rural practice)?

36. What difficulties/challenges did you face when you first joined general practice in NZ?
- How did you deal with these difficulties and challenges?

With regards to your patient population:

37. Currently, do you work in a high needs or low needs area? (Deprivation index?)
- What are some of the challenges you face working in this area?
 - Which ethnicities comprise your patient population?
 - Do your patient populations have a higher prevalence of any particular disease/illness when compared to the rest of the population? (Please elaborate)

Some IMGs have mentioned having difficulties with patients from cultures different to theirs.

38. Has your own cultural or ethnic background been an issue with your patient population?
- Both positive
 - Negative events

Earlier on I asked if you had received any training on cultural diversity:

39. How useful was your training in cultural diversity/sensitivity in providing health care to patients of different cultural backgrounds?
- Are you aware of the cultural demands of your patient population when consulting or treating them? (Please elaborate)
 - Has language been a barrier with patients of different cultural backgrounds?
 - How do you manage patients who have difficulty communicating in English?

If you have Māori patients:

40. How relevant was your training in cultural diversity (with a focus on Māori culture) in providing health care to Māori patients?
- In your opinion has their feedback, and health outcomes been positive?
 - Do you see a need for more training in cultural diversity as NZ becomes multicultural?
41. If you received no formal training in cultural diversity/sensitivity, did you have any difficulties when treating Māori patients?
- Do you still have any difficulties?
 - Would some formal training be useful?

Some IMGs have suggested that they attract patients of their own ethnicity or country of origin, especially those that speak the same language as their GP.

42. Have you experienced such trends in your practice?
- What are some difficulties/challenges in treating patients from your ethnic group?

In relation to the people you work with:

43. What impact do you think your culture has on your work?
44. Has your own cultural or ethnic background been an issue with your peers?
- Positive events?

- b. Negative events?
- 45. Has your own cultural or ethnic background been an issue with other health workers?
 - a. Positive events?
 - b. Negative events?
- 46. How have you dealt with negative events due to your ethnic or cultural background in relation to your work?

Continuity

- 47. Do you intend to continue working as a GP in NZ (barring retirement)?
 - a. If no, then what do you plan to do in the near future?
- 48. What difficulties/challenges do you continue to face despite being qualified to work independently in NZ?
 - a. How do you deal with these difficulties/challenges?
- 49. How well does the income you earn in NZ (general practice) compare with your country of origin or in another country where you have worked?
- 50. Can you describe how general practice in NZ is similar to your country of origin?
- 51. Can you describe how general practice in NZ is different to your country of origin?
- 52. In your opinion what are the key features/characteristics of NZ general practice?
 - a. What do you like about general practice in NZ?
 - b. What do you dislike about general practice in NZ?

One of the most important and meaningful experiences for any immigrant is their social adaptation into their new environment. Often some immigrants have few difficulties while others have many difficulties. I would like to know how it was for you.

Social/cultural adaptation

- 53. Generally, what were some difficulties/challenges you faced when you first arrived in NZ? (Weather, language, food, making friends, etc)
 - a. How well did you speak the English language prior to coming to NZ?
 - b. How many languages other than English do you speak? (Please state them)
 - c. How did you find communicating with the locals?

If you came with your family:

- 54. What first impression did your family have of NZ?
 - a. What types of difficulties/challenges did they initially face here?
 - b. Were there any special requirement such as schooling, and spouse's employment concerns that influenced your decision to choose general practice?
 - c. Did you have difficulties meeting these requirements?
- 55. Were there times when you thought of going back to your country of origin or to another country?
 - a. If so why?

And now having lived here for a number of years

- 56. Do you feel that New Zealanders have a better understanding of your culture now than they did when you first came here?

- a. Do you feel you have a better understanding of the NZ way of life/culture now?
- 57. In your opinion, what are the main features/characteristics/beliefs that make NZ different to your country of origin or to any other country for that matter?
- 58. In your opinion, do you get to practice and promote your cultural beliefs openly and freely?
 - a. If no, than why do you think this may be so?
- 59. In your opinion, what do immigrants need to know and practice in-order to better adapt to NZ?
- 60. Overall, how difficult has it been adjusting to life in NZ?
- 61. If you had the opportunity, what would you do differently (in relation to adaptation), and why?
- 62. Do you feel that a time will come when you will feel more like a New Zealander, than an immigrant?
- 63. Having been here for sometime, do you see NZ as you home now?
- 64. Would you recommend NZ to your friends, relatives and acquaintances for the purpose of settlement?
 - a. If yes, why?
 - b. If no then why not?)

I would like to thank you very much for taking the time out to talk to me today. It has been a really pleasure hearing your story, about the challenges you faced and how you overcame them.

65. Before we finish here today is there something else you would like to share about your experience of being an IMG/OTD in NZ?

Thank you very much for your time. If you wish I will forward you a copy of the transcript of this interview. If you agree than I may call you seeking clarification about something you said today. I would once again like to assure you that confidentiality will be maintained regarding what you have shared with me today. Once again thank you for your time.

Appendix E: Stakeholder Consent

STAKEHOLDER INFORMATION SHEET

Title: The Cross-cultural adaptation of International Medical Graduates (IMGs) to the work culture of general practice in New Zealand.

Principal Researcher: Mr. Madhukar Mel Pande

Address: 40 Bassett Rd, Johnsonville

Wellington.

Ph. (4) 477 9085

Email: melpande@yahoo.co.nz

Personal Note: This study contributes towards the achievement of the Doctor of Philosophy degree for the principal researcher.

Introduction:

It is the aim of this research to investigate the challenges faced by IMGs in adapting to working as general practitioners in New Zealand. The findings will be valuable in identifying areas where various stakeholders can channel their resources and expertise to make it easier for IMGs to adapt and provide quality primary health care to the populations.

The three broad categories that will be investigated with regards to IMG GPs in New Zealand will include:

- Positive aspects of general practice
- Negative aspects of general practice
- The Way Forward for general practice

Underlying these three will be sub-categories of:

- Rural and urban differences/similarities
- Lifestyle issues
- Partner/Family issues
- Working conditions including stress factors and morale levels
- Clinical and other training needs
- Opportunities for CME
- Community participation and involvement
- Other significant events and issues.

A copy of the full proposal is available to stakeholders to make an informed consent decision if they wish.

Confidentiality

The principal researcher would like to assure all stakeholders that the information they provide would be kept confidential and secure (In a locked cupboard with access only to the principal researcher). All audio-recorded face-to-face interviews will also be kept secure in locked-up facilities. Anonymity is assured to all stakeholders unless prior agreement has been reached to use their name and/or title in the thesis.

Therefore,

As the **principal researcher**, I promise to:

4. Be transparent and accountable to all stakeholders, participants, supervisors and sponsors with regards to my conduct and progress in this study;
5. Keep all information provided by stakeholders and participants secure and confidential;
6. Allow stakeholders and participants to unconditionally withdraw from this study at any time.

As a **participant in this study**, you agree to:

5. Provide accurate and timely feedback to questions asked for the purpose of this study;
6. Being contacted via email with questions asked for the purpose of this study;
7. Allow audio-recording of my face-to-face interview;
8. Review transcripts to demonstrate my clear intent as recorded by the principal researcher;
9. Permit the use of your name and/or occupational title in the Thesis

I, _____ (**Stakeholder Name**) have read or listened to the above information and I have decided that I will participate in the study described above. The principal researcher has explained the study to me and answered my questions. I know what will be asked of me. I understand the purpose of the study is to find out more about the challenges faced by IMG GPs working in New Zealand. I also understand that this study contributes towards the investigator's PhD. If I don't participate there will be no penalty or loss of rights. I can stop participating at any time, even after I have started.

I agree to participate in this study.

I agree to be audiotaped at the time of my face-to-face interview (please cross out if you disagree)

I agree to the use of my name and/or occupational title in the Thesis.

Stakeholder's Signature: _____ **Date:** _____

I, **Madhukar Mel Pande**, have explained to the above named individual, the nature and purpose, the potential benefits associated with participating in this study. I have answered any questions that have been raised and I will provide the participant with a copy of this consent form.

Madhukar Mel Pande _____ **Date:** _____
(Principal Researcher)

For any further enquiries please contact the principal researcher on the contact details listed above.

Appendix F: Stakeholder Interview Schedule

1. Demographic Qs- Please tell me a bit about your role at_____?
2. What forms of support and advice do you provide to IMGs?
3. What forms of support and advice have IMGs requested?
4. Is there any other support/advice your organisation can provide but currently isn't?
5. What feedback have you received regarding the support/advice and training you provide to IMGs (from IMGs and others)?
6. In your experiences, what do IMGs need to do or know in-order to succeed becoming a GP?
7. How is the pathway to GP fellowship determined by IMGs country of origin/training, work experience, age, ethnicity, other factors?
8. How do you assist IMGs along the vocational pathway?
9. How successful are the IMGs who enter the Voc pathway way? (success rates)
10. What is it like working with the MCNZ to assist IMGs with re-certification?
11. What other organisations do you work with to assist IMGs?
12. What can be done to keep more IMGs in NZ after they qualify to work here?
13. What can your organisation do to help retain more IMGs?
14. Any other comments...
 - Note: Further probing questions will emerge depending on the responses provided.