The professional and social integration of International Medical Graduates working in rural communities of NSW: A study assessing the utility of Han and Humphreys’ (2006) typological analysis

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Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

…………………………
(Padma Ramnathan)
Abstract

The demand for health care professionals in Western developed nations cannot be supplied by local labour markets. One of the challenges countries face is matching the supply of doctors to the demand particularly in rural areas. To overcome these shortages, countries have designed workforce policies to suit this particular area of labour market need. Australia is not immune to this shortage and relies on recruiting International Medical Graduates (IMGs) particularly to address the demand for doctors in rural areas of Australia. In response to this, state, territory and federal governments have introduced various policy measures to facilitate the supply of doctors in rural areas. Integrating IMGs to a new health system and a new geographical place is important for the success of these policies. The integration of IMGs to rural medical practice areas influences their retention.

There is limited knowledge about the professional and social integration of IMGs in rural communities of NSW, Australia. Consequently, this thesis examines factors of integration and how this impacts on retention. A particularly distinct approach to integration is provided by Han and Humphreys' (2006) four-fold typology. The study identified four types of IMGs based on how well IMGs integrate in rural communities. This thesis reports analysis of semi-structured interviews of IMGs working in rural communities of NSW, to examine the factors of integration and how this might influence retention of IMGs. Twenty-five IMGs (n=25) from seven non-metropolitan Local Health Districts (LHDs) in NSW were interviewed. Analysis of the interview data broadens the understanding of the dimensions of integration and the relationship between IMG integration and rural area retention.

The thesis research revealed all IMGs were professionally engaged in rural practice. Their ability to use a variety of medical skills, provide continuity of care to patients, and develop doctor-patient relationships led to strong attachment to rural practice. Although they were critical of aspects of their experience, such as professional development, training and workload, their overall experience was positive and far outweighed the disadvantages of working in rural practice. They were engaged with
rural communities and their families were happy and settled. Some IMGs showed a strong willingness to work in rural communities beyond the terms of their initial employment contracts.

There were complexities in the application of the Han and Humphreys’ (2006) typology to the NSW located IMG interviewees. Although all IMGs could be aligned to the typology, parts of the typology had a highly limited application and the typology struggled to address clearly the experience of IMGs whose integration was conditional. Regardless of IMG attachment to rural practice, IMGs who are presently integrated may leave rural practice in the future mainly for family reasons (i.e. education and employment opportunities). The link between integration and retention was found to be complex. Integration influences retention but does not guarantee retention. Family, social or cultural factors challenge retention of IMGs in rural areas. The results of the study cast some doubt on the utility of the Han and Humphreys’ (2006) typology in geographically different jurisdictions.

Understanding the factors that underpin the process of integration may benefit the development of policy measures to facilitate integration of IMGs into the Australian Health system and rural practice. The findings of this thesis suggest that initial support is needed which can be provided by health organisations to integrate IMGs professionally in the Australian health system and in rural practice. Support is also needed to IMGs’ families for increased retention in rural communities. Results from this thesis could inform how health organisations design orientation and integration programs for IMGs. The findings make contributions to knowledge, policy and practice. However, the limitations of the research are acknowledged and these might diminish the value of generalisations and their application outside the NSW context. Future studies of integration can extend to other states of Australia and also to other groups of health care professionals working in rural communities. Similar examinations of integration of participants also provide an opportunity to develop Han and Humphreys’ (2006) typology, so that it encompasses a variety of geographical settings.
# TABLE OF CONTENTS

TABLE OF CONTENTS........................................................................................................... I
LIST OF TABLES ................................................................................................................ V
LIST OF BOXES ................................................................................................................ VI
LIST OF FIGURES ................................................................................................................ VI
ABBREVIATIONS ............................................................................................................... VII

CHAPTER 1........................................................................................................................... 1
INTRODUCTION ................................................................................................................... 1
  1.1 BACKGROUND TO THE STUDY ....................................................................................... 1
  1.2 AIM OF THE THESIS ....................................................................................................... 5
  1.3 RESEARCH QUESTIONS ................................................................................................. 6
  1.4 SIGNIFICANCE OF RESEARCH FINDINGS .................................................................... 6
  1.5 STRUCTURE OF THE THESIS ......................................................................................... 7
  1.6 CONCLUSION ................................................................................................................ 8

CHAPTER 2........................................................................................................................... 9
GLOBAL SHORTAGES OF HEALTH PROFESSIONALS .................................................. 9
  2.1 INTRODUCTION .............................................................................................................. 9
  2.2 MIGRATION OF SKILLED LABOUR BETWEEN COUNTRIES ......................................... 9
  2.3 RECRUITMENT OF FOREIGN TRAINED HEALTH PROFESSIONALS ......................... 13
  2.4 USE OF FOREIGN TRAINED DOCTORS AS A WORKFORCE SOLUTION TO ADDRESS LABOUR MARKET SKILL
     SHORTAGES ...................................................................................................................... 18
  2.5 CONCLUSION .............................................................................................................. 24

CHAPTER 3......................................................................................................................... 26
AN AUSTRALIAN PERSPECTIVE TO LABOUR AND SKILLS SHORTAGES OF DOCTORS ...... 26
  3.1 INTRODUCTION .............................................................................................................. 26
  3.2 RELIANCE ON IMGS TO SUPPLEMENT HEALTH NEEDS OF COMMUNITIES ............... 27
  3.3 AUSTRALIA’S POLICY RESPONSE TO MEETING THE DEMAND OF DOCTORS IN RURAL AUSTRALIA .......... 30
      3.3.1 Distribution of medical practitioners within the federal and state jurisdictions .............. 38
  3.4 IMGS AS AN AUSTRALIAN MEDICAL LABOUR FORCE – OUTCOMES OF POLICY RESPONSE .................. 42
  3.5 CONCLUSION .............................................................................................................. 44

CHAPTER 4........................................................................................................................... 45
INTEGRATION ...................................................................................................................... 45
LIST OF TABLES

TABLE 2.1: MEASURES TAKEN BY CANADA, UNITED KINGDOM AND UNITED STATES OF AMERICA TO INCREASE SUPPLY OF HEALTH PROFESSIONALS ....................................................... 21

TABLE 2.2: PATHWAY FOR HEALTH PROFESSIONALS TO ENTER AUSTRALIA: VISA GRANTS ........................................... 24

TABLE 3.1: ENTRY POINTS FOR IMGS TO AUSTRALIA ........................................................................................................... 32

TABLE 3.2 GOVERNMENT REGULATIONS AND POLICIES FOR RECRUITMENT OF IMGS IN RURAL AREAS ........... 35

TABLE 3.3: PATHWAYS TO REGISTRATION FOR IMGS (GPS) TO PRACTICE AS A DOCTOR IN AUSTRALIA ..........37

TABLE 3.4: STATE, TERRITORY AND THE FEDERAL GOVERNMENT INITIATIVES IN RESPONSE TO HEALTH WORKFORCE NEEDS .................................................................................................................. 41

TABLE 3.5: GP HEADCOUNTS – MAJOR CITIES, INNER REGIONAL, OUTER REGIONAL, REMOTE AND VERY REMOTE, 2015-2016 .................................................................................................................................. 43

TABLE 3.6: GPS IN AUSTRALIA – MAJOR CITIES AND REGIONAL, RURAL AND REMOTE AREAS, 2015-2016....... 43

TABLE 3.7: IMGS IN GENERAL PRACTICE (AUSTRALIA), 2004-2005 AND 2015-2016 ........................................... 44

TABLE 4.1: DOMAINS AND INDICATORS OF INTEGRATION; PREVIOUS STUDIES OF DOCTORS WHO HAVE MIGRATED OR RELOCATED.................................................................................................................. 61

TABLE 4.2: HAN AND HUMPHREYS’ (2006) CLASSIFICATION INTO FOUR TYPES (SIMPLIFIED DESCRIPTION) ...... 62

TABLE 5.1: NON-METROPOLITAN LHDS OF NSW SHOWING GEOGRAPHIC SIZE AND POPULATION OF THE REGION ............................................................................................................................................. 78

TABLE 5.2: REGION WHERE IMGS OBTAINED THEIR BASIC MEDICAL QUALIFICATION MBBS ................................. 80

TABLE 8.1: HAN AND HUMPHREYS’ (2006) CLASSIFICATION INTO FOUR TYPES (SIMPLIFIED DESCRIPTION) ..... 148

TABLE 8.2: DETAILED CHARACTERISTICS OF HAN AND HUMPHREYS’ (2006) TYPES ................................................. 149

TABLE 8.3: IMGS’ ALIGNMENT TO HAN AND HUMPHREYS’ (2006) TYPES ................................................................. 151
LIST OF BOXES

**Box 5.1: Layers of Abduction** ............................................................................................................... 76

**Box 5.2: Example of Interview Response Coding** .................................................................................. 87

**Box 6.1: Thematic Map Drawn from Analysis of Interview Data** ......................................................... 97

LIST OF FIGURES

**Figure 1:** Map of NSW showing the seven non-metropolitan LHDs of IMG participants of this thesis. ................................................................................................................. 79
ABBREVIATIONS

AAS    Additional Assistance Scheme
ABS    Australian Bureau of Statistics
ACRRM  The Australian College of Rural and Remote Medicine
AIHW   Australian Institute of Health and Welfare
AMA    American Medical Council
AMC    Australian Medical Council
AoN    Area of Need
AMG    Australian Medical Graduate
ASGC-RA Australian Statistical Geography Standard – Remoteness Area
CPD    Continuing Professional Development
DWS    District of Workforce Shortage
FWE    Full-Time Workload Equivalent
GPET   General Practice Education and Training Limited
GPRIP  General Practice Rural Incentives Program
GP     General Practitioner
HETI   The Health Education and Training Institute
HSCHA  House Standing Committee on Health and Ageing
HWA    Health Workforce Australia
IRS    International Recruitment Strategy
IMG    International Medical Graduate
MCQ    Multiple Choice Question
MBA    Medical Board of Australia
NSW    New South Wales
OECD   Organisation for Economic Co-operation and Development
OTD    Overseas Trained Doctor scheme
RACGP  Royal Australian College of General Practitioners
NSW RDN New South Wales Rural Doctors Network
RHWA   Rural Health Workforce Australia
RLRP   Rural Locum Relief Program
RWA    Rural Workforce Australia
WHO    World Health Organisation
WONCA  World Organisation of Family Doctors
CHAPTER 1

INTRODUCTION

1.1 Background to the study

There are evident global labour market skills shortages of health professionals comprising nurses, allied health care practitioners and doctors (Clark, Stewart & Clark 2006; Mackey & Liang 2012; Crisp & Chen 2014). The shortages cross the divide of developed and developing countries but are more endemic and stark in developing nations (Crisp & Chen 2014; Marchal & Kegels 2003; Taylor et al. 2011). Yet developed nations mobilise resources to attract health professionals, often from developing nations (Alutiss, Bishaw & Frank 2014; Bach 2004; Martineau, Decker & Bundred 2002). These responses address the challenge of matching the supply of health professionals to the demand for health care services, a challenge that is often more acute in rural communities (Han & Humphreys 2005 & 2006; Martineau, Decker & Bundred 2002; Terry et al. 2011).

To address the shortage of doctors in rural communities, various policy measures have been introduced (McGraill et al. 2012). These policy measures are framed by sustained public and media concern about inadequacies in health care provision. This includes the lack of services for the aged, waiting lists in the public health system and the inaccessibility of health services for rural communities. This is not to suggest that the policy debate is a seamless or uncontested one. Some commentators dispute that there is a shortage of doctors both generally or in rural areas specifically. The alternative proposition is that the supply of doctors is inefficiently distributed between metropolitan and non-metropolitan areas. This position asserts that metropolitan communities are over-supplied with doctor resources and this surplus workforce could be redistributed to areas of need, without the requirement for additional recruitment, by either migration or increased supply of medical graduates (Birrell 2011).

Recruiting International Medical Graduates (IMGs) has become a pragmatic policy solution in addressing doctor shortages in Australia (Zubaran 2011), a policy response that has largely enjoyed bipartisan political support. IMGs form 43 per cent of the GP (General Practitioner) workforce in regional, rural and remote areas of Australia
(Australian Government Department of Health 2016). Beyond the recruitment of IMGs to rural and regional areas, most frequently a mandated feature of their recruitment, policy discussion has extended to the integration and retention of IMGs in rural communities. This interest canvasses the direct and indirect measures and circumstances that facilitate the integration and presumed retention of IMGs in rural communities.

Within these contexts, retention of IMGs is highly valued for its return on recruitment costs and also for the increased stability of health care services in rural areas. Relevant here is the interest of policy makers in mitigating the internal migration of IMGs from rural areas to highly urbanised areas following the moratorium period that prevents their relocation for ten years. Such migration disrupts rural health services (Han & Humphreys 2006) and also serves to harm the reputation of IMGs. However, corresponding analysis of the propensity of locally trained doctors to seek and retain employment in rural areas is often overlooked. This interest underpins both the research and policy interest in integration; the underlying presumption is that IMGs who are integrated are more likely to be retained in the rural community. Evident also is the presumption that IMGs will take the opportunity to move to urbanised areas once the tenure of their initial recruitment contract are concluded (Han & Humphreys 2006; Terry et al. 2011). Yet integration is a variable concept, theorised as both a process and an outcome, and embracing a number of domains, including the professional and the social. There are limited studies in Australia that examine the professional and social integration of IMGs in rural communities with previous research on IMG focussing more on employment integration, professional and practice support (Carlier, Carlier & Bisset 2005; Gilles, Wakeman & Durey 2008; Han & Humphrey 2005; Spike 2006; Terry & Lê 2013). This thesis is interested in examining IMGs’ professional and social experience in rural communities of the state of New South Wales (NSW), Australia. In this thesis, the term ‘rural’ is used as an umbrella term embracing remoteness, regionality and non-urban areas. The findings may assist in shaping policies designed to integrate and retain IMGs in rural communities of Australia. It can be beneficial to recruiters, workforce planners, policy-makers and health organisations (sections 9.4 and 9.5). Findings from this thesis may assist policy in several ways: by more carefully aligning IMGs to rural regions; recruitment processes may need to be more nuanced and interrogate more deeply the needs of
IMGs, and use in-depth knowledge about the needs of rural regions. Health organisations may benefit by using insights from this thesis in training and devising integration programs for IMGs.

**The Australian health system**

Australian Institute of Health and Welfare (2018) describes Australia’s health system as various connected health systems, rather than one unified system. It comprises of health professionals and service providers from a range of organisations, from all levels of government and the non-government sector working together to meet the health needs of its people. The federal, state, territory and local governments share responsibility of its operation, management and funding. The private sector operates and funds some health services like private hospitals, pharmacies and many medical practices (Australian Institute of Health and Welfare 2018; n.d..).

The approach adopted by this study is to assess the professional and social integration of IMGs in the NSW context utilising Han and Humphreys’ (2006) typology. This thesis through its analysis of the experience of IMGs provides a further detailed assessment of integration and retention and assesses the utility of the typology developed by Han and Humphreys’ (2006) to classify and differentiate the experiences of IMGs. In this way, what contributes to IMG integration can be clarified.

Han and Humphreys’ (2006) study rested on a premise that labour supply of medical professionals in rural areas remains a challenging issue for policy makers partly due to a failure to understand the factors that influence GP’s professional and social integration in rural and regional communities. The focus of their study was to provide long term solution to the problem, particularly in rural communities (Han & Humphreys 2006).

The typological study by Han and Humphreys’ (2006) was one of the few detailed examinations of the experiences of IMGs working in Australia. They identified characteristics of IMGs and distinguished them into four types based on their degree of integration in rural regions of Victoria. Their study was limited to participants in the state of Victoria in Australia and to date the study has not been replicated either in Victoria or in other states of Australia. Han and Humphreys’ (2006) study was based
on an explicit assumption that integration was the basis for retention of IMGs in rural communities. This research thesis provides the opportunity to assess this assumption.

Concepts used in this thesis

Integration - The approach adopted in this thesis is that integration is shaped by professional, family, social, cultural and personal factors. In this thesis, integration involves aligning IMGs into the Australian health system and rural practice, and involves integration of IMGs into a specific geographical location, which is a rural community of NSW. Integration of an IMG is assessed as being aligned to the Australian health system and rural practice, and being satisfied living in the rural community.

Retention - There are three aspects to retention: retention in a particular rural community of NSW, retention in rural practice in general in NSW and retention as an IMG in Australia. In this thesis, retention of IMGs is assessed by an IMG’s willingness to be retained in the same rural practice beyond the completion of the 10-year moratorium.

In this thesis, the term ‘rural’ is used as an umbrella term embracing remoteness, regionality and non-urban areas. This is consistent with the Australian Standard Geographical Classification – Remoteness structure (ASGC-RA) which uses ‘rural’ as an umbrella term that embraces remoteness, regionality and non-urban areas. Otherwise there is an interchangeable use of terms. For example, the Australian Institute of Health and Welfare (2016) uses ‘rural and remote’ interchangeably with the classification terms ‘regional and remote’ (Australian Institute of Health and Welfare n.d.; & 2017).

Foreign trained doctors (FTDs) or overseas trained doctors (OTDs) are those doctors that have been trained in their home country and now work in a host country where the receiving country is the host country. This thesis will use the term foreign trained doctors, overseas trained doctors or IMGs interchangeably depending on the source material discussed. In Australia, doctors who obtained their basic medical qualification from a country other than Australia or New Zealand are commonly referred as IMGs. In this thesis, IMGs will be specifically used when referring to doctors working in Australia.
Interest in the thesis

My initial research proposal for a PhD in the School of Business, University of Western Sydney was, Title: Exploring the challenges of Information Technology professionals from India working in Information and Communication Technology (ICT) companies in Australia. This interest sparked from my own observation that some Information Technology professionals face challenges when they first join work in a new work environment. As a migrant, this scholarly interest arises from my own experience working in a new work environment.

During the course of my PhD, there was a change of professionals from Information Technology professionals to IMGs working in rural communities of NSW. This change arose from my interest in integration and the evident policy debate concerning the integration of IMGs.

1.2 Aim of the thesis

The study is located in the broader context of Australian and international research on attraction and retention of IMGs in rural regions. There is limited knowledge about the professional and social integration of IMGs in rural communities of NSW. This is the first study to examine the professional and social integration of IMGs in rural communities of NSW. This thesis aims to develop insights about integration and retention of IMGs working in rural communities of NSW; it is the first qualitative study of the integration of IMGs engaged in general practice in rural communities of NSW. This interest in integration encompasses both the factors that may facilitate or hinder integration and the ways in which integration may be expressed. In doing so, this thesis will broaden the understanding of the dimensions of integration and provide an improved understanding of the relation between integration to retention. To achieve this aim, this thesis

- Identifies and assesses the policy frameworks that facilitate an increase of supply of doctors in rural areas and policy measure directed to retain them in rural communities;
- Critically assesses the conceptual framing of integration and how it is used by research scholars to the experience of IMGs;
• Deploys a qualitative methodology, involving semi-structured interviews with IMGs working in remote and regional areas of NSW; and
• Conducts a thematic analysis of interview data, and utilising this data in assessing the utility of the typology developed by Han and Humphreys’ (2006) to typify IMG integration.

In outlining the purpose and scope of the thesis it is useful also to outline what the thesis does not do. This thesis does not: (1) question the merits of relying on IMGs; (2) analyse the workings of the Australian health care system or the operations of the NSW Department of Health, and; (3) reflect on community attitudes to immigration or skilled immigration.

1.3 Research questions

The primary research question of this thesis is:

How effective is Han and Humphreys’ (2006) typology of professional and social integration in assessing the integration of IMGs in rural communities of NSW?

Supplementary research questions are:

Are there factors of integration of IMGs working in rural communities of NSW that fall beyond Han and Humphreys’ (2006) typology?;

How effectively does Han and Humphreys’ (2006) typology explain the link between integration and retention?; and

What are the measures that facilitate integration, and what are the measures more likely to facilitate retention in rural medical practice?

The justification for the research questions is discussed in chapter four.

1.4 Significance of research findings

Qualitative analysis of the integration of IMGs in rural areas of Australia is in an emergent state and is set against particular policy complexities. The policy complexities include the debates about the policy merit of skilled labour migration, the mandatory distribution of IMGs to rural areas and the uneven retention of IMGs in rural communities once they have met the demands of their initial recruitment contract.
The concept of integration is used to assess policy directed towards deployment of IMGs.

Insights about integration and retention will enhance policy makers and professional associations’ knowledge of IMGs’ experience working in rural communities of NSW (Han & Humphreys 2005 & 2006). The findings of this thesis can assist health organisations in supporting the integration and retention of IMGs to the Australian health system and rural practice. Improved understanding of the complex relationship between integration and retention can assist workforce planners in selecting and recruiting IMGs most suited to a particular rural community. Such improvements increase retention of doctors, thereby improving access to health services to rural communities. The findings can assist policy makers of health sector of NSW to target resources and incentives towards retaining those IMGs who are likely to remain in rural areas after completion of the mandatory practice period.

1.5 Structure of the thesis

There are nine chapters in this thesis. Chapter 1 provides the background and aim of the thesis. Chapter 2 and 3 outline the labour market and policy context that have facilitated the migration of IMGs. Chapter 2 presents an international perspective to global labour market skills shortages of health professionals, particularly doctors. This has resulted in the recruitment of foreign trained doctors by many countries in order to meet their health needs. In conjunction with Chapter 3, this chapter contextualises the labour market and policy responses for IMGs, a context that frames the aim of this thesis. Chapter 3 reviews the labour and skills shortages of doctors in Australia. This chapter discusses the use of IMGs as a solution to address its health needs, primarily the state, territory and federal government policy measures tailored to match the supply of doctors to the demand for increased health services in rural areas of Australia. Chapters 2 and 3 serve as a foundation for the detailed examination of integration and retention of IMGs which occurs in the next chapter. Chapter 4 incorporates a comprehensive review of the literature on integration, specifically how it is conceptualised for IMGs in a new country. It examines relevant research on integration noting that the term is subject to multiple framings and is deployed through a number of different policy contexts. This conceptual framing introduces the research questions that this thesis aims to address. The research design and methodology for the thesis is
discussed in Chapter 5. Within a constructivist interpretivist paradigm, this thesis uses qualitative methodology, utilising semi-structured interviews, and adopts abductive research inquiry. This approach is aligned to the aim of the thesis and the research questions. A constructivist interpretivist approach enabled the researcher to interpret participants’ social constructions of their experience to generate knowledge on participants’ experience. Abductive inquiry is used to explore, describe and understand participants’ social life (Blaikie 2000; Blaikie 1993). Chapters 6 and 7 presents the thematic analysis of 25 semi-structured interviews of IMGs working as GPs in rural communities of NSW. The four themes and associated sub-themes generated from the data analysis, Professional, Family, Social and Cultural and Personal are discussed in Chapter 6 and 7. Chapter 8 discusses the application of Han and Humphreys’ (2006) typology utilising the data generated from the thematic analysis. The approach adopted here is to assess the utility of Han and Humphreys’ (2006) typology in the NSW rural context. The final Chapter 9 discusses the findings and answers the research questions of this thesis. The contribution of this thesis, limitations and areas of future research are addressed in the final chapter.

1.6 Conclusion

This chapter provided the background to this thesis. It outlined the research problem and the approach taken to examine this problem. The following two chapters, Chapters 2 and 3, presents an international and Australian perspective to labour market skills shortages of health professionals, especially doctors resulting in recruitment of foreign trained doctors to meet their health needs.
CHAPTER 2

GLOBAL SHORTAGES OF HEALTH PROFESSIONALS

2.1 Introduction

The chapter presents an international perspective on labour market skills shortages of doctors resulting in the recruitment of foreign trained doctors by many countries in order to meet their health needs. The focus draws forward an examination of explanations for migration and public policy commentary about migration. As noted in Chapter 1, the focus of this thesis is not directed to migration or the theoretical explanations of it. Nonetheless debates about migration shape the context for the international migration of foreign trained doctors (Alutiss, Bishaw & Frank 2014; Dodani & Laporte 2005). To this end this chapter includes a brief overview of an explanation for migration as a means of situating the context in which the research of this thesis took place. Representative of the pattern of IMG recruitment, the focus is largely on the policy measures, visa and registration processes for foreign trained doctors. The emphasis of the discussion is the policy measures developed by Western countries specifically Canada, United Kingdom (UK), United States of America (USA) and Australia, to recruit doctors in addressing the shortages of health professionals.

2.2 Migration of skilled labour between countries

Rapid rates of economic development, technical advances and a slow growth in the supply of a local labour force has contributed to demand for foreign skilled labour causing international movement amongst those with a high level of skill (Castles 2013; Skeldon 2005, p. 6). The Organisation for Economic Co-operation and Development (OECD) classifies highly skilled as those human resources in science and technology that are either in, or have completed tertiary education (Skeldon 2005). Demands for information technology skills, teachers and health professionals exist with the latter forming the biggest group of skilled migrants that has facilitated global sharing of knowledge base within this profession (Martineau, Decker & Bundred 2002; Skeldon 2005).
Understanding reasons why people migrate can help explain their subsequent behaviour (Grant 2004; Sapeha 2016; Wulff & Dharmalingam 2008). Migration is a complex phenomenon and involves many factors (Iredale 2001; Schoorl et al. 2000). There is no universally accepted theory to explain the process of international migration (Schoorl et al. 2000). Indeed, Rajendran, Farquharson and Hewege (2017, p. 441) claim: ‘Portes (1997) considered that it is impossible to design one “Grand” theory of migration’. Different migration theories have been formulated to explain international flow of migration, including foreign trained doctors (Kurekova 201; Schoorl et al. 2000). Labour migration is analysed at different levels: micro-level theories; meso-level theories; and macro-level theories.

Micro-level theories focus on the human capital and demographic characteristics of individuals (e.g. age, education, qualifications, skill, gender and individual preferences). Human capital theory of migration suggests individuals make rational cost-benefit calculations about the decision to migrate (or not migrate), and when considering possible relocation destinations. The greater the difference of expected human capital returns between source and destination countries, the increased likelihood of migration. Thus human capital theory proposes a foreign trained doctor’s reason to migrate is influenced by wage differentials between source and destination countries and characteristics such as education, skills, and language proficiency (Sapeha 2017, pp. 6-7). For instance, Hawthorne (2015) notes proficiency in English has become a major characteristic required for skilled migration to Australia.

Influences other than micro-economic factors can also shape the decision to migrate or not migrate. Cliff, Grün, Ville, Dolnicar (2015) assert that gender is often overlooked when patterns of migration are analysed, particularly for women. The ‘push-pull model’ contends influences in the source country will ‘push’ (i.e. compel) individuals to migrate, or influences in the destination country will ‘pull’ (i.e. attract) individuals to immigrate, or a combination of both types of influences shape the migration decision. Push and pull factors are used as a rationale in the discussion of migration of health professionals (Rutten 2009; Zubaran 2012). Push factors are negative factors and described as being internal in the source country that drives a health professional away from the health system in which they were trained (Alutiss, Bishaw & Frank 2014, p. 3). Push factors such as poor work conditions, low remuneration, and political instability in the source country may make an individual
to migrate to developed countries to escape from these negative influences (Alutiss, Bishaw & Frank 2014; Dodani & Laporte 2005; Mackay & Liang 2012).

Pull factors are external in nature and provided by the destination country (Alutiss, Bishaw & Frank 2014; Dodani & Laporte 2005; Mackay & Liang 2012). At the individual level pull factors can include the desire for improved salary, better job prospects, better standards of living and quality of life, better equipped hospitals and professional development opportunities, and a safer working environment in the destination country. A range of these factors may motivate an individual to migrate (Martineau, Decker & Bundred 2002; Stewart, Clark & Clark 2007). The pull factors depend on job vacancies, government policies, professional registration requirements and work permit arrangements of the destination country (Martineau, Decker & Bundred 2002; Stewart, Clark & Clark 2007). Pull factors promote migration from less developed countries to developed countries. Krivokapic-Skoko and Collins (2016, p. 168) indicate pull factors can be divided between ‘natural’ and constructed’ attractors. The former includes the physical environment (e.g. landscape, unique flora and fauna, and proximity to a beach), climate, and physiographic factors (e.g. sense of remoteness). The latter are economic and socio-cultural, and include employment, accommodation, and social amenities (e.g. schools).

Meso-level theories focus on family units and/or households, rather than individuals. With this type of approach, the expected benefits of migration for all members of the family unit are considered (e.g. employment opportunities for adults, education opportunities for children, and other lifestyle options for household members). This ‘new economics of migration’ asserts household decision makers consider not only the potential benefits of migration, but also the risks involved. Meso-level concepts of migration are not restricted to human capital or economic factors. Social factors such as national, ethnic and cultural networks within destination countries can also influence the migration decision. This ‘network theory’ of migration emphasises the role of relations between a diaspora community and non-migrants in destination countries, and the networks within a diaspora community (e.g. friends and relatives) (Schoorl et al. 2000).

Macro-level theories, in contrast, suggest factors other than individual decisions shape migration. Neoclassical macro-economic theory explains how labour markets
influence migration flows. The flows are from low-wage to high-wage countries. Low-wage countries are a source of labour supply to meet the demand for labour in high-wage countries. With this theory the focus is on wage differentials between source and destination countries, so that labour market variations (e.g. labour demand, labour supply, and wage levels) are the main explanatory variables. However, migration policies of destination countries limit the application of this theory (Grant 2004, p. 15). Migration systems theory seeks to overcome this limitation by appreciating migration occurs within ‘a system’ where countries and regions are connected by several types of linkages, where changes in one link will affect other linkages. In simple terms, ‘globalisation’ influences migration, so that labour mobility is a key factor for systems theory. Thus migration includes both temporary and permanent relocations (Schoorl et al. 2000). The network theory and the push-pull model can explain the direction of migration. Network theory explains how friends or family in destination country could influence a foreign trained doctor’s choice of country (Massey et al. 1993; Schoorl et al. 2000). The push-pull model also explains the motivation of a foreign trained doctor to migrate. The push-pull model places particular weight on the policy provisions enacted by destination countries to facilitate migration. The motivation for a foreign trained doctor to migrate cannot be explained by just one migration theory as migration may involve many factors. In addition, the reason for migration may not just be economic related reasons but could also be non-economic related such as better lifestyles, climate, an education and prospects for household members, and reuniting with relatives (Khoo 2013).

Research on the factors shaping migration has produced mixed results. For example, Grant (2004) found a combination of migration theories that explains the relocation of doctors from South Africa to Canada. The political situation in South Africa in the early 1990s was a push factor (Grant 2004, pp. 2-3). The increased demand for medical practitioners in Canada was a pull factor (Grant 2004, p. 7). Wulff and Dharmalingam (2008, pp. 151-152) found diaspora community networks or ‘social connectedness’ was an important reason for migration to Australia. Cliff, Grün, Ville, Dolnicar (2015, p. 124) argue influences that attracts migrants to a destination country are not necessarily those that might keep them there. As their study found economic factors were less important than social and cultural considerations for the retention of skilled woman migrants to Australia. For skilled migration, Hawthorne (2015) notes barriers
to foreign qualification recognition (FQR) in destination countries can influence an individual’s decision to migrate. Krivokapic-Skoko and Collins (2016) found ‘natural’ pull factors (attractors) can be an important reason for the destination of migrants, yet the unfulfilled expectations of economic and socio-cultural pull factors (constructed attractors) can diminish the likelihood of remaining in a particular location in Australia. And Sapeha (2017) found labour market opportunities (i.e. likelihood of employment) were a pull factor for migration to Australia. The diversity in theoretical approaches to migration is evident also in the rationale for policy measures adopted by developed nations to recruit skilled migrants, including skilled health professionals. The immigration policies of destination countries, Canada, United Kingdom, United States of America and Australia, are outlined in this chapter.

2.3 Recruitment of foreign trained health professionals

In the post-colonial period, developing countries started to expand their health services by training their own nationals (Bach 2004, p. 624). At the same time, growth in health systems in developed countries placed more demand in health professional staff. This led to the movement of health professionals between developing and developed countries (Bach 2004). Bach (2004) stated that the establishment of accurate data on flows of health workers could assist in effective migration management. Better workforce planning is important within source and destination countries to address health imbalances in the health workforce (Bach 2004; Crisp & Chen 2014, p. 951). The source country is the sending country or home country of the individual and the destination country being the receiving country or the host country of the individual. Mejía's (1978) study on physician and nurse migration in the late 1970 showed a detailed analysis of the flows and stocks of the physician and nurse workforce from forty countries. Mejia (1978) claims that in the year 1972, six per cent of the world's physicians (140,000) were located in countries other than in their countries of origin, who migrated from source countries such as India, Pakistan and Sri Lanka mainly to the United States of America, the United Kingdom, Canada, Australia and Germany (Bach 2004, pp. 624-625; Mejia 1978, pp. 208-210). Mejia (1978) study estimated that about 135,000 nurses, which were four per cent of the world's workforce were outside their country of birth or training. These migration patterns were mainly determined by colonial and linguistic ties (Bach 2004, pp. 624-625; Mejia 1978). Since the 1970s the pattern of migration changed resulting in an increased transfer of health professionals.
from developing to developed nations. Globalisation of markets, free trade agreements and changes in population dynamics over the past two decades have facilitated health migrations from source countries such as Egypt, Cuba, former Soviet Union, and the Caribbean to countries such as Great Britain, Australia, Gulf states and Canada (Alutiss, Bishaw & Frank 2014; Martineau, Decker & Bundred 2002). Although previous studies have noted the difficulty in providing a precise picture of global migratory flows, there is a pattern that is characterised by migration from low and middle-income countries to high-income countries in North America and Western Europe (Alutiss, Bishaw & Frank 2014, p. 2).

Globally, health care professionals have migrated mainly from developing to developed (Castles 2013; Clark, Stewart & Clark 2006; Skeldon 2005). This phenomenon has accelerated in recent years due to national shortages of nurses, physicians, pharmacists and other health care practitioners not just from less affluent to more affluent countries, but also among developing countries and even between developed nations. This pattern of labour transfer has resulted in a growing global labour market for professionals in health care. The globalisation of the health care labour market has had a profound effect on the ability of many national health care systems to deliver vital services to their populations. In developed countries, national health care systems experience shortages of nurses and doctors due to a function of demand increasing faster than supply (Clark, Stewart & Clark 2006). The World Health Organisation (WHO) has determined that nations need a minimum of twenty doctors for every 100,000 people to be able to provide even basic care (Clark, Stewart & Clark 2006). There is an increasing demand for health professionals in developed and ageing societies. Part of the reason is the aging population places more demand in the health system (Crisp & Chen 2014; Grignon, Owusu & Sweetman 2012; Skeldon 2005; WHO 2014). Almost nine out of ten migrating doctors relocate to just five countries: Australia, Canada, Germany, United Kingdom and United States of America. Certain OECD countries (including Germany, France, Japan) use migration as a ‘quick fix’ to address health workforce needs in destination countries as training extra doctors and nurses could take a few years to have an effect (Dodani & Laporte 2005; WHO 2014).
A key rationale for international migration of health professionals is in response to meet the health needs of the receiving or destination country (Grignon, Owusu & Sweetman 2012). A combination of government policies, environmental factors and individual actions influence the decision to migrate. All this takes place at various levels: international, national, employer and individual. At the national or international level, migration is influenced by many government policies depending on the demand for health professionals that regulate the flow of health professionals (Martineau, Decker & Bundred 2002; Stewart, Clark & Clark 2007; WHO 2014).

The availability of limited data makes it difficult to quantify the flow of health professionals in a globalised world. Nonetheless, WHO reported in 2006 that there was a global shortage of almost 4.3 million doctors, midwives, nurses, and other health professionals. For instance, 75 countries had less than 2.5 health personnel per 1000 population, which is the ‘minimum number necessary to deliver basic health services’ (Aluttis, Bishaw & Frank 2014, p. 2). Nonetheless, the freedom of health workers to offer their services in a globalised employment market must be seen within the context of international undersupply of staff in health (Aluttis, Bishaw & Frank 2014, p. 1).

The pattern of migration of health professionals is a national labour market response to skills shortages in developed nations (Rutten 2009; Zubaran 2012). Various financial, professional, political, social, and personal factors can act as either push or pull factors that contribute a health professional to migrate (Alutiss, Bishaw & Frank 2014, p. 3). Khoo et al. (2007) indicates most Indians and Southeast Asians are attracted by better employment opportunities and higher salary offered by developed countries. Increased demand for medical professionals provides them an advantage to migrate to developed nations (Zubaran 2011). Both push factors in source country and pull factors of destination country influence a health professional to migrate.

Some developed countries bring health professionals into their health care systems through active recruitment by employers or government supported agencies that are sponsored through government support. For example, the British National Health Service (NHS) recruitment program identifies health care professionals interested in emigrating, recruiting doctors on an individual basis and recruiting nurses in groups of ten, twenty, or more from a specific country (Clark, Stewart & Clark 2006, p. 47). If the demand for staff is greater than local supply, employers look for foreign trained
health professionals to fill the shortages (Martineau, Decker & Bundred 2002; Stewart, Clark & Clark 2007). This raises an ethical issue on the recruitment of health professionals from developing countries. The following section discusses this.

**Ethical dilemmas in the recruitment of foreign trained health professionals**

The research scholarship is divided on the merits of health professionals migrating especially from developing countries to developed countries. The debate is on ‘brain drain’ of health professionals contributing to an imbalance of health workforce in the source countries which already face a shortage of these skills (Marchal & Kegels 2003; Taylor et al. 2011). The debate being that the loss of key medical professionals deprives source countries of access to adequate health care, yet health care cannot be adequately provided in destination countries without recruiting immigrant health professionals to meet the growing demand (Marchal & Kegels 2003; Skeldon 2005). Migration of individuals from one country to another must also be seen from the perspective of the right to freedom of movement and it may not be ethical to restrict this right of personal choice (Mackey & Liang 2012; Rutten 2009), yet such framing leaves unanswered the unmet health needs of source countries. While concern exists to limit the perceived damage of the exodus of health professionals from developing countries, the rising demand for skilled professionals in potential countries of destination creates policy dilemmas and contradictions (Marchal & Kegels 2003; Skeldon 2005).

In order to address these ethical challenges that developed countries face while recruiting health professionals from mainly developing countries, where there is already a shortage of health professionals, WHO in 2010 adopted a global code of practice on the international recruitment of health professionals with a focus on ethics and protecting less-developed source countries. In response some developed countries have devised their own protocols on ethical ways of recruiting international health professionals (Grignon, Owusu & Sweetman 2012; Kuehn 2007). A code of practice for ethical international recruitment was introduced by World Organisation of Family Doctors (WONCA). WONCA produced two documents for ethical recruitment of doctors from foreign countries. First, the ‘Health for all Rural People: The Durban Declaration 1997’. This was a global initiative, taken by all rural health professionals. The aim was to reduce the inequities of the world’s rural population and to achieve
health for all rural people by year 2020. Second, ‘A Code of Practice for the International Recruitment of Health Care Professionals: The Melbourne Manifesto 2002’ was developed to encourage rational workforce planning by all countries in order to meet their health needs particularly in rural and remote regions; to discourage activities that could harm any country’s health care system and to promote the best possible standards of health care around the world. All countries that recruit international health care professionals are obliged to adopt this code of practice which would balance the rights of individuals to travel against the needs of communities (World Organisation of Family Doctors 2002). Although the research scholarship is divided on the positive and negative implications that health migration brings, it is likely to remain important as the factors that have facilitated its expansion are likely to grow in strength (Rutten 2009).

The WHO’s ‘Global Code of Practice on the International Recruitment of Health Personnel’ was adopted the World Health Assembly (WHA) in May 2010. This code is voluntary as member states are only ‘strongly encouraged’ to adhere to the code. Buchan (2010) suggested effective implementation of the code across a diverse and dynamic range of countries, interests, and standpoints would be challenging, particularly if private sector employers are actively recruiting from source countries that have a shortage of health care workers. Edge and Hoffman (2013) investigated the impact of the 2010 WHO code on recruitment of foreign health care workers in Australia, Canada, the United Kingdom, and United States of America. They gathered data from 42 stakeholders in these four nations, which covered government agencies, private sector recruiters, and health workforce professional organisations. Awareness of the code was varied, with the United Kingdom being the most aware and the United States of America being least aware. They found ‘Eighty-six per cent of respondents reported that the Code has not had any meaningful impact on their country’s health workforce recruitment practices, policies or regulations’ (Edge & Hoffman 2013, p. 6). A similar study was conducted by Tam, Edge and Hoffman (2016). Using the same research method as the Edge and Hoffman (2013) study, data was collected from 44 stakeholders in the same four counties. The authors report: ‘The main findings between the initial impact evaluation of the Code and the current one (conducted at eleven months and four years post-adoPTION, respectively) are strikingly similar. In both studies, the majority of key informants reported that no significant policy or regulatory
changes to health worker recruitment had occurred in their countries as a direct result of the Code’ (Tam, Edge & Hoffman 2016, p. 7). The 2013 ‘Review of Australian Government Health Workforce Programs’ (Mason 2013) made specific comment on the relevance of the 2010 WHO code (and similar international protocols) to the Australian context. The Review stated these codes have the status of ‘guidelines’, but can discourage targeted recruitment from countries with shortages of health workers. The Review specifically noted the Australian Government supported the WHO global code of practice endorsed at the WHA in 2010, and has ‘an expectation that member states/countries will abide by and implement the WHO Code’ (Mason 2013, p. 423).

2.4 Use of foreign trained doctors as a workforce solution to address labour market skill shortages

As a response to labour market shortages, foreign trained doctors were increasingly recruited by Western countries as a solution to this problem. Given the world-wide shortage of doctors (Humphreys et al. 2009; Terry et al. 2011; Terry, Lê & Hoang 2014), one of the challenges many OECD countries find is in matching the supply to the demand for the services of doctors. Recruiting the right numbers, training doctors to a national standard, tailoring migration policies and retaining them can be problematic. On the supply side, the ageing of the doctor workforce can be an issue in matching the demand (Hawthorne 2012; Simoens & Hurst 2006). The demand for doctors is expected to increase as patient health care expectation grows with higher standard of living, as medical technology advances and an increase in the average age of the population (Hawthorne 2012; Mackey & Liang 2012; Simoens & Hurst 2006; Terry et al. 2011). In addition to generating more local medical graduates, IMGs are recruited to address health needs of communities (Zubaran 2011).

A key concern for host nations is an unequal geographical distribution of their doctor workforce contributing to shortages in rural areas. Metropolitan areas, in contrast, encounter surpluses of doctors as they prefer to settle in areas where there is a greater range of amenities which may include greater employment opportunities, more attractive career pathways, better access to education services for children and superior cultural activities (Simoens & Hurst 2006, p. 38). This view is also supported by the studies of Han and Humphreys’ (2005) and Terry and Lê (2013). They noted that doctors moved out of rural practice in Australia to accommodate family or personal
aspirations (Han & Humphreys 2005; Terry & Lê 2013). Regions with the greatest need and lowest entry hurdles may become a stepping stone for some foreign trained doctors to other locations within the country. The tendency to relocate to large cities does not address the issue of shortages of doctors in underserviced areas (Grignon, Owusu & Sweetman 2012; Lehmann, Dieleman & Martineau 2008).

**Policy frameworks**

The policy context concerning labour shortages for qualified health practitioners, both nationally and internationally, has shaped the pattern of research scholarship. To overcome shortages of doctors, many countries have designed workforce policies to suit this particular area of labour market need. This has been done with a view to ensure that efficient geographical distribution of doctors takes place in a more balanced way and the health needs of the community are met. Policies such as launching international recruitment campaigns, tailoring migration policies to ease migration or arrangements that foster shared learning between health care systems have been formulated (Simoens & Hurst 2006). For example, Canada has made changes to its migration process to favour entry of doctors. Australia and the United States of America have relaxed immigration requirements for foreign trained doctors who are willing to practice in rural areas (Simoens & Hurst 2006; WHO 2014). For instance, the United States of America allows Foreign Medical Graduates to apply for a H1B visa. The Graduate Medical Education (GME) programs in the United States often come on a different type of temporary visa the J-1 visas. FTDs are usually required to return to their home (source) country for at least two years before re-entering the United States of America however, they are exempted from this under certain conditions. A state department of public health may sponsor up to 30 doctors on J-1 visa per year to serve in underserved communities (AMA 2018). In 2002, the United Kingdom launched an International Fellowship Programme in order to promote employment in the NHS (Simoens & Hurst 2006; NHS England). NHS aims to recruit around 600 overseas doctors into general practice in 2017-18 and aims for a total of at least 2,000 doctors over the next three years. United Kingdom is expanding the intake of students into medical schools by 25 per cent (NHS England). Table 2.1 outlines measures taken by Canada, United Kingdom, and United States of America to increase supply of health professionals in order to address health labour market shortages. In Australia, an IMG
can apply under these visa subclasses: Employer Nomination Scheme (ENS) visa (subclass 186); Skilled Independent visa (subclass 189); Skilled Nominated visa (subclass 190); Training visa (subclass 407); Temporary Graduate visa (subclass 485); Skilled Regional (Provisional) visa (subclass 489); Skilled Regional (Provisional) visa (subclass 489) – State or Territory nominated and Temporary Skill Shortage visa (subclass 482) – Medium-term stream (Australian Government Department of Home Affairs (2018). The visa categories for a GP to enter Australia are outlined in Table 2.2.

Developed countries have immigration policies to address shortages of health professionals in rural, remote, and underprivileged areas. Some examples of this are: provisional licenses to practice in Canada; employer sponsored visas in the United Kingdom; J-1 visas in the United States of America, or provision of temporary visas to practice in Australia. These strategies seem to be successful (WHO 2014). These policies have contributed to the increase in the number of international health professionals in the past decade in each of these four countries to different degrees; 22 to 24 per cent in Canada, 37 per cent of registered doctors in the United Kingdom, 26 per cent in the US and 26 per cent in Australia are foreign trained (WHO 2014).

Policies have also been designed and aligned with migration policies to attract and retain health professionals in rural areas through the education sector such as medical and nursing school locations, admissions policies, scholarships, ‘bonding’, health sector hardship pay, schooling for children, and professional career development (Crisp & Chen 2014). Some countries have also implemented supply-side policies which are designed to influence the geographical distribution of doctors to attract and retain physicians in rural or deprived urban areas (Simoens & Hurst 2006; WHO 2014). These include educational policies, education-related funding policies, regulatory administrative policies and financial policies (Simoens & Hurst 2006). These policies differ between OECD countries and are designed to match their health care workforce (Simoens & Hurst 2006). In Australia, the Medical Rural Bonded Scholarship (MRBS) Scheme 2015 and the Bonded Medical Places (BMP) Scheme were designed to address doctor shortages outside metropolitan areas across Australia (Australian Government Department of Health n.d.,d; Simoens & Hurst 2006, p. 39).
Table 2.1: Measures taken by Canada, United Kingdom and United States of America to increase supply of health professionals

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Measures Taken</th>
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<tbody>
<tr>
<td><strong>Canada</strong></td>
<td>Jurisdictions across Canada have taken some measures taken to address the shortage of health professionals:</td>
</tr>
<tr>
<td></td>
<td>- Between 2002 and 2006, the number of seats for first year medical students was increased by 22 per cent.</td>
</tr>
<tr>
<td></td>
<td>- Increasing the number of international medical graduates (IMGs).</td>
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<tr>
<td></td>
<td>- Immigrate as a provincial nominee</td>
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<tr>
<td></td>
<td>Between 2001-2003, about 2964 health professionals migrated under the economic migration category (Hawthorne, 2011).</td>
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<td></td>
<td>A number of initiatives by government ministries (health and/or immigration) have been taken to address fair access and registration practices for health professions in many provinces of Canada. Some programs are the Foreign Credential Recognition Program in 2003, Health Canada’s Internationally Educated Health Professionals Initiative in 2005 and the Foreign Credential Referral Office (FCRO) established in 2007. The Foreign Credential Referral program supports initiatives to assist foreign trained health professionals with bridge training or guidance through the regulatory process of becoming a health professional in the Canadian workforce. FCRO engages with partners within the Government of Canada, Provinces/Territories, and Stakeholders to advance efforts to improve foreign credential recognition. Also, steps such as training via bridge training programs, assistance with assessment exams towards the improved integration of international educated health professionals into the Canadian workforce have been placed. FCRO has been effective in assisting Internationally Trained Individuals (ITIs) in becoming well-prepared for employment that fits with their skills and experience. If ITIs are not working at the same occupational level, they maybe in a related occupation.</td>
</tr>
<tr>
<td><strong>United Kingdom</strong></td>
<td>Government initiatives to recruit foreign trained health professionals have been an important component to the United Kingdom’s health care workforce strategies for decades. Immigrants make up more than a third of medical practitioners, pharmacists, and dental practitioners in the health workforce (WHO 2014). In 2008, many foreign nationals employed as health professionals reported work as the primary reason for migration.</td>
</tr>
<tr>
<td>(UK)</td>
<td>The establishment of GP International Recruitment Office by NHS to recruit around 600 overseas doctors into general practice in 2017/18 and aim for a total of at least 2,000 doctors over the next three years. The international recruitment scheme will initially focus on doctors in the European Economic Area, whose GP training is recognised in the United Kingdom under European law and already get automatic recognition to join the General Medical Council’s GP Register. Over the next several years expanding the intake into medical schools in England by 25 per cent.</td>
</tr>
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</table>
Different visa routes for immigrant health professionals:

- Sponsored by an employer in the United Kingdom, where an employer must advertise vacancies locally and demonstrate an unsuccessful attempt to hire from within the EEA before they can sponsor a work permit;
- From other European Economic Area (EEA) - With the decline of deliberate recruitment efforts and the tightening of visa and professional registration requirements, European Economic Area (EEA) nationals have grown as a share of newly registering doctors and nurses. Particularly notable increases in recent years have come from crisis-hit EU countries such as Greece and Spain (WHO 2014);
- Health professionals arrive through family unification;
- As refugees.

The 2008 policy reform introduced a more systematic way of determining which occupations faced shortages in the labour market to ease the immigration process to employ foreign trained health professionals. The Migration Advisory Committee had a list of occupations that faced shortages in the labour market which made it easier for foreign health professionals to apply for jobs. In 2010, 32 per cent of health professionals and 22 per cent of associate health professionals entered via this route (WHO 2014).
China, India and the Philippines are the main source countries for doctors and nurses coming to the United States. Unlike the four countries, bringing in foreign trained health professionals to the United States of America has not been a result of solely tailoring immigration policies in targeting health professionals (WHO 2014). Most immigrants to the United States come through family unification when compared to employment-based immigration which is comparatively small in number.

Visa options for health professionals:

- Employment based immigrant visas are divided into five preference categories. Under the Employment Fourth Preference (E4): Certain Special Immigrants category, Foreign Medical Graduates can apply for a visa;
- The Family-Based Immigrant Visas. This visa type has two categories. The Immediate Relative Immigrant Visas - These visa types are based on a close family relationship with a United States (U.S.) citizen. The number of immigrants in these categories is not limited each year.
  The Family Preference Immigrant Visas - These visa types are for specific, more distant, family relationships with a U.S. citizen and some specified relationships with a U.S. Permanent Resident. The number of visas in this category is limited each year.

There are two types of visas, H-1B and J-1 visa:

- The temporary worker visa, known as the H-1B visa – This visa is available to bring in doctors. To qualify for work visa, doctors must have passed the necessary examinations, already completed necessary training and be fully licensed to practice in the United States. Experienced foreign-trained doctors require a United States residency permit (Green card);
- IMGs participating in Graduate Medical Education (GME) programs in the United States often come on a different type of temporary visa the J-1 which is sponsored by the Educational Commission for Foreign Medical Graduates (ECFMG). Unlike the H-1B visa, doctors on J-1 visas are usually required to return to their home country for at least two years before re-entering the United States. This was designed to encourage the circulation of health professionals back to their home countries. However, the home residence can be waived under certain circumstances. If the applicant can demonstrate that he or she will suffer from prosecution in his or her home country or last permanent residence, if the applicant’s spouse or children who are U.S citizens or permanent residents would face hardships or if the applicant is sponsored by an interested government agency to work in U.S. The agencies are: The department of Health and Human Services, The Department of Veterans Affairs, The Appalachian Regional Commission, The Department of Agriculture and The Department of housing and Urban Development, the State Department of Public Health. The State Department of Public Health may sponsor up to 30 doctors on J-1 visa per year to serve in underserved communities.

**Table 2.2: Pathway for health professionals to enter Australia: visa grants**

<table>
<thead>
<tr>
<th>Pathway</th>
<th>Details</th>
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| **Temporary labour migration**               | - Temporary 457 visa migrants - Between 2005 to 2006 and 2009 to 2010, under this category 34,870 health professional were sponsored to Australia.  
  - From 2010 to June 2013, under this category 22,110 health professional were sponsored by employers.  
  - From June 2013 to June 2014, under this category 7970 health professionals were sponsored to Australia.  
  - Temporary visas for a GP are outlined in Chapter 3, Table 3.1.                                                                 |
| **Permanent skilled migration**              | - General Skilled Migrants - From 2005 to 2006 and 2009 to 2010, under this category 15,940 with health qualifications arrived.  
  - From June 2010 to 2013, under this category 9,466 permanent health professional migrated, including 2,830 doctors.  
  - The latest data (2014) reveals 4,719 doctors, nurses, and dentists came to Australia as permanent skilled migrants (Hawthorne 2015).  
  - Visa categories for a GP to enter Australia. These visa holders can live in Australia permanently. These visa types are outlined Chapter 3, Table 3.1. |
| **Trans-Tasman migration**                   | - Health professionals were admitted from New Zealand, under free entry rights under the Trans-Tasman Arrangement. This included 1,163 New Zealand doctors. |
| **Spouse and family migration**              | - Additional health professionals arrive to Australia each year as the dependents of labour migrants, or through the family reunion category. |
| **Humanitarian migration**                   | - Health professionals are admitted annually through Australia’s humanitarian category.                                                     |


### 2.5 Conclusion

The review of migration literature identifies the contested place of migration in the public domain, and these contests equally shape the pattern of policy measures. The international policy context outlined in this chapter shapes the policy measures introduced in Australia. These are outlined in the next chapter. Important considerations that are framed by this chapter includes a discussion on the international migration of skilled labour with an explanation of migration flow, the recruitment of foreign trained doctors by many countries in order to meet their health needs, the policy framework to facilitate an increase of health professionals in Western countries such as, Canada, United Kingdom, United States of America and Australia. Australia’s tailoring of immigration policy to meet health labour market needs is not unique. Chapter 3 discusses the Australian policy responses to labour market shortages of
doctors’ particularly IMGs in rural areas of Australia. Chapter 3 identifies the policy framework that various states, territories and federal government have adopted in recruiting IMGs and retaining IMGs in rural regions of Australia. Policy measures are largely predicated on an anticipated integration of IMGs with the aid to retention into the Australian health system and rural communities. Chapter 4 entails this discussion.
CHAPTER 3

AN AUSTRALIAN PERSPECTIVE TO LABOUR AND SKILLS SHORTAGES OF DOCTORS

3.1 Introduction

Following from the previous chapter, this chapter reviews the shortages of doctors in Australia. A review of the scholarship and policy measures is undertaken in order to obtain a better understanding of shortages of doctors in Australia, how these shortages are positioned and the policy responses to the shortages so framed. The dominant narrative in policy dialogue assesses that Australia similar to other OECD countries faces a shortage of health professionals. Consistent with this narrative, Australia relies on IMGs in meeting its health needs particularly in rural communities where recruiting and retaining doctors is problematic. This has led to policies and regulations to meet this demand. Migration policy facilitates an increase in IMGs, and in alignment to this policy various state, territory and federal government policy measures have been introduced. These policy measures are outlined in this chapter as is the available data that enables an assessment of policy outcomes. The data presented in this chapter characterises IMGs working as GPs in Australia and in NSW. It is important to note that federal level regulation is overlaid by state and territory legislation, resulting in different outcomes in regulatory structures between different state jurisdictions. While policy measures presume a shortage of locally trained doctors, these assumptions are contested, a debate that will be addressed in this chapter.

Meeting the health needs of communities in Australia

The demand for more doctors is reported to be more significant in outer metropolitan, rural communities and especially communities with high indigenous populations when compared to metropolitan areas (Gilles, Wakeman & Durey 2008; Han and Humphreys 2005; 2006 & Hawthorne 2012). Health needs are exacerbated by factors such as: older persons are likely to have chronic condition which may require more frequent visits to the GP; population growth means the demand of doctor services increases; an aging doctor workforce means new doctors are needed to fill the workforce gap; and decreasing working hours by doctors in general and by female
doctors in particular opting for part-time work to maintain work-life balance. These and other are factors influence demand for medical services and medical practitioners (Brooks, Lapsley & Butt 2003; Harrison & Britt 2011; Hawthorne 2012; House Standing Committee on Health and Ageing 2012). There is a demand for doctors to work in hospitals, in regional general practices, and in some speciality areas, such as emergency care (Smith 2008).

Recruitment difficulties due to shortages of doctors and high levels of workforce turnover create challenges for rural, remote and other under-served areas contributing to poor health services for the community (Humphreys et al. 2009). Policies directed at this issue include expanding education and training opportunities for Australian doctors, but in the interim Australia relies on IMGs to supplement the medical workforce (Humphreys et al. 2009). Since 1950, Australia in a similar way to many other developed countries has turned to immigration to supplement its doctor workforce (Brooks, Lapsley & Butt 2003; Harrison & Britt 2011; Terry et al. 2012). IMGs provide a major resource to fill the health care gaps in rural Australia including health care needs of indigenous Australians (Zubaran 2011).

3.2 Reliance on IMGs to supplement health needs of communities

Australia’s IMGs recruitment efforts are borne out of a necessity to redress rural health disparity and previous government policy reaction to speculative high doctor-to-population ratio and misdistribution (Terry et al. 2013). These assumptions led to sustained underproduction of medical graduates in Australia and increased reliance on IMGs recruitment (Terry et al. 2013). Compulsory schemes (discussed in section 3.3) were implemented to ensure IMGs filled rural and remote positions to sustain access to health services due to higher rates of illness and poor access to health services in these communities (Birrell 2004; Hawthorne 2012; Terry et al. 2011). By examining previous Australian studies and the available data, it is clear that despite government initiatives to increase the doctor workforce by means of expanding education and training for doctors trained in Australian universities a reliance on IMGs still persists particularly in rural and remote areas (Humphreys et al. 2009; Terry et al. 2013). Policies have been put in place as a response to this issue (Han & Humphreys 2005; 2006; Hawthorne 2012; Rural Health Workforce Australia 2016b). There is an accepted view by scholars (Brooks et al. 2003; Humphreys et al. 2009; Han &
Humphreys 2005 & 2006; Hawthorne 2011) that this demand is met by relying on IMGs. Data indicates an increase in the GP headcount by 23.45 per cent from the year 2011 to 2014 in rural and remote regions of Australia (Rural Health Workforce Australia 2016a; Rural Health Workforce Australia 2016b). The WHO has supported this claim by adding, ‘Australian health ministers have set a goal for domestic self-sufficiency by 2025, their policy imperative is to recruit overseas trained health professionals within the next 13 years’ (WHO 2014, p. 112). Therefore, migration of health professionals will remain a national priority for Australia (Hawthorne 2011; 2012).

Although there is broad commonality and agreement by scholars (Han & Humphreys 2005 & 2006; Hawthorne 2011; Smith 2008; Lê & Terry 2013) on the nature of the global labour market for medical professionals, there are nonetheless areas of contest in the research community. Australian rural communities face shortages of doctors and rely on IMGs to supplement this demand (Han & Humphreys 2005; 2006; Hawthorne 2011; Lê & Terry 2013; Smith 2008). However, Birrell (2011) disputed the claims of a shortage of doctors in Australia, and as a consequence calls for a review of the GP workforce needs along with the District of Workforce Shortage (DWS) area classification. This reasoning is the basis of Birrell’s call for a review of and cessation of the recruitment via immigration of IMGs (Birrell 2013). Birrell’s argument rests on a particular reading of the available data on GP to population ratios, with his assessment being that the ratio of population to GP is below the benchmark of 1,500 population-to-Full-time-Workload Equivalent-GP benchmark, and there is no need to recruit more IMGs. Birrell (2011) claims that a 1,500 population-to-FWE-GP benchmark is considered adequate in meeting the health needs in non-metropolitan regions of Australia except in some remote locations of Queensland and Western Australia. A FWE is a measure of service provision taking into account doctors varying workloads. It is a standardised measure used to estimate the workforce activity of GPs (Australian Government Department of Health 2008). FWE is calculated by dividing each doctor’s Medicare billing by the average billing of full time doctors for the reference period (Australian Government Department of Health 2012). Data shows that the new method of measuring GP workload is by Full-time Service Equivalent

1 Table 3.1 outlines the precise basis of the DWS classification but in short it is a means of policy makers delineating areas of acute medical workforce need.
Birrell (2011) provides additional support to his argument by relying on data that identifies GPs billing on Medicare. This data shows an increase from 67.6 per cent in 2003-2004 to 79.1 per cent in 2010-2011. He argues that there is a sizeable stock of under-used IMGs trying to enter the workforce in Australia: ‘Australia is awash with doctors wishing to becoming GPs’ (Birrell 2011, p. iv). He argues there is no need for more limited-registration,\(^2\) of IMGs being sponsored under the 457 visa claiming that there were 2,663 IMGs sponsored under the 457 visa in one year from 2011-2012.\(^3\) In short, Birrell’s arguments challenge other research scholarship in the area, in particular on the presumption that the shortage of qualified medical practitioners in rural and regional areas persists (Han & Humphreys 2005; Hawthorne 2011; Smith 2008; Terry & Lê 2013). The scholarship that disputes Birrell’s (2011; Birrell 2013) reasoning stands by the underlying assertion that a persistent shortage of doctor resonates in rural communities. Shortages of doctors in rural areas are reflected in the GP workforce data and the various policy measures put in place by the state, territory and federal government of Australia. Based on a calculation by Harrison and Britt (2011) for general practice utilisation per GP, it was found that there is an unequal distribution of GP workforce between urban and rural regions in Australia. Older people have over eight times the general practice utilisation of younger people, so by 2020, the increase in general practice utilisation as a result of population aging could increase by up to 45 per cent above that of demand from population increase alone (Harrison and Britt 2011). Hence there is a need for more GPs in regional and remote areas (Harrison & Britt 2011). Hawthorne (2011) maintains that Australia will meet its demand of doctor workforce through migration.

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\(^2\) Limited registration is available to doctors whose medical qualifications are from a medical school outside of Australia or New Zealand. Doctors with limited registration work under supervision in an Area of Need (AoN) where there is a shortage of doctors (Medical Board of Australia 2017a; Medical Board of Australia 2017b).

\(^3\) The various visa options are summarised in Tables 3.2.
3.3 Australia's policy response to meeting the demand of doctors in rural Australia

This section discusses migration policies, health policies and pathways to registration for IMGs to practice in Australia. Policy makers identified the number of local graduates as insufficient to satisfy the growing needs of doctors particularly in rural regions (Terry et al. 2011; Terry & Lê 2013). IMGs are recruited from countries with comparable medical systems, such as New Zealand, Britain and Ireland and other developing countries to supplement its health needs (Smith 2008). IMGs are also recruited from regions such as Asia, Africa, Middle-East, Europe and South America (Terry et al. 2011). Data by Australian Bureau of Statistics (2015) shows an increase in aged population by almost 20 per cent since 2010. Between 2010 and 2015, people aged 65 years and over contributed to more than 60 per cent of population growth in areas outside of capital cities. There are approximately 2.2 million people aged 65 years in metropolitan cities and 1.4 million lived in non-metropolitan areas. This indicates that older populations showed a preference retiring in coastal and rural parts of the country (Australian Bureau of Statistics 2015) which places a demand on doctors in rural regions. This data could also be included along with other age group population that use GP services to calculate the GP to population ratio in rural regions (Harrison & Britt 2011).

In response to meeting Australia’s health needs states, territories and the federal government have adopted policies and regulations to recruit IMGs. Such policy objectives have been supported by both Labor and Coalition governments (Han & Humphreys 2006; Smith 2008). IMGs entered Australia either via skilled migration temporary visas or permanent residency visas. With a temporary visa, the doctor can stay up to a stipulated time-frame. A permanent visa allows the doctor to stay permanently in Australia. Short-term demand of doctors is addressed through temporary visas. Prior to March 2018, the Temporary Business (long stay) Visa (Subclass 457) allowed temporary foreign workers, sponsored by employers, to work up to four years (Birrell and Healy, 1997; Khoo, et al. 2007). This program was introduced in 1996.\(^4\) The 457 visa was replaced with the new Temporary Skill Shortage (TSS) visa in March 2018 (Australian Department of Immigration and

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\(^4\) This visa will be referred as the 457 visa in this thesis.
The TSS is valid for one to four years. The 457 visa was the temporary visa pathway for doctors entering Australia. The spouse and children of IMGs were also granted visas to come to Australia. An approved business can be the sponsor for a 457 visa (Australian Department of Immigration and Border Protection n.d.; Khoo et al. 2007; Smith 2008). In assessing this pathway, Khoo et al. (2007, p. 484) noted:

… there is no restriction on the number of 457 visas that can be issued annually and no limitations on renewals. Spouses and dependent children can come to Australia with the skilled employee; spouses have full work rights, and there is no restriction on visa holders applying for permanent residence.

Alternatively, the medium-term demand for doctor resources is met through the General Skilled Migration programme, for example the employer nomination scheme and the Skilled Nominated visa (Australian Government Department of Home Affairs 2018; Hawthorne 2011). The GP can stay in Australia permanently.

In summary, the federal government has adjusted immigration policies by establishing multiple permanent and temporary residency visa categories that encourage medical migration of appropriately qualified IMGs. Table 3.1 outlines entry points for IMGs to Australia, dissected by categories of skilled migration and types of visas. There were approximately 5000 visas granted to IMGs between the year 2006-2012 which included both temporary and permanent visas (Health Workforce Australia 2014).
Table 3.1: Entry points for IMGs to Australia

<table>
<thead>
<tr>
<th>Types of visas</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The duration of years for temporary visas for IMGs was increased from 2 years to 4 years (Smith 2008);</td>
<td></td>
</tr>
<tr>
<td>• In May 2004, medical practitioners were included on the Department of Immigration's ‘Skilled Occupations List’ which means IMGs no longer needed a sponsor to immigrate (Smith 2008);</td>
<td></td>
</tr>
<tr>
<td>• As of March 2006, medical practitioners were included on the Department of Immigration's Migration Occupations in Demand List. If an occupation is on the nominated Migration Occupations in Demand List, the visa application will receive priority processing (Smith 2008).</td>
<td></td>
</tr>
</tbody>
</table>

The Migration Act 1958 (Cth) section 30 allows for temporary or permanent migration visas. Doctors can enter Australian medical practice under:

- A Temporary Business (long stay) visa (Subclass 457), which allows an employer to sponsor the doctor for up to 4 years with option of renewal;
- Medical Practitioner 422 visa allows an employer to sponsor a doctor for up to four years in an AoN region;
- Occupational Trainee visa 442 allows a doctor to work in an hospital for up to one year (Smith 2008).

Temporary visas for a GP include:

- Training visa (subclass 407) - This visa allows a GP to take part in workplace-based training to enhance skills and can stay up to 2 years. For eligibility, be nominated (unless your sponsor is a Commonwealth Government agency) or be invited (if your sponsor is a Commonwealth Government agency) and usually be at least 18 years of age;
- Temporary Graduate visa (subclass 485) a GP can live, study and work in Australia temporarily after he/she has finished studies;
- Temporary Skill Shortage visa (subclass 482) - This visa, referred to as the TSS visa, enables employers to bring in skilled workers that cannot be sourced in Australia. The visa is valid for 1-4 years. TSS visa holders can work in Australia in their nominated occupation for their approved sponsor under the Medium-Term stream;
- Skilled Regional (Provisional) visa (subclass 489) – This visa allows skilled workers to live and work in regional or low-population growth metropolitan areas of Australia for up to four years. The main conditions to apply for this visa include being sponsored by an eligible relative (Invited pathway) or be invited to apply (Invited pathway);

Skilled Regional (Provisional) visa (subclass 489) – State or Territory nominated. The main conditions to apply for this visa include being nominated by a state or territory.
Permanent residency visa - Join medical practice by either completing the Australian Medical Council examinations, or through employment as provisionally registered junior hospital doctor, or as General Practitioner in ‘Area of Need’ locations (Smith 2008).

There are four main permanent resident visa categories:

- Employer nomination scheme;
- Regional sponsored migration scheme;
- Labour Agreements;
- General Skilled migration.

In 2002, the Australian government amended immigration policy allowing international students to be trained at Australian medical schools as full-fee paying students. By December 2009, close to 3000 international students enrolled in medical courses (Hawthorne 2011; 2012). They were eligible for placement as interns at public hospitals for a one-year period. By 2003, internships were extended to an indefinite time frame allowing these students to apply for permanent residency (Smith 2008). In 2007, major reforms were made to general skilled migration visa. International students did not have an automatic right to permanent residency status (Parliament of Australia 2010).

Visa categories for a GP to enter Australia. These visa holders can live in Australia permanently.

- Employer Nomination Scheme (ENS) visa (subclass 186) - This visa is a permanent residence visa for skilled workers. For eligibility, the applicant must be nominated by an approved Australian employer; be under 45 years of age; meet the skills, qualifications and English language requirements; meet the other requirements of one of the streams of this visa - the Temporary Residence Transition stream, the Direct Entry stream or the Labour Agreement stream;

- Skilled Independent visa (subclass 189) - This stream is for Points-tested skilled workers who are not sponsored by an employer or family member or nominated by a state or territory government. For eligibility the applicant must have a relevant occupation; have a suitable skills assessment for the occupation; meet the points test pass mark of 65 points; be under 45 years of age at time of invitation; have Competent English; be invited by the office to apply;

- Skilled Nominated visa (subclass 190) - This visa allows skilled workers who are nominated by an Australian state or territory government to live and work in Australia as a permanent resident. For eligibility, the applicant have a relevant occupation; have a suitable skills assessment for the occupation; meet the points test pass mark of 65 points; be nominated by a state or territory government agency; be under 45 years of age at time of invitation; have Competent English; be invited by us the office to apply.

In addition to migration policies, there are a number of federal and state regulatory measures used to align the recruitment of IMGs to perceived areas of shortages. Health policy measures and legislation such as Area of Need (AoN), District of Workforce Shortage (DWS) and The Health Practitioner Regulation National Law (NSW) were introduced by the state and federal government (Australia Government Department of Health 2015; Australian Government Department of Health n.d., a; Australian Government Department of Health n.d., c; Area of Need Program 2013; NSW Government Health 2017b; Smith 2008). The objectives of each of these policy measures are outlined in Table 3.2. There are conditions that frame the recruitment program. Australia has a related ‘Condition of Service’ program, used since the late 1990s, which dictates that IMGs are initially restricted for up to 10 years to practise only in specific rural locations. Under this policy (specifically Section 19AB of the Health Insurance Act 1973), IMGs can only access private practice subsidies if they work in a government-designated DWS area where the undersupply of doctors is most acute (Australia Government Department of Health 2015). A significant reason for the introduction of this policy was to reduce the perceived oversupply of general practitioners in metropolitan areas (McGrail et al. 2012) and to address shortages of doctors in rural communities (Terry et al. 2011). Through this policy, the number of IMGs filling general practice training positions in Australia has been steadily increasing since the end of the 1990s, particularly in rural areas of need. IMGs occupied more than 25 per cent of the medical workforce, with about 65% of them working in locations outside capital cities (Armstrong et al. 2007; Smith 2008). In the year 2014-2015 about 43 per cent of IMGs (GPs) worked in regional, rural and remote areas of Australia (Rural Health Workforce Australia 2016b). Based on this data, IMGs made up 46.2 per cent of the full-time equivalent GPs in non-metropolitan area and 38.7 per cent in metropolitan areas (Birrell 2011). In short, IMGs form a substantial proportion of doctor workforce in non-metropolitan areas.

As a short-term solution to address Australia’s doctor shortage, one recruitment strategy which enabled the active recruitment of IMGs was by the establishment of a policy incorporating 'Area of Need' (AoN) provisions by state governments. This policy facilitates the active requirement of IMGs to fill these areas of need where shortages are more acute (Smith 2008). In NSW, for example, under Section 67 of the Health Practitioner Regulation National Law (NSW) which came into effect on 1 July 2010, limited registration is granted to enable a health professional to practise in an AoN (Table 3.2).
<table>
<thead>
<tr>
<th>Section 19AB of the Health Insurance Act</th>
<th>Australia has a ‘Condition of Service’ program used since the late 1990s, which dictates that IMGs are initially restricted for up to 10 years to practise only in specific rural locations. Under this policy (specifically Section 19AB of the Health Insurance Act), IMGs can only access private practice subsidies if they work in a government-designated DWS area where the undersupply of doctors is most acute. Section 19AB of the Act applies to IMGs and foreign graduates who gained their first medical registration or became permanent Australian residents or citizens on or after 1 January 1997. Section 19AB restricts their access to Medicare provider numbers and requires them to work in a district of workforce shortage in order to access Medicare benefits arrangements.</th>
</tr>
</thead>
<tbody>
<tr>
<td>District of workforce shortage (DWS)</td>
<td>Australian Government Department of Health is responsible for making DWS determinations. A DWS is a geographical area in which the local population has less access to Medicare-subsidised medical services when compared to the national average. Its aim is to achieve an equitable distribution of medical services across Australia. DWS was introduced in October 2001 by the government and continues to be used to identify areas of Australia that experience the most acute needs for medical services, as evidenced by a comparative shortage of doctors who are billing Medicare.</td>
</tr>
<tr>
<td>Area of Need (AoN) Program</td>
<td>The objective of the AoN program is to assist in the provision of medical services to locations that have limited access to such services. AoN is determined by the state and territory governments. The methods of defining an area of need may vary between different states. Generally, an area of need determination is granted when a vacant medical position remains unfilled after recruitment efforts have taken place over a period of time and all attempts to fill the position with Australian trained doctors has taken place.</td>
</tr>
<tr>
<td>The Health Practitioner Regulation National Law (NSW)</td>
<td>The Health Practitioner Regulation National Law (NSW) came into effect on 1 July 2010. Section 67 of this legislation allows limited registration to be granted to enable a health professional to practise in an AoN. The Health Minister in each state or territory is responsible in determining an area of need and may delegate this power to an appropriately qualified person. The NSW Minister for Health has delegated this authority to the NSW Ministry of Health. The Medical Board of Australia is then responsible for deciding an individual applicant eligibility, qualification and suitability to practise in an ‘Area of need’ position (NSW Health 2013).</td>
</tr>
</tbody>
</table>

IMG registration and pathway to practice in Australia

All medical practitioners must be registered to practice in Australia (Medical Board of Australia 2017a). Three types of registration apply to an IMG, general registration, limited registration and provisional registration. General registration allows an IMG to practice if they have completed the standard or competent authority pathway (Table 3.3). Provisional registration allows an IMG to work under supervision for a period of 12 months making an IMG eligible for general registration. Limited registration allows an IMG to work under supervision in an AoN where there is shortage of doctors (Medical Board of Australia 2017a; 2017b).

The means of IMGs gaining registration to work as a doctor in Australia involves consideration of two pathways, the Competent Authority or Standard pathway (Birrell 2011; Hawthorne 2011; Health Workforce Australia 2012; Medical Board of Australia 2017a; Medical Board of Australia 2017b; NSW Rural Doctors Network n.d.,). Table 3.3 outlines the key conditions for each pathway. The Competent Authority pathway is for IMGs who are seeking general registration with the Medical Board of Australia (MBA). After securing an employment offer and getting their qualifications verified by Australian Medical Council (AMC), IMGs are eligible to apply to the MBA for provisional registration. After completion of 12 months supervised practice, IMGs can apply to MBA for general registration. There are no exams to be taken under the Competent Authority pathway. The Standard pathway is for IMGs who are not eligible to apply through the Competent Authority pathway to obtain general registration as a medical practitioner in Australia. This involves two ways. One path is taking the AMC exam and clinical examination before securing employment. An alternative path is to secure employment first and then taking the AMC exam or completing workplace based assessment. Both pathways require the completion of 12 months supervised practice (Medical Board of Australia 2017a; Medical Board of Australia 2017b). Table 3.3 provides further details of the key conditions in these pathways.
Table 3.3: Pathways to registration for IMGs (GPs) to practice as a doctor in Australia

<table>
<thead>
<tr>
<th>Competent Authority pathway</th>
<th>The Competent Authority pathway is for IMGs who are non-specialist or specialists (including general practitioners) and are seeking general registration with the Medical Board of Australia (MBA).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under Section 53 of the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law), MBA can grant provisional or general registration on the basis of equivalency of qualifications or through the successful completion of an examination.</td>
<td>Eligibility to apply – Primary qualification in medicine and surgery awarded by a training institution recognised by both the Australian Medical Council and the World Directory of Medical Schools (WDOMS).</td>
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<tr>
<td></td>
<td>Those with completed training or assessment with an approved competent authority (MBA) may apply for provisional registration via the Competent Authority pathway.</td>
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<tr>
<td></td>
<td>IMGs must have secured an offer of employment before applying to MBA for registration.</td>
</tr>
<tr>
<td></td>
<td>Before applying to the board, applicants must apply to the Australian Medical Council (AMC) for primary source verification (PSV) of their qualifications.</td>
</tr>
<tr>
<td></td>
<td>IMGs apply to the MBA for provisional/general registration.</td>
</tr>
<tr>
<td></td>
<td>IMGs complete 12 months of supervised practice.</td>
</tr>
<tr>
<td>Competent Authority pathway registrants may be eligible to apply for general registration with the board if they meet the requirements of the registration standards for English language skills, recency of practice and professional indemnity insurance.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard pathway</th>
<th>The Standard pathway is for IMGs who are not eligible for the Competent Authority pathway. This pathway has two alternative processes leading to the award of the AMC Certificate:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Standard pathway (AMC examinations) – Assessment is by examination only – the AMC Multiple Choice Question (MCQ) Examination and the AMC Clinical Examination.</td>
<td>IMGs who have a primary qualification in medicine and surgery awarded by a training institution recognised by both the Australian Medical Council and the World Directory of Medical Schools (WDOMS) can apply for assessment under this pathway involving the following steps:</td>
</tr>
<tr>
<td></td>
<td>Apply to the AMC for primary source verification</td>
</tr>
<tr>
<td></td>
<td>Pass the AMC MCQ examination</td>
</tr>
<tr>
<td></td>
<td>Pass the AMC clinical examination</td>
</tr>
<tr>
<td></td>
<td>Secure an employment offer</td>
</tr>
<tr>
<td></td>
<td>Apply to MBA for provisional registration</td>
</tr>
<tr>
<td></td>
<td>Complete 12 months of supervised practice.</td>
</tr>
</tbody>
</table>

2. Standard pathway (workplace-based assessment) – Assessment is by examination and workplace-based assessment – the AMC MCQ Examination and workplace-based assessment of clinical skills and knowledge by an AMC-accredited authority. This involves the following steps:

- Secure an employment offer
- Apply to MBA for provisional registration
- Complete 12 months of supervised practice. During this time either – Pass the AMC MCQ and clinical examination or complete work based assessment and receive AMC Certificate.

Source: Compiled from Birrell (2011); Hawthorne (2011); Health Workforce Australia (2012); Medical Board of Australia (2017a); Medical Board of Australia (2017b); NSW Rural Doctors Network n.d.,
3.3.1 Distribution of medical practitioners within the federal and state jurisdictions

In addition to specific regulatory measures there are additional initiatives that have been taken to meet the health needs of communities, particularly those in rural and remote regions of Australia. The federal government increased the number of government funded medical school places nationally by 60 per cent resulting in an increase of domestic medical graduates to 69.2 per cent from 2006-2010 (Australian Bureau of Statistics 2013; Terry et al. 2013). Together with education and training of local doctors, other initiatives have also been adopted in meeting health needs of the community (Australian Bureau of Statistics 2013). The Australian Government Department of Health funds Rural Health Workforce Australia (RHWA) which is responsible for managing national programs to address the supply to demand of doctors especially in rural and remote communities (House Standing Committee on Health and Ageing 2012). Programs implemented by RHWA through Rural Workforce Agencies (RWA) are the International Recruitment Strategy (IRS); the Five Year Overseas Trained Doctor (OTD) scheme; the Additional Assistance Scheme (AAS), the Rural Locum Relief Program (RLRP); and the establishment of General Practice Education and Training Limited (GPET) in 2001 by the Minister for Health and Aging. GPET is to fund regionally based vocational education and training in general practice for medical graduates (House Standing Committee on Health and Ageing 2012). These initiatives are outlined in Table 3.4. The AAS, RLRP and GPET programs are common to both Australian Medical Graduates (AMGs) and IMGs.

To improve the geographic distribution of the medical workforce in Australia, further initiatives were introduced. The establishment of Health Workforce Australia (HWA 2010) was a way to manage reforms to Australia's health workforce (e.g. increasing the supply of the workforce through improved education and training, and the recruiting of overseas trained health professionals (Australian Bureau of Statistics 2013)). The Australian Government Department of Health (previously known as Department of Health and Ageing) has developed a website called 'DoctorConnect', which provides information aimed at IMGs (Australian Government Department of Health).

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5 HWA closed in August 2014 and its functionality was transferred to Australian Government Department of Health.
Health n.d.,a). State government departments created dedicated recruitment divisions to facilitate medical migration (Smith 2008); The Rural Doctors Network (NSW RDN) in NSW is one such division that is designated by the Australian government as the Rural Workforce Agency (RWA) for health in NSW. The aim is to provide standard health care to rural and rural communities through the provision of highly skilled health workforce.

There are incentives for IMGs to take up rural practice (Table 3.4). IMGs can claim reduction in the ten-year period based on rurality of regions they work (Rural Health Workforce Australia n.d.,). GPs also receive financial incentives for taking up work in rural and remote regions of Australia where attracting and retaining GPs is difficult (Table 3.4). In NSW, strategies have been in place since 2014-15 to support the growing needs of medical services with a focus on rural and regional areas. One such program was the introduction of the Rural Preferential Recruitment Service (RPRS) which supports doctors to spend the majority of their internships in a rural location. NSW Rural Doctors Network funds over $1.4 million to the support of training of GPs in rural NSW. The NSW Rural Generalist Training Program was introduced to train GPs with advanced skills to deliver services to rural communities (NSW Rural Doctors Network n.d.,).

An important consideration in assessing the government initiatives to support the health needs of rural communities is the federal government’s own designation of regionality and remoteness, the Australian Standard Geographical Classification – Remoteness Areas system (ASGC-RA). The ASGC-RA is a geographic classification system that was developed in 2001 by the Australian Bureau of Statistics. It is a statistical geography structure which allows quantitative comparisons of census data between city and country Australia. The structure classifies regions into broad geographical categories, called Remoteness Areas (RAs) that are defined by the physical distance of a location from the nearest urban centre based on population size (Australian Bureau of Statistics 2001; Australian Government Department of Health 2013b). This designation includes areas that are classified under the ASGC-RA System (Australian Government Department of Health 2013b) as:

- metropolitan (RA1)
- inner regional (RA2)
- outer regional (RA3)
• remote (RA4)
• very remote (RA5).

Different departments use different classification system which makes this area of policy complex to understand. A new classification, The Modified Monash Model (MMM) was launched in 2015. It is a classification system that categorised metropolitan, regional, rural and remote areas according to both geographical remoteness and town size (Australian Government Department of Health n.d.,b). The MMM was developed by researchers at Monash University. This model uses the ASGS-RA (2006) as a base for classification, and further differentiates areas in Inner and Outer Regional Australia based on local town size (Australian Government Department of Health n.d.,e). The categories range from MM1 to MM7. The change was required as there has been much criticism from rural doctors and rural communities about the ASGC-RA. The system implemented in 2010, which is used to determine eligibility and incentives under a range of health workforce programs for doctors working and training in rural areas. It was criticised for creating incentives for doctors to move to large, coastal towns (Australian Government Department of Health n.d.,e). It did not recognise the challenges of recruiting doctors to small rural towns. For example, doctors would receive the same incentives to move to Townsville, a coastal town with a population of approximately 172,000, as they did to move to Charters Towers, an inland town with a population of approximately 8,000. General Practice Rural Incentives Program (GPRIP) is the first scheme to adopt the MMM classification system to better target incentives to rural doctors (Australian Government Department of Health 2017). This model has taken into account more recent factors of categorising areas according to both geographical remoteness and town size thus making this a useful model for targeting incentives. However, at the time of thesis data collection NSW did not use the MMM, as that jurisdiction relied on the ASGC-RA.

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Although the MMM is being used as the basis of some health measures such as the GPRIP, other systems of classification are solely reliant on the ASGC-RA. The designation of non-metropolitan Local Health Districts in NSW, which was central to the research design of this thesis, remains based on the ASGC-RA.
<table>
<thead>
<tr>
<th>Table 3.4: State, territory and the federal government initiatives in response to health workforce needs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>International Recruitment Strategy (IRS)</strong></td>
</tr>
<tr>
<td><strong>Five Year Overseas Trained Doctor (OTD) Scheme</strong></td>
</tr>
<tr>
<td><strong>Additional Assistance Scheme (AAS) common to both IMGs and AMGs</strong></td>
</tr>
<tr>
<td><strong>Rural Locum Relief Program (RLRP).</strong> This program is common to both IMGs and AMGs.</td>
</tr>
<tr>
<td><strong>General Practice Rural Incentives Program (GPRIP) - GP Component</strong> This program is common to both IMGs and AMGs.</td>
</tr>
</tbody>
</table>

3.4 IMGs as an Australian medical labour force – outcomes of policy response

Notwithstanding the contested reasons for Australia’s health professional shortages and the requirement for specific policy measures, Australia is currently reliant on IMGs to meet its health needs. In 2007, the OECD stated about 43 per cent of doctors working in Australia were foreign born where some of these doctors may have received their qualification from the host country (OECD 2007). By 2011, IMGs constituted 36 per cent of Australia’s registered medical workforce (WHO 2014). Between 2006 and August 2011, 12,696 doctors migrated across all immigration categories. This is triple the number Australia accepted from 1996-2000 (WHO 2014). The main source countries were the United Kingdom/Ireland, India, Sri Lanka and Bangladesh, China, Malaysia, South Africa and the Philippines (WHO 2014).

Within Australia there is also a difficulty in obtaining longitudinal data on IMG recruitment and retention from a single source. This makes it difficult to assess the number of doctors that are recruited, retained or leave rural practice. There are various data sources providing information on the number of GPs which have been collected at different times, using a range of methods, and categorised differently both nationally and internationally. International data is sporadic and not collected routinely resulting in an absence of comprehensive contemporary data. There is no centralised source from where this data can be obtained making it difficult to obtain exact numbers on the headcount of GPs from one single source. Lack of data on retention of GPs makes it difficult to assess the supply to demand of doctors particularly in rural communities. Therefore, information about the number of GPs, including IMGs, in Australia and in NSW is obtained from different sources (e.g. Australian Department of Health and RHWA).

**GP workforce in Australia: a reliance on IMGs**

The majority of GPs whether locally trained or IMGs are employed in major cities; this conclusion is based on a headcount of GPs from 2015-2016. Sixty-eight per cent of GPs work in major cities with only 32 per cent of GPs working in regional, remote and very remote areas (Australian Government Department of Health 2016). Table 3.5 provides GP headcounts in major and regional, remote regions of Australia for the year 2015-2016.
Table 3.5: GP headcounts – major cities, inner regional, outer regional, remote and very remote, 2015-2016

<table>
<thead>
<tr>
<th>GP headcount</th>
<th>National</th>
<th>Major cities RA1</th>
<th>Inner regional RA2</th>
<th>Outer regional RA3</th>
<th>Remote RA4</th>
<th>Very remote RA5</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015-16</td>
<td>34,606</td>
<td>23,596</td>
<td>6,477</td>
<td>3,197</td>
<td>647</td>
<td>689</td>
</tr>
<tr>
<td></td>
<td></td>
<td>68%</td>
<td>19%</td>
<td>9%</td>
<td>2%</td>
<td>2%</td>
</tr>
</tbody>
</table>


Table 3.6 includes both AMGs and IMGs working in major cities and regional, rural and remote areas of Australia. In proportionate terms there are more IMGs in regional, rural and remote areas than in major cities. Through migration policy and various policy measures, Australia has been successful in supplementing its GP workforce with IMGs both, in urban and rural areas.

Table 3.6: GPs in Australia – major cities and regional, rural and remote areas, 2015-2016

<table>
<thead>
<tr>
<th>GP workforce</th>
<th>Major cities</th>
<th>Regional, rural and remote areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian medical graduates</td>
<td>60%</td>
<td>57%</td>
</tr>
<tr>
<td>International Medical Graduates</td>
<td>40%</td>
<td>43%</td>
</tr>
</tbody>
</table>


Table 3.7 outlines IMGs as a proportion of the GP workforce in Australia’s major and regional and remote areas for the year 2004-2005 and 2015-2016. Since 2004-2005, there has been an increase in the proportion of IMGs working as GPs both in major cities and regional and remote regions of Australia (Australian Government Department of Health 2016). The proportion of IMGs has increased in regional, rural and remote regions from 33 per cent in 2004-2005 to 43 per cent in 2015-2016. This growth is lower than in major cities which show an increase in IMGs by 14 per cent over the same period. What is unclear from this data, is whether the nominally greater increase of IMGs in urban as opposed to rural areas, reflects the lack of retention of IMGs in rural communities. A lack of data on IMG retention this assessment difficult.
Table 3.7: IMGs in General Practice (Australia), 2004-2005 and 2015-2016

<table>
<thead>
<tr>
<th></th>
<th>IMG as a proportion of the GP workforce in major cities</th>
<th>IMG as a proportion of the GP workforce in regional, rural and remote areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004-2005</td>
<td>25%</td>
<td>33%</td>
</tr>
<tr>
<td>2015-2016</td>
<td>39%</td>
<td>43%</td>
</tr>
</tbody>
</table>


Nationally, the percentage of IMGs working in rural and remote areas is greater than the percentage of IMGs working in major cities (Australian government Department of Health 2016). In rural and remote regions of NSW IMGs constitute 36 per cent of the GP workforce (NSW Rural Doctors Network 2017; 2018). The data shows there is a strong reliance on IMGs in rural, regional and remote communities of NSW to meet its health needs.

3.5 Conclusion

Consistent with the other Western nations, Australia has utilised migration policy to specifically supplement its doctor workforce. Beyond this broad use of migration policy, explicit policy measures are utilised to increase doctor resources in rural and remote regions. There are a range of policy complexities, including IMGs practising as GPs have a moratorium period to continue rural practice, uneven distribution of IMGs once they have completed their compulsory period of employment. Integration to and retention of IMGs in rural communities is important given the range of policy measures that have been introduced to ensure that they are employed in particular geographical areas of shortages. Research in this area is shaped by the policy context and its complexities where a combination of state, territory and federal government policy initiatives are directed towards recruiting and retaining IMGs. A review on the scholarly literature of integration will be completed to examine and assess how factors of integration may influence retaining doctors working in rural communities. It is this research that underpins the scholarly interest in those factors that shape the retention of IMGs in rural practice. This will be addressed in the next chapter.
CHAPTER 4

INTEGRATION

4.1 Introduction

Integration to and retention of IMGs to rural practice and communities is important given the range of policy imperatives implement to recruiting, integrating and retaining them in rural communities. This chapter examines relevant research studies on integration noting that the term is subject to multiple framings and deployed through a number of different policy contexts. Some attention to the breadth of the theoretical framing is provided here but the primary focus in this chapter is on the term integration as it is used to assess policy directed towards the deployment of IMGs. This focus directs attention to what comprises integration and how it is represented, and what political and social outcomes derive from it, such as retention within a nominated labour market. This focus introduces a particular spatial and cultural dimension as the research largely concerns the deployment of IMGs in Western settings. The chapter then moves to the conceptual framework used in this thesis and the reason for choosing this framework. Han and Humphreys’ (2006) typology provides one of the more specific treatments and guides specifically the dimensions of integration and its influence on retention, particularly as they concern IMGs in Australian rural communities. Following from this, this chapter articulates the research questions of the thesis.

4.2 Conceptualising integration

Within the research addressing integration, there is considerable attention to conceptualising integration in precise terms or what it means to be integrated. Robinson (1998, p. 118) questions the coherence or wisdom of defining integration in precise or unified terms, concluding that; ‘integration’ is a chaotic term: a word used by many but understood differently by most’. The use of the term transcends disciplinary boundaries including social science, psychology, management or engineering (Raghuram 2007) but if there is to be a common starting point it is a study of the ‘other’ or ‘otherness’ that may be cohered around legal or citizenship status, race, class, religious or cultural differences (Penninx 2005) where research assesses
the dynamic relation of ‘otherness’ to dominant, entrenched or perceived mainstream interests. Within the research on integration there is a significant subset of studies directed to the integration of migrants, and more recently arrived refugees. Such research intersects with theories of immigration – from ‘assimilation to multiculturalism to racialisation and ethnicisation’ (Wimmer & Glick Schiller 2002, p. 226) but even allowing for this diversity in theoretical framing, integration is largely viewed as a problem to be solved, with a deficit of integration largely confined to those who come from outside the nation state. A normative perspective is evident in conceptualising integration either to facilitate transition of migrants in a new place or country, and to bring employees to a common standard of skills, values, and ethics in an organisation (Ager & Strang 2008).

This type of problematisation enabled a focus within the research scholarship on policy, both inclusionist and exclusionist, (Penninx 2005), where integration is frequently identified as an explicit policy goal and outcome for migrant or refugee program outcome (Ager & Strang 2008). The breadth of research that has emerged from this focus has underlined what Castles et al. (2001) has identified as the unresolved contestability around how integration is defined, modelled and measured. One immediate differentiation is whether scholars see integration simply as an outcome, or a process, or adopt a framework that is inclusive of both process and outcome (Ager & Strang 2008; Raghuram 2007; Sigurjonsdottir 2016). Evident also is an interest in the factors – cultural, institutional, economic, political – that frame, shape or guide the process and outcomes of integration (Ager & Strang 2008). Thus the available research includes studies that identify factors that guide the process of integration, locate broad themes or domains of integration and determine indicators that are expressions of integration or produce a desired outcome (Ager & Strang 2008; Penninx 2005; Raghuram 2007).

This broad framing of the use of integration in social science, particularly as it concerns migrants and refugees is evident in research studies. There is research that attempts to map comprehensively the domains or themes of integration (Ager & Strang 2008; Penninx 2005), or research that attempts to focus on particular domains of integration, be they professional, family, community, social, cultural, personal or natural environment (Brehm 2007; Han & Humphreys 2005; Kasarda & Janowitz 1974; Terry & Lê 2013). Research may also be with a view of assessing what factors
facilitate or hinder integration and have developed functional models or framework of integration, including indicators of integration (Ager & Strang 2008; Cutchin 1997a; Han & Humphreys 2005; Auer & Carson 2010). The frameworks can be used as a guide by organisations, workforce planners or policy makers to develop strategies in attracting, integrating and retaining professionals or migrants in a new country or a new environment. Factors draw from structural integration such as employment and education (McGrath, Henderson and Phillips 2009 & Spike 2006; Auer & Carson 2010) or community integration such as a sense of belonging and acceptance by the community (Cutchin 1997a; Han & Humphreys 2005; Terry & Lê 2013). Within this scholarship, there is considerable diversity and interchangeability in terminology. For example, Ager and Strang (2008) and Penninx (2005) uses the terminology of domains, dimensions and themes, to describe broad areas of integration and use the terminology of factors or indicators as a means to guide the discussion or measurement of integration within a particular domain, dimension or theme. This may mean for example, factors that are held to be critical or which describe areas within particularly domains, for example within professional integration, such as job satisfaction, or social integration, such as community acceptance (Cutchin 1997a; Cutchin 1997b; Hancock et al. 2009). Alternatively, indicators may be used to measure outcomes within the domain of employment, for example, permanent/casual, full-time/part-time, occupation or it may be satisfaction with employment. Other scholars use the term indicator or factors more broadly and also ambiguously; for example, employment is an indicator of integration (McGrath, Henderson & Phillips 2009; Spike 2006). Factors can also be phenomenon - institutional, cultural, social - that shape or facilitate the process of integration (Raghuram 2007; Sigurjonsdottir 2016) studies in this tradition focus on factors that facilitate or hinder the process of integration and may leave unattended the conceptualisation of the term integration.

To advance the debate about what constitutes integration, Ager and Strang (2008) studied refuge re-settlements and developed a conceptual framework comprising four interrelated main themes and ten domains. Based on commonalities in perceptions of successful integration, the framework identified broadly based domains reflecting normative understandings of integration but also assessed that contextualised international and national indicators would need to be negotiated for each domain. The themes and related domains included: Makers and means (employment, education,
housing, health); social connection (social bridge, social bonds, social links); facilitators (language and cultural knowledge, safety and stability); foundation (rights and citizenship) (Ager & Strang 2008). This framework is also identified by Ager and Strang (2008) as a tool to facilitate the integration of refugees and to inform policy development; this is despite the authors consciously not theorising or mapping the factors that shape integration. The framework has been used for policy formulation, for debates on integration and as a guide to develop services for refugee integration. While using the framework in a specific context, individual or local indicators for each domain have to be reconsidered. Ager and Strang’s (2008) framework has been used in assessing the role that faith community’s play on integration of refugee resettlements in the US labour market.

Penninx (2005, p. 141) attempts a project similar to that of Ager and Strang (2008) and identifies three analytically distinct domains or dimensions of integrated, ‘the legal/political, the socio-economic and the cultural/religious dimensions’. Raghuram (2007) maps two slightly broader domains – the structural or labour market side and the socio-cultural side (Raghuram 2007). Penninx (2005, p. 141), unlike Raghuram (2007), eschews any modelling that identifies normative requirements or indicators in these particular domains or dimensions, being more focused on the process of integration, explicitly ‘the process of becoming an accepted part of society’. Thus Penninx (2005), as well as Raghuram 2007 and Sigurjonsdottir 2016, places a particular focus on the actors involved in integration, both individual and collective, in this instance the immigrant and the receiving society, processes and mechanisms that operate at the organisational and institutional level, and the temporal aspect of integration, namely that it occurs over a period of time. The process of integration involves a dynamic tension between the identity of the migrant and the fundamental norms and values of the host society; this tension also involves the access to labour market and other opportunities provided by the host country and the factors that may mediate that process (Raghuram 2007, p. 2247). This interest has a particular policy ambition, namely that understanding the factors that inform the process of integration will assist in devising policy measures to facilitate integration.

Within the study of integration there is particular focus on employment; variously interested as either a key domain or indicator of integration (Sigurjonsdottir 2016). Seeking employment is a key reason people in general settle in rural communities
Cutchin’s (1997a) study developed a framework of domains used as a facilitator of integration of physicians in rural communities of United States of America. Studies of Spike (2006) and McGrath, Henderson and Phillips (2009) focussed on professional integration of IMGs. They explored professional issues and challenges IMGs face and how best to integrate them in the Australian health system. Han and Humphreys’ (2005) study explored factors of integration of IMGs in rural communities of Victoria with a view to enhance the prospects of their long-term retention. The study found that a welcoming community, family factors such as higher education for children and job opportunities for a spouse were important factors of ongoing integration in rural communities.

International research examining integration assumes the perspective that integration of doctors in rural communities is the basis of retention (Cutchin 1997b, p. 1661). The commonality of these studies (Cutchin et al. 1994; Cutchin 1997b; Wulff & Dharmalingam 2008) is that they have been conducted with an aim to explore factors that support the process of integration which in turn could influence the length of residence or retention in a new setting or environment. Research by Cutchin et al. (1994) in rural eastern Kentucky found ‘sociocultural integration’ to be the most important aspect for retaining rural practitioners. The precise reference to sociocultural aspect reflects the importance of various social relations in a rural practice setting, including acceptance by the community, recreational opportunities, family satisfaction, family ties to the area, and an agreeable religious support structure. Cutchin et al. (1994) suggested that professional, community, family and personal factors were found to influence choice of practice location. A Canadian study noted that the influence of spouse is significant in the choice of practice location. The two main influencing factors are opportunities for work and professional advancement, and community lifestyle in rural regions (Kazanjian & Pagliccia 1996). A subsequent study by Cutchin (1997b) explored factors that facilitate integration. A framework was developed with three domains: Physician self, medical community and the community at large which provided an understanding to the process of integration. Cutchin (1997a) concluded that integration is a type of progress that builds bonds with place that in turn encourages retention. Better integration may improve the quality of experience which in turn influences retention (Cutchin 1997a).
Research assesses how social ties with the community can reduce migrants moving out of regional areas of Australia (Wulff & Dharmalingam 2008). Migrants make social ties with the community by involving themselves in local or community activities, sports or the local club. The social tie a migrant makes with the community is referred as social connectedness. The study concludes that the more involved migrants are with the community the less likely they are to move out of the region. The two important factors of social connectedness are involvement of the migrant in community activities, and involvement of migrant school or sporting activities of their children (Wulff & Dharmalingam 2008).

Some studies (Brehm 2007; Kasarda & Janowitz 1974; Lehmann, Dieleman & Martineau 2008) have demonstrated that there are influences other than professional factors that shape choice of location and the length of residence in a location. An understanding of these factors would assist in developing strategies for recruitment and retention. Lehmann, Dieleman and Martineau (2008) explored factors of attracting and retaining health personnel in rural areas. Family, preference of location, natural environment, rural upbringing, working conditions and remuneration influenced health personnel’s decision where to take up practice. The study noted that there is a complex interplay of factors that impact attraction and retention of health personnel.

Social ties and environmental factors such as mountains, lakes, rivers, wildlife, and scenery were also found to influence community attachment which in turn influences retention. Using community attachment model, Kasarda and Janowitz (1974) attempted to study factors that influence community attachment through means of making social bonds. Length of residence was the key factor to community attachment. The study was conducted in rural, small urban and large urban setting. The study examined five variables that influenced social bonds and sense of community. The variables are: community size, population density, length of residence, social class and life cycle (age). The study found that length of residence had a positive influence in making social bonds within the community. Number of friends in the community gave a strong sense of community and had a moderate effect on staying in the community. Membership in local organisations had an influence on community interest but less effect on sense of community or desire to stay. The size of the community had less effect in influencing social bonds (Kasarda & Janowitz 1974). Brehm (2007) demonstrated that apart from social attachments with friends and other community
members, natural environment played a role in community attachment by providing a particular way of life. This study used community attachment as a conceptual framework in understanding how specific elements of the natural environment provide a sense of place.

### 4.2.1 Integration of IMGs or health professionals in a new country

The professional integration of IMGs in a new setting is researched from a particular perspective; specifically, what facilitates integration of IMGs to a new health system. Some international studies (Cameron, Este & Worthington 2008; Hancock et al. 2009; Khan et al. 2015; Wong & Lohfeld 2008) have also examined challenges that doctors face working in rural communities of a new country. Wong and Lohfeld (2008) explored the recertification training experiences of IMGs in Canada with a view to design medical training programmes. This could facilitate familiarising IMGs to a new medical system. Khan et al. (2015) reviewed barriers that new IMGs face in the United Kingdom health system. They noted that different training methods in medical schools between countries, using the English language, and different socio-cultural backgrounds can be problematic for new IMGs which could act as barriers in training and career progression. Some IMGs choose to compromise their medical specialty just to secure a job in the new country (Khan et al. 2015).

There are both international and Australian research studies focussing on integration and retention of IMGs in rural communities. While some studies squarely focussed on professional integration (Gilles, Wakerman & Durey 2008; Khan et al. 2015; Spike 2006; Wong & Lohfeld 2008) there were some studies that focussed on both, professional and social integration (Cameron, Este & Worthington 2008; Han & Humphreys 2005 & 2006; Hancock et al. 2009; Terry & Lê 2013; Terry, Lê & Hoang 2014). IMGs are placed in rural communities to fulfil the health needs of the community and it is important that IMGs receive appropriate training and orientation to work in a new medical system (Khan et al. 2015; Wong & Lohfeld 2008). Integration is studied as a set of behavioural outcomes, which may include being settled or retained (Auer & Carson 2010; Cameron et al. 2008; Cutchin 1997a; Cutchin 1997b; Hancock et al. 2009). A smooth initial transition to a new cultural and practice environment is also found to be an important component of retention (Hancock et al. 2009). Programs that
are supportive of initial integration, such as information sessions, information on social and community activities, orientation programs by recruiters or health organisations is thought to improve integration and retention (Hancock et al. 2009, p. 1370). Community factors are also found to contribute towards improved retention. Factors such as showing appreciation to doctors, getting support from communities, having connections with the community, the presence of physical/recreational assets in the community and reciprocity between the doctor and community assists in retaining doctors in rural communities (Cameron, Este & Worthington 2008).

Studies have developed frameworks that can be used as a guide to integration and to aid in developing policies (Ager & Strang 2008; Cutchin 1997a; Cutchin 1997b). Some research seeks to identify the benefits of integration to get a desired outcome, and in doing so, seamlessly identify retention as an outcome of integration (Cutchin 1997b; Hancock et al. 2009). Research studies seek to identify factors of community attachment or social, personal and environmental factors that shape choice of location and their length of stay (Brehm 2007; Kasarda & Janowitz 1974) or research seeks to identify professional factors of integration mainly structural integration to re-train and familiarise IMGs in a new medical system (Khan et al. 2015; Wong & Lohfeld 2008). Research shows that there is no common definition of integration or a general consensus about how integration is measured.

4.2.2 The Australian perspective

Within the scholarship on the integration of IMGs in Australia, integration takes the meaning of smooth transition to a new work environment, the Australian health system. These studies have a consistent approach to the way they conceptualise professional integration (Carlier, Carlier & Bisset 2005; Gilles, Wakerman & Durey 2008; Han & Humphreys 2005; Pilotto et al. 2007; Robinson & Slaney 2013; Spike 2006; Wright et al. 2012). Identifying professional needs and challenges working in a new health system can assist in devising training and orientation programs for IMGs for a smooth transition to the Australian health system.

It is unlikely that Australia’s reliance for IMGs will diminish in the foreseeable future (Hawthorne 2011; 2012). Data reveals a decline in the mean length of stay in rural practice by a GP from 9.3 years in 2010 to 7.2 years in 2014 (Rural Health Workforce Australia 2016b). This makes it important to integrate IMGs to improve their retention
in rural areas. IMGs may require different types of support and assistance during GP training in rural locations. Understanding the specific support needs of IMGs in order to minimise the challenges associated with working in a rural environment is essential if they are to be retained in rural communities (Robinson & Slaney 2013). This understanding may assist policy makers to devise integration programs which may increase the likelihood of retention. Retention improves access to health services by reducing turnover and minimising the cost of recruitment of new staff (Russell, Humphreys & Wakeman 2012).

The motivations of previous research studies are three-fold, and are discussed further in this section. One motivation is linked to the policy context where the interest for policy makers lies in addressing medical workforce shortages particularly in rural communities of Australia (Han & Humphreys 2005 & 2006). This is seen by the regulations and various government initiatives in place to improve retention of medical professionals. Second, due to varying medical systems between countries there is a need for re-training and familiarising IMGs to the Australian health system, here integration is conceptualised as a desired outcome leading to professional integration (Gilles, Wakerman & Durey 2008; Spike 2006). Third, where integration is studied to seek factors that aid the process of integration, here integration is represented as a set of behavioural outcomes, for example being settled or being retained in employment (Auer & Carson 2010; Cameron et al. 2008; Cutchin 1997a; Cutchin 1997b; Hancock et al. 2009).

A subset of studies has squarely focussed on factors that act as barriers of integration to the Australian health system. The premise of research studies (Carlier, Carlier & Bisset 2005; Gilles, Wakerman & Durey 2008; Spike 2006) was to examine difficulties IMGs may encounter working in a new health system. These studies were conducted with a view to inform training and familiarising IMGs with the Australian health system (Carlier, Carlier & Bisset 2005; Gilles, Wakerman & Durey 2008; Spike 2006). Variation in medical knowledge, clinical skills, cultural norms and professional attitudes of IMGs makes it imperative to provide adequate training to familiarise IMGs to the new health system. This has been emphasised in previous studies (Carlier, Carlier & Bisset 2005, Gilles, Wakerman & Durey 2008; Spike 2006). IMGs have to work with greater independence in rural practice where most of them are placed following government regulations. Familiarising IMGs with the Australian health
system through orientation programs and providing sufficient clinical training will enable IMGs to work with greater confidence in rural practice. This calls for a more structured, systematic training approach rather than an ad hoc approach (Carlier, Carlier & Bisset 2005; Gilles, Wakerman & Durey 2008; Spike 2006). Addressing these barriers may help IMGs integrate with the Australian health system. IMGs constitute a heterogeneous group that come from diverse backgrounds with differing levels of knowledge and skills (Pilotto, Duncan & Anderson-Wurf 2007). This may be because medical education programs vary widely in terms of duration, curriculum, standards and training from country to country. In addition, they may have difficulties adjusting to life in a Western culture or practising medicine in a new English language environment (Pilotto, Duncan & Anderson-Wurf 2007). To reduce clinical challenges IMGs may encounter, it is important to learn the protocols of medical practice (Pilotto, Duncan & Anderson-Wurf 2007), get an exposure to the level of technology that is used routinely in Australian hospitals, and familiarise with commonly encountered Australian health problems (Carlier, Carlier & Bisset 2005).

Challenges or barriers working in rural practice

The research studies of McGrath, Henderson and Phillips (2009), McGrath et al. (2012), Pilotto, Duncan and Anderson-Wurf (2007) and Wright et al. (2012) examined the training, mentoring and education needs of IMGs in order to facilitate integration of IMGs to the Australian health system. Pilotto, Duncan and Anderson-Wurf (2007) study examined clinician needs in training IMGs for clinical practice in Australia. The main issue that emerged was communication. English as a language acted as a barrier to learning. Some issues were accent, understanding of regional dialects, and colloquial speech. IMGs could have communication problems at the subtler level such as reading the non-verbal cues in an interaction and responding with cultural appropriateness. The study stressed the need to develop IMGs’ skills in communicating with patients and other staff, and raise the standard of everyday English (Pilotto, Duncan & Anderson-Wurf 2007). Challenges IMGs encounter working in rural communities are: the need for more education in updating knowledge, familiarising with the Australian health system, learning the referral process, learning the local treatment regimens, communication with patients and other staff and orientation to local communities (Wright et al. 2012). The study acknowledged that addressing IMG training and education needs would be beneficial in integrating IMGs
in the Australian health system. Providing online information to IMGs on the registration process, the procedures and content of the AMC exam or about general practice itself would help IMGs prepare for the exams and make informed decisions about their move to Australia (McGrath, Henderson & Phillips 2009). Access to information before departure from their country of origin, improving website information, providing more support for bridging courses, funding more observer programs, providing an IMG liaison officer at hospitals, reducing the difficulties associated with passing the Australian Medical Council examination, providing support for IMGs’ families, and relaxing the rules about when and where IMGs can practise medicine would be worthwhile (McGrath, Henderson & Phillips 2009). Some of the barriers in undertaking the AMC examinations were found to be financial cost associated with the exam, understanding procedural steps for the examination and insufficient information on examination content and standard (McGrath et al. 2012).

Smith’s (2005) study examined the issues doctors faced working in rural practice of Queensland. Adequate training and education maybe useful to doctors prior to sending them to rural practice (Smith 2005). Rural exposure and training incorporated into hospital based programs prior to sending them to rural and remote communities would reduce these challenges (Smith 2005).

**In response to a particular policy context - The 10-year moratorium**

The impact of particular policy measures forms its own sub-set of scholarship. This area of scholarship was interested in examining whether the condition of service restrictions influence IMGs’ ‘sense of satisfaction’ where satisfaction was interpreted as job and social satisfaction in their current work-location (McGrail et al. 2012). Section 19AB of the Health Insurance Act (commonly referred to the 10-year moratorium) applies to IMGs from the date of first medical registration in Australia, and where the doctor had not held medical registration in Australia prior to 1 January 1997, or had not applied to sit the Australian Medical Council exams before 1 January 1997. Under Section 19AB of the Health Insurance Act, IMGs cannot make claims on Medicare rebate for their services. However, this restriction maybe exempted if an IMG is willing to practice in government-designated DWS area where the undersupply of doctors is most acute (Australian Government Department of Health n.d.,d; NSW RDN 2018). McGrail et al. (2012) using quantitative approach investigated the professional and non-professional satisfaction of GPs in their current location of rural
practice, primarily distinguishing between those who are restricted to practise only in an area of workforce shortage and those who are free to choose their practice location. This study identified non-professional satisfaction was lower for mandated GPs over non-mandated GPs. Similarly, some aspects of professional satisfaction such as autonomy in practice and using variety of skills was lower for mandated GPs over non-mandated GPs (McGrail et al. 2012).

Along with professional factors, research studies examined factors that facilitate integration to inform how this impacts settlement process in a new environment. Here, integration is studied from the point of view of what facilitates the process of integration in a new country and how this aids retention (Dywili et al. 2012; Han & Humphreys 2005; Terry & Lê 2013; Terry, Lê & Hoang 2014). Research examined the professional experience and the challenges IMGs encounter working and living in rural and remote regions of Tasmanina (Terry, Lê & Hoang 2014). The study noted that the level of professional satisfaction was high despite the challenges. Some of the challenges were registration process, navigating the new medical system and, communication with patients and colleagues. Beyond employment training including clinical support, peer support, improved medical facilities there is a need for support with access to cultural group or foods for their on-going integration (Terry, Lê & Hoang 2014).

In assessing the experience of overseas trained health professionals in Australia, Canada, United Kingdom, New Zealand and United States of America, Dywili et al. (2012), found a difference in their actual experiences and their expectations. Health professionals are expected to have adequate clinical and interpersonal skills, cultural understanding and communication skills. Whereas, the expectations of health professionals were recognition of previous experience, sufficient orientation, cultural acceptance from communities and continued support for IMGs and their families. They confirmed that addressing this gap may assist in integrating them in rural and remote areas and may improve retention rates (Dywili et al. 2012).

Several Australian studies have identified specific difficulties experienced by IMGs and their families, including community integration, which can significantly impact on their satisfaction (Durey 2005; Han & Humphreys 2005). In examining the experience of IMGs and their spouses living in rural and remote areas of Western
Australia, it was seen that most IMGs enjoyed rural practice but their spouse had difficulties (Durey 2005). Social isolation was a main concern. The study suggested that community activities may assist settling-in process and meeting the social needs of the spouse was found to be an important factor of retention (Durey 2005).

The aforementioned studies seek to identify the benefits of structural integration and community integration (Auer & Carson 2010; Han & Humphreys 2005; 2006; Terry et al. 2011; Terry & Lê 2013). The term structural integration is used for professional integration (Auer & Carson 2010). A common approach taken in these studies is to identify factors that facilitate the process of integration with desired outcomes to professional, family, social and cultural themes example settled, satisfied or retained. These studies do not define the term integration or retention or discuss how retention is measured.

In Australia, the research into integration has arguably reflected the imprecision in the term integration itself, as it encompasses research that focuses on acculturation (the process of adopting the cultural traits or social patterns of another group), place attachment (adjustment/adaptation process) and embeddedness (to attach) (Auer & Carson 2010; Halvorsen, Treuren & Kulik 2015; Terry et al. 2011). Although these terms are distinct from the term integration, they all explain the process of integration. This is seen by their shared approach where they discuss factors or strategies that could positively influence the process of integration with the aim of improving retention. These studies (Auer & Carson 2010; Halvorsen, Treuren & Kulik 2015; Terry et al. 2011) examine similar phenomena but choose to use different terms to explain the process of integration. This could be due to the limitations of the concept of integration and its usage in studies.

**Acculturation**

A smaller subset of studies uses acculturation to explain the process of integration. Terry et al. (2011) examined the experiences and challenges of IMGs in rural and remote regions of Australia and how this explains the process of acculturation. This study states that profession integration is crucial, but community, family and cultural needs are important for successfully integrating IMGs and their families in rural and remote regions. A subsequent study by Terry and Lê (2013) explored the experiences and challenges faced by IMGs working in rural and remote regions of Tasmania and
how it can explain the acculturation process. The findings indicate that IMGs encounter both professional and social challenges which influence their on-going stay in Tasmania. Some of the professional challenges include working in a new medical system, communication at different levels within primary care and communication with patients, cultural differences, dealing with unfamiliar health conditions, fear of job security, loss of status or discrimination within the workplace. The study also identified factors which determined the retention of IMGs which included: job opportunities in Tasmania after completing AMC examination, limited vocational training positions and lastly the support provided to IMGs and their families in terms of skills training, relief through locum doctors and more community engagement for families. However, social connectivity with the community, spouse employment, obtaining high quality academic access for children, and cultural and religious connectivity are factors important for retention (Terry & Lê 2013).

**Place attachment**

Auer and Carson (2010) use the terms attachment and adaptation to explain the process of integration. For example, the term ‘place attachment’ emerges from how well migrants adapt to their new conditions. Auer and Carson (2010) examined how the process of forming place attachment between GP and practice location influences prospects for retention in Northern Territory. Northern Territory of Australia experiences very high turnover rates of staff. This study takes the perspective that successful settlement or making place attachment is key to retention. Place attachment is an idea to remain in the same location. There are four dimensions of place attachment: the structural, personal, social, and environmental. The main challenge for GPs is to establish place attachment, for example newly arrived GPs need to establish a sense of place attachment or will move from the location. This study examined whether GPs use adjustment or adaptation strategies to cope with the move to new locations. Adjustments were short term trade-offs between work and lifestyle ambitions and adaptations were attempts to change themselves and their environment to fulfil lifestyle ambitions. The study suggests that there is interplay of these four dimensions in forming place attachment. Structural dimension is important but personal, social and environmental dimensions could act as facilitators of retention. Such an understanding may inform recruitment and particularly retention programs and contribute to improved workforce planning (Auer & Carson 2010).
**Embeddedness**

This study examined a similar phenomenon as integration but choose to use the term ‘embeddedness’ to explain the process of integration. A study by Halvorsen, Treuren and Kulik (2015) examined how migrants use different strategies to attach or embed themselves on-the-job and off-the-job. The study claims that the more the attachment the more difficult it would be to leave the organisation or community. On-the-job and off-the-job embeddedness plays a role in retention. Migrants used strategies to make fit and links at work and the community. Some of the fit and links of work are the job itself, the fit between values of employee to the organisation, the fit between employee and supervisor. Some of the fit and links off work are being a part of community, lifestyle and embracing the country as home. The study found that sacrifice such as customising organisation benefits to fit an individual need, matching employees to jobs of interest and passion and increasing on-the-job and off-the-job fit and links may truly embed employees to an organisation.

Terms such as acculturation and settlement success (Terry et al. 2011), place attachment (Auer & Carson 2010) and embeddedness (Halvorsen, Treuren & Kulik 2015) have been used in understanding integration and its influence on retention. Terry et al. (2011) identified the experience, challenges and acculturation of IMGs throughout rural and remote regions of Australia. Likewise, Auer and Carson (2010) examined how GPs made place attachment in their new location utilising the model of four dimensions of place attachment: the structural, personal, social and environmental. Halvorsen, Treuren and Kulik (2015) examined how migrants embedded themselves on the job and off the job in a new country. These studies have used distinct terms of integration where the studies seek to identify factors that facilitate the process on integration and how this may impact retention. However, these studies do not define the term retention or measure degrees of retention.

This is not to suggest that in the integration literature more broadly, particularly as it concerns employment, that retention is identified universally as an implicit outcome. In Australia, some scholars have taken a homogenous approach whereby they examined factors that facilitates or hinders the process of integration (Carlier, Carlier & Basset 2005; Dywili et al. 2012). Studies by Pilotto, Duncan and Anderson-Wurf (2007) and Gilles, Wakerman and Durey (2008) examined professional factors that are
needed for a smooth initial transition of IMGs to the Australian health system. On the other hand, Smith (2005) and Spike (2006) have examined barriers or challenges that doctors face working in rural regions of Australia. Along with professional factors, some studies examined factors that facilitate the process of integration and how this may inform retention. Integration is not an outcome in and of itself. The presumption here is that better integration is held to increase the likelihood of retention where retention is implied but not often explicitly addressed. These studies have examined factors that could assist the process of integration with the Australian health system or/and in rural and remote areas in a positive manner with the likelihood of improving retention (Auer & Carson 2010; Durey 2005; Han & Humphreys 2005; Terry & Lê 2013).

Drawn from the research studies, Table 4.1 illustrates how these studies address what may be thought of as key domains (Structural and socio-cultural) or indicators of integration (behavioural expression). This reflects the different emphases within research projects, as to ambiguities in the way integration is conceptualised.
Table 4.1: Domains and indicators of integration; previous studies of doctors who have migrated or relocated

<table>
<thead>
<tr>
<th>Structural and Socio-cultural</th>
<th>Behavioural expression</th>
</tr>
</thead>
<tbody>
<tr>
<td>A need to integrate into the new medical system. For this to happen, IMGs need support from medical organisations (Gilles, Wakerman &amp; Durey 2008; Spike 2006)</td>
<td>A sense of belonging. This sense of belonging comes from being accepted by the community (Cutchin 1997a; Cutchin 1997b; Hancock et al. 2009)</td>
</tr>
<tr>
<td>English language skills – for employment and education (Khan et al. 2015; Pilotto, Duncan &amp; Anderson-Wurf 2007)</td>
<td>Satisfaction with place, sense of place (Auer &amp; Carson 2010; Hancock et al. 2009)</td>
</tr>
<tr>
<td>Connecting to ethnic group or place of worship (Han &amp; Humphreys 2005)</td>
<td>Reciprocity between the doctor and community (Cameron et al. 2008; Cutchin 1997b)</td>
</tr>
<tr>
<td>Quality education for children and job for partner (Han &amp; Humphreys 2005; Terry &amp; Lê 2013)</td>
<td></td>
</tr>
</tbody>
</table>

4.3 Han and Humphreys’ (2006) approach to integration

The distinctive nature of Han and Humphreys’ (2006) approach was the development of a four-fold typology. The study attempted to relate characteristics of IMGs to their different degrees of integration into rural communities and their intentions relating where to settle. The four types identified were based on IMG characteristics that distinguish between IMGs who integrate better than others in rural communities. Han and Humphreys’ (2006) study forms the conceptual reference point of this research thesis.

Using semi-structured interviews with 57 IMGs practising in rural Victoria, their study investigated factors that impact on the process of integrating IMGs into rural communities an identified characteristics of individual IMGs who adjust or integrate better into rural practice and life with those who are less likely to do so. This was based
on personal, family and professional factors. By doing so, IMGs were classified into four types – Integrated, Ambivalent (unsure about their future settlement place), Satellite Operators (city-oriented) and Fence-sitters (affiliated with city fringe areas) (Han & Humphreys 2006). Although Han and Humphreys (2006) do not address their conceptualisation of integration in detail, their treatment embraces and replicates some of the complexities in the scholarship, as their research interest assesses integration to be both a process and an outcome, and their research examines factors that shape that process and outcome.

Han and Humphreys’ (2006) study provided a table outlining the characteristic of each of the four types (Table 4.2).

Table 4.2: Han and Humphreys’ (2006) classification into four types (Simplified description)

<table>
<thead>
<tr>
<th>Satellite Operators:</th>
<th>The Ambivalent:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families settled in the city; the doctors commute to work until they are allowed to practise in the city</td>
<td>appreciates rural life and practice, but unsure about long-term rural settlement; may settle either rural or urban</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fence-sitters:</th>
<th>The Integrated:</th>
</tr>
</thead>
<tbody>
<tr>
<td>enjoy the advantages of both rural and urban life and practice, unable to live away from the city</td>
<td>Appreciates rural life and practice; able to live as a minority; pragmatic about the limits of rural communities</td>
</tr>
</tbody>
</table>


The Integrated were found to be more positive and usually take a pragmatic approach in dealing with issues and are aware of the advantages of rural life and practice. They have valuable relationships with their colleagues and appreciate Australian medicine and the new environment. This group comprised of IMGs from different religious/ethnic backgrounds with most of them having exposure to rural medicine prior to migration. The Ambivalent have unresolved concerns about family, education and employment and are unsure about where they would settle once their period of mandatory practice is complete. With a bit of persuasion, they can be retained in rural practice after the completion of their mandatory period thus moving them from the Ambivalent to the Integrated type. The Fence-sitters live in the city fringe areas (60-100 km from city centre) and commute to work. They enjoy rural practice with access to the city. The Satellite Operators work in rural communities until the completion of
mandatory period and then move to the city. They are very unlikely to stay in rural practice as they do not feel integrated in rural communities (Han & Humphreys 2006).

Han and Humphreys’ (2006) study acknowledged the difficulties in the crisp delineation of IMGs into types that is suggested by any typology. Types or categories are rarely mutually exclusive even if typologies by their very nature present them in this way. An ambiguity about Han and Humphreys’ (2006) four types arises, are the types a ranking such that IMGs that were classified as the Integrated were more integrated than IMGs who were classified as other types? To this extent then the type of the Integrated may reflect Han and Humphreys’ analysis that IMGs so classified were more integrated than the other types. Yet this is not a point that is pursued forcefully by Han and Humphreys’ (2006) although they classify them to a ‘type’ that aids retention making it difficult to separate the type Integrated from the analysis of the typology as a whole. Their study was based on an explicit assumption that integration aids retention, where retention refers to the likelihood of IMGs to remain in rural practice after completion of their mandatory period (Han & Humphreys 2006). This thesis provides an opportunity to assess this assumption.

**Critique of Han and Humphreys’ (2006) study**

The typology developed by Han and Humphreys’ (2006) has not been the subject of extensive critique with subsequent references to it failing to engage in extensive commentary concerning its utility. Subsequent research examining integration have cited Han and Humphreys’ (2006) study (Dywili et al. 2012; Hancock et al. 2009; Terry et al. 2011; Wong & Lohfeld 2008). These studies have been discussed previously in this chapter.

In subsequent research, Humphrey and colleagues had extended his interest beyond integration to focus more squarely on retention (Buykx et al. 2010). Retention refers to the length of time between starting and finishing employment with a particular organisation (Buykx et al. 2010). This research proposed a comprehensive rural and remote health workforce retention framework which addressed factors known to contribute to avoidable turnover (Buykx et al. 2010). This framework had six essential components that should be included in any comprehensive retention strategy (i) maintaining an adequate and stable staffing (ii) providing appropriate and adequate infrastructure (iii) maintaining realistic and competitive remuneration (iv) fostering an
effective and sustainable workplace organisation (v) shaping the professional environment that recognises and rewards individuals making a significant contribution to patient care and (vi) ensuring social, family and community support. However, they concluded that one-coat-fits-all health workforce retention strategy is unlikely to be effective everywhere and should be sufficiently flexible to meet the specific needs of health professionals working in different contexts (Buykx et al. 2010). For example, in some areas it might be lack of appropriate and affordable accommodation that contributes most to poor staff retention; whereas in others it might be lack of opportunity for career progression that influences health worker decisions to leave. While all six components identified above should be considered, services might choose to target retention in ways that best suit their circumstances (Humphreys et al. 2009). Buykx et al. (2010) framework has been used in subsequent studies of retention. One such study is by Mbemba et al. (2013) synthesising the main factors that influence nurse retention in rural or remote areas. An Australian study by Li et al. (2013) aimed to examine rural GPs’ preferences for different types of retention incentives.

4.4 Towards a Research Question

As already noted, integration is a complex term with an imprecise conceptualisation and a research scholarship that addresses multiple domains of integration and assesses both the contested outcomes or indicators of integration and the processes through which integration occurs. The assessment of integration within this thesis occurs within a particular policy context, namely where migration policy facilitates the employment of IMGs and their deployment to rural communities under particular conditions. Thus the study of integration in this thesis has a particular interest in the professional domain of employment. Yet following Ager and Strang (2008) and Penninx (2005), integration is understood as involving inter-related domains, including but not limited to social and cultural domains. Further, there are complexities within each of the domains that bear further examination; employment is a broad domain potentially encompassing multiple indicators through which integration may be measured, and subject to multiple factors that shape the process of integration. As identified in Chapter 1, integration in this thesis is understood as aligning IMGs with the Australian health system and rural practice, and involves integration of IMGs into a specific geographical location, which is a rural community of NSW. Integration of
an IMG is measured as being aligned to the Australian health system and rural practice,
and being satisfied living in the rural community.

Han and Humphreys’ (2006) typology was an attempt to detail and typify indicators
of integration within the professional and social domains. Han and Humphreys’ (2006)
typology identified characteristics of IMGs who integrate better than those who are
less likely to do so in rural communities. Their rationale was that recognition of such
a typology would be useful to direct policies towards support and incentives to those
doctors most likely to remain in rural practice on completion of their mandatory period
(Han & Humphreys 2006). They also call for the examination of Australian social
structures that may create barriers for IMG integration or explore how rural societies
could change to make the process of integration easier (Han & Humphreys 2006).

The outcomes from integration are important. Within current policy contexts there is
an under theorised but presumed link between integration and retention. Cutchin et al.
(1994) identified socio-cultural integration as a significant aspect of retention.
Similarly, Han and Humphreys’ (2005) assessed that successfully integrating new
migrants into rural communities not only reduced their loneliness and isolation, but
also enhanced the prospects of their long-term retention. While these outcomes are
identified, the precise nature of the link, for example how integration supports
retention is not explicitly addressed, highlights the need for further research. As
identified in Chapter 1, retention of IMGs is measured by an IMG’s stay in the same
rural community beyond the completion of the 10-year moratorium. Policy makers
have sought to address issues of labour shortages through a regime of immigration
policies. Yet the available research suggests that simply the importation of labour is
insufficient to ensure that health demand is met in a sustained way. Research (Auer &
Carson 2010; Han & Humphreys 2005; 2006; Terry & Lê 2013) has identified
professional and social integration as a facilitative measure to retention, but where the
precise indicators of professional and social integration are under-explored and under-
theorised. The research questions of this thesis seek to partly address these concerns.

This thesis provides insights into the domains and factors of integration. In addition,
identifying IMGs based on their level of integration (IMG type) may assist in better
alignment of IMGs to rural practice (Han & Humphreys 2006). This may have positive
effects on retention, reduce turnover with improved access to health service in rural
communities (Russell, Humphreys & Wakerman 2012). Additionally, this thesis provides the opportunity to identify factors that may not be contemplated by Han and Humphreys’ (2006) typology. These factors could assist policy makers in targeting programs towards integrating IMGs in rural communities of NSW.

4.5 Research question

This thesis replicates Han and Humphreys’ (2006) typological study in assessing the professional and social integration of IMGs in rural communities of NSW to gain an understanding of integration and retention. As such, the research question is:

How effective is Han and Humphreys’ (2006) typology of professional and social integration in assessing the integration of IMGs in rural communities of NSW?

Supplementary research questions

In answering the thesis research question, other questions will also be answered, including:

Are there factors of integration of IMGs working in rural communities of NSW that fall beyond Han and Humphreys’ (2006) typology?

How effectively does Han and Humphreys’ (2006) typology explain the link between integration and retention?

What are the measures that facilitate integration, and what are the measures more likely to facilitate retention in rural medical practice?

These research questions are informed by the previously cited research and are directed to contributing to that research. Recognising that there is no unified definition or theory of integration, the research question addresses directly Han and Humphreys’ (2006) typology with a view to assessing its utility to typify and identify the factors of integration as experienced by IMGs working in rural areas of NSW. The questions are also aimed at explaining the explicit link between integration and retention that is evident in Han and Humphreys’ (2006) typology. The link between integration and retention is conceptualised in imprecise terms, yet noting the distinct interest of Australian health care policy in the retention of IMGs in rural areas.
4.6 Conclusion

This chapter has highlighted the challenges in conceptualising integration, the divisions in the scholarship as to whether integration is an outcome or a process and the diversity in nomenclature used to scope, describe and theorise integration. There is a small but emerging area of scholarship in Australia assessing the integration of health professionals, an interest informed by the labour shortages in the Australian health services labour market, particularly in rural regions, and government policy responses to those shortages. Han and Humphreys’ (2006) typology was an attempt to typify integration with a view also to retention. The utility of their particular framework frames distinctively the research inquiry for this thesis. The aim of this thesis is to examine the integration and retention of IMGs and understand the link between integration and retention. The definition of integration and retention and how it is measured in this thesis is identified in Chapter 1. The research design to support the aim of the thesis is addressed in the following chapter.
CHAPTER 5

METHODOLOGY AND RESEARCH DESIGN

Every research must start somewhere (Kaplan 1964, cited in Blaikie 2000)

5.1 Introduction

Chapter 4 highlighted the need for a greater understanding of the themes, domains and dimensions of integration and its influence on retention of IMGs working in rural and remote regions of NSW. The importance of more detailed research scholarship in this area arises from the particular features of the Australian labour market, primarily shortages of doctor resources in rural areas. Policy deployed by multiple tiers and iterations of government has featured the use of migration to import IMGs to Australia and then use the conditions of that migration and recruitment to deploy IMGs to rural areas for a stipulated period. Although data is imprecise, there is considerable policy interest in retaining IMGs in rural areas, and addressing the internal migration of IMGs to urban areas. This chapter presents the research design and methodology that is used to answer the research questions of this thesis that were presented in Chapter four. The primary research question being, how effective is Han and Humphreys’ (2006) typology in assessing the professional and social integration of IMGs in rural regions of NSW. This thesis aims to examine the professional and social factors of integration and the link of integration to retention in greater detail by utilising Han and Humphreys’ (2006) typology in the NSW context.

This chapter discusses the epistemological and ontological position of the research study. It presents the rationale for deploying a qualitative methodology and an abductive logic inquiry and the reason for selecting this approach. This discussion is followed by the process and method of data collection and data analysis.
5.2 Research Paradigm

Denzin and Lincoln (1998, p. 23) remarked ‘The researcher approaches the world with a set of ideas, a framework that specifies a set of questions that are examined in specific ways. Every researcher speaks from within a distinct interpretive community, which configures, in its special way, the multicultural, gendered components of the research act’. Yin (2010) argues that qualitative research is relativist rather than realist where multiple realities exist and as much as possible needs to be done to prevent a researcher from inadvertently imposing their own (etic) interpretation onto a participant’s interpretation (emic).

In research, paradigms are used as an overarching philosophical system (Denzin & Lincoln 1998). Paradigms are belief system that attaches users to a particular world view (Denzin & Lincoln 1998). Another definition of paradigm advanced by Creswell (2007) situates paradigm as a set of beliefs that guide action. A paradigm encompasses three elements – epistemology, ontology and methodology (Crotty 1998; Denzin & Lincoln 2018). Ontology raises questions about the nature of reality and the nature of human being in the world. Epistemology asks how do we know the world? What is the relationship between the inquirer and the known? Methodology focuses on how we gain knowledge about the world and the best means of gaining this knowledge (Creswell 2007; Denzin & Lincoln 1998, p. 185; Denzin & Lincoln 2018).

In ontology we ask the question, what is the nature of reality? Is social reality independent of our consciousness (Crotty 1998) or is there a single reality (Denzin & Lincoln 2018). Is social reality a product of our consciousness where reality is constructed based on individual experience (Crotty 1998), acknowledging also that there could be multiple realities (Denzin & Lincoln 2018). Here, the researcher embraces the idea of multiple social realities and reports these multiple realities where these realities are perceived as subjective (Creswell 2007; Denzin & Lincoln 2018).

Epistemology enables the researcher to decide what kinds of knowledge is possible, how do we know this knowledge and what we know of this knowledge (Crotty 1998; Denzin & Lincoln 1998; 2018). There can be multiple views of reality, based on an individual’s experience with reality (Bunniss & Kelly 2010; Denzin & Lincoln 2018) and social realities can have multiple meanings (Creswell 2007). There is an alternative view. In a positivist worldview, the ontological and epistemological views
are objective which claims that there is single truth, and scientific research can attain this truth (Crotty 1998; O’Leary 2000).

In framing research design, researchers identify particular ontological and epistemological positions. This thesis has adopted a constructivist interpretivist paradigm, reflecting ontological and epistemological positions grounded in subjectivity. A ‘constructivist interpretative’ paradigm works within a relativist ontology in that there are multiple realities; a subjective epistemology, where the knower and subject co-create understandings using a naturalistic set of methodological procedures (Bryman 2008; Denzin & Lincoln 1998; Denzin & Lincoln 2003, p. 35; Denzin & Lincoln 2018). An interpretivist position is assumed to acknowledge that the world is socially constructed by social actors and is being interpreted from their viewpoints, where there is an active role for the researcher in the entire research process (Denzin & Lincoln 2018). Here, meaning is constructed by participants based on their interaction with social reality (Crotty 1998). The constructed meaning arising from the analysis of participants’ accounts is the foundation of knowledge (Denzin & Lincoln 2018). In this thesis the research question was directed to the study of integration, with the research design directed to gathering data about participants’ accounts of their integration in rural medical practice and rural communities. Different IMG participants’ may construct meaning in different ways in relation to the same phenomena of integration. The researcher through analysis and interpretation of these accounts gains understanding of a phenomenon of the 25 IMG participant perspectives (Creswell 2007). The researcher generates an account and analysis that reflects participants’ experiences (Denzin & Lincoln 2018). In this way, the researcher produces knowledge that is reflective of participants’ reality (Creswell 2007 p. 115). Researcher’s own personal experiences and cultural background may shape the interpretation of data (Creswell 2007). This acknowledgement reflects the comments of Denzin and Lincoln (2018): ‘Researchers cannot know the real without recognising their own role as knowers. Who we are and how we understand the world is a central part of how we understand ourselves, others and the world’ (pp. 115-116).

In constructing the research design, a researcher constructs steps to ensure that the research moves from paradigm to the empirical world (Creswell 2007; Denzin & Lincoln 2003, p. 36) A strategy of inquiry comprises a bundle of skills, assumptions and practices that researchers employ as they move from their paradigm to the
strategies of inquiry put paradigms of interpretation into motion. At the same time, strategies of inquiry connect the researcher to specific methods of collecting and analysing empirical materials (Denzin & Lincoln 1998, p. 29). The methodology, methods and strategy of inquiry more broadly, including their alignment and support of the research question, are outlined in the following sections of this thesis.

5.3 Why qualitative research?

Qualitative research is used across many disciplines, anthropology, linguistics, education, nursing and public health (Yin 2010). In qualitative research, meaning is represented using words rather than numbers (O’Leary 2004). Qualitative research is appropriate when we need to explore a problem on a specific group of people in a real-world setting (Creswell 2007; Yin 2010). The primary research question of this thesis is, ‘How effective is Han and Humphreys’ (2006) typology of professional and social integration in assessing the integration of IMGs in rural communities of NSW?’ This research study examines the professional and social experience of IMGs working in rural and remote regions of NSW. Qualitative approach suits the goal of the research study by offering the advantage of a detailed examination of the professional and social experience of IMGs. From this first-hand knowledge, future research studies can be designed (Neuman 2000).

Qualitative research is creative and interpretive (Bryman 2008; Creswell 2007; Denzin & Lincoln 1998, p. 29). Qualitative research allows us to choose a suitable method, grounds the logic for choosing this method, and allows us to acknowledge philosophical assumptions (Crotty 1998; Creswell 2007). Qualitative research enables interpretive methods to understand human experience (Creswell 2007; Denzin & Lincoln 1998). Qualitative research is an analytical process where new insights and understanding evolve during the process of data collection and analysis (Corbin & Strauss 2008; Silverman 2013). The researcher interprets the phenomenon in terms of the meanings people bring to them (Creswell 2007, p. 36).

Studies examining factors of integration or retention have deployed a range of research methods: quantitative, mixed methods, qualitative approaches. Quantitative approaches have primarily been used to examine professional satisfaction of IMGs and
GPs in Australia. For example, a survey study conducted by McGrail et al. (2012) examined the professional and non-professional satisfaction of IMGs and GPs in Australia. Russell, Humphreys and Wakerman (2012) examined factors of retention of GPs in rural and remote areas of Australia using a quantitative methodology. A mixed method approach has also been used to examine the experience and challenges of IMGs working in rural regions of Tasmania (Terry; Lê & Hoang 2014), the training and support needs of IMGs (Wright et al. 2012). For example, Wright et al. (2012) used questionnaires to evaluate an educational program offered to IMGs and semi-structured interviews to obtain an understanding on retention of IMG in rural areas. Qualitative approaches have been previously used to examine the factors of integration of doctors in rural and remote areas. For example, a study by Auer and Carson (2010) examined how the process of forming 'place attachment' between GP and practice location might influence prospects for retention. Terry and Lê (2013) examined the experiences and challenges of IMGs living and working in rural and remote Tasmania through qualitative methods. Research study conducted by Rajendran, Farquharson and Hewege (2017) examined factors facilitating or hindering integration of skilled migrants in Australia, using in-depth interviews. The study provided initiatives to work-place integration. Cutchin et al. (1994) study examined retention of physicians in rural communities of Kentucky, United States of America. Qualitative approaches have been previously used to examine experiences of doctors working in rural regions (Han & Humphreys 2005) and in assessing the integration of IMGs to the Australian health system (Mcgrath, Henderson & Phillips 2009). Qualitative approach gained insights from participants (Silverman 2013).

However, studies have used a quantitative approach or a mixed method approach. For example, research study assessed Australian immigrants’ reason to stay or leave their initial destination, and used survey method (Sapeha 2016). Another study examined the positive and negative factors living in rural and regional Australia, and also used surveys (Krivokapic & Collins 2014). Cliff, Grun, Ville and Dolnicar (2015) study assessed the retention factors of skilled female migrants in Australia using a mixed method approach.

Consistent with the research methodology of the above qualitative studies on IMGs, this thesis deployed a qualitative approach because its interest lies in gaining insights into actual experience of IMGs working in rural and remote regions of NSW. This
enables not only a nuanced understanding of professional and social integration of IMGs in rural communities but also an improved understanding on the link between integration to retention.

There are several methods of collecting qualitative data and semi-structured method is one of them (Creswell 2007; Denzin & Lincoln 1998). Interviews present itself as a useful tool to access the experiences, thoughts, and opinions of participants on the research topic (Silverman 2013). To get a detailed understanding, we need to talk to IMG participants and allow them to provide an account of their experience in their own words (Creswell 2007). Semi-structured interviews provide the participants an opportunity to describe their experiences in their own words. This approach generates a rich description and understanding of IMGs’ experiences working as GPs in rural and remote regions to enable analysis. This thesis relied on participants’ experiences and their responses to the interview questions which were drawn from Han and Humphreys’ (2006) study. An interview presents itself as a useful tool to access the experiences, thoughts, and opinions of participants on the research topic (Silverman 2013). This method gives the participants an opportunity to describe their lived experience. In saying so, this method is not devoid of its limitations. In semi-structured interviews, the question order effect cannot be followed strictly where it may not be possible to ask all the questions in the same order as in the interview guide, second participants may be giving a desirable answer rather than the real answer and third, the problem when the interviewer and the participant may not share the same meaning of terms (Bryman 2008; Bryman 2016; Silverman 2005). Despite the limitations, qualitative approach using semi-structured interviews is most suited as the aim is to explore the actual experiences of IMGs working in rural regions of NSW.

5.4 Research inquiry

This thesis assessed the professional and social factors of integration of IMGs in communities of NSW using Han and Humphreys’ (2006) typology. Han and Humphreys’ (2006) used critical realism inquiry which argues that social reality has ontological depth and consists of domains of actual, empirical and real. That is, an actual phenomenon of the IMGs’ integration may have produced various perceived (empirical) views, which can be further explained by relevant social structural or real underpinning factors (Han & Humphreys 2006). They cite the use of critical realism
but go no further in fully explaining this. Han and Humphreys’ (2006) in their area of investigation used life histories to understanding of social phenomena. Using a biographical, life-history methodology 57 semi-structured interviews were conducted. Using an existing framework for a thesis has its own merits. It provides the researcher a set of ideas, the phenomenon to study, the context, the participants, the mode of data collection and ideas about data analysis (Miles & Huberman 1994, p. 17). I have replicated their study in a number of ways. Semi-structured interviews were used to collect data from IMG participants. The topics of Han and Humphreys’ (2006) interview questions were used in formulating an interview guide for the semi-structured interviews. Analysis of the interview data was used in assessing the professional and social integration of IMGs in rural communities of NSW. However, I have not applied the philosophical stance of critical realism in shaping the analyses of interview data, as Han and Humphreys’ (2006) give no guidance on this precise approach, or why it was relevant to their study. Indeed, critical realism is absent from all studies regarding integration and related social processes of IMGs.

Rather, I have used a constructivist interpretivist approach which assumes a subjective view of both ontology and epistemology (Creswell 2007; Denzin & Lincoln 2018) where researchers mainly rely on the participants’ responses of their experience. To analyse data, I have taken an abductive methodology, which is a spiral, non-linear approach in analysing participants’ responses which is their reality, the way they have constructed and interpreted their activities together embedded in their own language. The key objective of abductive inquiry is to explore, describe and understand participants’ social life (Blaikie 1993; Blaikie 2000). This strategy of reasoning was used as this has the advantage of answering both what and why questions (Blaikie 2000, p. 122). Abductive research strategy is appropriate in interpretivism that is concerned with deriving expert accounts of social life from the everyday accounts that social actors can provide. IMG participants working in rural communities can provide firsthand knowledge about their experience living and working in rural communities. Participants can give an account of their social world, their construction of reality, conceptualising and giving meaning to their social world in their own language. Thus abductive strategy entails ontological assumptions that view social reality as the social construction of social actors. This can be regarded as relativist where there is multiple
and changing social realities. The epistemological assumptions of the abductive research strategy regards social scientific knowledge as being derived from everyday concepts and meanings from socially constructed mutual knowledge. The task of the researcher is to discover the motives and actions, and the situations in which they occur, in the technical language of social scientific discourse to provide an understanding of the activities (Blaikie 2000; Blaikie & Priest 2016). This strategy begins by deriving concepts from participants’ responses in lay language which produces a closer account of participants’ experience. From this the researcher derives categories and concepts that form the basis of an understanding or an explanation of the problem at hand (Blaikie 2000).

There is the merit of abduction over deductive or inductive methods. In a deductive method, a theory or a hypothesis is tested. In an inductive method, from observations generalisations are made. Social theories or ideal types are not developed in an inductive approach (Blaikie 2000). In both these methods, the researcher and the participants are independent of social reality. In the abductive strategy, the researcher pays more attention to participants’ social constructions and actively constructs an account in technical language based on the firsthand accounts provided by the participants. This process of construction is not neutral; researchers have to invest something of themselves into their account (Blaikie 2000; Ong 2012). Abduction is based on cyclic or spiral process rather than a linear process and contains multiple layers as set out in Box 5.1. Constructing technical accounts (meanings and interpretations) from first hand lay accounts of participants is a hermeneutic process, intersecting with social theories and perspectives. It occurs in the context of conceptual assumptions rather than in a blank slate. In this thesis, integration was used as a social theory and perspective in understanding and making sense of participants’ professional and social experience. Interpretivists can generate abstract descriptions produced from social actors’ accounts. In this way, this approach could produce understanding of these firsthand or first order accounts of participants through means of description to explanation to constructing types (Blaikie 2000 & 2016; Ong 2012).
Box 5.1: Layers of Abduction

| Everyday concepts and meanings |
| Provide the basis for |
| Social action/interaction |
| About which |
| Social actors can give accounts |
| From which social theories can be generated or understood in terms of social theories or perspectives |

Source: Blaikie (2000, p. 177).

5.5 Research design

The current section discusses data collection methods, the selection criteria for participants and the ways of recruiting participants for this thesis.

5.5.1 Data collection method

The following section discusses the main mode of data collection for this research thesis. Semi-structured interviews were the means of data collection.

Semi-structured interviews

Semi-structured interviews were the main mode of data collection method for this thesis. A semi-structured interview allows the researcher to structure the questions related to the topic and ask open ended questions to the participants (Creswell 2014). Prior to developing the interview questionnaire, reading academic journals on interview design and implementation along with attending data collection research workshop was undertaken. The interview questions were not provided but they were inferred from Han and Humphreys’ (2006) study. The purpose of doing this was to keep relevance around the topic of professional and social integration (Kvale 1996). The questions were based on: participants’ backgrounds; personal and family
settlement experiences in rural Australia; employment histories prior to and after arriving in Australia; likes and dislikes about rural life and practice; factors that facilitated or inhibited their integration in the community; informal relationships they have developed; reasons for staying or leaving rural practice; and the level of community or professional support towards IMGs and their families (Appendix 4). An interview guide was developed. After the first interview, the questionnaire was revised slightly. Amendments like paraphrasing the questions were made to the interview protocol for use in subsequent interviews. Interview questions were open-ended which enabled to probe or seek clarification of matters based on the participants’ responses (Kvale 1996). Twenty-five semi-structured interviews were conducted over the telephone. This was due to the cost and the distance associated with travelling to different rural regions of NSW.

Given the nature of semi-structured interviews, questions from the interview guide were asked to all 25 participants. If the participant response included answer to a question that was later in the interview guide, then that question was not asked. Probing questions were asked for clarifying or if more information was needed (Bryman 2008). This helped in obtaining perspectives from multiple participants about their professional and social experience working in rural communities of NSW. This generated a rich set of data for analysis.

Variations between this research study and Han & Humphreys’ (2006) study are noted. The wording of the interview questions may have been different to Han and Humphreys’ (2006) study. Due to the distance of rural communities from Sydney, face-to-face interviews were replaced by telephone interviews. The limitations of telephone interviews are the lack of informal communication such as missing facial cues, body language, or missing some key information (Creswell 2007). The difficulty in finding participants during the data collection period allowed for a total of 25 interviews to be conducted. This feature was different to Han and Humphreys (2006) study that interviewed a total of 57 participants.
5.5.2 Selection criteria for participants

There were three criteria in order to be a participant for the interview. This was to keep relevance with the aim of the thesis, examining the professional and social experiences of IMGs (GPs) working in rural and remote regions of NSW. The criteria were:

- Have a MBBS qualification from a country other than Australia and New Zealand
- Must be a GP or GP registrar
- Must be working as a GP or GP registrar in one of the seven non-metropolitan LHDs of NSW. The LHDs are Far West, Hunter New England, Mid North Coast, Murrumbidgee, Northern NSW, Southern NSW and Western NSW.

The New South Wales Ministry of Health divides New South Wales into fifteen separate regions, called LHDs (Local Health Districts) out of which seven districts belong to non-Metropolitan NSW LHDs and the remaining eight belong to metropolitan LHDs. The non-Metropolitan LHDs - Far West, Hunter New England, Mid North Coast, Murrumbidgee, Northern NSW, Southern NSW and Western NSW. The regions (RA) and the non-metropolitan LHDs of NSW are detailed in Table 5.1. The map of NSW (Figure 1) shows the seven non-metropolitan LHDs of NSW.

Table 5.1: Non-metropolitan LHDs of NSW showing geographic size and population of the region

<table>
<thead>
<tr>
<th>Region</th>
<th>Geographic Size and Population Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Far west</td>
<td>Bordering three states, Far West LHD covers 194,949 square kilometres in remote NSW. Its population size is approximately 30,000 people.</td>
</tr>
<tr>
<td>Hunter New England</td>
<td>Hunter New England LHD covers a region of 131,785 square kilometres. The estimated resident population is 873,741 people.</td>
</tr>
<tr>
<td>Mid North Coast</td>
<td>Mid North Coast LHD covers an area of 11,335 square kilometres. It has an estimated population of more than 211,000 people.</td>
</tr>
<tr>
<td>Murrumbidgee</td>
<td>Murrumbidgee LHD is 125,561 square kilometres. The estimated resident population is 287,869.</td>
</tr>
<tr>
<td>Northern NSW</td>
<td>Northern NSW LHD is 20,732 square kilometres with an estimated population of 288,241 people.</td>
</tr>
<tr>
<td>Southern NSW</td>
<td>Southern NSW LHD is 44,534 square km. It has a population of approximately 199,000 people.</td>
</tr>
<tr>
<td>Western NSW</td>
<td>Western NSW LHD covers around 250,000 square kilometres. The LHD has a population of 270,775 people.</td>
</tr>
</tbody>
</table>

Relevant here is the spatial distribution of 25 IMG participants of this thesis. Nineteen IMG participants of this thesis were from inner regional (RA2) region, four IMGs came from outer regional (RA3) region and two IMGs were from remote regions (RA4) of NSW. All 25 IMG participant of this thesis come from the seven non-metropolitan LHDs (Figure 1). The Australian Government Department of Health uses the ASGC-RA classification system (Australian Bureau of Statistics 2001; Australian Bureau of Statistics 2014; Australian Government Department of Health 2013b).

Figure 1: Map of NSW showing the seven non-metropolitan LHDs of IMG participants of this thesis.

Source: NSW Government Health n.d.,

Purposive sampling was used in selecting participants for this study. Purposive sampling involves selecting participants that are most suited in understanding the topic of the thesis, integration and retention of IMGs in rural and remote regions. This also helps in obtaining perspectives from the participants that are relevant to the research question (Bryman 2008; Bryman 2016; Creswell 2007; Creswell 2014). In sequential sampling, samples can be added as the research evolves (Bryman 2016). GP registrars were added to the initial sample due to the difficulty in recruiting GP participants. In
addition, snowball sampling was also used along with purposive sampling. This technique is useful as the participants referred other participants for the interview (Creswell 2007). Only IMGs who met the selection criteria were included as interview participant for the thesis research. For example, those IMGs who were in the process of studying for the AMC exam which is mandatory in order to work and practice as a doctor in Australia were excluded. Through these means a total of 25 participants were interviewed with ages ranging from 35-75 years. All 25 interviews were conducted from July 2014 until July 2015.

Participants of this study had obtained their basic qualification from a number of different countries (Table 5.2). This maximised variation of perspectives from the group. Participants included new IMGs as well as experienced IMGs with the number of years of practice in rural region ranging from less than one year to more than forty years. There were 17 IMGs who had either trained or worked in rural regions overseas. Table 5.2 shows the regions where IMG participant of this thesis obtained their basic medical qualification MBBS.

**Table 5.2: Region where IMGs obtained their basic medical qualification MBBS**

<table>
<thead>
<tr>
<th>Regions</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Asia</td>
<td>9</td>
</tr>
<tr>
<td>Western Europe</td>
<td>3</td>
</tr>
<tr>
<td>East Africa</td>
<td>1</td>
</tr>
<tr>
<td>Southern Africa</td>
<td>3</td>
</tr>
<tr>
<td>East Asia</td>
<td>1</td>
</tr>
<tr>
<td>West Asia/Middle East</td>
<td>2</td>
</tr>
<tr>
<td>Pacific region</td>
<td>1</td>
</tr>
<tr>
<td>South America</td>
<td>1</td>
</tr>
<tr>
<td>Eastern Europe</td>
<td>1</td>
</tr>
<tr>
<td>South East Asia</td>
<td>2</td>
</tr>
<tr>
<td>North East Africa</td>
<td>1</td>
</tr>
</tbody>
</table>
5.5.3 Recruiting participants

Participants were recruited from the seven non-metropolitan LHDs (Table 5.1). Only those IMGs who sent an expression of interest were contacted via e-mail or phone.

**Stage 1**

Participants were recruited by advertising in quarterly newsletters, ‘Monday Message’ of rural workforce agency (RWAs) in NSW. RWAs recruit and support health professionals in rural and remote communities. They also provide support for overseas-trained doctors with professional registration, securing provider numbers and immigration information (NSW Rural Doctors Network 2018). The recruitment methods were based on contacting the Rural Workforce Association and professional associations, and placing recruitment notices in the communication mediums of those organisations. The names of the organisations are kept confidential. The use of social media was also used to recruit participants. This was done by placing advertisements at various IMG associations in NSW. I also attended a seminar for IMGs in Sydney and gave a brief presentation about my research to seek participants. Advertisements were placed in various GP organisations or health institutes such as GPSynergy and HETI (The Health Education and Training Institute). These recruitment methods had very poor or nil responses from potential participants.

There were five responses from the advertisement placed in the newsletter, ‘Monday Message’, showing an expression of interest to participate in the study. Three participants were recruited through this method; the other two did not meet the selection criteria and hence were not included in the interview. A formal e-mail of introduction from Western Sydney University was sent along with an information sheet providing them sufficient information about the research. I was successful in interviewing three participants through this method. Those IMGs who expressed an interest to participant but who did not fit the selection criteria were not included.

Interviews started only after ethics approval from University’s Human Research Ethics Committee. Each participant was given a pseudonym - IMG1, IMG2, IMG3 etc. which was in the order of the interview conducted. Interviews were conducted over the phone. Telephone digital voice recorder was used to record the interviews.


**Stage 2**

Due to the low response rate of participants, a second approach to recruiting participants was employed. This was by means of calling GPs working in the seven non-metropolitan LHDs of NSW over the telephone from the mailing list of Yellow pages, White pages and the public domain. A list of postcodes that fall under the seven non-metropolitan LHDs of NSW was made. GP practices that were identified from this list were telephoned. This was to obtain names of IMGs working in those practices. The GPs were then contacted via post and/or email to invite them to participate in this research study.

Correspondence to GPs included a Project Information Sheet and a Consent Form. Contact to the GPs was made after one week of sending invites to them. This was done to find out any expression of interest. Those GPs who expressed an interest to participate in the interview, the interview day and time was negotiated. A suitable day and time that was proposed by the participant for the interview was accepted. Through stage 2 recruitment, I was able to recruit 22 participants. Telephone interviews were conducted only after receiving a signed consent form or after obtaining consent over the phone. Due to time constraints, GPs preferred phone consent prior to the interview. This was done by first reading the information about the study to them. Once consent was obtained over the phone, interviews commenced.

A total of 25 interviews were conducted after obtaining informed consent from the participants either via phone or written consent via email or post. This is fewer than 50 that was originally planned, and less than Han and Humphreys’ (2006) study. Due to the difficulty in obtaining more participants for the interview within the stipulated time-frame of this thesis candidature, 25 interviews were considered sufficient to answer the research question. Bryman (2012, pp. 426-427) suggests samples fewer than 20 interviews allows for sustainable inferences from data.

In qualitative research, there is a lack of general consensus on how data saturation is determined or used in practical terms to estimate sample sizes for purposively sampled interviews (Guest, Bunce & Johnson 2006, O’Reilly & Parker 2013; Mason 2010). Research indicates that the size of purposive samples be established before the start of field work and sampling continue until theoretical saturation is reached. Theoretical saturation is a concept that is not clearly defined (Guest, Bunce & Johnson 2006). However, the authors argue that the research questions and the conceptual framework
can set boundaries for sampling decisions (Miles, Huberman & Saldana 2013). When
participants are chosen according to common criteria it makes the participants
homogenous, the information gathered would meet the aim of the research study
(Guest, Bunce & Johnson 2006; Miles, Huberman & Saldana 2013). Sampling in
qualitative research is concerned with the richness of information and, the number of
participants required depends on the aim of the study, the conceptual framework and
the availability of time and resources (Mason 2010; O’Reilly & Parker 2013).

Malterud, Siersma and Guassora (2016, p. 1753) noted a recognised principle for
determining the appropriate number of interviews for a qualitative study is it ‘should be
sufficiently large and varied to elucidate the aims of the study’. However, they argue this
principle provides no guidance for research planning. To overcome this problem, they
instead suggest qualitative research should focus on the concept ‘information power’
supplied by interviewees, where the greater information power gained from interviews,
the lower the number is needed, and vice versa (Malterud, Siersma and Guassora 2016, p.
1754).

They also argue studies applying well established theoretical perspectives can generate
adequate information power with fewer interviews than studies exploring emerging fields
of knowledge if the information power of the small number of research participants
‘address and elucidate something crucial to theory’ (Malterud, Siersma and Guassora
2016, p. 1755). As discussed in Chapter 4 of the thesis, there is a growing body of
theoretical perspectives concerned with the concept of integration. Answering the primary
and secondary research questions of this thesis has the potential to add to the
understandings of how the concept of integration applies to IMGs in both the NSW and
Australian contexts. Malterud, Siersma and Guassora (2016, p. 1759) conclude sample
adequacy and data quality can be more important than the number of research participants
if the information power of a sample is sufficient to meet the goals of the study.
Consequently, it is asserted the combination of homogeneity of the IMGs interviewed and
the information power obtained from these interviews was more than adequate to
contribute new knowledge from the analysis.

The issue of the appropriate number of interviews is related to the concept of
‘representativeness’. Representative sampling is a contested idea for qualitative studies, in
contrast to quantitative studies (Lincoln & Guba 1985). The positivist paradigm of
research has representativeness as the basis for generalisations. The post-positivist
paradigm of research questions this assumption because research populations are rarely homogenous. Rather than seeking representativeness, the goal is to have ‘contextual similarity’ among the research participants (Lincoln & Guba 1985, pp. 296-298). Guest, Bunce and Johnson (2006, p. 76) suggest if research participants are selected because they meet common criteria, their shared experiences and/or perceptions can yield a relatively homogeneous group. In this thesis, common selection criteria used was that IMGs practice medicine in a rural or remote area of NSW. Therefore, the IMGs interviewed had a contextual similarity.

Participants were informed that they could withdraw from participating at any time without any consequences. None of the participants withdrew from the interview. Data collected from interviewees were kept strictly confidential and participants were also informed about de-identifying their names in any analysis, publication and thesis (Kvale 1996).

5.6 Data analysis

Data analysis for this thesis was done manually using typed transcripts of the interviews and coding was represented on a grid table in a word document. This approach provided familiarity with the data and insight into the intuitive aspects of analysis (Webb 1999). The data collected from interviewees was thematically coded and analysed. Using abductive strategy, analysis involved integration as the central idea to match theory to data. This was consistent with both, the theory and the data (Sinkovics & Alföldi 2012) where the concept of integration was applied to the data collected. The steps involved in analysing the data of this thesis included making sense of the data, leading to identifying similarities and dissimilarities from the responses, noting patterns, making connections between them and further grouping them to sub-themes and broader themes (Clarke & Braun 2006; Han & Humphreys 2006).

The software program ‘Dragon voice’ recognition was initially utilised to transcribe interviews. But because of its high error rate in transcription, the researcher decided to do the transcription of all 25 interviews. This was found to have less errors and fewer misinterpretation of participants’ responses. The initial transcripts were read several times by the researcher (in consultation with my thesis supervisors) and any syntax irregularities were identified and corrected. All 25 interviews were transcribed verbatim. Prior to transcribing, I listened to the interview recordings a few times. This
made the transcribing process a bit easier as I became familiar with the participant’s responses.

Temple and Young (2004) argue who produces a transcript can shape research outcomes. They likewise suggest advantages of having the interviewer also being the person who complies or transcribes the transcript, so long as they remain objective. The sequence of interview, transcription and analysis all done by the same person has virtue in contrast to each activity being done by different persons (Temple & Young 2004, p. 167).

First, the initial transcripts were read several times by the author (in consultation my thesis supervisors) and any syntax irregularities were identified and corrected. Second, the transcripts were then considered in the context of the topic for each of the interview questions, and where necessary the audio recording of the interview was further consulted. This process resulted in additional minor changes made to the transcripts so that the issue-specific information contained in the interviewee’s response was more apparent. The outcome of these procedures is reflected in the verbatim quotes reported in the thesis. The minor grammatical changes made to the transcripts were intended, as far as possible, to retain the ‘voice’ of the interviewees. In sum, the emphasis was on producing interview transcriptions that convey the meaning of the participants’ expressions rather than an exact reporting of their words. This method is consistent Regmi, Naidoo and Pilkington’s (2010) concept of transliteration.

Thematic analysis was selected as the means of data analysis as it is seen as a foundational method for qualitative analysis (Clarke & Braun 2006). Clarke & Braun (2006) argue that it is the first skill a new researcher must learn. It is flexible and not tied to any theoretical framing (Clarke & Braun 2006). Analysis of data was done manually; no computer programs were used. Coding of data was based on similarities and differences from a large set of data. Themes were generated that represented the data. Supporting quotes were used to describe these four themes (Creswell 2014). The discussion of these four themes is presented in Chapters 6 and 7. Using this approach provided meaningful insights on IMGs’ experiences working and living in rural communities.
5.6.1 Step-by-step process of data analysis

Step 1 - Before organising data on a word document, I made sense of the data by listening and reading the transcripts. Dominant responses, recurring responses, variations in responses, issues raised and any key points made by the participants were noted down in a separate word document.

Step 2 - Data analysis involves organising, disassembling data, reassembling data and interpreting data (Yin 2011). In organising the data, interview questions and their responses 1-25 were arranged in a sequence in a word document.

Step 3 - The next step was to disassemble data. This involved breaking down the participants’ responses to smaller fragments. I wrote down initial codes that I would be looking for in the responses for each of the interview question. The codes were informed by the demographics of the participants, Han and Humphreys’ (2006) professional and social expressions of integration and from the data itself. Here is an example

<table>
<thead>
<tr>
<th>Did you work in a rural region overseas?</th>
<th>Coded for (prior) rural experience overseas</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural training overseas</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rural practice overseas</td>
<td></td>
</tr>
</tbody>
</table>

Recurring issues or ideas brought up by the participants were classified as important. Some interview questions that produced similar responses were grouped together. This helped in data reduction. For example, questions 10, 12,13,14,16 and 24 were grouped together. These questions were around participants’ experience living and working in rural regions (Box 5.2).
### Box 5.2: Example of interview response coding

<table>
<thead>
<tr>
<th>Question</th>
<th>Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. How has your settlement experience been in this rural region?</td>
<td>Coded for experience with settlement – social, personal professional and family</td>
</tr>
<tr>
<td>12. What do you like most about rural practice?</td>
<td>Coded for likes about rural practice</td>
</tr>
<tr>
<td>Is there anything particular that attracts you to rural practice?</td>
<td>Coded for retention</td>
</tr>
<tr>
<td>13. What factors do you think will make you stay longer in rural practice?</td>
<td>Coded for most rewarding factor</td>
</tr>
<tr>
<td>14. What is the most rewarding thing to you working in rural region?</td>
<td>Coded for unfavourable factors of working in rural practice</td>
</tr>
<tr>
<td>24. What is your overall view of integration in rural practice and life?</td>
<td></td>
</tr>
</tbody>
</table>

Reassembling data

Step 4 – This has three parts

- This involved grouping initial codes based on commonalities together and labelling the group. This is level 1 coding.
- Constant comparisons were made with the codes. Level 2 coding involved further grouping of these codes that showed a pattern. These became initial themes and then revised themes following cross-checking. These initial and revised themes were again grouped together and became a sub-theme. A sub-theme is more easily identified as indicative of positive or negative factors of IMGs’ experience. In some instances, by virtue of greater consistencies in participants’ response and the emphasis they gave to it. In other instances, there was diversity in the topics addressed and IMGs’ experience of it features both positive and negative factors.
Sub-themes showing a pattern were grouped together and placed under a major theme. Each theme and sub-themes were given a name. These are identified in Box 6.1. The names were informed by previous studies of integration which had identified major domains, themes or dimensions of integration. These steps had to be reviewed several times to see if the themes relate to the entire data set. Memos and diagrams were used during the analysis process (Bryman 2008; Bryman 2016). Memos were used during the process of analysis to write down initial codes from the data, variations in data or recurring aspects and diagrams were used to link codes and group them. All data from the analysis were grouped under the four themes, there was no redundant material.

The process of analysis generated four main themes. Each theme consisted of few sub-themes. This was arranged in a flow chart in a word document. The four themes generated are relevant to the research question and represents data from 25 interviews. The four themes are discussed in Chapters 6 and 7 of this thesis.

Step 5 – As in any qualitative research, new understandings develop during the analysis process. I attempted to classify IMGs to Han and Humphreys’ (2006) four types. The precise basis of classification of IMGs into four types is not explicitly mentioned in Han and Humphreys’ (2006) study. They did not outline their method of allocating their 57 IMG to each of the types. Additionally, they did not record in detail how many from the 57 IMGs aligned to each type. This was done based on Table 8.2. This table was put together by drawing characteristics of each type from Han and Humphreys’ (2006) study. This formed a detailed description of the four types which was used to classify IMGs of this thesis. There were complexities in classifying some of the IMGs of this thesis into one single type. This was when IMGs showed characteristics of more than one type. The complexities of classifying were also seen when elements of retention were taken into account. This is discussed in greater detail in Chapter 8 (Table 8.2).

Using Han and Humphreys’ (2006) study provided a lens on what to see or extract from the data and assisted with organising data by grouping relevant pieces of information together. Positive and negative expressions of integration were identified during the data analysis process. This generated four themes. Based on Table 8.2, IMGs of this thesis were classified into Han and Humphreys’ (2006) types. IMGs
showed strong or weak alignment to a particular type. These were IMGs that showed majority characteristics of a single type or showed the main characteristics of a single type as outlined by Han and Humphreys’ (2006) typology. IMGs belong to a single type but also showed few characteristics of another type. This is not to suggest that there were no complexities in categorisation. The complexities raised when IMGs showed characteristics of more than a single type or when elements of retention were taken into account. This is discussed in greater detail in Chapter 8.

Qualitative research is not without its limitations because of its subjective nature and difficulty in generalising (Bryman 2008). There is no consensus in how qualitative research is evaluated. To assess the quality of research Lincoln and Guba (1985) proposed the term trustworthiness meaning ‘truth value’, but also argue that there can be no absolute truth about the social world. In qualitative research, scholars use terms such as goodness, rigour, trustworthiness, credibility, validity or reliability to gauge the quality of research (Creswell 2014; Lincoln & Guba 1985). Researchers also take the perspective of viewing qualitative validation in terms of quantitative equivalents. Validity and reliability are two criteria in quantitative research that are also used to assess qualitative research (Creswell 2007). For some scholars these terms can be aligned to the concepts of Credibility, Dependability, Confirmability and Transferability, although the latter constructs are preferred as a means of assessing the quality of research design. Validity assesses whether the research measures what it intends to measure; it is aligned to the constructs of credibility or transferability (Miles & Huberman 1994; Cresswell, 2007, 2014). Reliability which assesses the consistency and reliability in the research process is aligned to the concept of dependability (Creswell 2014). Quality of research, according to Corbin and Strauss (2008), is when the findings resonate with the participants’ experience giving insights to the topic under investigation. They suggested researchers must meet four criteria to demonstrate the quality of qualitative research. They are Credibility, Dependability, Confirmability and Transferability (Lincoln & Guba 1985). This thesis uses each of these four criteria to address the quality of this research study.

Credibility

Credibility refers to the believability of the findings (Lincoln & Guba 1985). For a research to be credible, the knowledge produced must be reflective of participants’
experience (Lincoln & Guba 1985; Creswell 2007). The issue of credibility of this thesis is addressed by answering two questions raised by Miles and Huberman (1994) and Miles, Huberman and Saldana (2013). Do the findings of the thesis make sense? Are the findings relevant to the research question?

In this thesis, Han and Humphreys’ (2006) typology was used in assessing the professional and social integration of 25 IMG participants. Interviews were the only source of primary data collection. However, a considerable amount of time was spent on data collection, transcribing the data, reading the transcripts and data analysis to develop an in-depth understanding of the views and perspectives of the study participants. This involved a process of, within method triangulation, involving consistent and routine cross-checking of interview data for internal consistency (Flick, Kardorff & Steinke 2004; Jick 1979). Multiple participants’ accounts converged. Some of the findings of this study are linked to previous studies, specifically previously identified domains, themes or dimensions of integration (Chapter 4). The results of the data from participants’ responses are presented by drawing themes based on similarities and differences in data. The four themes generated (Box 6.1) captures a rich detailed description of the participants’ experiences, underlying the credibility of the narrative accounts (Creswell & Miller 2000).

Utilising Han and Humphreys’ (2006) typology in assessing the professional and social experience of IMGs provided a lens on what to see or extract from the data. Their study assisted with organising data by grouping relevant pieces of information together. Factors that influenced the process of integration positively, factors that influenced the process of integration negatively and factors that influenced retention were identified during the data analysis process. The result of the data from participants’ responses is presented in the aggregate. Some results of this study are linked to past studies and some results are new. This is discussed in Chapter 9. The finding can be used as a guide to inform policy or practice. Contribution to policy and contribution to practice is found in section 9.4 and section 9.5 respectively of Chapter 9.

**Dependability**

Dependability refers to the soundness of the research process - methodological rigour and how it has been carried out (Lincoln & Guba 1985; Miles & Huberman 1994;
Miles, Huberman & Saldana 2013). The issue of dependability is addressed by answering these two questions raised by Miles and Huberman (1994) and Miles, Huberman and Saldana (2013). Is the research process done with care? Is it stable over time and across researchers and methods? The research design to address the research question of this thesis is discussed in this chapter. Purposive sampling was used to select a representative group of participants for the thesis (Bryman 2008). Participants for this thesis were only from the seven non-metropolitan Local Health Districts (LHDs) of NSW (Section 5.6.2); they were IMGs with their basic qualification (MBBS) from a country other than Australia or New Zealand and they were all GPs practicing in rural communities of NSW. A detailed discussion of the research design and implementation, data gathering and steps of analysis is provided in section 5.6 of this chapter. This would enable readers and future researchers to assess and repeat the study.

This thesis sought to replicate features of Han and Humphreys’ (2006) study in a different geographical region, noting the time and resource constraints. The rationale was to obtain relevant knowledge on professional and social integration of IMGs enabling an understanding on integration and its influence on retention. Features that were similar to Han and Humphreys’ (2006) approach include semi-structured interviews, participants worked in rural and remote regions but from a different state (NSW), interview questions were derived from Han and Humphreys’ (2006) journal article.

Dependability is the equivalent of reliability in quantitative research. Dependability refers to the extent to which similar findings can be obtained if the study is repeated over time (Miles & Huberman 1994). Han and Humphrey’s (2006) typology can be used as a guide to design the research process. Using Han and Humphrey’s (2006) typology in assessing the social and professional integration of IMGs in a similar context that is IMGs in rural regions of Australia can produce an understanding on integration. A detailed discussion of the research design and implementation, data gathering and steps of analysis is provided in this chapter (section 5.7). This would enable readers and future researchers to follow the same research process utilising Han and Humphreys’ (2006) typology to repeat the study in a different rural region or with a different group of participants to examine their experiences.
The approach outlined here can be utilised however, the results may vary. Integration has no agreed method of measurement as discussed in chapter four. The result depends on the demographics of the participants, geography of the place and government regulations and policies at that given point of time. For example, if the research were to be repeated in a few years’ time it is possible that the results would be different because of changes to state and federal government policies or a change in participant demographics, age or gender ratio or the geographical region. Variations in results between this study and that carried out by Han and Humphreys’ (2006) may arise due to a different philosophical approach adopted by this thesis to Han and Humphrey’s (2006) critical realism approach. Care was deployed in replicating the features of Han and Humphreys’ (2006) study, notably through the identification of rural regions, in the context of a different state of Australia, and in the recruitment of participants.

**Confirmability**

Confirmability refers to what bias the researchers can bring into the research process (Lincoln & Guba 1985; Miles & Huberman 1994; Miles, Huberman & Saldana 2013). The issue of confirmability is addressed by answering two questions raised by Miles and Huberman (1994) and Miles, Huberman and Saldana (2013). Do the conclusions depend on the participants’ responses and the conditions of inquiry? Can the study be replicated? Using Han and Humphreys’ (2006) typology in assessing the professional and social integration of 25 IMGs provided a lens for the phenomenon under investigation. Han and Humphreys’ (2006) study provided ideas about the setting of data collection method: semi-structured interviews, selecting participant group, interview questions, guide to designing relevant interview questions and a lens during the data analysis process. The research process as detailed in this chapter enabled the finding that is a reflection of participants’ experience.

Bias may shape the understanding and analysis of the data (Creswell 2014). Due to my background as a migrant, I was aware this may bias the analysis of data. However, there is an advantage. My own experience as a migrant in a new country places me in a better position in understanding IMGs experience.

**Transferability**

Transferability refers to the generalisability of the findings to a larger population or the extent to which the findings from the data can be transferred to other settings
Lincoln and Guba (1985) argue that transferability depends on the similarity of the sending and receiving context.

The findings of this thesis are based on a small sample size of 25 IMGs located in the seven non-metropolitan LHDs of NSW. The participants were chosen according to common criteria, IMGs working as GPs in rural or remote areas of NSW. The participants had contextual similarity (Lincoln & Guba 1985). The findings can be generalisable to similar contexts within the same population, that being IMGs in rural and remote regions of Australia. Analysis of the thesis data produced rich insights of IMGs’ experience and the findings are discussed in the context of the research scholarship about the integration and retention of IMGs. Thus, the transferability would depend on the judgement of the applier, in this instance health organisation, workforce planners, policy makers (Bryman 2008; Lincoln & Guba 1985). The findings of this thesis can be used as a guide to inform policy or practice.

The research is transferable, if participants are homogenous.

Han and Humphreys’ (2006) study can be utilised to repeat the research process in different rural regions, or on different participant groups.

The research design deployed through this thesis has met the criteria of Credibility, Dependability, Confirmability and Transferability as described by Lincoln and Guba (1985).

5.7 Ethical Considerations

An ethics application seeking approval to conduct this research using the research method and procedures was approved by the UWS Human Research Ethics Committee (Western Sydney University). The application to the human ethics committee was submitted by my Supervisors on my behalf (Approval number H10619). Field work commenced only after approval from ethics committee. Data collected from interviewees are kept strictly confidential and pseudonyms for each response are used. Each participant was given a pseudonym (e.g. IMG1, IMG2 etc.) and data presented in this thesis is de-identified, a requisite condition of the ethics clearance. This

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7 Since 2015, the University of Western Sydney (UWS) has changed name and is now known as Western Sydney University.
8 The ethics approval is found in Appendix # 1.
included removal of any reference to country of origin or explicit rural location. Informed consent was obtained from all participants before the commencement of the interview. Informed consent from the 25 participants was obtained either by a signed consent form sent via email or post or phone consent. A second application to the ethics committee was submitted by my Supervisors with changes with recruitment method of participants for the study. All the study participants were treated with respect during the research process (Kvale 1996). All interview questions were put forward to the participant in a polite manner; the researcher listened patiently to participants’ responses and ensured to conduct interviews at a time most suited to participants. Details of the Information Sheet supplied to participants is shown in Appendix # 2.

5.8 Conclusion

Studies of integration designed to draw forward detailed descriptions of integration rely on qualitative research design. This pattern of research scholarship and the qualitative nature of Han and Humphreys’ (2006) research were key influences on the qualitative research design deployed in this thesis. Replicating Han and Humphreys’ (2006) research method was required to assess the application of their typology in the NSW context. Recognised here is the number of interviews (25), the limitation of the study to one state in Australia and the uneven distribution of participants across different rural areas in NSW; these limitations would shape future research in this area. The following chapters, 6, 7 and 8 discusses the results from the data analysis of this research thesis.
CHAPTER 6

PROFESSIONAL EXPERIENCE: INTERNATIONAL MEDICAL GRADUATES WORKING IN RURAL REGIONS OF NSW

6.1 Introduction

This chapter and the following chapter presents the qualitative analysis of 25 semi-structured interviews with IMGs working in rural communities of NSW. Data analysis generated four main themes, ‘Professional’, ‘Family’, ‘Social and Cultural’ and ‘Personal’. Box 6.1 outlines these themes and sub-themes of the analysis. Following a brief overview of each of the four main themes, this chapter focuses on the ‘Professional’ theme, while the following chapter, Chapter 7, discusses the ‘Family’, ‘Social and Cultural’ and ‘Personal’ themes.

The first theme, ‘Professional’ is related to IMGs’ work experience in rural practice. IMGs consistently revealed professional life as important in their own description and reflection of their experience working in rural practice. Analysis of the data indicated the clear importance they gave to professional aspects of their engagement. Hence this theme was prominent based on the importance IMGs afforded to their professional life. IMGs’ sense of satisfaction and positive engagement to work is paramount for a GP to continue work in rural practice. IMGs’ professional satisfaction and engagement are important aspects for them to remain in rural practice.

The second theme, ‘Family’ is related to the experience of IMGs and their families in rural region. Family as referred to by IMGs is comprised primarily of partner and children. IMGs with family consistently revealed that their decision to stay or leave after the moratorium period was mainly based on their family needs, job opportunities for partner and quality education for their children.

The third theme, ‘Social and Cultural’ needs is related to IMGs’ perspectives of social life and cultural needs. Social life comprised of friends, family members’ social life in the community and engagement with the community. This theme addresses family members’ social life as opposed to IMG concerns about higher education for children.
and employment for partner. While there were some IMGs who identified a lack of social life as a drawback impacting their length of stay in rural practice, more IMGs made a conscious-effort in engaging with the local community. This theme also comprised of the cultural needs of IMGs and their families. Place of worship and keeping ties with people from their own background is important to some IMGs. While only a few IMGs have identified this theme as important in their decision-making to stay or leave rural practice most of the participants did not raise the issue of place of worship or ethnicity to be important. This theme was not important for all participants. Meeting their cultural needs was important for these IMGs in their decision-making to stay or leave rural practice.

The fourth theme, ‘Personal’ is about the lifestyle, personal likings or preferences of working and living in rural region. The advantages of working in a small community, their ability to maintain work-life balance and the geographic location itself were seen as favourable factors to take up rural practice. This theme is found to be least influencing in their decision-making to leave rural region. However, these personal factors could be attractive reasons or motivators for an IMG to take up rural practice. The themes and sub-themes are represented in Box 6.1.
Box 6.1: Thematic map drawn from analysis of interview data

**Theme Professional**

**Sub-themes**

Satisfaction working with patient
Providing continuity of care and the ability to use variety of skills

**Workload**

Infrastructure and system

- Choice of location of practice
- Lack of medical facilities or resources
- Understanding Australian medical system

Professional development and career progression

- Good mentoring and supervisory program
- Access to continuing professional development and career development
- Concerns about training and support for IMGs

**Theme Family**

**Sub-themes**

Job opportunities for spouse or partner
Opportunities for children

**Theme Social and Cultural**

**Sub-themes**

Family, friends and community
Cultural needs

- Place of worship
- People from own home country

**Theme Personal**

**Sub-themes**

Working in a small community
Work-life balance
Geographic location
Analysis was done by reflecting and retrieving the most meaningful material of IMGs’ experience on these four themes (Miles, Huberman & Saldana 2013). The themes were shaped by critical analysis of previous research studies. The listing of themes in Box 6.1 reflects the order of importance of themes, where importance reflects both the importance of factors to IMG participants and the importance of these factors to the assessment of integration and retention. The Professional theme is ranked according to the importance IMGs afforded to their professional life. The main reason IMGs are in the rural region is for work. Family, Social and Cultural and Personal theme is ranked according to the importance IMGs afforded to their family, social and cultural and personal areas covered by the themes and to the factors to the assessment of integration and retention.

To sum, the Professional theme was the most dominant theme. Analysis of data indicated the clear importance IMGs gave to family factors such as higher education for children or job opportunities for partner. Family theme is important not only in integrating IMGs and their families in a new rural region but also in retaining IMGs in rural practice. Hence this theme was the next important theme. The next theme is Social and Cultural. To those IMGs for whom social life and cultural needs were important, these factors became decision-making factors to stay or leave rural region. The Personal theme is found to be the least impacting in IMGs’ decision-making to leave rural practice.

The discussion of this analysis will be presented in two chapters.

6.2 Professional

The professional sub-themes provide an understanding of IMGs’ overall experience in rural practice. This theme has five sub-themes: Satisfaction working with patients, providing continuity of care and ability to use variety of skills, Workload, Infrastructure and system and, Professional development and career progression. Each of these sub-themes is addressed in the following sections.

The first two sub-themes were found to positively influence IMGs’ engagement to work. Most of the participants showed high level of professional satisfaction and attachment to rural practice. IMGs perceived themselves as care providers to patients. Patients’ reciprocation in terms of gratitude, loyalty and trust were positive factors to
a IMGs’ sense of satisfaction with work. Continuity of care developed doctor-patient relationship that demonstrated an element of trust between GPs and their patients. Family-oriented practice offered IMGs the opportunity to treat the entire family. Working in rural practice also allowed IMGs to use diverse skills, acquiring hands-on experiences which in turn broadened their knowledge and skills. Their knowledge, skills and prior experience contributed towards their professional attachment. The factors that positively influenced IMGs’ attachment to work were the ability to use a wide range of skills, receiving good professional support from the practice and the opportunities to avail career development programs to upgrade knowledge and skills. The two sub-themes that contributed to IMGs’ sense of satisfaction and engagement to rural practice were their satisfaction from working with friendly, loyal, appreciative patients and the ability to provide continuous care to their patients along with the ability to use variety of skills. This is reflected in the two sub-themes, Satisfaction working with patients and Providing continuity of care and ability to use variety of skills.

This very evident professional engagement is not to suggest that there were no aspects of IMGs’ professional experience that caused IMGs some concern. Generally, these were outweighed by those factors that shaped professional satisfaction. This noted some of the concerns that emerged from the data were heavy workload; having to work extensive hours, experiencing difficulty taking time-off and getting locum doctors to cover them when on leave. Responses also revealed issues of support and training for IMGs particularly in getting support for Australian Medical Council (AMC) Part 2 and Fellowship exams, on-going training and education for career progression, indirect supervision and understanding the medical system. Some other issues were lack of medical facilities or specialists, how Medicare works for GPs and patients and knowing the referral system. IMGs also expressed a desire to be able to choose their location of practice. Although for most IMGs the move to rural regions was due to Medicare restrictions, responses also revealed a few different reasons for IMGs move to rural practice. For some it was preference of rural over urban, a willingness to cover workforce shortage and work in areas of need, ability to practice in specialty areas or choosing to work in a particular rural region so they could be with their family which was the case especially with female GPs. These are discussed within the sub-themes,
Workload, Infrastructure and system and, Professional development and career progression.

6.2.1 Satisfaction working with patients

For many IMGs’, professional satisfaction came from the patients themselves. They enjoyed working with patients well known to them. Being appreciated by patients was another factor highly regarded by many IMGs. Doctors felt a high degree of satisfaction when the patients thanked them for what they do. IMGs also mentioned that the patients keep coming back to them displaying an element of trust between doctor and patient. When asked the question: What is the most rewarding thing to you working in rural region? Most of the responses were very similar.

IMG17 - Most rewarding thing, the patients! Patients really love you, really appreciate you. They are really thankful that there is a doctor there who will help you out and they are very loyal and helpful and that’s the most rewarding thing I would say, more than anything else.

IMG10 - The patient appreciation is very important for me.

IMG4 - I think the patients, you get to know them, they appreciate a lot.

IMG23 felt more appreciated working in rural practice over city practice.

IMG23 - I feel more appreciated here than the big cities.

Patients’ gratitude was another big factor of satisfaction. IMGs reported how thankful patients were towards their GPs.

IMG6 - At the moment I can’t say any of that rather than the gratitude of the people around and I am not earning much than I was earning in [name of country withheld]. I was staying alone but I save less. Because my private practice in [name of country withheld] was actually pretty good. At the moment I am working in the hospital less and GP more, if I work like that there will be
change, but at the moment I am a GP I am not doing much with the economy, only thing is working with the people and that’s the only satisfaction.

These are some of the responses which demonstrate trust patients have for the doctor.

IMG10 - There is good connection between you and patient.

IMG5 - Working with the friendly people. They trust on the doctors and they do what we ask them to do ... I personally feel overall I am working for the people as part of the community. So I feel I am part of the community as a GP.

6.2.2 Providing continuity of care and ability to use variety of skills

In addition to patients’ appreciation and gratitude, IMGs reported positively about working in a family-oriented practice. The ability to see patients on a regular basis, spending more consulting time with them and providing not only ‘a patient’ but sometimes the entire family continuous care, was looked upon favourably. Some considered this to be different from city practice.

IMG11 - Just communicating with the town rural community and the satisfaction of treating them and getting close to them. You are dealing with the whole family, not just one particular member of the family.

IMG3 - It’s bit more of an old-fashioned family kind of GP work. Different to what you get in the city here and different to what you get back in [name of home country withheld] as well. So I kind of prefer that.

Some responses spoke more directly about continuity of care. The longitudinal follow-up, the opportunity to manage them fully were seen as advantages working in a rural practice.

IMG9 - It’s like a longitudinal follow up. You can follow up a patient for a long time.
IMG19 - *Well you are managing them to the full, given the chance that patients keep coming back to you.*

This IMG considered providing continuous care to patients as the most rewarding thing working in rural practice.

IMG14 - *I think the continuity of care might be the most rewarding thing.*

Most IMGs related positively to rural practice because of their ability to use a range of skills. Dealing with a variety of health related medical issues was viewed as challenging but rewarding at the same time providing them an opportunity to widen their knowledge and skills.

As one IMG said:

IMG14 - *I really like how general it is and you just have to deal with whatever comes through the door and it could be absolutely anything.*

Rural practice provided them with an exposure to different disciplines of medicine and encountering a wide variety of challenges was considered favourably by many IMGs. IMGs agreed they had to work with greater autonomy in rural practice.

IMG9 - *It gives me opportunity to have exposure to all the disciplines of medicine.*

IMG11 - *The independence of working in the rural area, the wide variety of challenges you meet in the rural practice.*

The ability to provide overall care to patients rather than simply referring them to the specialists was another factor looked upon positively by some IMGs. Treating different conditions was considered to be good for their own professional development.

IMG17 - *What’s good about rural practice is you get the variety of different things. In a city practice where I worked before although it is not exactly the*
same here as Australia but still you can relate. What’s good here in rural practice is you get variety of pathology where you get lot of complex medical problems as well where patients are not going to go to the specialists directly, straight away or go into the Emergency Department so you get the patients coming here and only if we can’t handle that we end up sending them to the hospital or the specialist. So variety with patients, slightly more complex medicine that you deal in rural practice compared to city practice.

IMG15 expressed contentment about providing holistic care to patients. The ability to see his patients on a regular basis and getting to know them well helped this IMG in providing good overall care to the patient.

IMG15 - Rural practice is more about overall care rather than fragmented care.

IMG20 - It is rewarding to be able to treat different conditions appropriately and learn more every day ... at the same time it is good for your own professional development I would say.

Access to base hospital with visiting rights and the ability to do more hands-on work other factors considered positively by IMGs.

IMG12 - Well you get more hands-on-experience and you get to work simultaneously in the hospital as well.

IMGs gained professional satisfaction by working with friendly patients and providing them continuous care. Their sense of engagement came from the ability to use variety of skills which provided IMGs’ exposure to different disciplines of medicine which enabled them to broaden their knowledge and skills. Dealing with more complex medicine was considered advantageous over city practice. The opportunity to practice more hands-on along with having access to the base hospital was viewed very favourably by IMGs. They worked with greater autonomy than their city counterparts.
IMGs raised some concerns that they were critical off but not sufficient to leave rural practice. The difficulty in taking time off when needed which was attributed to shortage of GPs, the lack of facilities, lack of time in terms of training and attending courses for preparation of AMC Part 2 and Fellowship exams, and opportunities for career development drew a negative response from IMGs. These are demonstrated within the following three sub-themes.

### 6.2.3 Workload

Although satisfied and engaged to rural practice, IMGs acknowledged heavy workload as an issue. GPs working as solo practitioners and GPs working in some practices have raised concerns about taking time-off from work to attend courses or for personal reasons. Finding locum doctors to cover them when on leave was also problematic. Extensive hour of work with numerous consultations left them with no time to review and discuss cases with other colleagues.

**IMG9** - *I am a solo practitioner. There is always a problem in terms of having holidays and time off whenever I wanted.*

**IMG15** - *We find hard to get the locum doctors so we have to cover the doctors.*

This IMG who owns GP practice says.

**IMG8** - *but I am looking for a colleague to join me hopefully soon (laughs) before I burn out.*

IMG20 thinks due to high work pressure getting more time to review cases, for meetings with supervisors becomes difficult.

**IMG20** - *I think sometimes I would like to get more support ... because there is really no time, when you have any question there is not really time because there is a lot of pressure and a lot of patients to see ... Like to be able to review more cases, to have more meetings with my supervisors and more time basically.*
This IMG thinks workload is the main pressure working in rural practice.

**IMG21 - it is mainly the work load where the pressure is.**

This IMG showed preference working in a large practice over a small practice. This allows other doctors to cover them while on leave, making it possible to take some time off work.

**IMG17 - Personally, workwise I think you need to be in a good big team rather than being isolated or solitary single practitioner with one or two practitioner can tire you up especially if we can’t get long leave or vacations. So being in a large practice is very important.**

A number of IMGs highlighted the importance of fixed leave allocations or the ability to take time off work in order to gain time for training purposes or to maintain a good work-life balance.

### 6.2.4 Infrastructure and system

The sub-theme Infrastructure, system and regulation comprised of distinct areas. They are Choice of practice location, Lack of medical facilities or resources and Understanding the Australian medical system. These areas are discussed within this sub-theme.

**Choice of location of practice**

Many IMGs expressed dissatisfaction about the lack of choice of practice location. Some IMGs had prior knowledge about their work location. Most IMGs took up rural practice as a result of Australian government’s regulation. Section 19AB of the Health Insurance Act 1973 restricts their access to Medicare provider numbers and requires them to work in a District of workforce shortage (DWS) for a minimum period of ten years (referred to as the 10-year moratorium) from the date of their first Australian medical registration. However, responses revealed other reasons for IMGs to take up rural practice. This included the ability to practice in their field of speciality, partner’s work in the same rural region or personal preference of rural over urban.
IMG1 has expressed discontentment working in the rural region as he and his partner find themselves socially isolated. He is there only because of the 10-year moratorium restrictions and will leave rural practice after the completion of the moratorium period.

IMG1 - Okay… when we came here, we thought we will stay for the rest of our life, my wife and myself. Then we said I don’t think we can do it anymore. We might be moving to another rural practice ... The problem is the 10-year moratorium, it is very crippling ... It is a bit different here, your question how long I will stay here, I think once I get my fellowship I will leave basically.

Some other responses included:

IMG12 - I chose rural practice because I didn’t have any other choice to practice elsewhere and I needed to finish my RACGP exam and therefore I decided to go through rural areas and practice.

IMG25 - Here is the job that I found so automatically I came because that was the job that I found at that time.

A female GP’s view on the moratorium was negative. She said it caused fragmentation of family because her husband who is a doctor works in a different rural region.

IMG18 - But one thing I would like to put about I am not a big fan of this moratorium because at the end of the day a person’s personal circumstances should be considered you know… like there is a lot of fragmentation in the family which can get really difficult at certain stages.

IMGs may have taken up rural practice initially due to Medicare restrictions. However, it was found that some IMGs later made a conscious decision to stay in rural practice well past the moratorium period.

IMG8 - The idea was that I was going to start my own general practice as soon as I became fully qualified and had finished my moratorium yeah but as I said due to the frustration, we went to [name of rural town withheld]. But during
the two years in [name of rural town withheld], my moratorium finished and so I was fully qualified and had no restrictions whatsoever so it was yeah... around that time my husband wanted to move back to [name of rural town withheld].

IMG15 said he would like to continue practising in the same practice but said it depended on access of Medicare provider number.

IMG15 - No I got medical provider number to work in this practice up to this December only then after that it will depend on subsequent application.

Another disadvantage of the 10-year moratorium could be that some IMGs have to compromise from being a specialist in their home-country to being a GP here due to the restrictions placed on most IMGs to practice in rural areas of Australia.

IMG20 completed a post-graduate degree in Anaesthetic and worked as a specialist back home for four years before coming over to Australia. She applied for a position of an Anaesthetic but was unsuccessful in getting a position and subsequently applied for a role of a GP in rural practice.

IMG20 - Actually I was trying to work as an anaesthetic here and ... because I hadn’t worked in Australia as an anaesthetist I couldn’t get through any other positions.

This was what IMG8 had to say:

IMG8 - I started to work in General practice, because I with a small child, it suited me ... I was so interested in pursuing my O & G (Obstetrics and Gynaecology) but it would have had to mean moving to Adelaide, being apart from my husband ummm you know with a small child so it just wasn’t feasible. And general practice presented itself as a very viable alternative and most importantly I could still do my Ante-natal care of patients and see a lot of Women’s Health you know so I didn’t totally lose my Gynae kind of ...yeah.
Some IMGs, even though on the 10-year moratorium, chose rural regions due to personal reasons such as the ability to practice in their field of interest, preference working in rural regions over urban cities or wanting to be in a quiet place which supports a certain way of lifestyle.

This IMG chose to practice in the rural region because he could practice in his field of speciality, Surgery. He also mentioned that he could put his previous surgery experience to use.

IMG22 - *I think I am still in moratorium but yeah and that is not the reason why I came here.*

IMG22 - *I can do surgery.*

Some IMGs chose their location of practice because their spouse worked in that rural region.

IMG23 - *It was the job that my husband got here and he did not want to miss the chance and he is a surgeon. He finished fellowship here and he was offered a job in [name of rural town withheld] and we decided to move.*

IMG2 - *My husband lives here.*

IMGs preferred the ability to choose their location of practice due to the disadvantage it placed on them. Although IMGs had prior knowledge that their initial work would be in DWS and AoN, most IMGs took up rural practice because of government restrictions which allows them to obtain limited registration with a period of supervised employment in an AoN or DWS region only.

*Lack of medical facilities or resources*

IMGs were appreciative of their ability to use variety of skills in medicine dealing with a broad spectrum of medicine. Given the breadth of their practice where they had to deal with a variety of issues, most IMGs expressed the lack of specialists support as a challenge working in rural practice. Because of limited resources they agreed it was
something for them to manage. They also acknowledged that the waiting time for patients to see a specialist was long. There was shortage of resources like allied health, and difficulty in finding locum doctors was another concern. Their views were:

IMG21 - Availability of the resource, we are talking about the medical resource. In a big city we have plenty of big hospital and specialist around which we can ask for help. Whereas in small area you are kind of managing people most of the stuff by ourselves... yeah that’s the most challenging part.

This IMG expressed the difficulty patients in rural towns faced; lengthy travel time to the practice and the wait-time for patients to consult a GP.

IMG24 - Some people having difficult to see a GP, they have to drive for half an hour or more than half an hour to get through and they have to wait appointment for 2 weeks to get a script. That is the real drawback in rural area.

Some IMGs considered telemedicine an option to consult patients in remote regions, but at the same time thought it is not always the best way of consulting patients. IMG9’s view on telemedicine is:

IMG9 - Telemedicine I think is ... a good idea for really remote areas but my personal opinion is there is nothing like personal medicine where you see the patient in front of you. Because Telemedicine is really a compromise, which I don't think should be used to a great extent.

Understanding the Australian medical system

IMGs acknowledged the need for support with familiarising themselves with the Australian health system. The responses revealed three areas to this; learning the Australian way of practice, understanding how Medicare works for GPs and knowing the referral system.

All IMGs agreed that they have to familiarise themselves to the Australian protocol and guidelines of practice. They were of the view that it was different to the way things
were done in their home country. The first thing for IMGs to do in order to integrate in rural practice was to learn the new way of practice. Some responses were

**IMG14** - To learn all the acronyms and the Australian way of practicing because you have to adjust to Australian way of practicing no matter how good you think things were in your country you have to adjust to Australian way because you are in Australia now.

**IMG20** - I think sometimes I would like to get more support ... even if you have knowledge from overseas you still need to understand to use them in Australia-guidelines and protocols and sometimes there are things that you are not familiar with.

IMGs needed more support on knowing how Medicare works for them and for their patients as well. Some of the things they mentioned were entitlements for the patients, more clear information on Medicare benefits for the patient, how and whom to refer to and how best that be done in terms of cost. Another issue that was raised was the ambiguity about where IMGs could practice and for how long, how their visa status impacted where they could practice. This could be suggesting that a centralised information centre for GPs and for IMGs would be helpful.

IMG2 said that understanding the Medicare system was complex.

**IMG2** - I think there is a lot of getting to know the system, so complex! The Medicare number, what benefits the patients can get what they cannot... how to refer, who to refer to, what is the cheapest way to get your patient from getting to point B... that kind of stuff, very complex.

**IMG3** - If you go to GP organisation they don’t know the answers to all of the questions. Like I was saying Medicare as well, so I kinda find it difficult, that part of thing.

Another IMG was discontent with Medicare changing rules for IMGs. This IMG is willing to stay in his rural practice but said it all depended on Medicare. Medical
provider number is granted by Medicare to IMGs who take up rural practice. This is as per Section 19AB of the Health Insurance Act 1973.

IMG15 - Changing the Medicare requirement and rules every time. So that’s what I think is the most specially when it comes down to Internationally Medical Graduates, that’s the main hurdle or challenge to go through ... Medicare provider and Medicare and the moratorium that’s the biggest hurdle for any overseas doctor basically.

Knowing the referral system was another aspect IMGs have to familiarise with.

IMG22 - I think to work in rural they need at least few weeks or a month in a proper hospital where they are close to, they need to know what is the set-up in Australia, how they do referral ... so they just need to know the hospital system before you start as a GP otherwise it will be very hard understanding them too.

The lack of medical facilities or resources, support in understanding the medical system and the ability to choose practice location were raised by IMGs. IMGs’ concern of the lack of specialists and limited resources in rural regions was inherent. IMGs also acknowledged that knowing how to navigate the referral system and understanding how Medicare works is an important part of the training in integrating themselves to the Australian health system.

6.2.5 Professional development and career progression

IMGs were appreciative of the excellent professional support they received from their mentors or supervisors and other staff members. However, some of the concerns raised were indirect supervision and time issues due to workload. Consulting supervisors became difficult due to distance or because of heavy work-load. IMGs considered having access to continuing professional development as important. This was important for their career development. This sub-theme comprised of distinct areas. They are Good mentoring and supervisory program, Access to continuing professional development and career development and Concerns about training and support for
IMGs. Some factors under this sub-theme received negative responses from IMGs such as access to continuing professional development and career development, training and support for the AMC and Fellowship exams. These are discussed here.

**Good mentoring and supervisory program**

IMGs working in rural practice were appreciative of the professional support and training they received from their supervisors and other staff at the practice. Most IMGs were appreciative about the support they received from their supervisors, senior doctors and other staff members. Working in a big practice made it easier to seek advice from other staff members. IMGs suggested having a local mentor and being able to spend more time in training themselves would be beneficial.

IMG7 - *I think the level of professional support at the practice that I am is very good. We can actually call someone into your room and ask them questions that’s number one. And also there is the issue of continuous professional development that I am talking about where we actually sit together and discuss educational questions and then within the community there are also educational sessions that takes place. And then you also do your own stuff, online and whatever courses you are interested in. And you have got support.*

IMG5 - *I got very good support from my senior doctor.*

IMG6 - *At the moment I am still under supervision of my boss. He is the Fellow of Australian College of General Practitioners and the ACCRM college both, actually he is a very senior doctor like 25 years in Australia and he is always there when I need some opinion and apart from that I call other emergency department and they are very, very helpful to give opinion over the phone.*

IMG16 - *Yes the main support was through the practice.*

IMG16 - *I am in a big practice, so I have got lots of professional support.*

Another IMG, IMG19 shared his past experience when working in a hospital. He talked about a doctor taking new IMGs on hospital rounds which gave starters that
initial exposure to Australian hospitals and the way things are done here. This may have helped IMGs gain more confidence in taking on the challenge of working in a new country and health system.

IMG19 - *It was a very good thing that Dr [name withheld] ... he allowed us to join his medical rounds, he is so wonderful person ... they help Overseas doctors and from there on I was able to get back to the practice again.*

IMG25 tells about the supervision he received when he joined rural practice.

IMG25 - *I had a very good boss who was very supportive explaining things to how the Australian system worked. So... initially I spent one month working directly under him and then after I was working in conjunction with him. So yeah the professional support was very, very good.*

IMG20 felt a bit differently about the professional support she received. Getting assistance with how the guidelines and protocols work would be beneficial. The lack of time was considered to be a barrier in accessing professional support.

IMG20 - *I think sometimes I would like to get more support ... even if you have knowledge from overseas you still need to understand to use them in Australia-guidelines and protocols and sometimes there are things that you are not familiar with. Sometimes I don’t feel as supported as I want to feel ... because there is really no time, when you have any question there is not really time because there is a lot of pressure and a lot of patients to see ... Like to be able to review more cases, to have more meetings with my supervisors and more time basically.*

This IMG’s experience was quite different to most of the IMGs. IMG1 related quite negatively to the support and training he received. He commented about the difficulty in accessing supervisors who were a few kilometres away.

IMG1 - *I am not on any training program now. I am just as an area of need profession and no training program ... so I kind of had to train myself ... This*
is on the professional level, lack of training, lack of positive or negative feedback, lack of proper supervision, even in my first year of one and half year as an area of need doctor ... I had a supervisor who was doing nothing, he was away, few kilometres far from me.

**Access to continuing professional development and career development**

The ability to access continuing medical education program in upgrading their skills and knowledge was a significant area to many IMGs. Some IMGs expressed satisfaction with their on-going learning and training while for some other IMGs it was a challenge to keep up with on-going training. Medical education became one of the most significant factors for another IMG in deciding to leave rural practice if unable to pursue medical education.

IMG7 - *We got a lot of education going on every week. We do some clinical cases and also the kinds of patients we get are well appreciated. That is a plus!*

IMG17 - *Ongoing training and educational needs ... So these kinds of factors are the biggest challenge I have seen trying to keep on-going education, upgraded training and those kinds of things.*

Another IMG felt quite strongly about continuing education. He said:

IMG24 - *That if I cannot continue my medical education in certain area I will decline.*

This factor could be a reason in itself for IMGs to leave rural practice.

This was an insight from a GP who has practiced for more than 40 years. IMG9 talks about how important it is for doctors to have continuing medical education. Access to a medical school or meetings on medical education could help overcome this issue.

IMG9 - *You know exposure to other forms of continuing medical education. That is the main challenging problem. Nowadays, we are fortunate because we got a University here. I actually teach in the University. And we have also lot of meetings, extra-curricular meetings and medical education meetings so those challenges are almost overcome now.*
The area of professional engagement revealed aspects of IMGs’ experiences that caused IMGs some concern. Generally, these factors outweighed factors that shaped professional attachment to rural practice.

**Concerns about training and support for IMGs**

Some IMGs raised concern over lack of training and support for new IMGs when they come to Australia. Another area of concern was on-going training and education and receiving Continuing professional development (CPD) for career progression. Some IMGs complained about the lack of support for studies with the AMC exams; attending courses was problematic due to work-load and bearing the costs associated with these exams was expensive.

One area of concern for new IMGs was lack of supervision in the practice. This IMG commented that due to workload and the lack of time, senior doctors at the practice may be too busy to supervise new doctors. This may cause some new doctors difficulty to go about on their own in a new system and place.

*IMG5 - In rural practices, most of the time there are less numbers of doctors and doctors also are really busy with the practice. They may not get enough time to teach their junior doctors. When they start their job in Australia, they may not get the whole idea about the system and when they start to practice on their own they may face difficult to do all the things without supervision.*

IMG8 provided a suggestion to overcome this problem. She thinks it may be a good idea to buddy new IMGs with a local mentor. This can also overcome the problem of indirect supervision where the assigned supervisor is a few kilometres away.

*IMG8 - when IMGs come they really need to be buddied with very local mentor you know ... the nearest mentor is 60k away in another town so and it’s just not the way to go.*

Another area of concern for IMGs was about the availability of time, the cost involved, and the availability of structured training to take AMC part 2 examinations. They also acknowledged that being in rural practice put them in a disadvantaged position.
Provision of support with these exams would help considering it is a tough exam to pass.

IMG6 - when we come to Australia we are on our own and we have to find our pathway, especially when you work in the country and committing yourself I think government should look ... not in terms of money but to get our careers in an easy way. You know if I have to do part 2 I don’t have chance to go to a class courses and I can’t afford that and still I had to pay my own time and I mean being in the country isolated I don’t have any support to do part 2 at the moment.

IMG8 provided suggestion on training and support for IMGs for AMC exams and Fellowship exams. Providing IMGs support by conducting workshops to assist them with exams could increase the pass rate. This may even prove to be cost-effective to IMGs in terms of not having to pay exam fees each time they took the exam.

IMG8 - I think the main thing with good support... so all the doctors that are being supported through this kind of program and in sitting the Fellowship even if they get once a month once every 6-week workshop for few hours the pass rate is much better or probably just as good as a registrar whereas who didn’t get anything like that or trying to do it themselves, usually would have to sit at it a few times and you know it is a very expensive exam.

The lack of on-going training to upgrade their knowledge and skills was another area of concern in rural practice.

IMG8 - But that can be a big issue to some of these doctors who end up in rural areas with no support with studies, they can’t do any CPD (Continuing professional development).

This IMG’s comment on rural practice was that life was great only if IMGs had passed the requisite exams.
IMG17 - Life is great if you have your exams. If you have your fellowship and if you have a proper visa then everything changes ... doctors who don’t have fellowship, there is no proper structured training program for them to pass the exam ... Once you get your fellowship and a visa life changes, you can certainly enjoy a rural life.

Considering that AMC and Pre-employment Structured Clinical Interview (PESCI) were requisite exams for IMGs to practice in rural regions, more support could prove beneficial to IMGs’ training for these exams.

Another issue that emerged was recognition of prior learning. IMGs commented that they had difficulties in getting recognition of their previous training or experience. These were the views of IMG14 and IMG22:

IMG22 - It’s very hard to get recognition of what we have done as well. So that’s why I gave up as well in surgery, I came here ... Yes, work, the experience and the qualification.

Quality professional support from their mentors or supervisors and other staff members was viewed with gratitude. Responses also revealed that indirect supervision was not a very effective way of mentoring IMGs. In some cases, consulting supervisors became difficult because of heavy work-load and the physical distance of supervisors. Access to continuing professional development was viewed as a significant factor for their professional development. The lack of professional development could lead to dissatisfaction to rural practice. Structured training programs for IMGs studying the AMC-2 examination would produce better examination outcomes.

Alignment with previous studies

Broadly, this research study revealed that IMGs had a positive experience with their professional life working in rural practice of NSW. The positive experience with their professional life in rural practice was more so evident with the 25 IMGs working in rural areas of NSW. IMGs’ satisfaction working with patients, providing continuity of care and the ability to use variety of skills led to a strong attachment to rural practice. This reinforced the findings of previous studies (Dywili et al. 2012; Robinson &
Slaney 2013). For many IMGs’ professional satisfaction came from the patients themselves. IMGs gained a sense of satisfaction from working with friendly, loyal, appreciative patients. The satisfaction that IMGs got from their patients’ appreciation was seen as an intrinsic reward. Providing service to people in areas of need gave them a sense of contributing to a greater good (Hancock et al. 2009). This study revealed a strong sense of professional satisfaction among IMGs working in rural regions of NSW. IMGs’ attachment to rural practice seen in this thesis is a nuance that is under-emphasised in previous studies.

Providing continuity of care and the ability to use variety of skills led to strong professional attachment to work. IMGs gained a sense of professional engagement from the ability to provide continuity of care to their patients in rural practice and their ability to use a variety of skills. IMGs perceived themselves as care-givers to the members of the community. The ability to see patients on a regular basis, spending more consulting time with them and providing not only ‘a patient’ but sometimes the entire family continuous care was looked upon favourably. This feature was seen favourably by most IMGs which were consistent with an Australian study done by Dywili et al. (2012) and a study by Hancock et al. (2009). Their ability to use variety of skills dealing with a broad spectrum of medicine and having to work with greater autonomy was seen favourably by many IMGs.

The key to analysis was IMGs’ strong sense of engagement and attachment to rural practice but there were some difficulties or barriers that IMGs were critical off working in rural practice. Consistent with previous studies, this research study revealed workload as an issue that was raised by many IMGs working in rural practice. This was an issue for IMGs especially solo GPs and those that practiced in small centres (Smith 2005; Terry & Lê 2013). Similar to issues identified in previous studies, IMGs acknowledged that there were disadvantages being in rural practice. Access to preparatory courses for the exams was difficult due to the distance and difficulty in taking time off due to shortages of staff (Dywili et al. 2012). Taking time off for personal reasons, training purposes or consulting their supervisors was problematic. A number of IMGs highlighted the importance of work-life balance. Fixed leave allocations or the ability to take time off work when needed could aid in maintaining good work-life balance.
The lack of medical facilities or resources in rural communities, and understanding the medical system were issues identified in previous studies (Smith 2005; Wright et al. 2012) nonetheless, the ability to choose practice location was a factor not strongly evident in the literature. IMGs’ location in rural areas was mainly as a result of the Australian government’s 10-year moratorium requirement, this showed some alignment with previous scholarship (McGraile et al. 2012), but noting also that the scholarship presents diverse findings on this particular issue. However, there were some IMGs who moved to rural practice for work. As Halseth (1999, p. 373) states, ‘employment is a reason for their move to small communities’. Obtaining employment is an important factor of integration (Sigurjonsdottir 2016).

As part of the Australian government’s regulation (the 10-year moratorium), IMGs are restricted to work in areas of need or DWS where workforce shortages are acute. IMGs in rural practice expressed dissatisfaction over the lack of choice of location of practice. The key to analysis was the very strong positive account about their professional engagement to rural practice. Some of the disadvantages reported are the fragmentation of family and the ability to see their family on weekends only. Another disadvantage was that IMGs had to compromise from being a specialist in their home-country to being a GP due to the restrictions placed on where they could practise and for how long. This was also evident in a study in United Kingdom by Khan et al. (2015) who stated that IMGs changed their specialty interests just to be able to secure a job and earn a living in the United Kingdom. IMGs’ clinical skills and previous experience should be considered for effective ‘match-making’ of needs with skills (Spike 2006).

While working in a different medical system was nominated as either difficult or challenging, the level of dissatisfaction was less than that evident. This thesis noted IMGs’ positive experience out-weighed these barriers or challenges. The lack of specialist support and medical resources in rural regions was another challenge raised by IMGs. This was also highlighted by the findings of Smith (2005) where rural doctors reported lack of services such as specialists as problematic. They had to work with greater independence and autonomy than their urban counterparts. This is in alignment with Carson et al. (2010) study based in in Northern Territory, where they state that rural workforce professionals have to work with greater autonomy. Unlike city practice this was something for them to manage. IMGs acknowledged that the waiting time for patients to see a specialist was long and the difficulty in finding locum
doctors was another concern (Han & Humphreys 2006). IMGs reported navigating the medical system as complex (Terry, Le & Hoang 2014). The process of patient referral was also different from the home-country they came from (Wright et al. 2012).

Coming from a different medical system, IMGs stressed the need in training themselves to the Australian health system. IMGs acknowledged the benefits of mentoring and on-site supervision program that was provided to them. IMGs valued constructive and positive supervision (Wright et al. 2012). IMGs may find themselves in a disadvantaged position due to distance and workload issues which may make indirect supervision less effective. IMGs highlighted difficulties in accessing support that was provided to them in terms of supervision (Terry, Le & Hoang 2014). This was especially the case for IMGs working in more remote or isolated areas as solo GPs and those who worked in centres with fewer staff. They expressed disappointment about distant supervisory arrangements where the supervisor was a few kilometres away or the inability to consult their supervisor due to the lack of time attributed to workload.

Consistent with Smith (2005), the lack of supervision can be problematic in rural regions and preparing rural doctors through orientation and education in the rural context would be helpful. Due to the differences in medical education between western countries and other countries where medical training in Asia and Indian sub-continent (Khan et al. 2015) is more subject-oriented, teacher-centred, lecture-focused and hospital based (Pilotto, Duncan & Anderson-Wurf 2007) local training becomes imperative. The difference in the standard in medical schools; training and syllabus between countries such as the United Kingdom, United States of America, and some European countries and the graduates from the Institutions of Gulf Cooperation Council countries (Bahrain, Kuwait, Oman, Qatar, Yemen, United Arab Emirates and Saudi Arabia) (Khan et al. 2015, pp. 747-748) could also have a bearing on the AMC exam results. Supervisors and mentors understanding of the system from where the IMGs have graduated can have a positive impact on communicative interactions when it comes to training IMGs to the Australian standard (Pilotto, Duncan & Anderson-Wurf 2007). On-going training and career development is a significant factor for IMGs which can assist in forming a positive sense of attachment to rural practice. The lack of this factor showed weakened attachment to rural practice. IMGs emphasised the importance of on-going education and career development (Mbemba et al. 2013). This is consistent with the findings of Smith (2005) with junior doctors working in rural
practice in Queensland, Australia. Access to continuing professional development was significant for their retention (Humphreys et al. 2009). Another area of concern raised was the lack of structured training for AMC Part 2 examinations. As demonstrated by McGrath et al. (2012), difficulty of studying for and passing the AMC examination was an obstacle for IMGs. Another issue that emerged was recognition of prior learning. IMGs reported that they had difficulties in getting recognition of their previous training or experience. This was highlighted in both, the Australian studies by Wright et al. (2012) and Gilles, Wakerman and Durey (2008) that IMGs preferred their prior experience to be acknowledged and be fully registered as ‘Australian’ doctors.

Effective mentoring and supervision program, having access to continuing education and support with training and exams were all seen as significant factors offering IMGs a sense of professional attachment to rural practice. Professional support factors can be a concern to physicians in rural areas (Kazanjian & Pagliccia 1996) and providing support in assisting IMGs to feel integrated in rural practice is crucial in their integration to professional life (Terry & Lê 2013). Orientation to the Australian health system and work environment in rural and remote areas was reported as crucial to the integration process (Dywili et al. 2012, p. 176). Although there were complexities working in a new medical system, IMGs’ overall positive experience in their professional life far outweighed the issues they raised about rural practice. Through means of training, mentoring, supervision and on-going education these issues can be minimised. IMGs of this thesis found working in rural areas of NSW very satisfying, engaging and rewarding.

6.3 Conclusion

This chapter discussed the theme Professional and its five sub-themes. The Professional theme was found to be of central importance to the 25 IMGs, and thus its discussion took place in a separate chapter. The sub-themes identified key dimensions of IMGs’ professional engagement. This process of identifying the dimensions or factors of integration is important to the knowledge of integration of IMGs and also to foreground the assessment of the utility of Han and Humphreys’ (2006) typology. The key dimensions of this thesis featured prominently IMGs’ satisfaction with working with well-known patients, providing continuity of care and by virtue of the nature of
their rural setting and of rural practice, deploying a wide range of skills. Challenging aspects of professional life were acknowledged, most notably through their workload, limitations in infrastructure and the challenges of a new health system and a forced deployment. IMGs’ positive experience in rural practice far outweighed their negative experiences of practice. IMGs showed strong attachment to rural practice. IMGs’ engagement with and attachment to rural practice as outlined in this chapter is a nuance that is under-emphasised in policy discourses. The insights from this chapter may inform policy planning to integrate IMGs in rural practice of Australia.

The next chapter discusses the three themes: Family, Social and Cultural and Personal themes of IMGs’ experience in rural areas of NSW.
CHAPTER 7

FAMILY, PERSONAL AND SOCIAL EXPERIENCES:
INTERNATIONAL MEDICAL GRADUATES WORKING
IN RURAL COMMUNITIES OF NSW

7.1 Introduction

This chapter presents the qualitative analysis of the 25 semi-structured interviews that were conducted to obtain insights about IMGs’ experiences working and living in rural areas of NSW. The previous chapter discussed the ‘Professional’ theme. This chapter discusses three themes: ‘Family’; ‘Social and Cultural’; and ‘Personal’. These themes are discussed in rank of importance, where importance reflects both the importance of factors to IMG participants and the importance of these factors to the assessment of integration and retention. This is discussed in section 6.1. A thematic map is provided in Chapter 6 outlining the themes and sub-themes of this thesis (Box 6.1).

The theme Family is important as IMGs’ decision to stay or leave rural region was based on their family needs mainly, job opportunities for partner and quality education for children. These factors are important in retaining IMGs in rural practice. The next theme Social and Cultural factors influenced some IMGs in their decision-making to stay or leave rural region. However, family factors were more significant in influencing their decision to stay or leave rural practice. IMGs’ social life in rural region impacted their length of stay in rural practice. Cultural needs such as place of worship and socialising with people from their own home country were found to be important to fewer IMGs and these factors could influence their decision to leave rural region. The Personal theme concerns the lifestyle, personal likings or preferences of working and living in rural region. This theme was found to be least influencing on their decision to leave rural region. However, the factors under the Personal theme could be attractive reasons or motivators for an IMG to take up rural practice. These three themes are discussed here, including any relationship with the Professional theme discussed in Chapter 6. This is most evident in IMGs’ reflections on their evident
professional engagement and satisfaction and their concerns about their children’s future high school and university education and their spouse or partner’s employment.

7.2 Family

Family was the next most influential theme in determining not only IMGs’ overall experience but also their families experience in rural region. Although strongly attached in rural practice, IMGs considered the factors under this theme as significant in influencing their decision to leave rural practice. Family primarily comprised of partner and children. Many IMGs and their families had an overall positive experience in rural region. IMGs described how their families’ happiness was important for them to continue staying in rural region. The two sub-themes under this theme are also evident in Han and Humphreys’ (2006) study; job opportunities for spouse/partner and opportunities for children in terms of high schools and universities. IMGs can be grouped into three categories based on their views about staying in rural practice.

- IMGs without family
- IMGs with partner only
- IMGs with partner and children.

IMGs with family clearly expressed concerns for family members; limited job opportunities for partner and quality education for children were two main issues for IMGs.

7.2.1 Job opportunities for partner

Job opportunity for partner was an important factor for IMGs living in rural regions. Responses from IMGs who had family and those who did not have a family varied. IMGs with family had concerns about their partner finding a job in the rural town. Those IMGs with partners employed in the same town were happy with rural practice. IMGs that did not have a family showed greater willingness to work in rural practice suggesting they had no present concerns about family matters. Female GPs placed more emphasis on the availability of job for their spouse and this factor was crucial in their decision to leave rural region. However, this is not to suggest that male GPs did not place emphasis on their partner’s job opportunities. This sub-theme is important in IMGs’ future decision making to continue or leave rural practice. When asked about
their willingness to work in another rural region or the reasons to leave rural practice
the views from IMGs with families and single IMGs were quite different.

IMGs that had no family were open to the idea of working in rural regions making
them better candidates for recruitment to rural practice.

IMG20 - Yes, I would be open to working in other rural regions ... I enjoy in
the rural area.

IMG24 - I don’t have any problem working in rural area further from here.

IMG3 with a partner who had a job in the same rural region was willing to stay in the
same rural region forever. The reason he was happy to stay in the rural region was
because his partner had a job there.

IMG3 - Forever definitely!

These are some views from IMGs with family, partner and children. For female GPs,
the availability of job for spouse was a significant factor in their decision-making for
rural practice.

IMG4 - Yeah I would consider, main problem is if my husband finds a job as
well.

IMG18 - No probably not because my husband ... really depends if he is able
to find a job if we go very remote. I don’t know if he will be able to find a job
... and also we need opportunities for your children, their educational, extra-
curricular, sporting...you know, everything.

These were the responses of IMGs when asked what motivated them to take up rural
practice.

IMG14 - the fact that my husband has a farm here ... big, big, big factor and
he doesn’t want to leave his farm.

IMG7 - They are quite happy here, my husband is also quite happy here in
[name of rural town withheld] that’s why I moved here.

For IMGs with family, intentions of staying in the rural practice or leaving rural
practice depended on the availability of job for their partner, schooling needs for
children or if their partner moved out of town for work. This was especially for female GPs. Some responses were:

IMG17 - *I think the main issues would be schooling need for the children then my wife finding work.*

IMG2 - *If my husband moves and if my daughter goes to University then I have to think about whether I needed to move or not!*

IMG5 - *In the future my wife’s job opportunities are limited in this rural town and she is an accountant. This may contribute to make future decision about leaving rural town.*

Another IMG with family expressed a willingness to work in another rural region. Working in another rural region depended on the opportunity to do general practice, the social lifestyle for the family and proximity to the cities. He said:

IMG15 - *Depends, I am not sure!*

### 7.2.2 Opportunities for children

IMGs expressed satisfaction with primary school education for their children. However, they clearly had concerns for their children’s high school education and university education. Responses showed that IMGs considered quality education the most significant factor in their decision to remain or leave rural practice. Some IMGs were open to alternative solutions such as boarding schools for their children mentioning that government’s support with funding would be helpful.

When asked if they would like working in other rural regions, one IMG with family notes:

IMG12 - *I wouldn’t say so; I wouldn’t go to a very remote rural area because I have family. With family it will be difficult because there will be schooling, my kids would be schooling and I need to stay with them. So I won’t go to a rural remote area GP practice.*

Most of the IMG with children indicated they would consider leaving rural practice mainly for their children’s educational opportunities. Some IMGs’ responses were:
IMG6 - when he needs high school I might think of moving, and my wife need a job too.

IMG13 - I got a lot of challenges for my kids’ education.

IMG17 - I might look into relocating and that would be only mainly for my children’s education.

This IMG shared her plans about her children’s education.

IMG14 - I may probably go to bigger towns with the kids, they may probably go boarding when they go to secondary school.

Those IMGs who did not have family responded differently. Because they did not have family commitments they were more willing to stay in rural practice than the other IMGs. This shows they could be more retainable in rural practice. Their responses were:

IMG20 - I intend to stay as long as possible. Yes I really enjoy my job here.

IMG24 - I think I can stay as much as I can ... I don’t have a problem away from the city. I don’t really enjoy city life.

Another IMG indicated his future decision to leave rural practice would depend on the availability of job for spouse or access to a university.

IMG10 - It could be a family matter for example if your wife or your children want to attend any education or university, [name or rural town withheld] doesn’t have any University. Or if your spouse wants to find a job and there is no available job she intends to do so you need to move to another place where you find GP work and your wife can find another job or education system she wants.

IMG5 - In the future my wife’s job opportunities are limited in this rural town and she is an accountant. This may contribute to make future decision about leaving rural town.

These responses showed both these factors, limited job opportunities for partner in the same region and higher educational needs for children are influential to an IMG’s decision to leave rural practice. Some IMGs were willing to take on rural practice once
these concerns were taken care of. IMG17 commented when asked about his willingness to work in another rural region.

IMG17 - *I would consider but possible not in the next few years because like I said very earlier my children educational needs would be more important ... Those kind of things that comes first. But once they are out of the way possibly I’ll get back to rural work again in the long run.*

This was a suggestion provided by an IMG who is a practitioner in a remote region. She expressed a need for more support from the government for IMGs working in rural and remote regions. Some of them being, support with child-care and high school assistance for children in terms of financial assistance for boarding schools.

IMG14 - *At the moment we have got no childcare so we had rotating nannies that we have to find so there is very little support for that. I think the support systems need to be fixed up and also boarding school you know... at the moment we live in town and if we still live in town when our kids go to boarding school, because we got a secondary school around the corner we wouldn’t qualify for isolated children’s support scheme, financial support scheme (coughs) which is ridiculous ... The last 2 years has all been through distance education, there is no sporting opportunities, the level of education isn’t great ... You are not going to send your kids to secondary schools here if you can help it if you want to get a quality education. So I think this will be for a lot of rural practices, it is not so much about the money but being able to access child care and being able to you know to get the financial support, to send your kids to boarding school aahhhh probably more important than the actual remuneration.*

Broadly, the findings of this research studies showed some inconsistencies with previous studies which perceived the experiences of mandated IMGs in rural regions negatively (McGrail et al. 2012). This thesis demonstrated that most IMGs and their families had a largely positive experience in rural region of NSW. Families’ happiness was important for an IMG to remain in rural region. Family responsibility had more influence on female GPs (Lehmann, Dieleman & Martineau 2008). Their decision to move to rural practice was based on availability of work for their spouse and quality.
education in terms of schools or universities for children (Wright et al. 2012; Humphreys et al. 2009).

Irrespective of the satisfaction with work and the support IMGs received (Auer & Carson 2010) the main reasons cited by IMGs to leave rural practice was to provide children with quality education and to seek better job prospects for their partners. This finding was consistent with the study done by Wright et al. (2012) and a Tasmanian study by Terry and Le (2013). Findings also showed consistency with Halseth (1999) observation who stated that employment opportunities for partner can be a central issue in the decision making to move out of rural region. IMGs with no family were open to the idea of working in rural regions some basing their future decision to leave rural practice to family reasons. IMG may consider coming back to rural practice once their family needs are taken care of. As suggested by Auer and Carson (2010), this could demonstrate that at particular life stages IMGs might be able to fulfil lifestyle ambitions resulting in longer lengths of stay in rural regions.

7.3 Social and Cultural

This theme comprised of friends, family members’ social life, community and cultural needs of IMGs. It involved having a social life. Having friends and family was important to some IMGs. The views about social life were mixed. For some IMGs the lack of social life was a significant factor that influenced IMGs’ decision to stay or leave rural regions. However, for some IMGs the lack of social life was not a factor that influenced their decision to stay or leave rural regions, suggesting they are pragmatic about the limitations of rural life.

7.3.1 Family, friends and community

Some IMGs expressed their happiness living in rural region. They said the experience for them and their families was excellent. Their partners had a job and children went to a nice school. They had friends to socialise with and some IMGs commented that their future decision to move out of rural region would be based on whether their families wanted to move.

This is what IMG16 had to say about her family’s experience in rural region.
IMG16 - Excellent! We have all been happy, my husband got a job easily and he was trained in his job and we have made lots of friend and the children have a nice school. So we are really, really happy here.

IMG15 shared both his and his family’s experience in the rural town. He said it was excellent and that being in a small town gave him the opportunity to know everyone. The presence of a small home country community catered for his family’s social life as well. They did not have problems living in this rural town. Recreational facilities were accessible as big cities were just three hours away.

IMG15 - Social circle was very good, knew everyone and we were all like a friend. We do have a small [name of ethnic community withheld] community here which was main part of it like family not missing social life.

This IMG said that her family was happy and her husband worked in the same town.

IMG7 - They are quite happy here, my husband is also quite happy here in [name of rural town withheld] that’s why I moved here.

IMG9 who has been practicing for 40 years in the same town said his family’s experience was excellent. His children schooled in the same rural town and are appreciative about the quality of education they received. This is what he had to say about his family’s experience in the rural region.

IMG9 - Well I think it is excellent!

IMG9 - There is no problem ... Well I think it is excellent! There is no problem. My kids as you know have studied here and aaaahhh ... my daughters have done well. My younger daughter is now a renal physician. So she has done well. And in terms of integrating with the people around and at the same time obtaining the best possible education here as you can get anywhere in the world.

This IMG said his family’s experience in the rural town was excellent and that he would not leave this town mainly because family have settled well.

IMG25 - the experience for them was awesome.
IMG25 - For me it is mainly family, my kids would kill me if I want to move them somewhere else. So it’s mainly family perhaps … family settled here and so we are staying here.

Another IMG said she has both, friends from her own home country and had developed friendships with the local people too. Living in the present rural town worked well for her and her family.

IMG7 - I have got some [name of home country withheld] friends, started to get also some Australian friends and integrated in social life but still wants to maintain sort of the bond that we had before, we come from the same place if you like.

The responses from a few IMGs also revealed disappointment about the lack of family members around.

He said he and his family travel 3-4 hours occasionally to meet other family members.

IMG21 - But we have family in other big cities, we have to travel back and forth in a regular base.

His future decision to stay or move will depend where the family wants to live.

IMG21 - I think the family reason is one concern. If the family wants to stay in a big city then that’s the time we have to move.

This was IMG6’s response to his family experience.

IMG6 - so far there is just nothing wrong but bit of home-sick and my wife had her mum and dad back and forth and her sister is in States.

Even though well-integrated, some IMGs expressed a lack of social life as a downside to working in rural regions.

IMG23 - I think social life … there is not much of social life … We have integrated very well in the rural area more than the city. Yeah we did not have any problems. People are nice and friendly and supportive.

IMG6 - we lack … some our own … I mean nationality kind of thing in Australia rural areas but if I come to Sydney or Melbourne there are lots of people around and lots of friend but we here we lack … but I’m getting along
with this local community well so I think it’s been a problem in the beginning but becoming less now

IMG1 expressed social isolation but acknowledges that this is something for him to manage.

IMG1 - There is no social gathering, no house visits, no family visits ... I cannot ask the government to bring my family from Sydney to where I am now ... it is something for me to manage not for them.

Whereas to this IMG, not having friends and family close by was not a downside. However, his spouse was affected by this. The doctor was very appreciative of the fact that despite this, she was very supportive and that she managed well.

IMG11 - Initially the only problem was the distance between my friends and family. They lived in Sydney and I lived 250 kilometres - 300 kilometres away from them so the distance, number one. I suppose it didn’t bother me because I was tightly busy from 8-8 [8.00am – 8.00pm] but it affected my wife. She missed all the contacts but again she managed very well.

Another IMG expressed concern for their spouse and children. One IMG felt that it would be beneficial to live closer to old friends as they think this would be good for their children.

IMG13 - They are not enjoying here much and I got three kids ... they got lot of friends there and they are not enjoying here and lot of problems ... Couple of friends live in Sydney and Melbourne. I am thinking to live close to them it is good too for my kids to share these experiences too.

For some IMGs, having friends or family did not really matter. They were contented with the support they received from the community members. They engaged themselves with the local people and felt very welcomed there. They were open to a new culture and environment and made a conscious effort participating in events, clubs which they said made them feel integrated.

IMG9 - it has been wonderful, there has been no problem, we have integrated with the local people quite well, and they have accepted us well.
IMG11 - *Without their help, without their community support I don’t think I would have stayed there for 43 years.*

They made conscious effort to integrate themselves with the local community by participating in local events, games and becoming members of the local club. This is how they engaged themselves with the community.

IMG5 - *Yeah, I just participate in the old age people’s short trips around the towns and nearby towns and I used to help them during the Christmas time and the New Year time for the travelling. So I just involve with the old age people here, the senior citizen clubs and the other things. And also I used to play Tennis, in the evening I used to get involved with the other different community in this town who come to this town and I used to go to the Golf on Sunday. So a bit involved with that. So I have a bit of good community involvement in this local town. I know most of the people here.*

IMG7 - *You have to apply yourself, you have to integrate, you have to do the work and not expect people to come and embrace you.*

Some IMGs were found to integrate easily with the local community. They are open to a new culture and environment.

IMG9 - *Because I think again quite a lot depends on individuals as to how they integrate with local people.*

This IMG said that once social bonds are made with local people it becomes hard to leave and this may become one of the reasons to continue staying in the community.

IMG6 - *When we work in a community, when we get to know people it’s very hard to leave ... you know ... GP Practice. I think those are the factors that I will be doing the same job for the next few years.*

On the other hand, this research broadly suggested that there were only few IMGs who expressed a lack of social life for them or their family as a drawback living in rural regions. Some IMGs expressed lack of social life for themselves and their families. A few IMGs said that having no friends and family was found to be more difficult for their partners or children.
On a personal level, being in a rural community ... it is very hard to ... to make it clear for you it is ‘socially isolation’. There are no friends.

There is no much of social life ... we just work here.

Broadly, this thesis research demonstrates IMGs’ experience for them and their family in rural life is positive. IMGs reported that they made friends and had a social life and liked the community they lived in. They reported the patients were friendly and nice and some mentioned the town was a good place to raise kids. These findings were consistent with the past research of Cameron, Este and Worthington (2008) who noted that migrants developed a sense of belonging when the community is friendly and nice. Some IMGs also expressed a desire to maintain ties with people from their own background (Carlier, Carlier & Bisset 2005). They preferred to live in certain towns where they and their family could socialise with people from their own background (Terry & Lê 2013). They felt it was important for them and their kids to be able to interact with their friends of the same nationality.

Some IMGs made easy relations with community members whereas some IMGs made a conscious effort to integrate with the community. They engaged with the community by becoming members of the local club, played sport and participated in community events whenever they could. Getting involved in social and community activities could enhance the feeling of acceptance, belonging and wellbeing (Durey 2005). One IMG also stated that it would be difficult for him to leave this rural town because of the relationship he has developed with the community. This is also evident in previous examinations of Cutchin (1997a) and Cutchin (1997b) who stated that engaging with the community facilitated integration and participation develops obligations, trust and moral commitment with community members. Organisations can help employees engage with the communities in which they live offering both the IMG and community members the opportunity to get to know each other well (Halvorsen, Treuren & Kulik 2015). Developing social bonds could strengthen ties with the community and this improved with the length of residence (Kasarda & Janowitz 1974; Wulff & Dharmalingam 2008).

Even though some IMGs described a lack of social life in rural regions there were other factors that could make them stay in rural practice. Job opportunities for spouse,
engaging in community activities, easy access to entertainment in the cities, good school for children are factors that would retain IMGs in rural practice.

7.3.2 Cultural needs

Responses revealed that most IMGs were open to a new culture and environment. IMGs from Non-English Speaking Backgrounds (NESB) where English is not their first language, faced initial challenges of adapting to a new culture but were mostly towards or in the direction of integrating into their new environment. Some IMGs mentioned about the indifference they faced by locals during the early stages in rural town. They attributed this to people not knowing where they stand because they looked different, had a different accent and came from a different cultural background. They reported that once people knew where they stand, things got better. Many IMGs did not talk about socialising with people from their own background or the need of living close to their religious place of worship. This may be indicative that they are open to integrate with a new culture and environment.

While some IMGs did not explicitly voice cultural background or speak to it in any detail, there were a few IMGs who expressed a desire to live in close proximity to their religious place of worship and some IMGs wanted to maintain ties with people from their own ethnic background.

**Place of worship**

Having access to place of worship was important to some IMGs. This finding is consistent with the finding of Han and Humphreys’ (2005) study. IMG8 has expressed the importance of living close to a church. This IMG finds church a good place to engage themselves with the community.

**IMG8 - I try and engage in whatever I enjoy usually we are a Christian family so we find ourselves a local church and yeah try and sort of find ourselves a Church and usually that is important all the time that’s very important for us to be able to do so.**

Church is important to this IMG, and he prefers living in close proximity to his church. He acknowledged that it was something for him to manage. IMG1 has decided to leave his current rural practice after the completion of his moratorium period and live in a town within close proximity to a church.
IMG1 - So about my personal experience I have to be close to a church, my church. My church is 100kms far from here. If I move, example to Newcastle or to Sydney or to Melbourne ... the church will be 10-15 minutes away. So the church is the big thing for us.

People from own home country

Some IMGs expressed a desire to interact with people from their own home country while developing local friends too.

IMG7 - I have got some [home country] friends, started to get also some Australian friends and integrated in social life but still wants to maintain sort of the bond that we had before, we come from the same place if you like.

Some IMGs find it important to maintain ties with people from their own background. They seek for people from their own nationality and develop friendships so as to have a social life.

IMG4 - Basically there are more people coming from my similar background so we get socially.

Responses also revealed that IMGs from English speaking backgrounds had fewer initial challenges and integrated much easily than some IMGs from NESB.

IMG14 - I think it was a lot easier for me than it was for a lot of other Overseas trained doctors because I am from a somewhat similar background and you know I speak English well and I have a white skin ... I think that has made a difference.

IMG16 - Excellent! We have all been happy, my husband got a job easily and he was trained in his job and we have made lots of friend and the children have a nice school. So we are really, really happy here. It is just too small! ... I have no problems integrating in rural practice. It’s been a very positive experience.

IMG3 - You have an Australian ... partner to explain things, all cultural differences and things like that. But there are not many of those really.

Previous research studies suggested that social integration develops by interacting with community members and social networks (Brehm 2007; Kasarda & Jonowitz 1974). IMGs mentioned that church can be a good place to interact with the community. It
helped IMGs get to know people and make friends. This finding is consistent with the findings of Cutchin (1997b) who stated that anchors such as local social networks and churches play an important role in interacting members within a community. Some IMGs establish ties by socialising with people from their own nationality. They felt this was important to them and for their kids. This connection could assist IMGs with the settling down process by giving them a sense of support and belonging (Durey 2005).

7.4 Personal

This theme comprised of three sub-themes. They are, Working in a small community, Work-life balance and Geographical location. Although IMGs faced initial issues working in a new environment and setting, analysis suggested IMGs overcame these challenges with time.

IMGs showed preference to rural lifestyle over city life. Some IMGs preferred the quiet and peace of rural location. The key factors included less traffic, less commute time, easy access to schools, shops and other amenities which were considered to be an advantage over living in the city. Another benefit reported was the advantage of spending less time on the road and hence getting more time to spend with the family. For some exposure working in rural regions in home-country was a factor to take up rural practice.

Access to part-time work for female IMGs was considered a plus to their life-style. However, there were some IMGs who preferred working in certain rural regions only, like coastal regions and large regional centres. They also explained why they disliked going to very remote regions. For some it was the size of the rural region that was problematic, to some the remoteness while to some others, the natural environment itself.

These were some factors that showed weak attachment to rural life and practice. Lack of city attributes, lack of entertainment for them and children or the lack of a social life made working in very remote regions or inland regions unattractive. There were factors such as new accent, slang, getting used to a whole new environment and people, lack of privacy living in a small town or lack of friends that were perceived negatively by IMGs. But these factors in themselves were not sufficient in their decision to move out of rural practice.
7.4.1 Working in a small community

IMGs reported the benefits of working in a small community. The advantage of getting to know the patients well early on and providing them overall care was well appreciated. Having visiting rights to the hospital gave IMGs the ability to follow-up on their patients even after their admission to the hospital which was looked upon favourably by IMGs. These factors are relevant to both contexts, personal and working in a small community. IMGs reported as having a good work-life balance working in a small community. The factors such as lesser commute time to work, ability to spend more time with the family and the flexibility to work part-time especially for female GPs allowed them to maintain a balance between work and family commitments.

IMG16 - I enjoy being in a small community and also getting to know patients really well and having that ability to meet patients again easily.

IMG21 - The relationship in rural region is friendlier than the big cities and it is closer. You get to know everybody.

This IMG explained another benefit over city practice. Because GPs were given visiting rights to the hospital they were able to follow-up on their patients.

IMG19 - People know each other very well and in here you are given a visiting right to hospital so you could really look up to the patient and find out what happened because all my practice in the city before, I just admit the patient at the hospital for someone else I don’t know what happened so there is no follow-up.

This was what an IMG who worked in the same town for 43 years said. He mentioned that he would not have been able to do this without the support from the community. He found it very rewarding to provide care to the entire family.

IMG11 - You are dealing with the whole family not just one particular member of the family, you should treat the whole family and you have two or three generation under your care and you look after.

Some IMGs mentioned better financial incentives from the government for working in rural practice were motivators to take up rural practice. Facilities such as a car,
housing or cheaper housing were all seen as bonuses working in rural region. These were some of the responses:

IMG13 - Actually there are 2 reasons, one thing is ... it was the first job that I got. The other reason is they offered me a good package and lot of facilities ... house, car and bit of rewarding economical wise and financial wise too.

IMG7 - The fact is that number one, housing is cheap, that's a bonus. Here you get rural incentive ... working in the rural area from the government, that’s number two.

7.4.2 Work-life balance

Many IMGs enjoyed rural lifestyle. Some IMGs reported that life was more cost-effective with cheaper housing when compared to the city. When asked the question what do they like most about rural regions, their responses were:

IMG25 - For me it is mainly family, my kids would kill me if I want to move them somewhere else. So it’s mainly family perhaps...family settled here and so we are staying here.

IMG19 - Beautiful and peaceful place, no heavy traffic going to work.

IMG2 - It's been alright. I like the country side just because the schools are closer. I don’t have to drive hours together to get somewhere. It takes me 5 minutes to drop the kids off and just a short distance to work. There is not much traffic, it’s not noisy.

IMG10 - The lifestyle itself is really good here.

IMG25 - It’s the family lifestyle.

Having the flexibility of working part-time was considered favourably by female GPs. This arrangement helped them in maintaining a balance between work and family commitments.

IMG18 - That’s the beauty of general practice, they are quite flexible. I was lucky enough to find a practice which allowed me to go part-time and work school timing so me and my daughter we lived in the country town ... I pretty much worked during the school timing so I used to drop her off to school, go
to work and then pick her up from school. Aaaahhh yeah so that kind of worked quite well.

IMG2 - I used to work full-time now I am doing a 9-3 this year. This is the first time I have done which feels nice!

7.4.3 Geographic location

For some IMGs, geographic location mattered. Some IMGs preferred coastal over inland areas. Some preferred bigger towns over small towns. They perceived some rural regions as hostile and untrusting or not very nice. Several IMGs appreciated the benefits of working in a small community while there were a few IMGs to whom rurality or location did not matter. When asked about the kind of rural region they would like to work, some responses were:

IMG3 - I like working near the beach. I don’t think I would like to go inland, it’s nice and green here and wet whereas inland it is too dark. I think rural as long as it is near the coast.

IMG25 - Not exactly! No … no… the other rural places are not as nice and some of them are not close to the beach.

Some IMGs preferred working in larger towns over remote regions. The reason provided was personal indicating they missed the attributes of a big city. They also commented about the lack of privacy in small towns and everyone knowing everybody else.

IMG10 - It is a very small area, working and living there is really difficult for me.

IMG16 - I would. I don’t want to be too rural again I have to say. I miss the big smoke.

On the contrary there was one IMG to whom rurality did not matter.

IMG24 - I think I can stay as much as I can … I don’t have a problem away from the city. I don’t really enjoy city life.

IMGs acknowledged that they do face issues when they initially move to a new country and a new culture. Some issues they face are discussed below.
Familiarising with a new accent and local slang in a new geographical location were some of the common issues IMGs raised. They agreed that this was part of moving to a new country and that over time they overcame these issues. Learning a new health system was another challenge they encountered when they first came.

IMG14 - *I really struggled to understand what people were saying initially ... because they won’t say you have done it wrong because they say ‘Oh perhaps you may want to consider next time to take a different approach to that’ ... I didn’t realise that what they were saying was that you have done that wrong. They probably found me very abrupt and aggressive in my approach to things, where I was just being me! In [name of home country withheld] it might be perfectly appropriate you know ... so that took a while to adjust to and I have adjusted to a certain extent to Australia, but I will never turn into Australian.*

IMG25 - *Initially we had to adjust to the environment, also people-wise and culture, we had to adjust with that. But otherwise it’s been quite good.*

IMG22 who has worked in the city and is now working in the rural region has provided a suggestion to cope with this problem. He said that rural people have their own slang and this may cause difficulty for recently migrated IMGs to rural town. Providing new IMGs training in a hospital for a few weeks before they are sent to rural practice may assist them in overcoming issues of language and also acquiring a better understanding of the Australian health system.

IMG22 - *In rural area people are completely different. Their background, language what you call they use lot of slang and different so you can’t really understand half of their conversation ... I think to work in rural they need at least few weeks or a month in a proper hospital where they are close to, they need to know what is the set-up in Australia, how they referral and how they going there so they just need to know the hospital system before you start as a GP otherwise it will be very hard understanding them too.*

Some IMGs said they had to make an effort to prove themselves in their early stages as people were not sure about where they stand. They attributed this to their looks, new accent and different culture. But they also commented that once people got to know them there were no problems.
Their responses were:

IMG7 - The difficulty is sort of people not knowing where you are in terms of your experience, things that you would know and you don’t know and you have to work harder to prove yourself sometimes … yeah until they get to know who you are and they get relaxed … initially people are not sure of where you stand and that is mainly to do with the language, your accent, you look different so people are a bit weary initially, and then when you have done something then that’s when they start relaxing

IMG25 - So in the first instance you have to prove to people that you know what you are doing and so I had to go through that in my early stages of my work here. But yeah once that was done that went well.

Adapting to a new town, in a new country was another challenge they encountered. As this IMG said, situation is difficult until finding new friends or getting used to the loneliness. And then it gets better over time.

IMG10 - You are on your own most of the time, so when you move to new country you don’t have any friends so till you find couple of friends or you get used to situation being alone is little bit difficult.

The theme comprised of three sub-themes, Working in a small community, Work-life balance and Geographical location. IMGs acknowledged the benefit of working and living in a small community due to the personal benefits such as getting to know the patients well early on, close access to amenities or due to the environmental factors of the region.

Alignment to previous studies

The three themes discussed in this chapter share some alignment with previous research. The findings of this study suggest that IMGs’ preference for working in rural regions is influenced by their positive experience. The advantages of being in a small town and getting to know their patients well, and providing them continuous care were considered positive factors working in rural regions. This finding is in alignment with Dywili et al. (2012) who stated that a relaxed rural lifestyle and the professional enjoyment of providing continuity of care for patients could assist in retaining medical practitioners in rural regions. To some IMGs, the natural environment they lived in
provided a particular way of life (Brehm 2007; Humphreys et al. 2009). One IMG commented her ability to spend more time with her family attributing this to less traffic and amenities at close proximity. Another example was living close to a beach. This supported social interactions with family members on the beach. Participants reported that living in a small town with less traffic, easy access to amenities, living close to work, schools at a short distance aided in achieving a work-life balance. The ability to work part-time was another positive factor mentioned by female GPs. This suggests that professional aspect is not the only place attachment factor, there are other factors like natural environment or recreational assets (Brehm 2007; Cameron, Este and Worthington 2008). They could be important in retention of IMGs in rural regions of NSW. If a community that an IMG lived in offered amenities they valued and provided a lifestyle that suited those (Halvorsen, Treuren & Kulik 2015) could be motivators to take up rural practice.

IMGs acknowledged they faced issues initially moving to a new country and a new culture. Despite having good knowledge of written and spoken English, responses revealed issues that were evident in previous studies such as new accent and slang. Familiarising with colloquial speech, the use of nuances, non-verbal cues would be helpful (Pilotto, Duncan & Anderson-Wurf 2007). An Australian study revealed that rural indigenous elders in West Virginia were reluctant to consult IMGs due to perceived language barriers which were identified as a barrier to health care services (Dywili et al. 2012). For IMGs coming from culturally distant countries to Western countries, differences in socio-cultural terms also pose difficulties for IMGs in judging how far they can discuss things with the patients as evident in Khan et al. (2015) study. IMGs had to make an effort to prove themselves in their early stages of rural life. Community members were not sure about where they stood attributing this to their looks, new accent and different culture which improved over time. As evident in the study of Smith (2005) adapting to a new small town, in a new country was a challenge IMGs encountered. Although IMGs had few initial challenges, their overall personal experience was positive in rural life. The challenges lessened with support and their own efforts to integrate.
7.5 Conclusion

This chapter presented three themes that emerged from the qualitative analysis of this study: Family, Social and Cultural and Personal themes. The sub-themes identified key dimensions of the IMGs’ social, cultural and personal engagement. This process of identifying the dimensions or factors of integration is important to the knowledge of integration of IMGs and also to foreground the assessment of the utility of Han and Humphreys’ (2006) typology. These three themes provide an understanding of IMGs’ experiences and how these themes may influence IMG’s decision to stay or leave rural practice. Family factors such as job opportunities for partner and quality education for children are important for retention. Some IMGs used ways to manage their family responsibilities, for instance commuting from large regional centres every day or placing their families in large cities and IMG commuting on a weekly basis to place of work. Meeting family needs is important for IMGs to remain in rural practice. This study suggests that IMGs who are single or IMGs who have fulfilled their family commitments maybe better candidates to work in rural regions.

The next theme, Social and Cultural was also found to be important. This theme is found to impact IMGs’ length of stay in rural practice. Cultural needs were found to be important to fewer IMGs and can influence the decision to leave rural region. This factor was noted to be quite important to a few participants only. Many IMGs did not explicitly voice cultural background or speak to it in any detail which is indicative that many IMGs did not place much importance to the cultural aspect. Theme, personal, is about the lifestyle, personal likings or preferences of working and living in rural region. For many IMGs, this theme was found to be least influencing in their decision to leave rural region. But for some IMGs fulfilling personal aspirations was important. These factors could be attractive reasons or motivators for an IMG to take up rural practice.

This chapter discussed how factors from the three themes, Family, Social and Cultural and Personal can influence integration and retention of IMGs in rural regions. The factors discussed in this chapter were linked to those discussed in the previous chapter which detailed professional experiences. Consistent with Ager and Strang (2008) and Penninx (2005) who identified broad interrelated domains, themes or dimensions, the themes discussed in this chapter related to the professional theme. For many of the IMG participants in this thesis, their professional satisfaction was a dominant feature.
of their narratives – this satisfaction joined to what they identified as their social engagement with their community and appreciation of the environmental beauty of their location, the recreational features it offered and low commuting distances between work and home. For many IMGs, future family needs, primarily involving their children’s high school and university education or their spouse or partner’s employment, were the only key factors that mediated their resolve or interest in staying in their current location. The detailed thematic analysis, including the interrelationship between the themes, informs the application of Han and Humphreys’ (2006) typology which will be discussed in the next chapter.
CHAPTER 8
FACTORS OF INTEGRATION OF INTERNATIONAL MEDICAL GRADUATES IN NSW: APPLICATION OF HAN AND HUMPHREYS’ (2006) TYPOLOGY

8.1 Introduction

Han and Humphreys’ (2006) typological study provided insights into factors of integration including professional and social factors that impacted the integration of IMGs into rural communities. This chapter discusses the extent to which the experience of IMGs interviewed in this research study aligns with Han and Humphreys’ (2006) typology. The chapter discusses the complexities in categorising the IMGs of this thesis consistent with Han and Humphreys’ (2006) typology and discusses IMGs’ experience that was not sufficiently recognised in the typology.

The application of the typology to participants’ experience was foregrounded by the thematic analysis presented in Chapters 6 and 7. The analysis also provided rich explanations of the main themes, through the identification of sub themes, which provided direct commentary on integration. The thematic analysis underlined the interrelated nature of main themes and domains, most notably how professional integration and ongoing retention could be mediated by concerns addressing family needs in the areas of school education and partner employment.

8.2 Han and Humphreys’ (2006) approach to integration

Han and Humphreys’ (2006) study attempted to relate characteristics of IMGs to degrees of integration into rural communities and their future intentions of settlement. Han and Humphreys’ typology (2006) discussed in Chapter 4 categorised IMGs into four types: The Integrated, the Ambivalent, the Fence-sitters and the Satellite Operators. The central question in forming the typology which identified four types is ‘what are the characteristics of individual IMGs who cope best with their practice and life in rural communities?’, acknowledging also that there were some IMGs whose characteristics overlapped between the types (Han & Humphreys 2006, p. 190).
Simplified and detailed descriptions of each of the four types are outlined in Tables 4.2 (Chapter 4) and 8.2 respectively. The IMGs of this research were classified into types based on the ease with which they integrated with the local community, their experience about living in rural communities, their coping strategies they used with family needs and children’s education such as commuting to rural practice from the city or placing family in the city or their long or short term decision to stay or leave rural region. Each of Han and Humphreys’ (2006) types presents itself with characteristics having a degree of integration in rural life and practice. Han and Humphreys’ (2006) identified the Integrated as satisfied with rural life and practice, pragmatic about the limitations of rural life and therefore more retainable in rural region and practice. The Ambivalent type are in the process of integrating but unsure about their future locations and settlement. The Fence-sitters enjoy both urban life and rural practice but are unable to live away from the city. The Satellite Operators being the least integrated in rural life and practice making them the least retainable in rural region and practice after the completion of their mandatory period. Table 4.2 in Chapter 4 represents a simplified description of Han and Humphreys’ (2006) study as identified by Han and Humphreys (2006). As a point of reference Table 4.2 is repeated here as Table 8.1.
Table 8.1: Han and Humphreys’ (2006) classification into four types (Simplified description)

<table>
<thead>
<tr>
<th>Satellite Operators:</th>
<th>The Ambivalent:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families settled in the city; the doctors commute to work until they are allowed to practise in the city</td>
<td>appreciates rural life and practice, but unsure about long-term rural settlement; may settle either rural or urban</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fence-sitters:</th>
<th>The Integrated:</th>
</tr>
</thead>
<tbody>
<tr>
<td>enjoy the advantages of both rural and urban life and practice, unable to live away from the city</td>
<td>Appreciates rural life and practice; able to live as a minority; pragmatic about the limits of rural communities</td>
</tr>
</tbody>
</table>


Aligning the 25 IMGs of this thesis based on the simplified description of the four types (Table 4.2) inadequately captured the experience of the 25 IMGs of this research study. When in doubt in aligning IMGs based on the detailed table (Table 8.2), Han and Humphreys’ (2006) simplified table (Table 4.2) was used. The reason for this was because the analysis of this thesis produced a more nuanced understanding of IMGs experience which made it difficult to place some IMGs clearly into one of the four types.
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<thead>
<tr>
<th>IMG Type</th>
<th>Characteristics of the type</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Integrated</td>
<td>IMGs are more positive and pragmatic when dealing with issues; aware of the advantages and disadvantages of rural life and practice; enjoys rural life and practice; have valuable relationships with their colleagues; appreciates Australian medicine, new environment and the cooperative work environment; able to live as a member of a minority in Australia; Ethnic links and cultural heritage for children were important for IMGs from non-English-speaking backgrounds (NESBs), but not a factor to move to Melbourne; make friendships or informal relations with the local community and these interactions are not hindered by the absence of members of their own ethnic group; a supportive spouse who similarly appreciates a rural lifestyle; enjoy rural life and practice more than they do in the city; highly committed to country practice; living close to relatives is not a factor in determining their location of practice; quality education for children was a major factor in deciding their location of work; coped well with discriminatory comments or acts; well adapted to new culture; most had exposure to rural medicine prior to their migration. Neither urban nor rural upbringing predominated in this group.</td>
</tr>
<tr>
<td>The Ambivalent</td>
<td>Satisfied with rural practice but have concerns about family, children’s secondary education, job opportunities for spouse and hence less sure about their future practice locations; wish to be closer to children; spouse job a major concern especially with female IMGs; miss people from their own ethnicity and prefer linking with them, a deciding factor for them to stay or leave; they are in the process of integrating but unsure if they will remain in rural practice; may settle either rural or urban; will move when necessary and when they can. It was noted that with persuasion, IMGs from this group may settle in rural practice for a longer period of time.</td>
</tr>
<tr>
<td>Fence-sitters</td>
<td>Enjoy the advantages of both rural and urban life and practice, unable to live away from the city, prefers practising in close proximity to the metropolitan area; enjoys both urban and rural lifestyles; lives in city fringe areas (60-100 km from city centre); wishes to maintain cultural links to their ethnic community; wants to provide good opportunities for children in terms of education; values rural practice just like the Integrated; have easy access to city environment and ethnic communities.</td>
</tr>
<tr>
<td>Satellite Operators</td>
<td>Families settled in the city; the doctors commute to work either daily or weekly, until they are allowed to practise in the city; spouse and children live in the city, close to kin; sometimes resides in rural regions but will surely leave after meeting GP requirements; disappointed with the lack of city attributes; links with the city is important as they can maintain family’s cultural needs; personally satisfied living in cities; dissatisfied with their life in the country; will leave as soon as they can; do not look for ways to overcome problems; they may be happy with rural practice but anxious about family and personal life; develops friendship mostly with people from their own ethnic group.</td>
</tr>
</tbody>
</table>

8.3 Alignment of IMGs of this study to the Han and Humphreys’ (2006) typology

Table 8.3 (p. 146) shows the alignment of 25 IMG participants of this study to Han and Humphreys’ (2006) four types: The Integrated, the Ambivalent, the Fence-sitters and the Satellite Operators. There were three major classification outcomes when aligning IMGs to Han and Humphreys’ (2006) type:

‘Aligned’. This classification was used if IMGs showed a majority of characteristics of a single type.

‘Partial’. This classification was used if IMGs showed multiple characteristics of more than one type.

‘Not Aligned’. This classification was used if IMGs did not show multiple characteristics of that type.

Some examples assist to illustrate these outcomes. IMGs that showed the majority of the characteristics of a type were aligned to a single type. For example, IMG7 showed the majority of the characteristics of the Integrated type, in that the IMG was positive and pragmatic when dealing with issues. This IMG was aware of the advantages and disadvantages of rural life and practice. IMG7 developed valuable relationships with colleagues and regarded Australian medicine highly and was strongly attached to rural practice. IMG7 and family coped well with the new environment, had a social life and was happy working and living in the region. This IMG was aligned to the Integrated type.

IMGs were partially aligned to a type when IMGs showed characteristics of more than one type. For example, IMG25 showed many characteristics of the Integrated type and also showed characteristics of the Ambivalent type. This IMG is presently well-integrated in rural practice and life but has concerns about his family. This mainly concerned children’s secondary education and clearly indicated to move out of rural region when required to do so. IMG25 is represented in the table as partially aligned to both the Integrated and the Ambivalent type. Another example is provided by IMG13 who is partially aligned to two types, Integrated and the Satellite Operator. This IMG is integrated in rural practice but clearly indicated moving to the city for family reasons. Hence this IMG is partially aligned to the Integrated type and the
Satellite Operators type. The IMG indicated moving out of rural region after the completion of the moratorium period and the reason provided was to maintain links with old friends from the same ethnic background.

Table 8.3: IMGs’ alignment to Han and Humphreys’ (2006) types

<table>
<thead>
<tr>
<th>IMG PARTICIPANTS</th>
<th>INTEGRATED</th>
<th>AMBIVALENT</th>
<th>FENCE SITTERS</th>
<th>SATELLITE OPERATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMG7</td>
<td>Aligned</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMG8</td>
<td>Aligned</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMG9</td>
<td>Aligned</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMG11</td>
<td>Aligned</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMG14</td>
<td>Aligned</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>IMG20</td>
<td>Aligned</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>IMG24</td>
<td>Aligned</td>
<td></td>
<td></td>
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<tr>
<td>IMG3</td>
<td>Aligned</td>
<td></td>
<td></td>
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<tr>
<td>IMG23</td>
<td>Aligned</td>
<td></td>
<td></td>
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<tr>
<td>IMG15</td>
<td>Aligned</td>
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<tr>
<td>IMG16</td>
<td>Partial</td>
<td></td>
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<td>Partial</td>
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<tr>
<td>IMG2</td>
<td>Partial</td>
<td>Partial</td>
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<tr>
<td>IMG4</td>
<td>Partial</td>
<td>Partial</td>
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<tr>
<td>IMG5</td>
<td>Partial</td>
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<tr>
<td>IMG6</td>
<td>Partial</td>
<td>Partial</td>
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<tr>
<td>IMG17</td>
<td>Partial</td>
<td>Partial</td>
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<tr>
<td>IMG22</td>
<td>Partial</td>
<td>Partial</td>
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<tr>
<td>IMG25</td>
<td>Partial</td>
<td>Partial</td>
<td></td>
<td></td>
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<tr>
<td>IMG1</td>
<td></td>
<td></td>
<td></td>
<td>Aligned</td>
</tr>
<tr>
<td>IMG21</td>
<td>Partial</td>
<td>Partial</td>
<td></td>
<td></td>
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<tr>
<td>IMG19</td>
<td>Partial</td>
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<tr>
<td>IMG10</td>
<td>Partial</td>
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<td>Partial</td>
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<tr>
<td>IMG13</td>
<td>Partial</td>
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<td>Partial</td>
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<tr>
<td>IMG12</td>
<td>Partial</td>
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<td></td>
<td>Partial</td>
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<tr>
<td>IMG18</td>
<td>Partial</td>
<td></td>
<td></td>
<td>Partial</td>
</tr>
</tbody>
</table>

Notes: IMGs were ‘Aligned’ to a type if they showed a majority of characteristics of a single type. IMGs were ‘Partial’ to a type if they showed multiple characteristics of more than one type. IMGs were ‘Not Aligned’ to a type if they did not show multiple characteristics of that type. In the above table non-alignment is represented as a blank cell.
Summary of the table

All of the IMG participants could be aligned or partially aligned to one of the four types. Twenty-four out of the 25 IMGs showed either a clear or a partial alignment to the Integrated type. Ten out of 25 IMGs from this research thesis showed a clear and unambiguous alignment to Han and Humphreys’ (2006) Integrated type. These ten IMGs displayed the majority of the characteristics of Han and Humphreys’ (2006) Integrated type. This is discussed further in the chapter. Nine IMGs showed a partial alignment to the Integrated type and were also partially aligned to the Ambivalent type. These IMGs are presently integrated indicating a clear desire to move out of rural region when it becomes necessary to do so or were unsure about their future move given the uncertainty of their family circumstances. The clear number of IMGs who shared a partial alignment to both the Integrated and Ambivalent types pointed to the absence of mutual exclusivity between these two types. This complexity will be addressed further in the chapter. There were only two IMGs that showed characteristics of the Fence-sitter type but they were partially aligned as they also showed characteristics of the Integrated type. These IMGs are partially aligned to the Fence-sitter type as they met Han and Humphreys’ (2006) characteristic of commuting daily to work from the closest urban centre. One IMG out of 25 IMG participant clearly aligned with the Satellite Operators type. There were three IMGs that were partially aligned to the Satellite Operators type because they also showed multiple characteristics of the Integrated type. These three IMGs, IMG13, IMG16 and IMG19, although integrated, showed characteristics of Han and Humphreys’ (2006) Satellite Operators type. The characteristics were moving to the city after the completion of the moratorium period or the weekly commute to the city to see family. IMG13 desires to move to the city as this IMG wishes to maintain links with old friends from the same ethnic background. IMG16 desires to move to the city because this IMG misses the city and IMG19 who resides in the rural region commutes on a weekly basis to the city to see family. This complexity is discussed in the following section of this chapter. The alignment of IMGs of this thesis to each of Han and Humphreys’ (2006) four types is illustrated in the following section.

The Integrated type

Ten IMGs from this research thesis showed clear alignment to Han and Humphreys’ (2006) Integrated type. Ten IMGs showed very strong attachment to rural practice and
life, showing greater willingness to practice in the same rural region. This will be discussed further in the chapter. All the IMGs from this type showed strong attachment to rural practice enjoying patients’ appreciation, loyalty and continuity of care. They appreciated Australian medicine, their ability to practise variety of skills and the opportunity of dealing with more complex medicine in rural practice. They also appreciated the collegial or cooperative work environments that they perceive in rural practice (Han & Humphreys 2006, p. 195).

IMG14 - *I think the continuity of care might be the most rewarding thing.*

IMG11 - *The independence of working in the rural area, the wide variety of challenges you meet in the rural practice*

IMG 14 - *I really like how general it is and you just have to deal with whatever comes through the door and it could be absolutely anything.*

IMG7 - *We got a lot of education going on every week. We do some clinical cases and also the kind of patients we get are well appreciated. That is a plus!*

IMG15 - *Coming back to this rural practice was basically from my previous experience as a Resident medical officer ... I knew almost everyone here ... So the main reason to come here as a General practice was I worked with all the specialists in the hospital*

IMG23 - *Everyone here help each other and communication is very good with the other GPs and with the specialists.*

The following IMGs displayed characteristics of Han and Humphreys’ (2006) Integrated type by taking a pragmatic approach in dealing with situations, promoting relationships with colleagues, patients and developing friendships with community members (Han & Humphreys 2006, p. 194)

IMG7 - *You have to apply yourself, you have to integrate, you have to do the work and not expect people to come and embrace you.*

IMG8 - *I try as much as possible doesn’t matter where we move to try and integrate as much as possible with the community as best we can.*

IMG15 - *I had a very good social circle here as a for one and half years, social circle was very good knew everyone and we were all like a friend. We do have*
a small [name of home country withheld] community here which was main part of it like family not missing social life.

IMG14 - This is my own practice ... must say I didn’t find it all that easy, I studied in [name of overseas city withheld] ... I grew up in a small town in [name of home country withheld] ... I spend my time in [name of overseas city] and quite liked it and then to go from [name of overseas country withheld] to [name of rural town withheld] was a big change! ... So it took a lot of adjusting and I think moving town within Australia twice, I found it quite difficult to adjust to but I think now that we have lived here for a while you know I am much more settled. If that makes sense, some things just take time.

IMG9 and IMG23 felt welcomed and accepted by the community. They feel they have integrated well into rural practice and the rural region.

IMG9 - it has been wonderful, there has been no problem, we have integrated with the local people quite well, they have accepted us well.

IMG23 - We have integrated very well in the rural area most than the city. Yeah we did not have any problem. People are nice and friendly and supportive.

The view of IMG11 who has practiced in the same rural region for forty-three years appreciated the support of his spouse. He felt accepted and welcomed by the community, developed friends and set-up own practice, worked in the same rural town for forty-three years. This IMG displayed many characteristics of Han and Humphreys’ (2006) Integrated type namely the adjusted to the new environment, the adaptation to the local community, having a social network and the support of his spouse.

IMG11 - I came over here and I found the town where I am at the present. I did not change. In the last 43 years I am in the same place. They accepted me very well and they welcomed ... Prior to my arrival there was one more GP but they accepted my presence and I worked and I got attached to the local hospital which had 32 beds and I ... my practice took over very quickly and I got good set of friends, I’ll call them friends and at the same time entire community maybe half the community are my patients.
IMG3 enjoys working in the current rural region. Less commute time to work, the quiet and peace of the place and ability to use variety of skills was looked upon favourably.

IMG3 - Not having to commute to work for an hour everyday (laughs), makes a big difference. Takes about 10 minutes to drive to work. It’s a quiet, peaceful area in [name of rural town withheld] to practice, at the end of the day. There is a lot of variety. In urban practice you seem to get a lot of rather minor, uninteresting illness in my experience, whereas in rural practice you get diverse there is a lot more of different things in urban practice.

The views of these two IMGs who reported that they enjoyed rural practice and lifestyle more than they do in the city were happy working and staying in rural regions.

IMG20 - I intend to stay as long as possible. Yes, I really enjoy my job here.

IMG24 - I think I can stay as much as I can ... I don’t have a problem away from the city. I don’t really enjoy city life.

These IMGs were placed in the integrated type as they aligned to Han and Humphreys’ (2006) characteristics of the Integrated type. They integrated significantly into rural communities, were strongly attached to rural practice; enjoying patients’ appreciation, loyalty and continuity of care. They enjoyed Australian medicine and integrated themselves well into their new environment. They made a conscious effort to anchor in the local community, promote relationships with colleagues and patients and were able to live as a minority in a foreign culture. They reported the benefits of rural practice and lifestyle over city practice and life (Han & Humphreys 2006).

This is not to suggest the alignment was without its complexities. The complexity of aligning IMGs to the types was evident when IMGs showed characteristics of more than one type. This made it difficult to categorise few IMGs of this thesis clearly and completely into one type. This is demonstrated by providing two examples. IMG19 who is well-integrated, appreciates and prefers rural practice over city practice. This IMG travelled few hours on the weekend to see family. Commuting to the city to meet family is a characteristic of the Satellite Operators type. However, the satisfaction of living and working in rural region that this IMG showed is in contrast to Han and
Humphreys’ (2006) Satellite Operators type where IMGs are dissatisfied with rural life and preferred living in the city.

IMG19 - I really enjoyed the work and the place

And then he says

IMG19 - the only thing is I wasn’t able to bring in my family straight away. Maybe if you bring in the whole family and stay there early that would be the best. The thing is my kids were all grown up and still in Uni so there was separation; we had to come back on the weekend because they are in the Uni in Sydney so I think that was the only thing difficult ... The travel, the trips...the long, long trips specially when I worked in [name of rural town withheld] for my family here and then going back to work on Sunday night ... Aaahhh...That was very difficult.

IMG19 - Two and half hours so I travel on the weekend

IMG19 resided in the same rural town as the practice and commuted on a weekly basis to the city to be with his family. Unlike Han and Humphreys’ (2006) Satellite Operators type, this IMG appreciated rural life and practice and showed most characteristics of an Integrated type but also showed this feature of weekly commute to the city to meet with family which is a characteristic of Han and Humphreys’ (2006) Satellite Operators type. Hence IMG19 was partially aligned to the Satellite Operators type.

IMG16 is well-integrated in the rural region. This is what IMG16 had to say about her family’s experience in rural region.

IMG16 - Excellent! We have all been happy, my husband got a job easily and he was trained in his job and we have made lots of friend and the children have a nice school. So we are really, really happy here.

IMG16’s intentions to leave rural regions is:

IMG16 - Just because I want to go to Brisbane (laughs). Basically to go to a bigger area, it is small here. So we are going to move to North of Brisbane because we have access to the city.
IMG16 showed multiple characteristics of the Integrated type but intends to move to the city which is a characteristic of the Satellite Operators type (Table 8.1). Hence IMG16 was partially aligned to the Integrated type and also the Satellite Operators type.

**The Ambivalent type**

Nine IMGs showed characteristics of the Integrated type and also characteristics of the Ambivalent type. Hence their partial alignment to both the Ambivalent type and the Integrated type. These IMGs are presently integrated but have an ambivalent future. They have unresolved concerns about family – future education for their children and employment opportunities for their partner (Han & Humphreys 2006). Although these IMGs showed professional attachment to rural practice their future stay in the same rural practice clearly depended on family factors such as children’s high school or university education or job opportunities for partner. They clearly considered moving to the city if it becomes necessary and will do so when they can.

IMG17 and IMG25 who were currently well-integrated in rural practice said

*IMG17 - It’s been great, no problems at all. It’s all good and we are quite happy, settled down nicely and no problems*

*IMG25 - It’s been good. I have seen other overseas doctors who have come here, where in [name of rural town withheld] their integration has been quite perfect.*

But when asked what would make them leave rural practice this was their response

*IMG17 - I might look into relocating and that would be only mainly for my children’s education.*

And then he said

*IMG17 - I would consider but possible not in the next few years because like I said very earlier my children educational needs would be more important ... But once they are out of the way possibly I’ll get back to rural work again in the long run*
IMG17 was also willing to go back to rural practice once family factors are taken care of. Similarly, IMG25 mentioned their move out of rural town would be when his daughter goes to University.

IMG25 - Oh… when my daughter goes to University. We’ll move to close to where she will be in University.

IMG5 and IMG4 who were well-integrated in rural practice say their future decision about leaving rural town maybe due to job opportunities for their partners.

IMG5 - In the future my wife's job opportunities are limited in this rural town and she is an accountant. This may contribute to make future decision about leaving rural town.

IMG4 - The hard part is that my husband is an IT professional, the thing is that there is no scope for IT professional so because of that I have to go somewhere my husband where he will get a job … if he gets a job here we will stay here. I am happy to stay here.

IMG2 and IMG6 who are integrated have also mentioned children’s higher education as a reason to leave rural practice. IMG21 reason to leave rural region would be when family wants to live in the city.

IMG2 - If my husband moves, I have to go … I don’t have to but it just makes it easier with my 3 kids. And if my daughter goes to University then I have to think about whether I needed to move or not!

IMG6 feels integrated in rural life and practice but unclear about his long-term stay in the rural region.

IMG6 - I think specially the attitude of the person I believe in first place to come around any obstacle and if we put effort to manage we can face challenges

IMG6 - when he needs high school I might think of moving, and my wife need a job too

IMG21 - I think the family reason is one concern. If the family wants to stay in a big city, then that’s the time we have to move
The nine IMGs of this thesis that showed characteristics of the Integrated type also had an ambivalent future. All these IMGs are well-integrated and engaged in rural practice but are more likely to leave rural prompted mainly by factors such as children’s education or job opportunities for partner. The primary issue to note with categorisation of these IMGs are that they are presently well-integrated on a range of grounds but identified that they would relocate in future years for reasons such as children’s education or employment opportunities for partner.

IMG10 who is integrated in rural life and practice preferred staying in his current rural region but mentioned that his future decision to leave rural practice would be availability of job for spouse and access to a university.

IMG10 - Life is more cost effective and more easy to manage life here rather than the big city.

IMG10 - it could be a family matter for example if your wife or your children want to attend any education or university

When asked the question ‘Given that you like working here, would you like working in other rural regions?’ the reply was

IMG10 - Yes, I prefer generally to work in rural area rather than ... not really I usually go to the other town one day a week it is about 50km from here, our practice has another branch there so we support that community too, so I usually go there one day a week and the population there is about 1700 people in that area. It is a very small area, working and living there is really difficult for me. But this kind of town rather medium size, [name of rural town withheld] is really good area and I always like to work in this kind of area or very small community.

This IMG mentioned that he works one day per week in a very small town and that he would dislike living in very small towns. He indicated that his future intention to move out of rural practice would be for job opportunities for partner or children’s education.

The Fence-sitters type

Two of the IMGs showed many characteristics of the integrated type but also showed characteristics of the Fence-sitter type. One of the main characteristic of this type is the daily commute to work from a city centre. Both IMG12 and IMG18 are integrated...
in rural practice and commuted daily from the closest urban centre to their work practice. Hence IMG12 and IMG18 were partially aligned to the Fence-sitter type.

IMG12 - it is very good, no complain yeah. I think they are thoroughly satisfied ... So integration was very good, there was no problem ... the whole community, the school community and hospital community aahhh integrated us into their activities and other stuff so we had no problems.

IMG12 - I travel from the nearest urban centre ... It is about 45 minutes’ drive

IMG18 - You get to do lot more hands-on like you get to be more involved in the patient care and you just feel a bit more involved. Yeah I think that’s quite nice and generally I mean and also like you are not in a big rush like you still live in a small community, you still get to know the family, with the patients at a much deeper level I feel.

IMG18 - my current practice I have been there only for a few months like not that rural, probably about one-hour drive, from [name of rural town withheld], it’s nice but I really don’t enjoy the commute, it is really tiring.

IMG18 who enjoys rural practice considers family factors as most important in her decision in staying in rural practice along with ongoing education and financial incentives.

IMG18 - it again depends as I said, family, you know education of your children whether they are able to get the right exposure and all the other activities so that plays a very important role and also... as well as professional support like you know in the form of education ... I think the major part especially being a female GP would be family commitment whether your partner is able to find a job in the same place because at the end of the day you don’t want to be living a fragmented family life with one person in a different place the other person in a different place I think that plays a very important role especially being a female GP and having children and all those stuff.

IMG18 - I have my job until end of this year. I am still a registrar which is like training so our jobs are only for 6 months and then we have to keep applying again to Medicare and other practice so that’s how it works and so it’s not permanent employment.
This again demonstrates the heterogeneity of IMGs of this thesis where IMG18’s current work location is only for six months and the next location of practice will be decided by Medicare.

In discussing the alignment of IMGs to the Fence-sitter type only two IMGs, IMG12 and IMG18 were partially aligned to this type. This is because they met the characteristic of commuting daily to work from the nearest urban town. They resided in the closest urban town not because of their inability to live away from the city but the reason provided by IMG12 for living in the closest urban town was to fulfil family needs. Hence, they were aligned to Han and Humphreys’ (2006) Fence-sitter type.

Basing categorisation on the commute characteristic alone, many IMGs could not be classified into this type as 23 out of 25 IMGs resided in the same town as their practice. This is partly due to the geography of NSW where rural regions may not be at a commutable distance from the city of Sydney. The map of NSW (Figure 1, Chapter 5) shows the distance of the seven non-metropolitan LHDs from the city of Sydney, NSW. New South Wales (NSW) is a state on the east coast of Australia bordering Queensland to the north, Victoria to the south, and South Australia to the west. It covers a region of 809,444 square km with an estimated population of 7.8 million as of June 2015. Han and Humphreys’ (2006) study was based in Victoria. It is the smallest state in Australia. It covers a region of 227,420 square kilometers with an estimated population of about 6.2 million and is bordered by Tasmania to the south, New South Wales to the north, the Tasman sea to the east, and South Australia to the west. (Australian Bureau of Statistics 2016; Maps of World 2017).

**The Satellite Operators type**

Only one IMG from this thesis showed majority characteristics of this type and hence was aligned to this type. A characteristic of Han and Humphreys’ (2006, p. 200) Satellite Operators type is ‘personally satisfied living in cities and dissatisfaction living in rural region’. They will seek to move out of rural practice as soon as they meet GP practice requirements. Three IMGs that are integrated were partially aligned to the Satellite Operators type as they showed one or two characteristic of this type. Two of these IMGs showed strong attachment to rural practice and are presently integrated in rural region. They displayed Han and Humphreys’ (2006) characteristics of the Satellite Operators type such as commuting on a weekly basis to meet family in the
city and wanting to leave rural region after completion of the moratorium period. One IMG who is integrated but was also partially aligned to the Satellite Operators type as this IMG wishes to maintain links with family or friends from a similar ethnic background. These factors became reasons to move out of rural region after the completion of the mandatory period. Hence the partial alignment of IMG13 to this type. This issue of IMGs showing characteristic of more than one type is dealt under the Integrated and the Ambivalent types.

IMG1 can be aligned to this type as this IMG expressed a desire to move out of rural region after the completion of the mandatory period. IMG1 and his partner initially planned to stay there forever. The reasons provided were, dissatisfaction with rural life, social isolation and lack of church and so have planned to leave and move to another rural practice after the completion of the Fellowship exam.

IMG1- Okay...when we came here, we thought we will stay for the rest of our life, my wife and myself. Then we said I don’t think we can do it anymore. We might be moving to another rural practice

IMG1- It is a bit different here, your question how long I will stay here, I think once I get my fellowship I will leave basically.

Their experience in rural town influenced their decision to move out of rural region.

IMG1 - it is ‘socially isolation’ ... there is no social gathering, no house visits, no family visits

Having access to a church was an important to them. This IMG has decided to move to another rural practice that is closer to a regional city and practice in a rural town that can be commuted to every day.

IMG1 - It is a personal decision more than anything else. So about my personal experience I have to be close to a church, my church. My church is 100kms far from here.

Thus, IMG1 was aligned to the Satellite Operators type as this IMG has decided to move out of rural region after the GP practice requirements are met. This IMG was dissatisfied with the lack of metropolitan attributes and the move out of rural region
was to maintain social and cultural needs. This aligns with Han and Humphreys’ (2006) characteristics of the Satellite Operators type.

IMG13 who is integrated in rural practice is also partially aligned to the Satellite Operators type. IMG13 resides in the same rural town as practice, said he enjoyed rural practice and claims he is not a big city lover but would want to move to a city and be close to his old friends from the same ethnic background as it would benefit his children. IMG13 demonstrated characteristics of Han and Humphreys’ (2006) Satellite Operators type such as wanting to maintain friendship with old friends from a similar ethnic group.

**IMG13 - I am happy with the current job I am doing so probably stay another two and half three years**

**IMG13 - I am thinking to move ... not a big city lover but with friends can share the same thing you know some friends we schooled together, spend most of the time together and couple of friends live in Sydney and Melbourne. I am thinking to live close to them it is good too for my kids to share these experiences too.**

**IMG13 - probably another until I finish my moratorium because it is four and half years now ... so probably stay another 2 and half 3 years**

He also mentioned that his wife has problems with communication and finding a job is problematic even though she has the skills. His children also do not enjoy being in rural region as they have no friends.

**IMG13 - My wife, she had bit of a problem. She is good in English but communication wise talking to people here, it is a bit challenging for her ... She was a medical laboratory technologist ... but she could not find a suitable job here even though she got the skill**

**IMG13 - They are not enjoying here much and I got three kids ... they got lot of friends there and they are not enjoying here and lot of problems**

This is an example of an IMG showing characteristics of more than one type. IMG13 who is integrated but also displayed characteristic of the Satellite Operators type such as wishing to maintain links with family or friends from a similar ethnic background.
This became a factor to leave rural region after the completion of the mandatory period. Hence IMG13 was partially aligned to the Satellite Operators type. This is a feature of Han and Humphreys’ (2006) Satellite Operators type where IMGs migrate to the city once they meet GP practice requirements.

Most of the IMGs of this thesis were aligned or partially aligned to the Integrated type as they showed strong attachment to rural practice, appreciating patients’ loyalty, gratitude and providing continuity of care. Some of the presently integrated IMGs showing ambivalent future were partially aligned to the Integrated type and the Ambivalent type. Both the Satellite Operator and the Fence-sitter types had limited application to the IMGs of this thesis.

There were complexities in categorising the IMGs of this thesis to one of the four types. It may be seen as straightforward to simply categorise IMGs into one of the four types based on an approach, which suggests apply the ‘type’ that is most applicable. Yet a straightforward application with this sample of 25 IMGs, would have reduced the richness of the data and underrepresented the interrelated nature of their experiences. The complexities of aligning arise when detailed characteristics of Han and Humphreys’ four types are taken into account (Table 8.2). The main issue faced during categorisation were when IMGs showed characteristics of more than one type. This was most evident between the Integrated and the Ambivalent types. The demarcation between Han and Humphreys’ (2006) Integrated and Ambivalent types is unclear. Han and Humphreys’ (2006) typology was insufficient in dealing with IMGs that showed characteristics of the Integrated and the Ambivalent type such that the well-integrated IMGs of this thesis clearly indicated their intention to move out of rural region when it was necessary to do so, mainly for children’s higher education or job opportunities for spouse. A contributory factor here was the inherent tendency of the Han and Humphreys’ (2006) typology to combine integration and retention within each of the four types. Another issue in applying the typology to the 25 IMGs of this thesis may arise from the geographic or spatial differences between NSW and Victoria; plainly, rural areas in Victoria are more accessible to the capital city of Victoria, Melbourne. To this point, aligning IMGs to Han and Humphreys’ (2006) four types was a challenging task.
The thematic analysis and the application of the typology also identified aspects of IMGs’ experience that was not sufficiently recognised in the Han and Humphreys’ (2006) typology. The following section of this chapter discusses these aspects.

8.4 IMGs’ strong attachment to rural practice

This section discusses the characteristics of the Integrated type that IMGs of this thesis have demonstrated. It then turns to the discussion of how some of these IMGs surpassed the characteristics of Han and Humphreys’ (2006) Integrated type.

Han and Humphreys’ (2006) Integrated type show characteristics such as enjoying patients’ appreciation, loyalty and continuity of care and appreciating Australian medicine. They are pragmatic about the advantages and the disadvantages of rural life and practice, they are not hindered by the lack of their relatives or the absence of members of their own ethnic group. They enjoy rural practice and lifestyles more than the city. They value relationships with colleagues, patients and community members consciously seeking to make friends in the community. They also appreciate having a supportive partner (Han & Humphreys 2006, pp. 194-197).

IMGs’ engagement to rural practice that was evident in this thesis is under emphasised in Han and Humphreys’ (2006) Integrated type. All the IMGs from this type showed strong attachment to rural practice enjoying patients’ appreciation, loyalty and continuity of care not just with the patients but with their family members as well. They appreciated Australian medicine, their ability to practise variety of skills and the opportunity of dealing with more complex medicine in rural practice. They highly appreciated the collegial or cooperative work environments that they perceive in rural practice. Their strong professional attachment to rural practice is demonstrated in Chapter 6 of this thesis. The descriptor of Han and Humphreys’ (2006) Integrated type does not capture the intensity of their strong attachment to rural practice that IMGs of this thesis have shown. Some IMGs’ experience surpassed and showed additional characteristics in comparison to Han and Humphreys’ (2006) Integrated type. Some IMGs expressed greater willingness to stay in the same rural practice. Single IMGs showed more willingness to stay in rural practice than IMGs who had families. IMGs having the opportunity to practice in their field of specialty were keen to work in the same rural practice forever. Those owning a GP practice stayed in rural practice beyond the moratorium period. This thesis also showed that when family factors such
as schooling for children are taken care off by means of boarding schools or if their social, cultural or personal aspirations are met IMGs are willing to stay in the same rural practice.

The views of these two IMGs, who had no families, were well-integrated in rural practice and happy to remain in the same rural region.

IMG20 - I intend to stay as long as possible. Yes I really enjoy my job here.

IMG20 - I would be open to working in other rural regions. I would be more than open. I enjoy in the rural area.

IMG24 - I think I can stay as much as I can ... I don’t have a problem away from the city. I don’t really enjoy city life.

IMG22 works in an area of interest in surgery and IMG8 has stayed in rural practice beyond the moratorium period.

This is the view of IMG22 who had strong attachment with the specialty work he was doing in the rural town. Even though he expressed a desire to stay all his life in the same practice, he showed concerns of his child’s higher education.

IMG22 - I am going to stay here all my life ... I think I am still in moratorium but yeah and that is not the reason why I came here ... I can do surgery, most of the surgery which I do and we have got a beautiful hospital, brand new hospital as well with all new facilities.

Even though IMG22 showed concerns about high school education for his son he was willing to stay in the same rural practice.

IMG22 - At the moment it’s alright ... in high school we have issues

IMG8 owns a GP practice and has stayed in rural practice beyond the moratorium period.

IMG8 - I started my own general practice

IMG14 put tremendous effort in setting up her own practice and is very involved with her GP practice. She expressed concern about children’s high school education but was open to the idea of sending them to boarding school indicating that assistance from the government with regards to children’s education would be beneficial.
IMG14 - The last 2 years has all been through distance education, there is no sporting opportunities, the level of education isn’t great ... So I think this will be for a lot of rural practices, it is not so much about the money but being able to access child care and being able to you know to get the financial support, to send your kids to boarding school aahhhh probably more important than the actual remuneration.

IMG3 who appreciated rural practice and showed willingness to remain in the current rural practice forever. When asked how long he would like to stay in the rural region, this IMG replied

IMG3 - Forever definitely!

And then he said

IMG3 - I like working near the beach. I don’t think I would like to go inland, it’s nice and green here and wet whereas inland it is too dark. I think rural as long as it is near the coast.

This IMG preferred working in rural regions that was closer to the beach over working in inland rural regions.

IMG15 expressed willingness to stay in the same rural practice and region but had concerns about Medicare restrictions and his ability to practice there. His intention to remain in the same rural practice was because of his ability to do general practice; family having a good social life with people from their own ethnic background and with few hours’ access to cities.

IMG15 - I intend to stay as long as possible but it will depend on the Medicare restriction.

IMG15 - We do have a small [name of ethnicity withheld] community here which was main part of it like family not missing social life.

When asked the question, ‘Given that you like working here, would you like working in other rural regions?’

IMG15 - Depends, I am not sure! ... Other area it all depend on how far it is from Metro cities and work situation there.
The IMGs mentioned in this section demonstrated strong attachment to rural practice and would be more retainable in rural regions if their needs were taken care of.

Yet again, this thesis revealed IMGs who remained in rural practice even if they had to compromise on certain factors. IMG23 was integrated in rural practice but had issues with lack of social life and decided to leave rural region at one point of time. Despite missing having a social life, IMG23 felt integrated.

**IMG23 - We have integrated very well in the rural area most than the city. Yeah we did not have any problem. People are nice and friendly and supportive.**

**IMG23 - there is not much of social life.**

**IMG23 - The kids ... one of them did very well at school and he only spend 2 years here and then he went to Uni. The other one, he struggled socially, I mean he did very well in the end like he achieved very good and topped in the HSC but socially he struggled he felt isolated and he felt I don’t know he becomes very isolated at school. It was terrible, at some stage we decided to move because of that.**

Similarly, IMG11 who was well-integrated and practiced in the same rural region for 43 years appreciated the support of his spouse even though she missed family and friends.

**IMG11 - I came over here and I found the town where I am at the present. I did not change. In the last 43 years I am in the same place. They accepted me very well and they welcomed.**

IMG23 and IMG11 who were integrated remained in rural practice even though they had to compromise on some important factors in their life. ‘They acknowledged that difficulties exist in rural regions and were pragmatic about what can be done or what cannot be done in their communities’ (Han & Humphreys 2006, p. 194).

**IMGs’ experience that was not identified in Han and Humphreys’ (2006) typology**

There were aspects of IMGs’ experience in this thesis that was not identified in any of Han and Humphreys’ (2006) types. An expression of integration that was evident in this thesis was the importance of having access to place of worship. This factor was
also identified in Han and Humphreys’ (2005) study. IMG8 mentioned church as a very important aspect of their life and access to church would be one deciding factor for choosing location of practice.

For IMG8 being close to a church was very important. This was a characteristic not seen in any of Han and Humphreys’ (2006) four types. However, the importance of place of worship was a factor identified in their 2005 study.

IMG8 - but wherever we moved to we tried to settle as best as possible, it really can be hard sometimes for them and now that they are at school aaahh ... we do think very carefully before we make any major decisions but the hope is that this move back to [name of rural town withheld] is it for a while until they finish school but in life you can never tell.

IMG8 - I try and engage in whatever I enjoy usually we are a Christian family so we find ourselves a local church and yeah try and sort of find ourselves a Church and usually that is important all the time that’s very important for us to be able to do.

This IMG was integrated but gave importance to their cultural needs such as having access to a church.

This section has demonstrated aspects of IMGs’ experience not sufficiently recognised in the typology. IMGs’ strong professional attachment to rural practice where some IMGs have shown greater willingness to work in the same rural region, along with the importance of having access to place of worship was recognised in this thesis. This in itself can be considered an advantage in using Han and Humphreys’ (2006) typology in this research thesis which revealed new aspects of IMGs’ experience working in rural and remote regions of NSW.

8.5 Conclusion

This chapter discussed the extent to which the experience of IMGs of this thesis aligned to Han and Humphreys’ (2006) typology. This process assists to answer the research question and supplementary questions established for this thesis. The chapter demonstrated the complexities of a clear categorisation of IMGs of this thesis to each of Han and Humphreys’ (2006) four types. It discussed parts of IMGs’ experience that were not recognised in Han and Humphreys’ (2006) typology.
Twenty-four out of 25 IMG participants of this thesis either aligned or partially aligned with Han and Humphreys’ (2006) Integrated type. They showed strong attachment to rural practice because of their ability to work in a broad spectrum of medicine along with providing continuity of care to patients. A number of IMGs were integrated but also ambivalent about their future employment and location. A contributory factor to this ambivalence was concern about the high school and higher education options for their children and job opportunities for their partner. This partial suggests that the types are not mutually exclusive. Han and Humphreys’ (2006, p. 202) Satellite Operators and Fence-sitters types ‘represent the groups who find the rural context unlikely to meet their aspirations. The Satellite Operators commute to or stay in rural communities just for the mandatory period, while Fence-sitters stay in commuting zones with ready access to the city’. There was limited application of the Fence-sitter and Satellite Operator types to the IMGs of this thesis. Only two IMGs from this thesis could be aligned partially to the Fence-sitter type as they commuted daily to work from the nearest urban town. Only one IMG from this thesis could be completely aligned to the Satellite Operators type. This IMG was dissatisfied with rural life had decided to move out of rural once GP requirements are met which is a characteristic of Han and Humphreys’ (2006) Satellite Operators type. Three IMGs that were integrated were partially aligned to the Satellite Operators type as they showed characteristics of Han and Humphreys’ (2006) Satellite Operators type.

Drawing from the literature review and the analysis of this research thesis that is discussed in Chapters 6, 7 and 8 the final chapter, Chapter 9 answers the research questions of this thesis. The next chapter addresses the thesis findings and discusses the contribution to knowledge and practice, the possible implications in terms of practice, the limitation of the findings and opportunities for future research.
CHAPTER 9

DISCUSSION AND CONCLUSION

9.1 Introduction

This thesis has examined the experiences of IMGs working as GPs in rural communities of NSW, Australia. A guiding rationale was the particular features of the Australian health services labour market, namely the shortages of doctors in rural areas and the explicit use of migration and related policy instruments to facilitate the deployment and retention of IMGs in rural areas. The integration of IMG is an under researched area internationally and especially in Australia. Integration is conceptualised in diverse ways, both as a process and an outcome encompassing a variety of domains or dimensions, and characterised by diverse scholarship as to how integration may be described, analysed or measured and what additional outcomes might arise from it. In this context Han and Humphreys’ (2006) attempt to typify integration and to link retention explicitly to integration, was a distinct although untested contribution to theory. This thesis utilised Han and Humphreys’ (2006) typological study with an aim to advance our understanding of the dimensions of integration and its influence on retention of IMGs in rural practice.

A qualitative approach was suited as the interviews with 25 IMG participants shed light on their experience working as GPs in rural communities of NSW. Thematic analysis of the interview data enabled an examination of the factors of integration within the professional and social domains that is reflected in the four themes: Professional, Family, Social and Cultural, and Personal. These are discussed in Chapter 6 and 7 of this thesis. The analysis resulted in a ranking of the themes and domains, a ranking that underlined the importance of professional factors to IMGs’ integration. The analysis also illustrated the interrelated nature of the themes, specifically the complex relation between professional engagement and IMGs’ concerns about the future education of their children and the employment of their partners. The thematic analysis also provided a rich explanation of the themes through identification of sub-themes, a dissection and elucidation that provided the foundation for analysing not only the factors of integration but also the complex relation between
integration and retention. Through this foundation, the usefulness of Han and Humphreys' (2006) four-fold typology, the Integrated, Ambivalent, Fence-sitter and the Satellite Operator to the IMGs of this thesis was assessed. This was discussed in Chapter 8 of this thesis.

Philosophical assumptions are important in guiding the research as to the choices made in research design to ensure that it addresses the requirements of the research question (Creswell 2007). This research study reflected a constructivist interpretivist philosophical worldview reflecting ontological and epistemological positions grounded in subjectivity (Denzin & Lincoln 1998). Data was collected from IMGs working and living in rural regions of NSW, an important context for understanding participants’ perspectives on integration in rural health communities (Creswell 2007). Twenty-five IMG participants provided an account of their social reality in a situated world that shaped their experience and their accounts of professional and social integration. The researcher constructed meaning from IMG participants’ accounts acknowledging this to be an interpretive process. The researcher by the process of interpretation and analysis of data was able to develop and produce knowledge of professional and social integration.

Following this introduction, this last chapter of the thesis has seven additional sections. Section 9.2 discusses the effectiveness of using Han and Humphreys’ (2006) typology in assessing the professional and social integration of IMGs in the NSW context. In doing so, this section addresses the primary research question and the supplementary questions of this thesis. Section 9.3 discusses the contributions to knowledge and sections 9.4 and 9.5, the contributions to policy and practice respectively. The limitations of the study are detailed in section 9.6 and recommendations for future research, section 9.7.

9.2 Research questions

How effective is Han and Humphreys’ (2006) typology of professional and social integration in assessing the integration of IMGs in rural communities of NSW?

Han and Humphreys’ (2006) study is one of the few studies in Australia that identified factors that facilitate or hinder professional and social integration of IMGs in rural communities and its impact on retention. They developed a four-fold typology which suited the aim of the thesis which was to advance our understanding of the dimensions
of integration and its impact on retention of IMGs in rural communities. Han and Humphreys' (2006) typology enabled an examination of professional and social integration as experienced by IMGs of this study. The utility of each of the types will be discussed followed by an assessment of the typology as a whole.

In assessing the professional and social integration of IMGs of this study, Han and Humphreys' (2006) Integrated type had resonance with the experience of many IMGs of this study. They are integrated significantly into rural practice and rural communities. They show a high level of professional satisfaction; enjoying patients’ appreciation, loyalty and continuity of care. Factors that attach them to rural practice are continuity of care to patients and their family members, the ability to use variety of skills and their ability to practice more hands-on medicine along with having access to the base area hospital. They have respectful relationships with their colleagues, value Australian medicine and the health care system’s cooperative work environment. IMGs are appreciative of the support they receive by means of mentoring and training. They develop relationships with locals by making friends or participating in local events giving them a sense of belonging. They are pragmatic about the limitations of rural life and try to get the best out of it. These characteristics align with Han and Humphreys’ (2006) Integrated type (see Table 8.3).

Han and Humphreys’ (2006) Ambivalent type had application to the IMG participants, however a key complexity needs to be acknowledged. This type was only partially applicable, as IMGs assessed to be ambivalent also demonstrated characteristics of being integrated. This feature was not strongly evident in Han and Humphreys’ (2006) typology. Han and Humphreys’ (2006) Ambivalent type appreciate rural life and practice but are unsure about their long-term rural settlement. The complexity of this categorising surfaced when some IMGs that are presently well-integrated in rural life and practice but also showed characteristic of the Ambivalent type. Thus, their integration was conditional. Regardless of IMGs’ satisfaction with work and the support they receive, some IMGs that are integrated will endeavour to move out of rural regions when their individual circumstances necessitate a relocation. The main reasons cited by IMGs to leave rural practice is family reasons; quality education for children or job prospects for their partners. This finding reinforced the results of Han and Humphreys’ (2006) typological study that IMGs’ decision to leave after the mandated period was based on their family needs, quality education for children and
job opportunities for partner. This study confirms that family factors are important and crucial in determining IMGs’ willingness to stay in rural areas. In addition, other reasons mentioned by some IMGs to leave rural locations are to fulfil their social, cultural or personal needs. These factors were considered important in their decision to stay or leave a rural area after the completion of the mandatory period. These findings are also consistent with by Terry and Lê (2013) study in rural and remote regions of Tasmania.

Likewise, Han and Humphreys’ (2006) Fence-sitter and Satellite Operator types both had limited application to the IMGs of NSW. Only two IMGs aligned to the Fence-sitter type as they commute daily from the closest urban centre or a regional city to work. They are integrated in rural practice, yet prefer living in towns or regional cities that have more opportunities for children’s education, employment opportunities for their partner or where they are able to fulfil other family, social, cultural or personal aspirations. The limited application of this type is due to the spatial features of NSW where rural regions may not be at a commutable distance from the city of Sydney. Han and Humphreys’ (2006) Fence-sitters type may be suited to a region where daily travel to rural regions from a large centre or city is possible for example, in the state of Victoria where rural regions are at a commutable distance from the city fringe areas of Melbourne.

There was only one IMG in this study that could be completely aligned to the Satellite Operators type. IMGs of this type are the least integrated and stay in rural regions until the completion of their moratorium period. IMGs may be satisfied with rural practice but feel socially isolated in rural regions. This type was least applicable to the IMGs of this thesis. Han and Humphreys’ (2006) Satellite-Operator type may also be suited to a region where weekly travel to rural regions from a large centre or city is feasible.

In summary, the application of Han and Humphreys’ (2006) four types for this thesis was mixed. Although all IMGs could be completely or partially aligned to the typology, two of the types were more applicable and two were less applicable. The lack of application of the Fence sitter and the Satellite Operator types was influenced by the spatial features of NSW but in the case of the Satellite Operator also underpinned by the strong professional and social integration of the IMG participants of this study. The Integrated and the Ambivalent types had conceptual merit. The Integrated type had resonance to the majority of the IMGs of this thesis some IMGs
could be clearly and fully aligned to the Integrated type. The Ambivalent type applied only in conjunction with the Integrated type. Some IMGs were partially aligned to both the types as they displayed characteristics of both the Integrated and the Ambivalent types, the presently integrated with an ambivalent future. The application of the Fence-sitter is limited, shaped by the spatial features of NSW where many rural regions are not at a commutable distance from the city of Sydney. The Satellite Operator has limited application (see Table 8.3).

This study has found factors of integration not evident in Han and Humphreys’ (2006) typology. Most specifically, IMGs showed strong professional attachment to rural practice with some IMGs showing greater willingness to work in rural regions (Chapter 6). These aspects were under-emphasised in Han and Humphreys’ (2006) Integrated type. In assessing the professional and social integration of IMGs working in rural communities of NSW, IMGs that formed the focus of this thesis challenged the crispness of the typology suggested by Han and Humphreys’ (2006) study. Han and Humphreys’ (2006) study acknowledged the difficulties in the clear delineation that is suggested by any typology. Typologies have drawbacks such that they are neither exhaustive nor the categories or types are mutually exclusive and are often based on assumption or arbitrary criteria. Typologies may not produce sharp distinctions between types (Smith 2002, p. 381). The complexity of clearly categorising IMGs into a single type was seen when IMGs showed characteristics of more than one type as demonstrated in Chapter 8. This was evident with IMGs showing characteristics of Han and Humphreys’ (2006) Integrated and the Ambivalent types. The primary issue with categorisation was IMGs who were presently well-integrated on a range of grounds but identified that they would relocate in future years for reasons prompted by children’s education or employment opportunities for partner. The Integrated and the Ambivalent types of this study are not mutually exclusive. A complexity in clear categorisation was evident when elements of retention were taken into account. The difficulty of placing IMGs clearly into the Integrated or Ambivalent type was seen with IMGs who are presently well-integrated but clearly indicating their probably move out of rural regions to accommodate their children and partner. Their integration in rural regions is conditional. This difficulty also highlighted the dilemma of a typology that attempted to capture current sentiment and behaviour with future anticipated behaviour and outcomes. There is a gap in the level or degree of
distinctiveness between Han and Humphreys’ (2006) Integrated type and the Ambivalent type, implying that integration and retention are not always closely related.

The typology fails to deal with the conditional integration of IMGs of this thesis. There is potential ground for a new type that falls between the Integrated type and the Ambivalent type, the ‘Conditionally Integrated’ type to accommodate the experience of these IMGs. The Fence-sitter and the Satellite Operator types had limited application. The typology inclusive of all five types may likely be more effective in certain geographical areas (Box 9.1).
Box 9.1: Extended Han and Humphrey’s (2006) typology - five-fold typology

<table>
<thead>
<tr>
<th>The Integrated</th>
<th>The Conditionally Integrated</th>
<th>The Ambivalent</th>
<th>Fence-sitters</th>
<th>Satellite Operators</th>
</tr>
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<tr>
<td>Appreciates rural life and practice; able to live as a minority; pragmatic about the limits of rural communities. Strong attachment to rural practice; greater willingness to practice in rural regions. Single IMGs showed more willingness to stay in rural practice than IMGs who had families. IMGs having the opportunity to practice in their field of specialty were keen to work in the same rural practice forever. Those owning a GP practice stayed in rural practice beyond the moratorium period.</td>
<td>Satisfied with rural life and practice but will move out of rural region to accommodate issues related to family; mainly children’s high school education or job opportunities for spouse.</td>
<td>Appreciates rural life and practice, but unsure about long-term rural settlement; may settle either rural or urban.</td>
<td>Enjoys the advantages of both rural and urban life and practice, unable to live away from the city. This type maybe applicable in NSW if IMGs are placed in rural practice that is commutable from a large urban centre or regional city.</td>
<td>Families settled in the city; the doctors commute to work until they are allowed to practise in the city. This type had less applicability in NSW, may only have application in particular spatial settings.</td>
</tr>
</tbody>
</table>
Han and Humphreys’ (2006) typological study has been partially useful in classifying the IMG participants of this study. Their study enabled the examination of professional and social integration of IMGs of this thesis. However, in categorising 25 IMGs of this thesis into the four types there were complexities. Answers to the thesis’ supplementary research questions help assess further the value of Han and Humphreys’ (2006) typology.

9.2.1 Research supplementary questions

Are there factors of integration of IMGs working in rural communities of NSW that fall beyond Han and Humphreys’ (2006) typology?

Han and Humphreys’ (2006) typological study attempted to relate characteristics of IMGs to their different degrees of integration into rural communities. They classified them into four types based on their level of integration in rural communities. This study produced a rich analysis of IMGs’ experience of integration, identifying factors that were under emphasised in Han and Humphreys’ (2006) typology.

The discussion now turns to Han and Humphreys’ (2006) Integrated type. IMGs of this type appreciated rural life and practice. This study shows that the majority of the IMGs are not just satisfied but strongly attached to rural practice. This depth of professional attachment was not sufficiently recognised by Han and Humphreys’ (2006) typology where this aspect of integration was identified as enjoying or appreciating rural life or practice. The three main sub-themes leading to strong attachment to rural practice are satisfaction working with patients, providing continuity of care to patients and their family members. This is discussed in section 8.4. This is consistent with an Australian study done by Dywili et al. (2012) and the study by Hancock et al. (2009) and also addresses dimensions of place attachment, as outlined by Auer and Carson (2010). The ability to use variety of skills was seen as a benefit of rural practice which was identified by previous study of Robinson and Slaney (2013). Many IMGs move to rural practice due to compulsion (the moratorium). IMGs of this thesis showed strong attachment to rural practice. This varied with the findings of McGrail et al. (2012) study that professional satisfaction of mandated IMGs in rural regions was significantly lower for job aspects such as lower satisfaction with variety of work, opportunities to utilise full range of skills, and responsibility than non-mandated doctors. However, a similar finding to this study was
documented in a recent study done by Terry, Lê and Hoang (2014) on IMGs in rural regions of Tasmania where IMGs were highly satisfied with their professional work. The distinction between the thesis findings and the work of McGrail et al. (2012) is interesting, noting that the McGrail et al. (2012) study utilised longitudinal panel data, was Australia-wide and relied on previously published scales of satisfaction. A further distinction was that the McGrail et al. (2012) study was comparative in its design, comparing mandated and non-mandated doctors. The authors noted also that despite the scale of their study one of its limitation was the absence of qualitative data thereby limiting their understanding of how IMG status impacts professional and non-professional satisfaction.

Some IMGs of this study expressed greater willingness to stay in the same rural practice even after the completion of the moratorium period. Those owning a GP practice have stayed in rural practice beyond their moratorium period. This supports the finding of Russell et al. (2012) study where they identified business ownership as having an important association with the retention of GPs. Single IMGs show more willingness to stay in rural practice than IMGs who have families. Previous studies have noted that family factors played an important role in retaining IMGs in rural regions (Robinson & Slaney 2013). If given the opportunity to practice in their field of specialty or in a specific geographic area some IMGs are keen to work in the same rural practice in the long term. This pertains to IMGs with children in primary school or IMGs who are single. McGrath, Henderson and Phillips (2009) suggested that providing support to families of IMGs can facilitate integration. The analysis advanced by this thesis suggests that if family factors such as schooling for children are resolved (for example, through access to a broader range of high school opportunities) or if their social needs are met IMGs show willingness to stay in the same rural practice. A lack of social life hindered IMGs’ integration and had a negative impact on retention (Terry & Lê 2013). Yet this study revealed that IMGs will work in rural practices even if it means compromising on factors such as social life for themselves or their spouse, noting also that IMGs’ experience, as evident in this study, also identified a clear willingness to engage with the community’s social networks and fabric. In addition, some IMGs of this study show willingness to practice in the same rural region but are concerned about Medicare regulations, their eligibility to get Medicare rebates if they continue working in the same rural region. Relaxing the rules about when and where
IMGs can practise medicine may facilitate integration (McGrath, Henderson & Phillips 2009).

An aspect of IMGs’ experience seen in this study is the importance of having access to place of worship. This was not identified in Han and Humphreys’ (2006) typology. However, this factor was identified in Han and Humphreys (2005). Previous studies have noted that IMGs’ social life in rural regions could impact IMGs’ length of stay in rural practice. Kasarda and Janowitz (1974) study suggests that social ties with communities improves length of residence. This thesis suggests that having access to place of worship is a factor that is seen as important to some IMGs when choosing location of practice. This factor was highlighted in Han and Humphreys’ (2005) study: place of worship can be a place of forming social bonds with community members and cultural needs such as place of worship and socialising with people from their own home country are found to be important factors to some IMGs (see also Carlier, Carlier & Bassett 2005). These factors could influence their decision to stay or leave rural regions.

In addition to extending the analysis of integration, this thesis has shown an improved understanding on the link between integration to retention than is evident in Han and Humphreys’ (2006) typological study. This will be discussed in responding to the next supplementary question.

*How effectively does Han and Humphreys’ (2006) typology explain the link between integration and retention?*

It was acknowledged in Chapter 4 that integration is a complex term with an imprecise conceptualisation where scholars see integration as a process, an outcome or both. Han and Humphreys’ (2006) typological study attempted to relate characteristics of IMGs to their different degrees of integration into rural communities classifying them into four types and identified retention as an outcome of integration. This view of the link between integration and retention is supported by other scholars that consider factors of integration as facilitators of retention (Cutchins 1997; Dywili et al. 2012; Han & Humphreys 2005; Hancock et al. 2009). However, the precise nature of the link, for example how integration supports retention, is not explicitly addressed. There appears to be limited understanding of the connection of integration to retention. Han and Humphreys’ (2006) typology that classified IMGs as the Integrated type were more
integrated in rural communities than IMGs who were classified as other types. They also classified them to a ‘type’ that aids retention where the integrated type is found to be more retainable in rural communities than the other types. However, this thesis shows that presently well-integrated IMGs may not be retained in rural communities. They would leave to accommodate their future or anticipated needs. These needs are mainly family reasons, higher education for children and job employment for partner. The link between integration and retention is more complex than suggested by Han and Humphreys’ (2006) typology.

IMGs that are presently integrated in rural life and practice may not necessarily stay in the same rural region after the completion of the moratorium period. They will endeavour to move out of the rural region when circumstances change mainly for family reasons and sometimes for social, cultural or personal factors reasons, although future relocation may not always be to a metropolitan area. This indicates that IMGs that are presently integrated may not be retained in the same location in the future. This is consistent with Han and Humphreys’ (2006) study where they acknowledged that IMGs’ high degree of satisfaction does not by itself guarantee their long-term stay in the same rural communities, although the complexity of this relation is not captured in their typology. IMGs’ personal and family needs along with government policies would influence their future location of practice (p. 203). However, their study did not clearly address the inter-relatedness of factors that this study has demonstrated which could play an important role in retaining IMGs in rural regions. Previous studies have recognised and discussed the complexities of retention. Russell, Humphreys and Wakeman (2012) and Hancock et al. (2009) acknowledged that retention of GPs is complex and involves the interplay of many factors. This thesis also illustrates that there is a complex interplay of factors such as job opportunities for spouse, higher education for children, social ties with friends and family and cultural factors such as access to place of worship or having a social circle with people from their own background that facilitates on-going integration of IMGs in a rural region.

This thesis reinforces Han and Humphreys’ (2006) finding that integration influences retention, but it does not guarantee retention. This suggests that integration is explicitly temporal where IMGs express a desire to move out of a rural region to accommodate future needs of their family, most particularly high school and university education for their children or job opportunities for their spouse.
What are the measures that facilitate integration, and what are the measures more likely to facilitate retention in rural medical practice?

Drawing from the findings of this study there are clear implications for health care policy and practice. Measures that facilitate integration include strong professional engagement, and strong connections between IMGs, their families and their rural communities, including through social and cultural activities. Measures that would facilitate further professional integration include systematic and on-going professional and career development, and mentoring by colleagues skilled in rural practice. A related measure would be training to assist IMGs familiarise themselves with the Australian health care system and resources to assist mediate the workload issues in rural practice. These professional measures are addressed in further detail in sections 9.4 and 9.5 where recommendation about policy and practice are detailed.

Measures to support retention is a complex policy objective as IMGs who are presently well-integrated may move from their current rural practice. Measures that would address this complexity are; a greater scope for choice by IMGs in their site of rural practice, a choice that may facilitate concerns over family employment and future educational needs. For example, resources to facilitate partner employment (including additional training) and a broader range of schooling and higher education opportunities for the children of IMGs. These measures are also addressed in further detail in is discussed in sections 9.4 and 9.5 of this chapter.

9.3 Contribution to knowledge

This study identified factors of professional and social integration of IMGs working in rural communities of NSW and assessed the effectiveness of Han and Humphreys’ (2006) typology in the NSW context. It is the only study to have applied the Han and Humphreys’ (2006) typology since the typology’s development. The originality of the thesis research is clear. IMGs and their families had an overall positive experience living in rural regions of NSW. IMGs overall positive experience far out-weighed their negative experience working as GPs in rural communities of NSW. This was demonstrated by their strong professional attachment to rural practice and their willingness to work in rural practice. The relationship between integration and retention is complex and circumstantial. Han and Humphreys’ (2006) Fence-sitter and
Satellite Operator types were less applicable in rural NSW. These findings are discussed in this section.

The thematic analysis utilised in this study generated four themes: Professional, Family, Social and Cultural, and Personal and this analysis assisted to identify factors of professional and social integration. These themes were consistent with, although titled differently to the analytic domains found by Ager and Strang (2008) and Penninx (2005). Consistent with the findings of Ager and Strang (2008) and Penninx (2005), the themes were interrelated, noting also that a number of the issues identified by Ager and Strang (2008) and Penninx (2008) around legal citizenship status and language were mediated by the context for this study. This context included the nature of IMGs’ migration status which has more certainty than other migrants or refugees, the explicit nature of IMGs’ employment contracts (as an underpinning basis of their migration) and the requirement, as part of IMGs’ recruitment and employment, to be proficient in English. Family was also a distinct theme, separate although also related to Social and Cultural, a distinction that addressed the concerns by IMGs for their future needs of their families, concerns that may likely impact on their retention.

The thesis confirms that the domains of integration are multiple and interrelated and identifies family needs as a distinct and important area of social and cultural integration.

Knowledge about IMGs’ integration – the professional experience

The thematic analysis generated and explained professional factors of integration. The majority of the IMGs of this thesis demonstrated strong professional attachment to rural practice with some IMGs showing greater willingness to work in rural practice. IMGs’ sense of engagement came from working with well-known patients, providing continuity of care not only to patients but their family members, and the ability to use variety of skills. Consistent with previous studies working with well-known patients, providing continuity of care not only to patients but their family members, the ability to use variety of skills along with the professional support and training IMGs received from their supervisors and other staff members at the practice contributes to IMGs’ strong attachment to rural practice (Dywili et al. 2012; Hancock et al. 2009; Robinson & Slaney 2013; Terry & Lê 2014). This thesis supports these findings with greater
emphasis that IMGs working in rural communities of NSW were professionally engaged to rural practice.

IMGs were critical of some aspects of administration and bureaucracy, but largely not at the expense of their professional engagement to rural practice. Previous studies noted workload or lack of specialist support as concerns working in rural practice (Han & Humphreys 2005; Smith 2005; Terry & Lê 2013). While the thesis found that factors such as workload, training and support, lack of medical facilities and resources, understanding the Australian medical system and the choice of location of practice are perceived negatively by IMGs, these factors are not sufficient enough to make them leave rural practice. Gilles, Wakerman and Durey (2008) suggest understanding accents spoken of non-migrants and cultural norms were important for successful integration. This study has similar findings. IMGs from Non-English Speaking Countries (NESB) face initial challenges in adapting to a new work environment, community and the local language. It is found that IMGs overcome these challenges over time indicating they are open to a new setting or environment and are towards integrating in their new environment. This thesis shows that IMGs have an overall positive experience that far out-weighed their negative experience working as GPs in rural communities of NSW. Yet, while the professional factors of integration were clearly necessary and influential to IMGs’ integration they were not sufficient to guarantee retention, given that IMGs also had regard to the future anticipated needs of their family.

IMGs in NSW are professionally engaged, a finding that confirms and extends previous scholarship given the importance of professional factors to the analysis of integration. Key areas of professional engagement were identified with some IMGs indicating their willingness in rural practice, notwithstanding the terms of the moratorium.

Knowledge about IMGs’ integration – family, social and cultural and personal experiences

The thematic analysis generated and explained social factors of integration, evident through the Family, Social and Cultural and Personal themes. IMGs and their families have an overall positive experience living in rural regions of NSW. They are satisfied
with their children’s primary education and describe how their families’ happiness is important to them to continue living in rural region. Regardless of a high sense of satisfaction with work and the support IMGs receive, some well-integrated IMGs will endeavour to move out of rural regions when it becomes necessary to do so. Consistent with other studies the main reasons cited by IMGs to leave rural practice is to provide children with quality education or to seek job prospects for their partners (Robinson & Slaney 2013; Terry & Lê 2013). The education needs pertain mainly to high or senior school education and to university education. IMGs were socially connected in their communities. They sought to make relations with community members by becoming members of the local club, playing sport and by participating in community events. An aspect that emerged from this thesis is IMGs desire to live in close proximity to their religious place of worship. This finding was evident also in Han and Humphreys’ (2005) study. Place of worship can aid in fostering social ties with members of the local community.

IMGs and their families based in NSW engage with their communities through social and cultural networks and relations that intersect with IMGs’ professional engagement. It is the anticipated future needs of their families that mediate the link between integration and retention.

Knowledge about IMGs’ integration and retention - applying the Hans and Humphreys’ (2006) typology

Applying the Han and Humphreys’ (2006) typology contributed to knowledge about IMG’s integration and retention. The task of applying the typology was underpinned by the thematic analysis presented in Chapters 6 and 7 and enabled a careful analysis of the factors of integration, analysed through that process, against the types as identified by Han and Humphreys (2006). The process also contributed to knowledge about the relationship between integration and retention, in that the relationship is not always direct and can be circumstantial.

On the basis of this study, Han and Humphreys’ (2006) typology of IMG experience reflects IMGs’ engagement with rural communities but has a number of limitations. Two of Han and Humphreys’ (2006) types, the Integrated and the Ambivalent had particular application, although Han and Humphreys’ (2006) Integrated type did not explicitly address the strength of some IMGs’ attachment to rural practice, as the basis
of their successful integration in rural communities. Yet it was the relationship between the two types of the Integrated and the Ambivalent that underscored complexities in the typology, specifically the way that Han and Humphreys (2006) had typified the relationship between integration and retention. The link between integration and retention is far more complex than suggested by Han and Humphreys’ (2006) study. IMGs that are presently integrated may not be retained in rural regions. Professional engagement may be necessary to integration but it is insufficient for long-term retention of IMGs in rural regions. A point of concern remains the employment and education prospects for partner and children. This is a challenge that is acute in rural communities. It is at this point that the rural aspect of the location of their employment is most apparent. IMGs may be professionally attached to rural practice, well-integrated in rural region but clearly considered moving to the city mainly for children’s higher education and job opportunities for partner. It was this aspect that most acutely problematized the assumed seamless relationship between integration and retention. This thesis finding has reinforced similar findings of previous Australian studies. Terry and Lê (2013) and Auer and Carson (2010) and Han and Humphreys (2005) confirmed that factors that challenged retention were spouse employment, obtaining high quality academic access for children, and maintaining cultural and religious connectivity. This thesis suggests that when IMGs’ family, social or personal needs or requirements are met they maybe more retainable in the same rural practice.

The application of Han and Humphreys’ (2006) Fence-sitter and Satellite Operator types was highly limited in this thesis suggesting that the typology as a whole may be suited to areas with particular spatial features. These aspects of Han and Humphreys’ (2006) typology may have suited a region like Victoria where rural regions are at commutable distance from the fringe areas of the city of Melbourne. Commuting from the city of Sydney to a number of rural area of NSW is impractical because of the distance. This knowledge generated from the application of the typology may assist policy makers to target strategies to place IMGs in rural regions that are commutable from an urban centre. Scholarship blends rural-remote. It is important to recognise the difference between rural-remote to build policy measures as the opportunities provided by rural and remote/very remote may be quite different. This could be done by using the concept of remoteness (RA) as an important dimension of policy development in Australia (Australian Bureau of Statistics 2014). Based on the experience of IMGs in
NSW, the Han and Humphreys’ (2006) typology is only partially effective in addressing integration. The typology was not able to address clearly the conditional nature of integration and the complex relation between integration and retention.

This study contributes to knowledge through its analysis of the professional and social factors of integration, its identification of the relatedness of these factors and its analysis of the effectiveness of Han and Humphreys’ (2006) typology to typify integration and its relation to retention. This analysis identified the complexity in the relationship between integration and retention.

**9.4 Contribution to policy**

Shortages of doctors and accessibility of health care services in rural areas of Australia has been the basis of IMG recruitment (Auer & Carson 2010; Humphreys et al. 2009; Han & Humphreys 2005 & 2006; Hawthorne 2012; Lê & Terry 2013). For policy makers and rural communities, the integration and retention of IMGs is an important objective. Australia has a number of regulatory measures in recruiting and retaining IMGs in perceived areas of shortages (Han & Humphreys 2005 & 2006; McGrail et al. 2012). State, territory and federal governments have been responsive in addressing these shortages through various policies. Health policy measures and legislation such as Area of Need (AoN), District of Workforce Shortage (DWS) and The Health Practitioner Regulation National Law (NSW) are initiatives by the government to recruit and distribute doctors particularly in rural and remote regions of Australia. Some of the incentives put in place for doctors to work in rural regions are financial, education related funding policies or a reduction in the 10-year moratorium for working in remote or very remote regions (Table 3.4).

This study finding can inform shaping some of these policies. Based on the findings this research some recommendations are made and include, support with professional and career development, support for IMGs’ families, mainly with schooling and partner employment in the rural region and IMGs’ ability to choose between rural locations.

**Professional and career development**

Previous studies asserted the need for more support with continuing education and professional development for doctors working in rural regions. Accessing continuing...
education and securing career development was a challenge to GPs working in rural communities (Auer & Carson 2010). Work-based and organisation based professional development should include ongoing medical education and fellowship training needs (Gilles, Wakerman & Durey 2008). Alexander and Fraser (2007) confirmed that providing professional support for career development through training and education is important for long term retention of GPs in rural communities. Consistent with research by Smith (2005) where rural doctors felt disadvantaged with the lack of ongoing education and training, participants of this thesis raised concerns about on-going medical education and CPD (Continuing Professional Development). Workload can also contribute to difficulties in accessing on-going medical education (Dywili et al. 2012). This study finding emphasises the need for support with CPD to upgrade and maintain IMGs’ knowledge, skills and registration. This will enable IMGs in keeping up-to-date with medical knowledge and opportunities for career progression. Curran, Rourke and Snow (2010) study identified strategies that would assist rural doctors with on-going medical education. This thesis has similar findings: access to on-going medical education and CPD was influential in retaining doctors and supporting what is already a strong and evident level of professional engagement. Isolation can be a deterrent in accessing medical education or CPD in rural regions.

Support with schooling, employment for spouse, social, cultural and personal needs

Previous studies have identified children’s education and partner employment to influence doctors’ retention in rural regions (Han & Humphreys 2005; Alexander & Fraser 2007; Terry & Lê 2013). This study supports this finding and suggests providing support to IMGs’ families, mainly with children’s high schooling and university education and support with partner employment in the rural region. This is crucial for IMGs’ retention in rural regions. More support would be needed to those IMGs working in remote or very remote regions. Support for schooling and university education may comprise resources to widen the choices that are immediately open to IMG families. Policy change and development would also include resources to facilitate partner employment, for example a liaison officer providing assistance to IMG’s partner with finding work in the community. Resources that would assist in widening the choices open to the secondary and university education options for IMGs children, for example assistance with placement and fees for boarding schools. This
thesis also recommends support with social links with community or access to place of worship as identified by Han and Humphreys’ (2005) study. This could be achieved by placing IMGs in rural locations that cater these needs. Considering IMGs’ personal needs, for example environmental factors such as the attractiveness of coastal regions can also be useful in matching IMGs to rural locations. Policy to support IMG recruitment in rural areas is currently a mix of compulsion and incentives. Policy based incentives such as the General Practice Rural Incentives Program (GPRIP) that provides financial incentives to doctors working in rural and remote locations, the OTD scheme that offers reductions to the 10-year moratorium to overseas trained doctors who are prepared to work in locations which are the most difficult to recruit. These schemes have been introduced as a means of making rural medical practice more attractive. Such incentives do not presently address family requirements, as they concern high school education and partner employment. Given that these issues are likely to impact IMG retention in rural areas; this is an area for policy address.

**Choice of rural location**

Previous studies of McGrail et al. (2012) noted that IMGs on the moratorium were less satisfied with some aspects of their professional and non-professional life than IMGs or GPs not confined to the moratorium. IMGs on the moratorium felt they had to compromise using their full range of skills, their autonomy and there was a lack of support with professional development. On the non-professional side, they had lack of social life, employment for partner was problematic and had lower satisfaction about schooling for children. The study confirmed that the long-term success of this policy could be problematic if these aspects are not addressed and hence they argue that the 10-year moratorium must be phased out. The findings of this study are distinct from McGrail et al. (2012) in that the IMGs evidenced strong professional and social engagement, although this study was not a comparative study that distinguished IMGs on the moratorium from other participants. While noting this distinction, this study found that many IMGs move to rural regions was due to Medicare restrictions. A recommendation would be providing IMGs more choice with rural practice locations based on their needs at that period of time. This was highlighted in McGrath, Henderson & Phillips (2009) study on relaxing rules about where and when IMGs can practice. This would enable IMGs to choose rural location that matches their needs. Identifying specific needs such as family, social, cultural and personal needs, location
preference, areas of specialty interest are important factors aiding IMGs’ on-going integration in rural communities. Another option would be better match-making of IMG type with the rural region by recruiters and workforce planners. Taking these factors into account while recruiting IMGs would also be likely to impact retention positively, given IMGs’ ambiguity about their retention or likely intention to move out of rural practice was likely to arise from their need to support the education and employment needs of their children and partner.

Australian health care policy is commitment to deploy IMGs in rural communities. The findings of this thesis suggest that the integration and retention of IMGs would be assisted by policy that facilitates greater choice for IMGs in choosing rural practice. It is important to distinguish rural from remote or very remote regions to develop or build on policy measures. For those regions that are remote or very remote presenting fewer opportunities, selecting and recruiting those IMGs who do not have immediate family concerns would be one option. Selecting a type of IMG, example an IMG showing greater willingness to serve rural communities could be better candidate. A contribution of four or five years in a very remote region may benefit these very remote communities. Finally, the routine provision of professional development is recommended to aid integration in rural practice and intersect with the IMGs’ strong and evident professional engagement.

9.5 Contribution to practice

Drawing from IMGs’ experience as analysed through this thesis, a number of recommendations are proposed as a recommendation to practice. The specific areas of practice span two areas: measures adopted by federal, state and local health authorities to facilitate IMG familiarity and transition to a new health care system, and; practices and resources within rural GP establishments. These recommendations may benefit health organisations in designing integration programs for IMGs. Previous studies have highlighted barriers associated with working in a new health system and a new geographical place. Some of the barriers are English as a language; interacting with patients and staff, familiarising with a new health system, understanding Medicare and the referral system (Han & Humphreys 2005; Pilotto, Duncan & Anderson-Wurf 2007; Robinson & Slaney 2013; Smith 2005; Spike 2006). The findings of this thesis revealed similar challenges IMGs faced working in a new health
system. Pilotto, Duncan and Anderson-Wurf (2007) and Spike (2006) have emphasised the need to integrate health professionals in a different geographical and medical system. Due to the difference in medical system between countries, supervisors and mentors better understanding of the system from which IMGs have graduated can assist supervisors with communicative interactions while training IMGs to the Australian standards (Pilotto, Duncan & Anderson-Wurf 2007). A related issue is the difficulties IMGs faced in getting recognition of their previous training or experience or gaining knowledge of the means through which this recognition could take place. Assessing IMGs’ medical qualification and their medical experience obtained in their home country should be considered when registering IMGs as ‘Australian’ doctors as highlighted previously by Gilles, Wakerman and Durey (2008) and Wright et al. (2012).

For effective familiarisation to the Australian health system, this study recommends support be given to IMGs in familiarising and re-training them to the new health system. This is crucial in integrating IMGs to the Australian health system and rural practice. In familiarising IMGs to the Australian health system, this study suggests orientation programs including aspects such as the referral system and Medicare, familiarising with the local slang, enhancing communication with patients and other staff. Providing assistance with day-to-day English and familiarising with the Australian slang would improve IMGs’ communication skills with patients and other staff members. It would be useful to consider these factors when designing the orientation program that would help in integrating IMGs in rural practice as suggested previously (Wright et al. 2012).

IMGs may require different types of support and assistance during GP training to practice in rural areas (Robinson & Slaney 2013). The finding of this study suggests mentoring IMGs by direct supervision and conducting workshops for training and preparing IMGs to work in rural communities could be effective in integrating IMGs to rural practice. Providing continuing professional development would assist IMGs in keeping up-to-date with their medical knowledge and in their career development.

The financial cost associated with the AMC exam, understanding procedural steps for the examination and insufficient information on examination content and standard were some of the difficulties IMGs faced (McGrath 2012). This thesis recommends providing information and assistance with exam preparation, AMC and Fellowship
exams. Previous studies noted that providing support by means of bridging course would be beneficial (Wright et al. 2012). Assistance with AMC exam would produce better outcomes of AMC exam bringing IMGs into the workforce and may minimise skill wastage (McGrath, Henderson & Phillips 2009). The finding from this research recommends a need for training IMGs working in rural regions especially for the AMC Part 2 exam. This could be provided through bridging courses, either online or by conducting workshops. This would reduce the difficulties associated with passing the AMC exam. For doctors that are in Australia and wanting to enter the medical workforce, assistance in the form of bridging programs in preparing for these exams could be beneficial.

Providing clear information such as contacts of other medical sites, relevant medical professionals on websites by medical regulatory bodies would aid discussion and clarification of any issues IMGs may have (McGrath 2012). Some IMGs highlighted difficulties in accessing support provided to them in terms of supervision (Terry, Le and Hoang 2014). This study notes this difficulty especially for IMGs working in more remote or isolated areas where they work as solo GPs and in those centres with fewer GP staff. This study recommends provision of direct supervision with a local mentor rather than indirect supervision. This method would be more effective in training and guiding them in rural practice.

The lack of specialists and medical resources is a challenge working in rural practice (Smith 2005). Rural GPs in Australia may have to provide specialist services, such as obstetrics care, anaesthesia services, minor surgery and even trauma management, because of the shortage of medical practitioners in those regions (Australian Government Department of Health n.d.,e) Unlike city practice, this is something IMGs have to manage. This thesis recommends training GPs to a level that is required for rural practice prior to sending them to rural regions (Smith 2005). Providing specialist support to rural GPs through phone or video conferencing may be a useful option to consider.

Previous studies have noted workload in rural practice as an issue (Han & Humphreys 2005; Smith 2005). The issue of workload is raised as a concern by IMGs of this study. Some of the concerns that emerged from this study regarding workload are having to work extensive hours, experiencing difficulty taking time-off and getting locum doctors to cover them when on leave. The issue of workload is paramount to IMGs
especially in solo GP centres and those that practiced in small medical centres. Providing relief through locum doctors in solo GP centres or small centres is recommended. The NSW Rural Doctors Network (RDN) recognises the importance of medical practitioner locum services to support rural GPs in New South Wales and provides a range of services to facilitate this (NSW Rural Doctors Network). Another recommendation would be placing doctors in remote regions on a quarterly or half-yearly rotation basis. Fixed leave allocation for doctors would be beneficial in maintaining work-life balance.

It is clear that IMGs represent a substantial workforce in rural communities of NSW and this calls for a need to integrate them in rural communities. The finding of this study suggests that professional support is needed to integrate IMGs professionally in the Australian health system and rural practice. The findings from this study can be useful in shaping integration programs. The NSW Rural Generalist Training Program was introduced to train GPs with advanced skills to deliver services to rural communities (NSW Health 2014-2015). The aforementioned recommendations maybe useful in training and integrating IMGs to rural practice.

9.6 Limitations of the study

This thesis has used qualitative research methods. Although attention was directed to Lincoln and Guba’s (1985) criteria of Credibility, Dependability, Confirmability and Transferability in assessing the quality of the research, the weaknesses and challenges ascribed to qualitative research are acknowledged. These include the challenges in standardising qualitative research processes, the difficulty in identifying and removing extraneous variables and the reliance on the insights and analysis of the observer, even where the observer is self-critical and reflective (Carr 1994; Seale 1999). Additionally, the analysis of the interview data was subjective, as was the coding, allowing for the close consultation with the supervisory panel and the clear and dynamic relationship between the coding utilising and the findings from previous research. The small size of the participant group is also acknowledged. The study participants were from the seven non-metropolitan LHDs of NSW and is confined to the state of NSW but not all health districts in NSW are represented equally in the study, noting the challenges of recruiting participants which were outlined in Chapter 5. For the study to be replicated in other non-metropolitan LHDs of Australia, support with recruiting participants is
needed. This relatively small sample size 25 IMGs means the findings cannot be generalisable to the whole IMG population working in rural and remote regions of Australia. The finding concerning the factors of integration and the utility of Han and Humphreys’ (2006) types may not be representative of the entire IMG population due to these limitations. However, the findings can be used as a guide to what may happen in another rural setting (Kvale 1996). If the study is replicated, the study may produce different outcomes based on the geography, demographics, heterogeneity of IMG population and government policies during that time period.

9.7 Recommendations for further research

There are ‘unanswered’ aspects of this thesis research that could be addressed by future research. These aspects were beyond the scope of this thesis but are important to developing an under researched area that has important implications for health care policy. Future studies of integration in NSW should include a large group of participants with the participants more evenly distributed across the seven non-metropolitan LHDs of NSW. This would enable an analysis about the impact of the degree of remoteness and also facilitate a comparative analysis between these non-metropolitan LHDs. Within a larger project, it would also be recommended to control for and compare different family types, so as to provide a more finely grained analysis of the impact of family in integration and also on the link between integration and retention. Future research would also assess the utility of Han and Humphreys’ (2006) typology in states other than NSW and Victoria. This would enable a further assessment of whether Han and Humphreys’ (2006) typology has greater application in areas where metropolitan areas are more accessible to non-metropolitan areas. This would include a comparative assessment between states, noting that the spatial features of states such as Tasmania and South Australia are distinct from states such as Queensland and Western Australia. Further research could also include a longitudinal study, assessing the pattern of IMG integrated and retention beyond the moratorium, specifically assessing whether IMGs extend their employment in their current rural area, another rural area or a metropolitan area.

9.8 Conclusion

This research assessed the professional and social factors of integration for IMGs working in rural areas of NSW. This aim was influenced by the strong disposition in
Australian migration and health care policy to the use of IMGs to meet health care shortages in rural areas of Australia. The unmet demand for health care professionals in Australia’s rural areas has been a persistent feature of the Australian health services labour market. Given these features there is emerging scholarship in the integration of IMGs in rural area often on the presumption that IMGs who are integrated are more likely to be retained and thus address the endemic feature of health services labour markets in rural areas.

The research utilised a qualitative approach; interviews with 25 IMGs based in rural areas of NSW. Thematic analysis of the data was undertaken to identify and explain factors of integration and this analysis supported the application of Han and Humphreys’ (2006) typology of IMG integration, a typology developed after a study based in rural Victoria. This study is the only study to have examined the experience of IMGs working in rural communities of NSW using a qualitative approach.

IMGs are well-integrated; professional engagement is highly important to this process and outcome. Professional factors of integration also intersect with family, social and cultural and personal factors in shaping integration. Applying the Hans and Humphreys’ (2006) typology assisted an understanding of the factors of integration and identified weaknesses in the typology. This process also reinforced the distinction between integration and retention.

Through its thematic analysis this thesis contributed to the knowledge of the factors of integration and the way in which integration may be typified. Professional and social integration is necessary to but not sufficient to guarantee retention. The remoteness of rural areas and the comparative lack of choice in high school education and university education are issues that will challenge the long term retention of well-integrated IMGs.

The thesis makes a worthy contribution to knowledge through confirming previously established professional and social factors of integration, identifying the conditional nature of integration and analysing the complexities between integration and retention. In the context of the integration of IMGs such complexities impact how integration and retention are typified and measured. The contribution to policy of this thesis lies in its findings concerning professional development as a means of supporting professional engagement and the importance of family to IMGs’ decisions to remain
employed in rural communities. Resources to sustain the supply of doctors to rural areas should address the family needs of IMGs; such resources should be additional to existing salary incentives. The contribution to practice concerns IMG workload as the findings confirm that there are ongoing weaknesses in those policy and practice measures that have been designed to address burdensome workloads in rural practice.
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APPENDICES
APPENDIX 1: Ethics Approval

ETHICS APPROVAL

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Office of Research Services
ORS Reference: H10619 14/011068

HUMAN RESEARCH ETHICS COMMITTEE

16 April 2014
Doctor Meg Smith
School of Business

Dear Meg,

I wish to formally advise you that the Human Research Ethics Committee has approved your research proposal H10619 “The professional and social integration of International Medical Graduates working in rural regions of NSW: A study assessing the utility of Han and Humphreys (2006) typological analysis”, until 1 June 2015 with the provision of a progress report annually and a final report on completion.

Conditions of Approval

1. A progress report will be due annually on the anniversary of your approval date.

2. A final report will be due at the expiration of your approval period as detailed in the approval letter.

3. Any amendments to the project must be approved by the Human Research Ethics Committee prior to the project continuing. Amendments must be requested using the HREC Amendment Request Form:


4. Any serious or unexpected adverse events on participants must be reported to the Human Ethics
Committee as a matter of priority.

5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the Committee as a matter of priority.

6. Consent forms are to be retained within the archives of the School or Research Institute and made available to the Committee upon request.

Please quote the registration number and title as indicated above in the subject line on all future correspondence related to this project. All correspondence should be sent to the email address humanethics@uws.edu.au.

This protocol covers the following researchers:

**Meg Smith, Michael Lyons, Padma Ramnathan**

Yours sincerely

Professor Elizabeth Deane

Presiding Member,

Human Researcher Ethics Committee
APPENDIX 2: Participant information sheet

Participant Information Sheet (General)

**Project Title:** The professional and social integration of International Medical Graduates working in rural regions of NSW. A study assessing the utility of Han and Humphreys (2006) typological analysis

**Project Summary:** This research project aims to study the professional and social integration of international medical graduates (IMGs) working as general practitioners (GPs) in regional and rural NSW. The study will assess the utility of Han and Humphrey’s typology (2006) of factors that impact professional and social integration of international medical graduates (IMGs). The typology distinguished four different types of IMGs based on characteristics of individual IMGs who adjust or integrate better into rural practice and life with those who are less likely to do so. Their study was based in Victorian rural and regional areas. My study is located in rural and regional areas of New South Wales (NSW) and will use a qualitative approach utilising semi-structured interviews with IMGs who are engaged in general practice in rural and regional areas of NSW. Qualitative means offer the opportunity to provide insights into factors of integration, including social, personal and professional factors, additionally providing the opportunity to identify factors that may not be contemplated by Han and Humphrey’s typology. Research in this area is shaped by the policy context, and a number of policy measures that are directed to the retention of IMGs on subclass 457 temporary visas, given the shortage of medical practitioners willing to practise in rural and regional areas. Increased knowledge of factors that facilitate integration can assist policy makers in the health sector in selecting and recruiting IMGs with characteristics most suited to rural practice which can have a positive impact on retention rates and thus address shortages of GPs in regional and rural NSW.

You are invited to participate in a study conducted by Padma Ramnathan, a researcher at the School of Business under the Supervision of Dr. Meg Smith, Director, Academic Programs (Human Resource Management and Industrial Relations) at the School of Business at University of Western Sydney.

**How is this study being paid for?**
The study is being sponsored by University of Western Sydney

**What will I be asked to do?**
This involves one-on-one interviews with the researcher which will be audio recorded and will last about 45-60 minutes. Interviews will be conducted over the phone or will be face-to-face. Face-to-face interviews will be held in a public place. Questions will be based on experiences working as GPs in regional and rural areas of NSW including questions on factors that has played a role or could possibly play a role in integration in rural life and practice.
How much of my time will I need to give?
Interviews with the researcher involves 40-60 minutes.

What specific benefits will I receive for participating?
This research will allow participants to provide feedback about their experiences working in regional and rural areas of NSW. Participants will assist in providing insights into factors that hinder or facilitates integration of IMGs working in rural and regional areas of NSW. From this study the researcher hopes to develop integration programs which can aid retention of IMGs in rural life and practice.

Will the study involve any discomfort for me? If so, what will you do to rectify it.
There will be no anticipated harm or inconvenience to participants other than participating in the interview. Participants can withdraw from the interview at any time without any penalties or consequences.

How do you intend on publishing the results.
Please be assured that only the researcher and my academic supervisors will have access to the raw data you provide.

The findings of the research will be published in PhD thesis and any scholarly article.

Please note that the minimum retention period for data collection is five years.

There are a number of government initiatives in place to centrally store research data and to make it available for further research. For more information, see http://www.ards.org.au/ and http://www.rdsi.uq.edu.au/about. Regardless of whether the information you supply or about you is stored centrally or not, it will be stored securely and it will be de-identified before it is made available to any other researcher.

Can I withdraw from the study?
Participation is entirely voluntary and you are not obliged to be involved. If you do participate, you can withdraw at any time without giving any reason.

If you do choose to withdraw, any information that you have supplied will not be used in this study or published in my thesis or any scholarly article.

Can I tell other people about the study?
Yes, you can tell other people about the study by providing them with the chief investigator's contact details. They can contact the chief investigator to discuss their participation in the research project and obtain an information sheet.

What if I require further information?
Please contact Padma Ramnathan on 0402103259 should you wish to discuss the research further before deciding whether or not to participate.

Padma Ramnathan, Principal researcher on 0402103259.

What if I have a complaint?
This study has been approved by the University of Western Sydney Human Research Ethics Committee. The Approval number is [enter approval number]
If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Office of Research Services on Tel +61 2 4736 0229 Fax +61 2 4736 0013 or email humanethics@uws.edu.au.

Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

If you agree to participate in this study, you may be asked to sign the Participant Consent Form.
APPENDIX 3: Participant consent form

Human Research Ethics Committee
Office of Research Services

Participant Consent Form

Project Title: The professional and social integration of International Medical Graduates working in rural regions of NSW: A study assessing the utility of Han and Humphreys (2006) typological analysis

I, ...................................., consent to participate in the research project titled: The professional and social integration of International Medical Graduates working in rural regions of NSW: A study assessing the utility of Han and Humphreys (2006) typological analysis.

I acknowledge that:

I have read the participant information sheet and have been given the opportunity to discuss the information and my involvement in the project with the researcher.

The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.

I consent to the one-on-one interview with the researcher which will be audio recorded and will last about 45-60 minutes. Interviews will be conducted over the phone or will be face-to-face. Face-to-face interviews will be held in a public place. Questions will be based on experiences working as General Practitioners in regional and rural areas of NSW. Questions will also be based on factors that have played a role or could possibly play a role in integration in rural life and practice.

I understand that my involvement is confidential and that the information gained during the study may be published but no information about me will be used in any way that reveals my identity.

I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher now or in the future.
Signed: ____________________________

Name: ______________________________

Date: ________________________________

Return Address: _______________________

This study has been approved by the University of Western Sydney Human Research Ethics Committee.
The Approval number is: [enter approval number]

If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Office of Research Services on Tel +61 2 4736 0229 Fax +61 2 4736 0013 or email humanethics@uws.edu.au. Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
APPENDIX 4: Interview question guide

INTERVIEW GUIDE

Participants’ backgrounds – age, location of practice, years of practice, country of qualification

Personal and family settlement experiences in rural Australia

Employment histories prior to and after arriving in Australia

How has your experience been so far working in this place/practice?

How long do you intend to stay in this place/practice? Why? Likes and dislikes about rural life and practice.

Factors that facilitate or inhibited their integration in the community.

Are there factors that would make you stay longer in this place/ practice? Are there factors that make you leave this place/ practice?

How do you cope with challenges?

Informal relationships they have developed

Reasons for staying or leaving rural practice

The level of community or professional support towards IMGs and their families.

What do you think is an option to serve the remotest of regions in NSW? Remote access by Video conferencing / once a week visit to remote regions?
APPENDIX 5: Advertisement text for recruiting participants

Study on the professional and social integration of International Medical Graduates working in rural regions of NSW
Research study seeks participants. Be a part of an important integration/retention research.
Do you have a MBBS degree from a country other than Australia?
Are you working as a General Practitioner in one of these regional Local Health Districts of NSW?

Far West
Hunter New England
Mid North Coast
Murrumbidgee
Northern NSW
Southern NSW
Western NSW

Participation is voluntary and involves telephone or face-to-face interviews. If you decide to volunteer please call Padma Ramnathan on 0402103259 or alternatively e-mail to 17384894@student.uws.edu.au for further information.
The principal researcher for this study is Padma Ramnathan, Ph.D. candidate from the University of Western Sydney, Parramatta campus.
APPENDIX 6: Participant consent over phone

Introduction

I am calling from Western Sydney University. I am calling in regards to the interview that has been booked for today at … (time).

I will read out the information about my research study. Please feel free to ask me any questions you may have regarding this study.

Research project titled: The professional and social integration of International Medical Graduates working in rural regions of NSW: A study assessing the utility of Han and Humphreys (2006) typological analysis

Questions will be based on experiences working as General Practitioners in regional and rural areas of NSW. Questions will also be based on factors that have played a role or could possibly play a role in integration in rural life and practice. This study has been approved by the Human Ethics Committee at Western Sydney University. This involves 1-1 interview with me, the researcher, which will be audio recorded and will last about 45-60 minutes.

Before I read out the consent form, do you have any questions?

Now I will read out the consent form

Participant Consent Form

I, Dr …(name)…………………… give consent to participate in this study titled: The professional and social integration of International Medical Graduates working in rural regions of NSW: A study assessing the utility of Han and Humphreys (2006) typological analysis.

I acknowledge that:

Information about this research study has been read out to me. I have been given the opportunity to discuss the information and my involvement in the project with the
researcher.

The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.

I consent to the one-on-one interview with the researcher which will be audio recorded and will last about 45-60 minutes.

I understand that my participation is voluntary and that the information gained during the study will remain confidential. It may be published but no information about me (the participant) will be used in any way that reveals my identity. I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher now or in the future.

Do you give consent to participate in this interview?

Yes/No

If ‘yes’ then start the interview
This is your invitation- as a respected GP- to participate in a study on the professional and social integration of International Medical Graduates working in rural regions of NSW.

What is this study about?

My doctoral thesis aims to study the professional and social integration of international medical graduates (IMGs) working as general practitioners (GPs) in regional and rural NSW.

Why?

Your contribution in this study can provide input to policy makers of health sectors in NSW in targeting better support incentives or programs towards integrating IMGs in rural practice.

What does it involve?

Participation is voluntary and involves telephone or face-to-face interviews (45 minutes).

This research would allow participants (GPs) to provide feedback about their experiences – personal, social and professional experiences working in rural and regional areas of NSW. Your contribution to this project will remain confidential.

Has the study been cleared by a Human Research Ethics Committee?

This study has got the permission from the Human Research Ethics Committee at the University of Western Sydney. My Supervisors are Dr. Meg Smith, Director, Academic Programs (Human Resource Management and Industrial Relations) and Dr. Michael Lyons from the School of Business at University of Western Sydney.

I hope that you consider this invitation favourably. To inform your decision, an information sheet and a consent form is attached for your consideration. I will contact you further to determine whether you might like to participate in this project.

Further information?

For further queries or additional information, please contact: Padma Ramnathan, PhD Candidate

School of Business, University of Western Sydney (Parramatta campus)

Email:

Mobile: