Immigrant medical practitioners' experience of seeking New Zealand registration: A participatory study

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ATTESTATION OF AUTHORSHIP

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of another degree or diploma of a university or other institution of higher learning, except where acknowledgement is made in the acknowledgements."

Signed........Charles Mpofu

Date.....................18 July 2008

DEDICATION

For mum Elidah Jubane,

And

Holly and Cheryle

With love

ACKNOWLEDGEMENTS

ABSTRACT

This qualitative modified participatory study underpinned by social critical theory explored the experiences of immigrant medical practitioners seeking registration in New Zealand. The occupational science notions of occupation, occupational deprivation and occupational apartheid were used to understand the experiences of the participants. The objective of the study was to understand the experiences of the participants and facilitate their self-empowerment through facilitated dialogue, affording them opportunities for collective action. Data was obtained through in-depth interviews and focus group discussions with eighteen immigrant medical practitioners who were doctors and dentists as well as two physiotherapists. The two physiotherapists were sampled out of necessity to explore diversity in findings. Transcripts were analysed using thematic analysis. This method included the processes of coding data into themes and then collapsing themes into major themes which were organised under categories. Four categories were created in the findings describing the experiences of immigrant practitioners and suggesting solutions. Firstly; findings revealed that immigrant medical practitioners had a potential worth being utilised in New Zealand. Secondly; it was found that these participants faced negative and disabling experiences in the process of being registered. Thirdly; the emotional consequences of the negative experiences were described in the study. Fourthly; there were collectively suggested solutions where the participants felt that their problems could be alleviated by support systems modelled in other Western English speaking countries that have hosted high numbers of immigrant medical practitioners from non-English speaking countries. This collective action was consistent with the emancipatory intent of participatory research informed by social critical theory. This study resulted in drawing conclusions about the implications of the participants' experiences to well-being, occupational satisfaction as well as diverse workforce development initiatives. This study is also significant in policy making as it spelt out the specific problems faced by participants and made recommendations on what can be done to effectively utilise and benefit from the skills of immigrant medical practitioners. A multi-agency approach involving key stakeholders from the government departments, regulatory authorities, medical schools and immigrant practitioners themselves is suggested as a possible approach to solving the problems faced by these practitioners.

CHAPTER 1:   INTRODUCTION

This research on experiences of immigrant medical practitioners (IMPs) from non-English speaking backgrounds (NESB) was prompted by media stories about immigrant doctors and other health practitioners being underemployed in low skilled work in New Zealand while shortages in the medical workforce were also being reported. Informal conversations with educators in universities also revealed that it is common to find NESB immigrant medical practitioners (NESB IMPs) seeking transition into employment by either enrolling in certificate or undergraduate programmes in New Zealand universities or seeking employment in low skilled occupations. Internationally, that is in countries with health systems comparable to New Zealand the issue of NESB IMPs being underemployed in non-professional jobs because of fears of compromising competence and safety standards has also been happening in the background of medical workforce shortages. However in most of these countries especially Canada, the US, UK and Australia, government departments and local health authorities have acknowledged that initiatives aimed at enabling immigrant medical practitioners to meet registration requirements have implications not only for settlement outcomes but for diverse workforce development and meeting workforce shortages. In these countries employment transition issues of NESB IMPs have been jointly tackled by NESB representative groups, labour and health ministries, regulatory boards and local health service employing authorities.

This research was undertaken to generate knowledge and expand understanding of structural barriers in the employment of NESB IMPs who are doctors and dentists. The purpose of this project was to achieve a greater understanding of how NESB IMPs in New Zealand experience and manage hardships in attempting to meet recognition and registration requirements. The researcher and participants also sought to find solutions or make recommendations based on the issues discussed and the literature review on international examples of good practice. It was anticipated that the published findings of the study may contribute to improvements in various policy making processes and to promote greater awareness of the difficulties faced by such immigrants.

A modified participatory research methodology sitting firmly in a collaborative paradigm was used to articulate the occupational transition issues of eighteen NESB immigrant medical practitioners who are doctors and dentists. These immigrants included those who held World Health Organisation and New Zealand Qualification Authority recognised basic medical degrees and specialist qualifications such as

opthamology, pediatrics, ear nose throat specialities and gynaecology. The main regions of origin were East Europe, Central Europe, the Arab region, the Indian sub-continent, North Africa, china, and South Korea. These medical practitioners were either preparing for registration or had given up trying to get registered in New Zealand.

Aims of the study

The primary aim of this project is to gain understanding about

(i) the experiences of immigrant medical practitioners who come to New Zealand and face the challenges of re-registration in order to continue with their occupations.

(ii) how these people manage and cope with the experiences.

The secondary aim is:

(ii) To facilitate participants' critical awareness of the shared and individual nature of their experience and give them the opportunity to suggest ways of addressing obstacles they face when they wish to practice in New Zealand.

The above objectives fit within the methodologies that are political in nature, specifically participatory research underpinned by a critical lens. It is said that politics is concerned with the conflict between groups of people (who are occupational beings), the development of conflicts, the development of cooperative strategies to influence the outcome of conflicts and the resolution of conflicts (der Eijk cited in Kronenberg & Pollard, 2006). In the above example the first two objectives are spelling out the conflict while the last objective honours the necessity for resolution.

Significance of the study

This project will generate knowledge and expand understanding of structural barriers in the employment of immigrant medical practitioners. The project might achieve a greater understanding of the stresses and pressures faced by immigrant medical practitioners in New Zealand as they experience and manage hardships in continuing with the occupations they were doing in their countries. It is anticipated that the published findings of this study may contribute to improvements in various policy making processes. Although this project might not directly achieve this purpose it might serve to stimulate discussion. Park (1993) states that since much of the social injustice characteristics of modern society is structural in nature, participatory research acts as a catalytic intervention in social transformative processes.

Delimitations

Doctors and dentists who migrate through international medical graduate recruitment agencies are outside the scope of this study. In most cases these tend to have structures in place as they are privately run. Also the methodology of participatory research in some forms, usually have the "action" or implementation of strategies as part of the study. However due to the finite nature of the timeframe for this research the action part of the recommendations is outside the scope of this study. It may be pursued in my further studies or as a social project. Due to the limitation of time this study also does not look at employment outcomes of NESB IMPs after registration, that is their experiences in medical employment.

Summary of Chapter

In this chapter the researcher has introduced the study and given the aims and the significance of the study. The boundaries of the study have also been given. Below is a sub-section explaining the structure of the thesis.

Structure of the Thesis

Chapter 1: Introduction

This section introduces the thesis with aims of the study and the significance of the project. Delimitations of the study are also spelt out in this chapter

Chapter 2: Literature review

This chapter traces the international trends of the problems of NESB IMPs. This unveils current critical and philosophical debates about international standards in medical education. On exploring such philosophical debates, issues of marginalisation are identified and therefore confirm the situating of the study in a critical paradigm. The concept of "occupation" is defined in a **holistic way** and linked with issues of marginalisation. Concepts of occupational deprivation and occupational apartheid are also explored.

Chapter 3: Methodology

This chapter justifies the choice of a participatory methodology. The underpinning philosophical assumptions of this methodology are also explored. The chapter also justifies the use of a thematic analysis method within a participatory methodology. It also details how the process of thematic analysis was followed in the study.

Chapters on Findings: Categories

The following chapters focus on each of the categories that emerged in the findings

Chapter 4: Category of "the lost potential"

This chapter presents two sub-categories themes on participants' feelings that their potential is being under-utilised in New Zealand. These findings also portray how the potential of immigrant NESB IMPs is lost to other countries. Participants' motivation about being productive immigrants in New Zealand is also a theme.

Chapter 5: Category of negative and disabling experiences

This chapter presents the category on negative and disabling experiences with themes of obstacles that participants face in their attempts to get registered in New Zealand.

Chapter 6: Category of consequences

This chapter has two sub-categories; category one on feelings and emotions and category two on coping strategies.

Chapter 7: Category of suggested solutions

This chapter has one category about suggestions for collective actions

Chapter 8: Discussion and conclusion

This chapter attempts to join the findings into theoretical constructs (the overarching theme). The findings are compared with literature reviewed and discussions drawn.

CHAPTER 2:   LITERATURE REVIEW

Introduction

As the researcher already had some understanding that some NESB IMPs tend to face problems when they immigrate to New Zealand the researcher therefore reviewed literature to gain a general understanding of the scale of the problem in New Zealand and at international level. It was also important to gain an understanding of what has been done to address the problem here in New Zealand and internationally. It was also important to gain an understanding of how some professions in human and social sciences understand the issue of immigrants being deprived of opportunities to continue with their careers. Although there was no professional literature found specifically on the issue of the NESB IMPs the researcher managed to find important concepts such as occupational deprivation and occupational apartheid in the field of occupational science. These concepts fit well with emancipatory and critical ways of thinking as they assume that oppression exists and something needs to be done. It was necessary then to understand the concept of occupation (in relationship to immigrants' employment outcomes) in a holistic way rather than the trivial and simplistic way of viewing it as just getting a job and having income. In general this chapter pursues theory, concepts, background debates and opinion related to the topic and shows the relationship between these and the topic of study.

Background literature

Literature searches on issues of immigrant NESB IMPs were made in academic databases, nationally and internationally using the terms that are popularly used by anecdotal sources such as newspapers to describe these participants. The reason for using terms popularly used by anecdotal sources was that I was triggered to research on the issue because it is popularly reported in print and electronic media. These terms were "international medical graduates", "overseas trained doctors," and "refugee doctors." To widen the scope phrases such as "immigrant health practitioners" were used. This was because it was assumed that there was a possibility that some articles about immigrant health practitioners mentioned issues faced by doctors and dentists. It was interesting that most articles that were located were already capturing problems that these disempowered people face. The countries of immigration tended to be the US, Canada, UK, Australia and New Zealand. Further search strategies limited to New Zealand debates did not yield many academic materials although when anecdotal data

sources such as parliamentary debates, ministerial speeches, newspapers and magazines were searched more results emerged. This would appear to justify that the issue exists but there is need to articulate it and develop evidence that is specific to New Zealand at academic level.

The literature articles revealed that immigrant medical practitioners (IMPs) tended to face issues about the presumed inferiority of their qualifications and work experience. Other issues included lack of qualification recognition and meeting registration requirements. The literature also revealed that underemployment of NESB immigrant medical practitioners has been widely articulated but most of these studies did not have conscientisation and emancipation intent despite the political and structural orientedness of the problem. This therefore calls for a participatory study with a potential to transform social realities by way of exploring and creating shared common knowledge from the point of view of these marginalised, deprived and oppressed (de Koning & Martin, 1996) NESB IMPs. Such an endeavour can be a basis for transforming policy and practice with respect to diverse workforce development and utilisation of these under-employed immigrant medical practitioners.

A settlement perspective

Scholars have acknowledged that facilitating immigrants through recognising their skills and enabling their transition to new employment have implications for settlement and workforce development (New Zealand Immigration Service, 2004; Statistics New Zealand, 2004a). While employment of immigrants has been identified as a key settlement issue (Centre for Applied Cross-cultural Research, 2006), the recognition of NESB immigrant medical practitioners qualifications has been noted to be the most controversial in European countries (Hawthorne, 1997b; Kunz, 1975). Internationally studies have revealed that NESB immigrant medical practitioners are usually underemployed in low-skilled or non-career grades because of lack of recognition of their qualifications and experience and fears of compromising safety and competence standards (Groutsis, 2003; Haworth, 2002; Hawthorne, 1997b; Likupe, 2005; Osbourne, 2002) . Under-employment in low-skilled work and poor employment outcomes for graduate migrant health professionals have been documented and has been an issue of concern of the New Zealand Labour Department (Statistics New Zealand, 2004b). In New Zealand a former Minister of Health once referred to a scenario where immigrant doctors are underemployed in low skilled work while there are shortages in the medical workforce as a "sorry situation" (Government of New Zealand Ministerial Speeches, 2001).

The fact that the problem is significant nationally and internationally warrants the need to gain an understanding about the general trends in migration and how these have contributed to the issue.

Migration trends of medical practitioners

Significant migration of NESB IMPs has been observed to be simultaneously occurring in developed countries such as the UK, US, Canada, Australia and New Zealand and in the United Arab Emirates. The later is the only one of the mentioned countries that does not have a health system comparable to New Zealand. The reason for such a phenomenon reflects the desire for improved quality of life, enhanced opportunity, family reunion and adventure on the part of the doctors themselves (Hawthorne, 2001). The era of accelerated globalisation has also led to a significant number of NESB doctors migrating to ESB countries. For example the East-Western migration has been necessitated by war in the Balkans and the quitting of the Communist Economic (COMECON) bloc in search of political freedom and economic opportunity in the 1980s and 1990s (Hawthorne, 2001). Some immigrants who are NESB IMPs go through immigration as refugees, on spousal visas or other family reunification arrangements.

While the Non-English Speaking background (NESB) professionals have to overcome hurdles of registration processes, English Speaking Background (ESB) source country medical practitioners have been observed (Hawthorne, 2001) to be passing seamlessly into the Western countries labour market. In terms of bilateral alliances European doctors cannot easily be prevented from working in the UK because of European Union (EU) law. Although technically health trusts can test their language skills little is documented about them doing so (Butler, C., Personal communication, September, 15, 2007). It has also been acknowledged that these difficulties lead to several human rights and moral challenges (Canadian Federal Provincial Territorial Advisory Committee on Health Delivery and Human Resources, 2004).

Such concerns have mostly been directed to accreditation bodies and regulatory bodies which have been held responsible for not adequately recognising the skills and experiences of these immigrants. Professionals associations have laid such blame on these authorities on the grounds of lack of or delayed access to information as well as resources to help them work towards getting recognition in the systems. For example the Canadian Nurses Association (CNA) once issued a position statement that it,

> *"recognizes that it is essential for internationally educated nurses to have access to timely information as well as tools and resources (e.g., transition courses) to assist them in meeting regulatory requirements such as demonstrating language proficiency and passing the Canadian Registered Nurse Examination (CRNE)" (Canadian Nurses Association- Position Statement, 2002).*

In New Zealand the difficulties have been attributed to the cultural, legal and ethical organization of the medical field in New Zealand. This field is administered by regulatory authorities. For doctors it is the Medical Council of New Zealand and for dentists it is the Dental Council of New Zealand. Health and disability advocacy matters are also covered by legal instruments such as the Health and Disability Commissioner Act 1994 (the HDC). The following details particular aspects of their roles.

Regulatory issues in New Zealand

The Medical Council is the regulatory authority for doctors in New Zealand while the Dental Council of New Zealand regulates Dentists. The Medical Council of New Zealand and the Dental Council were established under section 220 of the Health Practitioners Competence Assurance Act 2003 (the HPCA Act). The HPCA Act is a legislative instrument that brought health professionals under one regulatory framework with the aim of protecting the public where there is risk of harm from the practice of the profession. The HPCA Act has powers over registration and oversight in setting standards of clinical competence, cultural competence and ethical conduct (B von Tigerstrom, 2004). Both New Zealand trained and overseas-trained practitioners have to meet safety, clinical and cultural competence before they can be registered to practice in New Zealand. The NESB IMPs are therefore required to sit the basic medical knowledge tests, followed by the practical clinical tests. These two tests ensure that the medical practitioners meet the clinical and the professional and ethical conduct requirements of the HPCA Act. Also as a standard of competence the NESB IMPs are expected to be culturally competent. Cultural competence is also a standard set by professional bodies and legal statutes such as the HPCAA Act. Cultural competence in the health sector has been defined in terms of professionalism and public safety. Cultural competence is also measured in terms involving and providing supportive environments for Maori stakeholders (Health Research Council of New Zealand, 1998).

Apart from the cultural competence requirements the HPCA Act has also necessitated streamlining of registration processes for NESB IMPs by setting the standards for communication competences. For example Sections 16(a) and (b) of the

HPCA Act 2003 require the Medical Council to ensure that any person given registration to practise medicine in New Zealand is able to communicate in and comprehend English sufficiently to protect the health and safety of the public (Medical Council of New Zealand, 2007). NESB IMPs applying to sit New Zealand Registration Examinations (NZREX) must therefore have a reasonable ability to comprehend and communicate effectively in English in the medical workplace as one of the pre-requisites for registration. For example at the moment they are required to have achieved an overall band of 7.5 or above in the academic module International English Language Testing System (IELTS) within the last two years. A minimum band of 7 is required in each of the four individual components of the test (listening, reading, writing and speaking). The Test of English as a Foreign Language (TOEFL) and Occupational English Test (OET) are not accepted by the Medical Council as alternatives to IELTS and this has complicated the registration processes of NESB IMPs. IELTS is the only English test approved by the Council and is the first test they take to meet the HPCAA communication competence requirements.

Further to the HPCA Act and professional regulatory bodies requirements the NESB IMPs also face registration obstacles of the vulnerable health practice in the light of the rise in consumer awareness and vigilance which necessitated the HDC Act. The HDC Act was legislated to safeguard the rights of the consumers and at the same time placing corresponding responsibilities to the providers through the Code of Health and Disability Services Consumers' Rights (Godbold & McCallin, 2005). The code of rights includes the patient's rights to effective communication, that of services of appropriate standard as well as that of services that comply with legal and ethical standards. The right to effective communication is safeguarded by regulatory bodies through setting minimum language requirements. Such an extension of the jurisdiction means that NESB IMPS practising in the New Zealand context are accountable to the medical profession and the HPCAA (B. von Tigerstrom, 2004) as well as the HDC.

In New Zealand, doctors who usually face having to go through the registration processes are those from countries with health systems that are not comparative to New Zealand and those from countries outside other multi-lateral alliances between English Western first world countries. In New Zealand a country with comparative health systems has been defined as that with similar public health indicators and practice environment as well as registration indicators as shown in table 2.1.

Table 2.1: Countries with comparative health systems

Public health indicators	Practice environment indicators and registration indicators	List of countries
Infant mortality rate Under 5 mortality rate Survival to age 65 Healthy life expectancy at 60 Life expectancy at birth	Percentage of registered medical practitioners per head of population Per capita total expenditure on health WHO health system achievement	Australia, Austria Belgium, Canada Denmark, Finland France, Germany Greece, Hong Kong Iceland, Israel Italy , Norway Republic of Ireland Singapore ,Spain Sweden , Switzerland The Netherlands United Kingdom United States of America

Adapted from: Medical Council of New Zealand (2007)

Doctors from countries with systems not comparative to New Zealand have to pass language tests as well as registration examinations. Table 2.2 shows a stage-by-stage process which they go through in the NZREX registration pathway.

Table 2.2: Process for NZREX Registration pathway

Registration process
1.   Pass an approved English language test
2.   Pass an approved medical licensing test e.g. US Medical Licensing Exam
3.   Pass the practical clinical tests
4.   Get provisional registration (internship year)
5.   Full registration

Overseas solutions

Canada

While in New Zealand there are no documented efforts for integrating overseas-trained doctors, in Canada conventions have been successfully held by a multiple of stakeholders to tackle the issue (Canadian Federal Provincial Territorial Advisory Committee on Health Delivery and Human Resources, 2004). Task forces, inquiries and reports to resolve the situation have been commissioned following concerns expressed

by the immigrant doctors representative organisations, members of the public, human rights organisations and other lobby groups. In Canada specific examples include reports such as; " Bridging the gap: A report of the task force on the recognition of foreign qualifications"; "Over-qualified underemployed: Accessibility barriers for immigrant women with foreign qualifications" (Canadian Federal Provincial Territorial Advisory Committee on Health Delivery and Human Resources, 2004); and also the "Canadian Task force on licensure of International Medical Graduates".

The Canadian Nurses Association has also developed a regulatory framework for the integration of international applicants. Although this is not a medical practitioners framework it has elements that are transferable to their issues. The following statement shows how committed the organisation is to the needs of nurses:

> *The frame-work recognizes that public protection must be maintained and also recognizes that internationally educated nurses must be provided with the best opportunity to achieve their full potential in practicing their chosen profession in this country" (Canadian Nurses Association- Position Statement, 2002).*

The position statements continued as follows:

> *The framework therefore identifies the infrastructure needed to assist internationally educated nurses to meet regulatory requirements and to make the transition into the Canadian health system (Canadian Nurses Association- Position Statement, 2002).*

Apart from Professional Associations and regulatory boardies universities in Canada have also been active in looking into the issues of NESB IMPs. For example on April 30, 2002 the University of Calgary organised a symposium which was named the International Medical Graduates National Symposium in collaboration with key stakeholders such as the regulatory authorities and associations, government ministries, invited representatives of governments to join with key stakeholders from the medical profession to discuss issues of immigrant medical practitioner issues. This meeting resulted in a positive outcome as there was an overwhelming vote in favour of a proposed initiative of supporting and assessing IMPs to be integrated to the system (Canadian Federal Provincial Territorial Advisory Committee on Health Delivery and Human Resources, 2004).

The UK

There have been a number of initiatives developed in the UK over the years addressing the needs of refugee health professionals at all stages of their pathways to

employment (either within the health sector or outside). A number of these initiatives received pump-priming funds from the Department of Health which delivered over £2million of funding from 2001 to 2004 (C. Butler, Personal communication, September 17, 2007).

The UK also has a multi-agency approach in facilitating recognition of skills of overseas-trained medical practitioners. Such programmes are facilitated by Local Health Authorities, medical schools in universities, settlement agencies under the immigration or labour departments as well as voluntary organisations. For example among professional organisations, the British Medical Association has both an international and refugee doctor liaison group which brings together interested parties from regulators (in the case of doctors this is the General Medical Council), the postgraduate medical deaneries, government bodies/agencies; for example the Department of Health, Home Office (that deals with immigration), Department for Work and Pensions, local health trusts, and organisations working with refugee and overseas health professional programmes. These organisations range from small community based charities through to adult education delivering English courses to medical schools delivering courses to refugee overseas doctors and dentists.

Examining both the Canada and the UK initiatives one can notice that involvement of voluntary organisations is common in the stated countries. This is a manifestation that the whole problem of NESB raises humanitarian issues. The second thing that can be concluded is that the involvement of immigration and labour departments suggests the government endorses what has been said earlier on, that this is not only a settlement issue but also a workforce development issue. It is also important not to overstate the integration structures in the above two countries as the NESB IMPs still face registration challenges (Borman, 2007; Lochhead, 2003; Margaret, 2002) of a different sort and advocacy organisations are still lobbying for improvements.

New Zealand Initiatives from 2001-2004
The bridging programme developed by the Ministry of Health together with the Overseas Doctors Association, the Medical Council, hospitals and medical schools, was designed initially to train up to 250 doctors over the three years in five intakes of 50 each. The course involved four and a half months of academic work followed by six months of clinical work and focused on the most important knowledge and skills needed for a doctor to practice safely and competently in New Zealand (King, 2002).

This programme was not a direct initiative to address the current needs of

overseas-trained doctors. Instead it was a tool to correct the injustices that were done to the skilled immigration category doctors (Hawken, 2005). This is evident in the statement by the then Minister of Health. "One of the things I really wanted to do when I became Minister of Health was to right the injustice for hundreds of overseas doctors who came to New Zealand under our immigration rules in the early 1990s, believing that they could practice medicine when they got here" (New Zealand Government Resources, 2002). This therefore may suggest that this programme might not have been incepted with the interest of these immigrants at heart. It was however designed "to save the politicians some political embarrassment" (Anonymous Medical Educator, Personal communication, October 10, 2007). The eligibility criteria stated in table 2.3 also shows further evidence of the exclusive nature of this programme:

Table 2.3: Eligibility criteria for the bridging programme

Eligibility criteria:

 Each overseas doctor must meet the following criteria :

Criteria 1
- hold an overseas medical qualification and Certificate of Good Standing verified by the Medical Council of New Zealand

Criteria 2
-have been granted residence in New Zealand under the General Skills Category (points system) of Residence Policy that was in force between 18 November 1991 and 29 October 1995 (while priority access will be given to principal applicants, the spouses/partners of principal applicants who were granted residence under those same criteria will also be eligible, provided they obtained residence under that same immigration policy).

Criteria 3:
 -have passed or been exempted an English test approved by the Medical Council.

Source: adapted from King (2000)

It can also be seen from table 2.3. that the above programme was not inclusive as most doctors who arrived outside the stipulated date were not included. Refugee doctors were also not eligible.

The New Zealand bridging programme however provided some useful points to consider when designing such a programme in the future. The experience of scholars like Hawken (2005) indicate that one challenge with overseas NESB IMPs is that they come from a wide range of countries and therefore their retraining needs differ. Hawken also noted that even their English proficiency levels do vary. This therefore is a challenge to New Zealand as a receiving country to design programmes that meet such a diversity of needs. The discontinuation of the bridging programme for NESB IMPs has

also left a gap in the integration processes. Since its discontinuation advocacies for its re-inception have included statements such as: "These courses have now been discontinued, and the question is what, if anything should take their place? "(Hawken, 2005, p. 61). The value of the bridging programme has been observed (Lillis, George, & Upsdell, 2006; Narasimhan, Ranchord, & Weathe, 2006) to be key not only for registration but for successful integration into employment after the registration processes.

Insights from local and international models

Literature review in this part of chapter shows that while recognising that regulatory and accreditation bodies have the primary responsibility, it has been observed that the integration of NESB IMPs is a collaborative responsibility of multiple parties including professional associations, immigration government departments, the applicants themselves, the educational institutions and immigrant support agencies. The knowledge gap identified in this review of literature on background information is mainly that internationally the NESB IMPs' problem has been articulated in anecdotal sources such as newspapers. However, the researcher has not come across any specific academic study that has been carried out to address the problem of NESB IMPs. No study has also been carried out with a critical awareness and emancipation intent. Further to that it has been noted that not much has been done in New Zealand about resolving the much internationally articulated problem of NESB IMPs' occupational issues.

A critical perspective

Having reviewed literature on the background to the problem the researcher then sought to gain an understanding about the international debates about presumed medical inferiority of third world countries trained IMPs. The debates were analysed though a social critical lens which explores issues about domination and emancipation of the "marginalized". There follows a review of literature on some of the debates that raise critical questions of inferiority and superiority leading to the oppression of NESB IMPs from third world countries. This oppression is seen through imposing restrictions that end up either excluding NESB IMPs from participating in the labour market or forcing them to participate in non-professional jobs. Before discussing global standards in medical education it is necessary to define and examine debates on the concept of professional regulation and frame the discussion within a critical paradigm that underpins this research.

Debates on licensing restrictions as a political process

Professional practice such as the medical profession is said to be a duty or a commitment that is bound by regulation and control (Hunt, 2004).The process of becoming a profession (professionalisation) is led by an autonomous group of practitioners with expertise and commitment to the generation of knowledge (Hunt, 2004; Totton, 1999). The issue of control and autonomy within the medical profession is of central concern in this discussion. Professional regulation is usually administered through the process of registration or licensing (licensure) by a professional governing body. In the medical field licensure is usually administered by independent regulatory authorities or colleges of surgeons and physicians. In New Zealand the regulatory authority is the Medical Council of New Zealand.

In his critique Totton (1999) states that the drive to professionalisation holds false beliefs about its own motivations. The primary conscious belief is that professionalisation is for the good of the client; that it will protect the public from being preyed upon by dangerous, incompetent and unscrupulous quacks in the modern era which is characterised by a growing demand for greater public accountability (Hunt, 2004). Hence control through licensing or registration is said to be for the good of the client. It is claimed that regularisation and standardisation inherent in professional practice protects the public from incompetent, 'dangerous' people and other forms of malpractice. However, some critics feel that "Professionalisation has its own self-motivating dynamic and as a an entity a profession tends to carve out a niche [and] it inevitably seeks to make boundaries around itself and to control admission" (Totton, 1999) and the only way to achieve this is by laying claim to a body of expert knowledge. However critics argue that the fundamental motivation involved is quite simply one of self-interest (Totton, 1999) and not public interest. Totton further states that the professionalisation process can be understood as one of expulsion, getting rid of something and forming boundaries towards `social closure', as well as the inculcation of public anxiety about who is a 'safe' practitioner. Indeed in New Zealand public anxiety has been inculcated in the sense that the media has blown out of proportion issues about incompetence of immigrant medical practitioners. For example on the 20th of May 2007 the Sunday Star Times, a New Zealand weekly newspaper, once put a caption that read: "Curse or cure" referring to safety issues about overseas-trained doctors. The same newspaper also displayed pictures of overseas doctor and titled the column "Foreign bodies" (Chisholm, 2007).

In discussing issues about professionalisation and self-regulation of the medical field, critical terms such as "monocultures of the mind" (Shiva, 1993) and medical dominance have been used. A critique by Totton (1999) equated the issue of self-regulation and dominance to that of "... multinational companies [where] generic uniformity leads to weeding out the unique and nonconformist (Totton, 1999, p. 8). In another critique Postle (1998) in Totton (1999, p.8) also stated that "a register of [acceptable practitioners] creates weeds and indeed for it to make sense, it has to create weeds, to justify the high .....[planting costs] of cultivars' (p. 154)."

The extent of the truth inherent is in this assertion can be considered by review from critical theoretical position. From a critical perspective licensure is viewed as an extension of the concern for self-regulation that characterizes professionalism. Acknowledging the important mission of protecting the health and safety of the public it has been observed (Cohen, 1973; Svorny, 1987) that in many cases, licensure has provided a means of according status and recognition to a body of specialized knowledge resulting in a "state-protected environment" wherein the profession is virtually autonomous (Cohen, 1973). The underlying assumption of licensing is that it is quality enhancing and therefore benefits the consumer. However it has been argued that "Professional licensure benefits producers by creating entry barriers into the profession, [although] consumers might also gain if licensure induces producers to supply high levels of quality. Whether consumers or producers gain most from licensure can be determined by examining the effect of licensure requirements on aggregate consumption"(Lowenberg & Tinnin, 1992). In saying so it has been found that in some cases restriction in licensure have led to reduction in consumption of quality and easily accessible services from medical practitioners (Lowenberg & Tinnin, 1992; Svorny, 1987, 1991). It is interesting to note that in New Zealand the restrictions that NESB IMPs face when seeking registration are based on the rationale that the medical council is protecting the public interest. Studies weighing public interests against the medical profession's interests in New Zealand have not been carried out. This study might therefore shed some light on the aggregate benefit.

Such debates on professional benefits versus public interests have led to attempts being made to diffuse the natural insularity of licensing boards by including public representation in regulatory boards and jointly promulgated regulations such as the HPCA Act in New Zealand. The benefits of such measures have not been explicitly researched in New Zealand.

The above discussion adds weight to the view that the licensing requirements of the Medical Council of New Zealand cannot go unchallenged. Having explored the critical and philosophical views about medical licensing, below are the debates about global standards in medical education.

Debates: global standards in basic medical education

International academic journals were searched using "terms standard in medical practice" and articles with terms such as "global standards in medical education" and "international standards in medical education" emerged. Further to deliberately searching for specific debates and to make the search overtly critical the above search words were prefixed with words such as "debates" and "controversy". The above search words were also prefixed with words such as "immigrant medical graduates".

Discussions on the concept of global standards in medical education were seen in literature as topical. The issue of global standards has become more topical as medical schools have grown in diversity and the market for the medical workforce became increasingly internationalized (Hays & Baravilala, 2004). Such instances where students migrate globally and practice in one country what they learned in another have led to debates about the concepts of global standards in medical education. The scenario where NESB (and third world) countries have been viewed as inferior has led to fears of putting first world countries in a position to set supernational standards for the former. Official documents and writings from receiving countries have shown evidence of presumed medical inferiority on NESB medical graduates (Hawthorne, 1997b). In this case there have therefore been questions raised in scholarly debates (Hays & Baravilala, 2004) about who should set the standards and what acceptable standards are:

> *It would not work to simply impose standards from developed countries on to others, and perhaps it should not be attempted. If required physician knowledge and skills vary from country to country, desirable standards for medical education may vary too, at least as they are perceived by the public and stakeholders (ten Cate, 2002).*

Attempts that have already been made in ESB countries were seen to have been along a predominantly developed world paradigm of basic medical education with little room for emphasizing what was unique, special or innovative about medical school curricula in less well resourced settings of developing countries (Hays & Baravilala, 2004). However despite such dilemmas of dominating paradigms, increasing global communication and migration have necessitated the implementation of global standards.

Non-dominating views have acknowledged that a common set of international

standards does not imply equivalence of educational content nor graduates. Educational objectives and the means by which they are attained will vary from one country to another. One argument (ten Cate, 2002) has been that, for example, global standards clearly should not be US standards nor should they be South African standards.

Such debates have led to the definition of what the international committee of expert medical educators termed Global Minimum Essential Requirements (GMER). These requirements were in the form of competences which were looked upon as outcomes of medical education. These competences fall into seven domains: (1)professional values, attitudes, behaviour and ethics; (2) scientific foundation of medicine; (3) clinical skills; (4) communication skills; (5)population health and health systems; (6) management of information; and (7) critical thinking and research (Stern, Wojtczak, & Schwarz, 2003). Although these debates show that the question of how to ensure that medical practitioners are trained to an acceptable standard is complex (Hays & Baravilala, 2004), research studies dating as far back as the 1970s indicate that in the medical profession there have been controversies leading to the NESB graduates being viewed as inferior. An overseas example is the Australian denigration of East European refugee doctors (Hawthorne, 1997b; Kunz, 1975). Backet, the chairman of the Australian medical examination committee, once said that compared to English speaking background (ESB), NESB candidates for accreditation had exceptionally high failure rates because:

> *It is unrealistic to expect …..foreign medical graduates who were poorly trained and had inappropriate postgraduate medical experience in a deprived environment will ever reach the standards of Australian trained doctors (Blacket, 1990a, p. 129).*

At this juncture the researcher therefore concludes that international standards do not require equivalence and conformity of NESB countries to NESB countries.. Standards of minimal requirements in basic medical education simply mean that all medical schools must ensure that a certain basic level of knowledge, skills and attitudes is obtained by every medical student before graduation (ten Cate, 2002). The differences in political, cultural and language contexts should not be taken as evidence of inferiority or superiority (Hays & Baravilala, 2004).

An occupational science perspective

Having understood the political nature of the debates it was important to gain an understanding of how some professions in human and social sciences understand the issue of immigrants being deprived of opportunities to continue with their careers.

Although there is evidently little professional literature specific to the issue of NESB IMPs important studies that have explored occupational deprivation and occupational apartheid in the field of occupational science were found. The concepts of occupational deprivation and that of occupational apartheid help in articulating and understanding the social imbalances and domination issues discussed above. A number of studies that have generated knowledge about the importance of occupation to an individuals' wellbeing were also looked at. It was noticed that the holistic understanding of the concept of occupation from occupational science literature is empowering to NESB IMPs as it does not simplify and trivialise their issue by defining it in terms of just getting a job and having income.

Humans are occupational beings

The definition of the concept of occupation (people's dignified and meaningful participation in daily life (Pollard & Kronenberg, 2005) as used in this study is that taken from the field of occupational science. Occupational science is the systematic study of humans as occupational beings (Clark et al., 1991). In the field of occupational science, occupation is said to be a central aspect of the human experience. This means that it is a natural human phenomenon, which forms the fabric of everyday lives (Cynkin & Robinson as cited in Wilcock, 1991).

The value of meaningfulness of occupation is seen in the definition that considers it as people's dignified and meaningful participation in daily life (Pollard & Kronenberg, 2005). By nature occupation has a meaning within the lives of individuals, hence occupations are said to have spiritual dimensions (Clark; Mattingly & Fleming as cited in American Occupational Therapy Association, 1995). The term spirituality is used here to refer to the non-physical and nonmaterial aspects of existence. In this sense, it is postulated that daily pursuits contribute insight into the nature and meaning of a person's life (American Occupational Therapy Association, 1995). Hence in order for an activity to be considered an occupation it must have personal and cultural meaning for the individual (Clark et al, 1991; Occupational Yerxa et al, 1989).

Apart from the spiritual dimension occupation has a psychological dimension. The fact that engagement in occupation is seen to be driven by an intrinsic need for mastery, competence, self-identity, and group acceptance, shows that occupations have a psychological dimension (Brown, 1986; Burke, 1977; Christiansen,1994; DiMatteo, 1991; Fidler & Fidler, 1983; White,1971 as cited in American Occupational Therapy Association, 1995).

Occupations can be broadly explained as having both performance and

contextual dimensions because they involve acts within defined settings (Christiansen, 1991;Nelson, 1988; Rogers, 1982 as cited in American Occupational Therapy Association, 1995). For example occupation can be said to include activities that are restful and productive which are carried out by individuals in their unique ways based on societal influences, their own needs, the kinds of experiences they have had, on their environments (Kielhofner, 1985 as cited in Wilcock, 1991).

On the other hand some occupational scientists tend to emphasise the survival/ economic dimension. Those who talk of survival/ economic dimension emphasise that occupation also has economic implications and enables humans to be economically self-sufficient (Yerxa et al., 1989). In this sense occupation enables humans to survive, control and adapt to their world, be economically self sufficient (Yerxa et al, 1989 in Wilcock , 1991) thereby experiencing social relationships and approval as well as personal growth (Wilcock, 1991). These ideas link with definitions that view occupation as work. However it must be emphasised that this study takes a broader holistic view of occupation rather than just viewing it as work.

In addition to the above views about occupation some occupational scientists have been explicit about the need to include the dimension of paid work in defining occupation. In this sense it is defined as a general term that refers to engagement in activities, tasks, and roles for the purpose of productive pursuit such as work and education, maintaining oneself in the environment (C. Christiansen, 1991; Wilcock, 1991). This is relevant as the concerns of the participants of this study extend further than the spiritual needs of being employed. These definitions that mention the survival and the economic aspects link well with the methodology of this study as the political and social needs of the participants are driven by being excluded from opportunities to be meaningfully occupied. It has been observed that the attainment of material wellbeing and socio-political entitlement is indivisible (Park, 1993).

Occupation and health and wellbeing

It is claimed (Kronenberg, Algado, & Pollard, 2006) that humans are occupational beings and thus engagement in occupations that humans find meaningful and useful in their environment is fundamental to experiencing good health and wellbeing. Wilcock (1998) observed that there is a three way link between health, survival and engagement in occupation. Health is the outcome of each organism having all essential sustenance and safety needs met and of having physical, mental and social capacities maintained exercised and balanced through the medium of occupation (Wilcock, 1998). Wilcock observed that survival is the outcome of the use of capacities

through occupations that provide for essential needs of the organism including supportive social, economic and material environments. The extent and quality of such survival for individuals and communities and societies depends on their total wellbeing including physical and social wellbeing.

In terms of looking at determinants, the views to be adopted by the writer are those that consider determinants of health in a way that is consistent with the social critical lens inherent in this research. According to the World Health Organisation (WHO) (1978) health is determined mainly by factors outside the domain of medical, technical or public health, such as, social, economic , and political conditions which result from unfair distribution of resources. It is therefore claimed that the key to improvement in health in this regard is strong political commitment to and empowering people to emancipate themselves and thus move towards of route of being healthy (Kronenberg et al., 2006). In occupational science such empowering acts are called enablement. Enablement is providing the person with the means to develop and maintain an individually meaningful occupational life trajectory premised on attaining a state of wellbeing (Kronenberg, Simó Algado & Pollard, 2005).

Having understood the holistic definition of occupational science the literature was reviewed mainly on what happens to people who are denied access to their occupations. Again in the field of occupational science concepts of occupational deprivation, and occupational apartheid were found useful.

Occupational deprivation of NESB IMPs

The concept of occupational deprivation is useful in comprehending issues of NESB IMPS who are finding it harder or impossible to continue with the occupations they have been doing meaningfully in their countries of origin. Occupational deprivation is defined as a state of preclusion from engagement in occupations of necessity and meaning due to factors that stand outside the immediate control of the individuals (Whiteford, 2000). In such situations where members of the society risk continued or lifetime deprivation scholars have argued that creating opportunities to enrich environments in which occupational deprivation is otherwise a hallmark becomes an imperative (Molineux & Whiteford, 1999b). This is because it has been observed that "Occupational deprivation over extended periods has been shown to have a detrimental effect on health, well-being and adaptation (Wilcock, 1998). Yerxa et al (1989) also suggest "individuals are most true to their humanity when engaged in occupation" (p. 7). Studies about the settlement outcomes of immigrants have also indicated that immigrants tend not to feel settled in the labour market until they are employed in the

jobs related to their previous experience (IP, 1997).

In situations where individuals risk occupational deprivation occupational enrichment is considered as way of intervention. Occupational enrichment is defined as, "the deliberate manipulation of environments to facilitate and support engagement in a range of occupations congruent with those that the individual might normally perform" (Molineux & Whiteford, 1999b). Implicit in the above definition is recognition of the complex and multifaceted nature of the environments in which humans engage in occupation (for example, social, physical, cultural). In the case of the issue of concern in this study the environments that need manipulation are mainly structural rather than physical. Occupational enrichment is the mechanism by which the state of deprivation discussed above can be redressed by affording the affected individuals an opportunity to meet basic survival needs, otherwise exercising personal capacities may be permanently lost (Molineux & Whiteford, 1999b). The concept of occupational enrichment is therefore another guiding principle for adopting an emancipatory focus in this research aimed at empowering the occupationally deprived NESB IMPs. Occupational enrichment also has not been articulated and researched in relationship to issues NESB IMPs face when they migrate to ESB countries.

Occupational deprivation can lead to occupational apartheid especially if viewed at societal level where some groups of people might be facing alienation. Occupational apartheid, is defined by Kronenberg and Pollard (2006, p.67) as

> *The segregation of groups of people through the restriction or denial of access to dignified and meaningful participation in occupations of daily life on the basis of race, colour, disability, national origin, age, gender, ... political beliefs, status in society, or other characteristic.*

It is also defined as the systemic or environmental conditions that deny marginalised people from rightful access to participation in occupations that they value as meaningful and useful to them (Layton & Lentin, 2006). The concept has been discussed in relationship to displaced populations (Kronenberg et al., 2006; Pollard & Kronenberg, 2005) and policy making contexts. However it is useful to note that it has been articulated in a larger scale like international and intercontinental migration. It has been noted in the previous sections of this literature review that the issue of NESB IMPs is controversial at the global level (Hawthorne, 1997a). The literature reviewed revealed evidence that the immigrant NESB IMPs have often faced restrictions because of their countries of origin as well as instances that result in social and political environments of their countries of origin. Recruitment practices encountered by immigrants in general

extend further than obstacles around recognition of overseas qualifications to employers' prejudicial discrimination against people with foreign characteristics (Benson-Rea, Haworth, & Rawlinson, 2000).

Occupational apartheid encompasses political and system wide forces that segregate people for cultural, racial, religious or socioeconomic reasons and restrict access and change meaningful daily occupations. Occasioned by political forces, its systematic and pervasive social, cultural and economic consequences jeopardize health and wellbeing as experienced by individuals, communities and societies (Layton & Lentin, 2006).

The assumptions of occupational apartheid are that not all people are equal, some are better, more worthy, deserve more than others and that is the natural way of the world which should not be inclusive. It is also based on a premise that some people are of different economic and social value than others (Kronenberg et al., 2006). Hence in this study, myths such as the natural inferiority of classes, races or cultural inferiorities can be dispelled by being problematised by way of being researched (Kronenberg & Pollard, 2006).

Because occupational apartheid involves the systematic segregation of occupation opportunity to NESB IMPs this refers to regulatory systems that exist in a given stratified social structure. This concept sits well in participatory research as it calls for critical awareness and identifying these social imbalances.

Within the environment of occupational apartheid Kronenberg and Pollard (2006, p. 67) explore the concept of occupational justice defined for now as "economic, political, and social forces which create equitable opportunity and means to choose, organize, and perform occupations that people find useful or meaningful in their environment" (Townsend, 1999). This is a broad view of human survival that acknowledges social, political and economic factors as well as health and human development issues of people who endure disabling conditions. Occupational injustice occurs within a system of occupational apartheid when participation in occupations is segregated, underdeveloped, disrupted, alienated, marginalized, exploited, confined, prohibited or otherwise restricted (C. Christiansen & Townsend, 2004)

Verschuur (2006) found that immigrants, refugees and asylum seekers are at a higher risk of developing occupational deprivation. This study is about immigrant medical practitioners and refugee medical practitioners who are deprived access to their chosen occupations in New Zealand. In terms of the participatory element of the methodology chosen it has been observed that;

> *The explicit aim of participatory research is to bring about a more just society in which no groups or classes of people suffer from deprivation of life's essentials....such as food, clothing, shelter, and health and in which all enjoy basic human freedoms and dignity (Park, 1993, p. 2) .*

In critical occupational science literature it has been observed that facilitation of human occupations depends on the political influences operating in the social and economic environment (Pollard & Kronenberg, 2005). What we do is dependant on the social opportunities and resources available to us to facilitate our occupational participation and exercise our occupational rights (Townsend & Wilcock, 2004).

This subsection of the review set to identify gaps in knowledge and learn some insights from what other scholars have written and this is presented below.

Summary: Insights and gaps in knowledge

The significance of an occupational science view of occupation is that it is a field that views human beings from an intrinsic and ecological perspective as can be seen in the definitions below. According to the American Occupational Therapy Association (1995) the multidimensional and complex nature of daily occupation should not be understated. In this study of NESB IMPs the central concern is that of experiences and the lived nature of experience; and this therefore calls for a science that honours the intrinsic and the external nature of experiences. The participatory research methodology used in this study also sees the creation of human inequalities as stemming from the social world which is external to the individual.

The preceding link between occupational deprivation and wellbeing signifies that viewing the issue of NESB IMPs as a matter of 'just getting jobs and getting paid' instead of viewing it in the context of health, wellbeing and adaptation tends to trivialise all endeavours in addressing this controversial problem. Although the definition of the concept and its link to wellbeing has been acknowledged, these concepts have not been explored in relation to employment outcomes of immigrant professionals especially undergoing significant loss of occupations. The concept has been explored mainly in New Zealand and Australia primarily in relation to occupational deprivation of people in prisons (Molineux & Whiteford, 1999a; Whiteford, 1997) and in relationship to vulnerable and displaced population groups (Kronenberg et al., 2006) .

CHAPTER 3:   METHODOLOGY

Introduction

This chapter will define the methodology used in this research and its philosophical underpinnings. Methods or procedures for gathering data will be spelt out and the rationale for their use described. Issues of ethics and rigour of the research will also be addressed in this chapter.

Methodology

The approach used in this research is qualitative research which is a term used to cover a wide range of approaches and methods that are naturalistic and interpretative. These approaches are concerned with understanding the meanings which people attach to actions, decisions, beliefs and values within their social world, and understanding the mental mapping process that respondents use to make sense of and interpret the world around them (Ritchie & Lewis, 2003). Researchers who use qualitative methods are interested in an in-depth truth. Qualitative approaches aim to study things in their natural setting, attempting to make sense of, or interpret phenomena in terms of the meanings people bring to them and they use a holistic perspective which preserves the complexities of human behaviour (Greenhalgh, 1997).

Within a range of qualitative methodologies the intention is to use an interpretive modified participatory research informed by social critical theory (Reason,1988) and occupational science concepts. This research is grounded in a critical social research paradigm (Smith, 1993) with participatory co-operative elements (Reason, 1988). This qualitative research approach grounded in critical interpretative perspectives has a participatory aspect which involves participants contributing to the interpretation of the data. The participatory element seeks to ensure that the processes of data gathering and interpretive analysis gives voice to the lived experiences of participants. The initiating researcher's role is to facilitate, guide and manage the research process. Participatory research methodology sits firmly in a collaborative paradigm, and in this paradigm sharing the life-world together against the background of common experience and history (Park et al 1993) is central. Personal experience and concerns of the researcher in the form of my own background as an NESB immigrant teacher from Zimbabwe is of value in this participatory research. This kind of research where one spends time with people, listening to their voices, understanding their perspectives, and sharing their problems has a potential to facilitate the formulation of

more effective policy and is politically and ethically sensitive (Ezzy, 2002).

Philosophical underpinnings

At the outset of the research it is essential to be clear about the nature of knowledge to be created, the process, the type of concepts and theory being used to formulate research questions and interpret answers and the assumptions about the nature of empirical data (ontology) and how they are collected. In this research it is believed that our world does not consist of separate things but of relationships we co-author and hence the reality we create is a co-creation (Reason, 2003), that is, collaborative interpretations of experience. It is said that ontology; defined as the theory about the world, its order and reality; affects how science is conducted and it determines epistemology (Cicmil, 2006) .

Based on the Greek words, *episteme* meaning "knowledge" and *logos*, meaning "theory," epistemology is concerned with the definition of knowledge, the sources and criteria of knowledge, the kinds of knowledge possible, and the relation between the one who knows and the object known. The question of whether we believe knowledge is objective or subjective and belief about "knowledge," where it exists and how we get it, naturally affects notions about research procedures. Epistemologically, this research has an approach underpinned by the concepts of "pragmatic epistemology" and "cooperative enquiry" (Cicmil, 2006); that is, collaboration between the researcher and the researched. All those in inquiry endeavour to act as co-researchers, contributing both to the decisions and to possible actions to be taken. The type of knowledge to come from this way of research is interactive as well as being self-reflective and practical. Interactive knowledge will be produced in the sense that dialogue and collective action will be guiding principles. The guiding principles are also connectedness and inclusion where sharing personal stories dominates proceedings (Park, 1993). The knowledge is also interactive in that it is derived from sharing the life world together (Park, 1993).

Knowledge produced is self-reflective knowledge which is driven by the "emancipatory" interest "aimed at the realization of autonomy from defective actions and utterances arising from social relations of power, domination, and alienation" (Oliga, 1996, p. 152). It is practical knowledge in the sense that it is useful to people in the everyday conduct of their lives and its contribution is increased well-being— economic, political, psychological, spiritual—of human persons and communities, and also contributes "to a more equitable and sustainable relationship with the wider ecology of the planet of which we are an intrinsic part" (Reason & Bradbury, 2001, p. 2).

Honouring the participatory element

As has already been explained, ideally in participatory research the researcher and the participants contribute almost equally in all stages of the research. In such a situation participants are called co-researchers or co-participants. However, in this particular study the researcher had more input than the participants and hence the adoption of the words 'participants' and 'researcher'. The idea of total equality in contribution was hard to implement due to the time constraints of this research.

In participatory research participants contribute in the formulation of the topic, the study objectives, methods of gathering data, analysing data and disseminating the study findings. In this research the participants contributed in shaping the topic, refining the study objectives as the researcher had already done some foundation work. For example in the initial study topic the title did not have the word 'registration' but the participants requested to have the word included somehow in the title as it captured the central aspect of their problems. Participants also partly analysed data, reviewed literature and helped in disseminating the preliminary findings of the research. For example they gave the researcher critical literature on registration issues to review and shaped themes in the focus group. It must be emphasised that the stage where participants contributed most was the data analysis, deciding categories and almost wholly contributed in the suggested solutions. Suggested solutions became a category on their own. The focus group was mainly dominated by participant contributions.

Participants

Ethics approval was sought and granted to audiotape eighteen interviews and the focus group meeting (Refer to appendix A and B). Initially the the researcher had planned to interview between 8 and 12 NESB immigrant medical practitioners who are doctors and dentists. However due to the overwhelming response the researcher decided to honour the philosophy of participatory research of avoiding exclusion. This was because there were some participants who expressed strong feeelings about articulating their issues and scholars such as Park (1993) state that in participatory research such people should not be left out. There were also some people who were not able to be interviewed but however wanted to participate in the focus group. In addition to this after the eleventh interview there were new ideas that emerged and the researcher felt that they have to be pursued. Hence all these issues made the researcher apply to the ethics commmittte to increase the number to eighteen (see appendix B). These participants included medical doctors, and dentists. Two physiotherapists were also interviewed to check how regulations vary in allied medical fields. See table3 .1. for the

numbers and detailed demographic information. The participants were immigrant medical practitioners who studied and practised in their countries of origin and were then in, or in the process of getting jobs or furthering their qualifications in New Zealand. The following exclusion criteria was used; they were supposed to be immigrants legally residing in New Zealand, medical practitioners e.g. medical doctors and dentists, studying, seeking a job or already in employment. (For a detailed description of the exclusion criteria refer to appendix C-advertisement). The participants were also supposed to be able to speak English reasonably well. Interested immigrant medical practitioners were invited to participate through advertisements placed on noticeboards in local universities and hospitals.

The main regions of origin were East Europe, the Arab region, the Indian sub-continent, North Africa, China, and South Korea. Specific countries of origin have not been included for the sake of preserving anonymity and this was at the request of participants. These medical practitioners were either preparing for registration or had given up trying to get registered in New Zealand. These immigrants included those who held World Health Organisation and New Zealand Qualification Authority recognised basic medical degrees and specialist qualifications such as Opthamology, Pediatrics and Ear Nose and Throat Specialities.

In the demograpghic data in table 3.3 participants' specfic specialities are not shown against their demographic data to preserve anonmity.

Table 3.1 Participants' demographic information

	Country	Immigration status	Qualification	Exper-ience (yrs)	Yrs in NZ	Present job	Age	Sex
1.	Central Europe	Skilled immigrant	MD, Specialist	15	15	Researcher	45-50	F
2.	East Europe	Joining family	MD	5	6	Administration	-	F
3.	NESB Europe	Joining family	Physiotherapist	5	5	Care giver	-	F
4.	Arab sub-continent	Refugee	Bachelor of Dental surgery	6	6	Taxi Driver	-	M
5.	Asian Continent	International student	Bachelor of Dental surgery	6	8	student	-	F
6.	Asian continent	Joining family	Bachelor of physiotherapy	10	10	student	-	F
7.	Indian-sub-continent	Refugee	MD, PhD, Professor, Specialist	32	10	Income benefit	55-60	M
8.	Middle East	Refugee	MD	11	10	KFC waiter		M
9.	Indian sub-continent	Migrant	PhD, Masters of Science, Bachelor of Medicine, Surgery	33	10	Community Support work	55-60	M
10.	.Asian Continent	International student	Specialist medical qualification	6	5	student	25-30	F
11.	Indian sub-continent	Refugee	MD, NZ postgraduate	25	10	Community Support work	-	M
12.	North Africa	Refugee	Surgeon	20	7	Community Support worker	-	M
13.	Central Africa	International student	Bachelor of surgery	6	5	Allied health professions	-	F
14.	West NESB Europe	Joining family	Bachelor of surgery	15	8	Commerce industry	-	F
15.	Sub-Saharan Africa	Skilled immigrant	MD	10	7	Doctor	40-45	M
16.	Middle East	Refugee	B. of Dental Surgery	15	8	Taxi driver	45-50	M
17.	East Europe	Refugee	MD	20	6	Taxi driver	-	M
18.	Asian continent	Skilled migrant	MD	9	5	Unemployed	-	M

Data gathering methods

Conducting the Interviews

In this research the first three interviews used the standard semi –structured

interview questions (see appendix H) in a more loose way. Initial interviews were conducted on the basis of a loose structure consisting of open ended questions. The aim of this was to use the questions to define the area to be explored, at least initially, and from which the interviewer or interviewee may diverge in order to pursue an idea in more detail (Britten, 1995). These interviews started with questions like: "This research is about experiences of NESB immigrant medical practitioners seeking registration in New Zealand. Can you tell me about your own experiences and what you think of such experiences?" Further questions that followed were based on what the interviewee said Although the same questions were used in the subsequent sessions, the interviews that followed were more in depth and less structured than the first three and they covered fewer issues but in much greater detail. This was because the direction to broaden issues had already been tentatively laid out in the first three interviews. and consisted mostly of questions seeking clarification and probing for details (Britten, 1995)

Since these were qualitative interviews the aim was to discover the interviewees' own framework of meanings. The research task was therefore to avoid imposing the researcher's own structures and assumptions as far as possible. The researcher needs to remain open to the possibility that the concepts and variables that emerge may be very different from those that might have been predicted at the outset (Britten, 1995).

As a qualitative researcher seeking to find themes from the interviews the researcher tried to be interactive and sensitive to the language and concepts used by the interviewee, and to keep the agenda flexible. The aim was to go below the surface of the topic being discussed, explore what people say in as much detail as possible, and uncover new areas or ideas that were not anticipated at the outset of the research. It was vital to check that respondents' meanings were understood instead of relying on personal assumptions. This is particularly important if there is obvious potential for misunderstanding (Britten, 1995).

Dialogue which takes the form of interviews is one distinguishing feature of participatory research. The study is designed as a participative inquiry based on active interviewing, involving reflective practitioners and pragmatic researchers who engage together in co-authoring theories and creating knowledge which is immediate, pragmatic, and contextualized. Both the participants and the researchers are encouraged to think more deeply about the research topic, and the implications of potential outcomes of the research for a wider range of interested parties (Cicmil, 2006).

Participants' registration experiences since arrival in New Zealand were

explored through semi-structured and open-ended interviews on a one to one basis. Participants were asked their preferences for the venue of interviews. Eight were interviewed in their homes and 4 were interviewed in other neutral places such as libraries. These interviews lasted for approximately one hour. Post interview reflections were also made by the researcher and recorded as journal notes for some interviews. These interviews were tape recorded, transcribed by a qualified transcriber who signed a confidentiality form (see appendix E). The transcriber's job ended with the transription itself and did not extend to interpretation of data. The researcher and the participant negotiated a convenient place to meet. Prior to the interview a copy of questions likely to be addressed were sent to the participant. These questions were not strictly predetermined and ordered. The interviewer sought to look for recurring and emerging issues of particular interest to the participants and the study. Hence participants were informed that whatever was said was useful and will be recorded and transcribed and that they were to receive a copy on which they could comment on and return to the researcher. Themes decided in the initial analysis were shared with participants and their comment and contribution invited in the form of feedback on transcripts sent to them. This collaborative interpretation of data was meant to honour the participatory nature of the methodology and a focus group described below was one way of honouring significance of collaboration in participatory research. According to Auerbach and Silverstein (2003) the decision on which comes first; the individual interviews or focus group interviews should be made considering that if the focus group comes first, people might express views that were dominant in the focus group when interviewed individually. This is because people tend to form their attitudes and beliefs relative to others attitudes and beliefs. Also having interviews before focus groups ensures that more in-depth data from each participant can be obtained whereas the focus group may give wider but not in-depth opinions.

Procedures for focus group meeting

One feature of the process of acquiring knowledge in particiaptory research is interaction and dialogue. Empowerment is realised through collective engagement in social processes (Park, 1993). This is the best platform for dialogue where people do not reveal private facts hidden from others but discuss in order to know themselves as a collectively disempowered commmunity needing to engage in social action (Park, 1993). Following the interviews a focus group to further explore themes and questions that emerged from the initial data gathering process was conducted. Specifically the focus group had three purposes. The first was to address follow up questions that

emerged from preliminary interview data analysis, secondly to brainstorm solutions to issues identified in the interview. The researcher and participants also sought to find solutions or make recommendations based on the issues discussed and the literature review on international examples of good practice. In the focus group they had an opportunity to view and comment on the preliminary data analysis. Apart from discussing the outcomes of this collaborative interpretation of data, further questions or areas requiring clarification were addressed.

The focus group meeting suited both the collaborative and the emancipatory intent of the study firstly because it is "a form of group interview that capitalises on communication between research participants in order to generate data" (Kitzinger, 2000, p. 20). Secondly the emancipatory intent was met by the fact that this meeting tends to permit conversation about sensitive subjects and allow for a safer environment to express criticism. Focus groups are said to take the interviews to a level / step further which is critical through group discussions. Also group perspectives do manifest through dominantly expressed attitudes and language (Kitzinger, 2000). The liberal nature is honoured by the fact that in the dialogue participants are said to use their own vocabulary, generate their own questions and identify their own priorities and hence this is an empowering approach (Kitzinger, 2000). Another element of a participatory research informed by social critical theory is empowerment which is fulfilled through conscientisation as participants had an opportunity to talk to other people with similar experiences thereby shifting away from self blaming psychological explanations of inadequacy to exploring structural solutions (Kitzinger, 2000). They also generate more critical comments than interviews and this is good for disempowered populations who may feel that some problems result from their inadequacies. Such an environment also allows the venting of feelings of frustration, the expression of criticism and the exploration of structural solutions. The goal of the focus group is to provide a safe forum for sharing and expressing of legitimate concerns.

In using focus groups Morgan (1997) offers some points of critiquing the procedure which were useful in ensuring rigour of the method. The first point was the consideration that there are of two levels of analysis where one has to ask the question; on what unit of analysis does the researcher focus on, the individual or the group? In this case the unit of analysis was the group as the individual nature of the experience had already been explored through individual interviews. When analysing talk at group level Morgan further warns that the researcher should consider the degree to which participants have censored or conformed their opinions to group dynamics. In this case

according to Kitzinger (1995) it must be considered that in a well conducted focus group people share anecdotes, comment and ask questions about each other's experiences and points of view and this helps to examine how and why people think the way they do. The third consideration to be made is whether the themes that come out are significant to an individual or all group members. The other thing to note was whether the focus group meeting reveals only anticipated or unanticipated data.

The thematic analysis method

The method used to analyse this qualitative research data is called thematic analysis and is loosely articulated by many scholars (Auerbach & Silverstein, 2003; Burnard, 1991; Ezzy, 2002; Luborsky, 1994) each of them taking a slightly different path but the approach and intent remains the same. However, the firm roots of this method are in grounded theory (Gaser & Strauss, 1967) and hence the similarities of terms used like coding, categories and themes. According to Luborsky (1994) thematic analysis traditionally involves reading through notes and transcripts to identify recurrent statements and behaviours that are then labelled, described and summarised to portray the person's most frequent, most important experiences actions and feelings. Thematic analysis is highly inductive as the themes 'emerge' from the data and are not imposed upon it by the researcher. In this inductive analysis (Patton, 1990) the patterns, themes, and categories of analysis "emerge out of the data rather than being imposed on them prior to data collection and analysis" (p. 390). In this type of analysis, the data collection and analysis take place simultaneously. Even background reading can form part of the analysis process, especially if it can help to explain an emerging theme.

A critique of the word 'emerging'

Although scholars like Patton (1990) tend to use the word emerge in this type of qualitative research, the analyst creates the interpretations, meaning that themes do not emerge. It could be suggested that using the word emerge implies that themes are sitting there, fully formed and waiting to be uncovered. Within this research the analyst researcher develops the themes working from his theoretical position.

Having clarified the use of the word emerging it is important to explain a closely comparative analysis, which is a procedure closely connected to thematic analysis. Using the method of thematic analysis, data from different people is compared and contrasted and the process continues until the researcher is satisfied that no new issues are arising. The commonality of themes can also be detected by what is called the

"dross." The dross is all that is not related to the topic of discussion and should be left out (Field & Morse, 1985).

Carefully considered judgments are made about what is really significant and meaningful in the data by using in vivo codes as much as possible. Comparative and thematic analyses are often used in the same project, with the researcher moving backwards and forwards between transcripts, memos, notes and the research literature.

The enthusiasm of thematic analysis in participatory studies is founded in its "direct representation of individuals' own point of view and descriptions of experiences, beliefs, and perceptions"(Luborsky, 1994, p. 190) and this is consistent with the qualitative paradigm which "aims to discover the lived experiences and meanings or the insider's view of the lived world"(p. 190) . This is justifiable in this emancipatory research where themes tended to give more weight to the voices of the marginalised and oppressed. Table 3.1 illustrates an example of how participants voices are represented from text to codes, themes and categories.

Table 3.2: Representation of participants' voices in thematic analysis

Transcript text	Code	themes	Category
I can…. deal with any kind of .. people in regard to their ethnic group. *a doctor like me who can speak English and speak French, Arabic, etc*	*Deal with any kind of people*	*Language and cross-cultural strengths*	**The lost potential**
so I feel for the New Zealand Medical Council, I mean I pity the DHBs, they can't recognize the people properly, they can't assess the doctors properly but well Australia does it so good on Australia. New Zealand is planting and Aussie is eating the fruits.	*NZ does not assess and recognise but Aussie does* *-Aussie eats the fruit*	*The lost potential*	

Unlike other methods such as grounded theory, thematic analysis does not have particular advocates. However, the different scholars who advocated for this method do offer some tools of ensuring trust of the result of thematic analysis as will be discussed in the rigour section.

Procedures for thematic analysis

In terms of procedures, familiarising with the data by listening to the tapes to

capture tones and emphasis in voice was the first step. This was then followed by reading and re-reading transcripts identifying persistent words, phrases and concepts. This was done within one transcript and across transcripts. The next step was to make cross comparison of themes from different transcripts to identify related codes and build them into themes. Themes were then grouped into categories. Where necessary, categories were subdivided into sub-categories. The final step was at write up level where themes were organized into abstract theoretical constructs that meet the research objectives. Below is a chain representation of the process. The process is not necessarily linear as represented in figure 3.1. It involves going back and forth as seen in table 3.2.

Transcript↔Code↔Theme↔ Subcategory↔ Category↔overarching theme

Figure 3.1: Representation of 'theming' process

Table 3.3: Thematic analysis steps

Stage	Description
1. *Read and read the data*	*Familiarise with the data*
2. *Identify persistent words, phrases, and concepts (coding)*	*Initially code the data openly by scrutinising the interview transcripts line by line word by word and look for in-vivo codes, identifying persistent words, phrases, concepts (Ezzy, 2002) in short identify concepts that are in data*
3. *Make a cross comparison of codes identified between transcripts and combine related patterns into themes*	*The next step to a thematic analysis is to combine and catalogue related patterns into themes.*
4. *Amalgamate themes into major themes (categories)*	*This is done when the researcher is convinced that nothing more can be found in the data.*
5. *Organize themes into theoretical construct*	*Here you organize themes into larger and more abstract ideas called theoretical constructs (Auerbach & Silverstein, 2003).*

Adapted from (Auerbach & Silverstein, 2003; Ezzy, 2002)

Categorizing themes

According to Bruner, Goodnow, and Austin (1972, p. 16), "To categorize is to render discriminably different things equivalent, to group the objects and events and people around us into classes, and to respond to them in terms of their class membership rather than their uniqueness" (p. 16). Bruner, Goodnow, and Austin further state that the act of categorizing enables us to reduce the complexity of our environment, give direction for activity, identify the objects of the world, reduce the need for constant learning, and allow for ordering and relating classes of events.

The categories created became the basis for the organization and conceptualization of the themed data (Dey, 1993). According to Lincoln and Guba (1985), the essential task of categorizing is to bring together into temporary categories those data bits that apparently relate to the same content. In other words the meaning of a category is "bound up on the one hand with the bits of data to which it is assigned, and on the other hand with the ideas it expresses" (Dey, 1993, p. 102). According to Dey a natural creation of categories occurs with "the process of finding a focus for the analysis and reading and annotating the data" (p. 99). At the perceptual level, categorizing consists of the process of identification, " a 'fit' between the properties of a stimulus input and the specifications of a category" (Bruner et al., 1972, p. 176). These categories, while related to an appropriate analytic context, must also be rooted in relevant empirical material.

Some categories also needed further sub-dividing. These subcategories were put within specific categories. This process of refining categories by subdividing them helped to inform the overarching theme.

As stated and according to Dey (1993) the basis of category generation are numerous varying from "inferences from the data, initial or emergent research questions, substantive, policy and theoretical issues, and imagination, intuition and previous knowledge" (p.100). However, in this research the identification of themes gave the researcher the first feel of how the categories manifested. All the mentioned bases of decision making on category generation were used as guidance. This act of relying on the data as the first basis of decision making is supported by Dey (1993, p. 100) who says that

> *.....the researcher should become thoroughly familiar with the data, be sensitive to the context of the data, be prepared to extend, change and discard categories, consider connections and avoid needless overlaps, record the criteria on which category decisions are to be taken, and consider alternative ways of categorizing and interpreting data*

After categorisation the researcher looked for themes emerging from the categories containing the data. The overarching theme was a product of reading, re-reading, coding, recoding, 'theming', categorisation and sub categorisation, all of which gave a sense of what was emerging from in this study.

Rigour

The trustworthiness criteria of principles of credibility, conformability, transferability and dependability suggested by Lincoln and Guba (1985) is widely used

in qualitative research and has been used in this research. Reason (1988, 2001) and Park's (1993) criteria for judging participatory research will also be used. The question of validity in participatory research should be viewed in the epistemological framework of critical and interactive knowledge and not in the epistemological framework of instrumental knowledge which postulates the need for objectivity (Park, 1993). In interactive knowledge validity is achieved by demonstrating evidence of empathy and connectedness of communal relations achieved. Critical knowledge caters for validity in as far as critical awareness of obstacles to emancipation is achieved by generating vehicles for transformation (Park, 1993). Authentic participation of the participants and evidence of genuine sharing of perceptions and outcomes of the research are some of the basis for judging trustworthiness of participatory research. The discussion of how Lincoln and Guba's (1985) criteria for judging trustworthiness in qualitative research was met follows below.

  Credibility. The criteria of credibility which requires that findings should be congruent with the experiences of participants is consistent with the way thematic analysis was conducted in this study. For example scholars like Ezzy (2002) contend that thematic analysis should allow for context and contextuality to emerge from the data and should reflect the experiences of the participants. Again thematic analysis is an inductive process because the categories or codes into which themes fit are not decided prior to coding data, instead they are induced from the data and this takes the researcher into issues or problems he/she has not anticipated (Ezzy, 2002). This study's interpretations were supported by data from participants and Auerbach and Silverstein (2003) state that if that is the case the interpretation is valid. In addition to this the participants' voices and their own subjective understanding, must be reported accurately and this was done by presenting findings as they were and reserving judgements to the findings chapters. The themes were also reviewed by participants and two colleagues reviewed the coded material which was in the form of direct quotes although full transcripts were not given to avoid compromising confidentiality.

  In relation to credibility it is said that in qualitative research thematic analysis provides us with a useful interpretative strategy for understanding interview material, not least because it encourages us to make cross-comparisons between different parts of interviews and between different interview participants (Wiles, Rosenberg, & Kearns, 2005). To this assertion another scholar (Burnard, 1991) argues that to what degree is it reasonable and accurate to compare the utterances of one person with another and are common themes in interviews really common. However in this study the earlier part of

the critique can be responded to by the fact that invivo codes were used for each interview. As for the issue of commonalities between themes a focus group was used as a follow-up to establish the commonality of themes. According to Aronson (1994) when patterns are seen it is best to obtain feedback from the informants about them. This can be done as the interview is taking place or by asking the informants to give feedback from the transcribed conversations. In the former, the interviewer uses the informants' feedback to establish the next questions in the interview. In the latter, the interviewer transcribes the interview or the session, and asks the informants to provide feedback that is then incorporated in the theme analysis. The main idea is to seek consensus from the participants before compiling the final list of themes.

The method adopted also included focus groups and therefore authentic collaboration is another way of ensuring the quality of a collaborative participatory research. In a focus group this is where dominance of one or two members is not allowed to happen. One thing done in focus group meetings was to avoid hierarchy and dominance by some members of the group. An effort was made to avoid a situation where some voices were left out. In this study this is why a further ethics application was made to increase the number of participants.

The other issue of consideration under credibility is triangulation of theory where after presenting the findings, literature was read on what similar studies elsewhere was found in relationship to the findings of this study.

Transferability. Transferability refers to the question of whether the study findings apply to participants in other settings. This has been confirmed by encouragement and support that other international organisations with similar problems of groups of immigrants who are medical practitioners. Representativeness of numbers is not an issue as the aim of a qualitative inquiry is to find deeper meanings rather than quantified facts.

Dependability. Dependability will be ensured by a clear description of the research methodology with a justification of the methods used. For example the reason for using thematic analysis in a participatory research was explained. Data analysis must be rigorous for example clear and transparent processes of methods, as methods can unavoidably influence the objects of inquiry. This includes clearly set objectives research design, data collection and analysis as has been done in this study.

Conformability- Can the study be replicated? Ideas about the ways the study could be replicated will be discussed in the final chapter where recommendations for potential research will be provided. Issues of reflexivity are considered under

conformability. It has been noted (Park, 1993) that in critical research where we claim to be examining our experience we might fool ourselves about our experiences, concerns and interests. However in participatory research this happens in the background of what is called critical subjectivity (Reason, 2003). This means that while we accept that we have the potential to fool ourselves in our way of doing research we develop the attention to looking at our way of doing things, intuitions and imaginings. By so doing Reason (2003, p. 225) states that we "improve the quality of our claims to fourfold knowing" by being critical and aware of our biases. Also in participatory research a devil's advocate is needed to challenge consensus collusion and this was my other role in the focus group.

Ethical issues

Ethical approval was sought from the AUT ethics committee and granted as described in Appendix A and B to audiotape the eighteen interviews and the focus group meeting.

Te Tiriti o Waitangi. "The ethics of research and the way knowledge is shared and gained incorporates the three principles of participation, protection and partnership" (AUT 2003, p8). For example the issue of registering NESB IMPs in New Zealand involves competence issues. Competence to practice is; in this study viewed in the light of cultural competence and safe practice with Maori and non-Maori Treaty partners. Although such issues are not directly explored in this research this can be an area of future research. Also in the focus group discussions, ethical, professional and legal practice discussions also accommodated cultural safety issues.

Do No Harm - In this research no harm is intended to be done to participants. For example since this research is situated in a critical paradigm, participants were allowed to voice their concerns without fear of harm. In voicing their concerns participants described instances of injustices that they have suffered and to this effect since they belong to a small community their identity was concealed to prevent situations of victimisation.

Issues of occupational deprivation and disruption also tend to trigger emotive feelings. This is why counselling at AUT University as a contingence measure was arranged (see appendix J-Counselling for research participants). Other issues of harm are culturally defined and since I might not know about some issues defined as harm in some cultures. The following contingency measures were arranged:

- Arranging the interview at a time and place conducive to the participant (see

> appendix D-information sheet).

- Allowing time at end of interview for debriefing.
- Where necessary I would make a follow up after two or so days to check the participant's wellbeing.

Voluntary Participation - Participation was through self selection where participants responded to advertisements. Participants were given an information sheet on response (See appendix D). This informed them of their right not to participate if they so decided. In cases where snowball sampling was used participants were also informed about the study purpose and their rights before participating. Participants were also made aware that they can withdraw anytime without being questioned about the reasons for withdrawal. For example one participant withdrew. The participant's information was not used in the study.

Informed Consent - Participants were fully informed about the research process both in writing and verbally. They were also given the opportunity to ask questions before and after the interview about the procedures. Participants also signed a consent form (see appendix G) before the interviews were conducted. Themes came from recorded interview notes and audio-tape recorded interview data and participants were made aware of the note taking and the tape recording process.

No Deceitful Practice - The participants were also given a chance to look at how their data has been interpreted and to know how the findings will be disseminated. In some instances where presentation was being made to various organisations participants were given a chance to view what was to be presented. Participants will also have access to my thesis through the library.

Confidentiality - Transcripts were free from anonymity. The transcriber was also required to fill in a confidentiality form as seen in appendix E. In critical research like this anonymity is very important. For example in this research the exact countries where some participants risk being identified was concealed. Generic geographical locations like North Africa, Indian sub-continent and East Europe were used instead of mentioning the exact countries (see table 3.3).

Summary of the chapter

In this chapter I have defined and given the justification of the methodology chosen and its underpinning philosophical assumptions. The method of thematic analysis has been explained. Data collection methods of interviews and focus group

have also been explained with the rationale of their use in this participatory research given. Rigour and ethical considerations in conducting this research has also been given.

In the next chapter I therefore present the findings of the research. The findings are presented in three chapters each of the chapter being dedicated to a category. Two of the chapters have subcategories with one category.

Prelude to research findings

Findings will be presented from chapter 4 to chapter 7 category by category as shown in figure 3.3. Each category has themes that describe the name of the category.
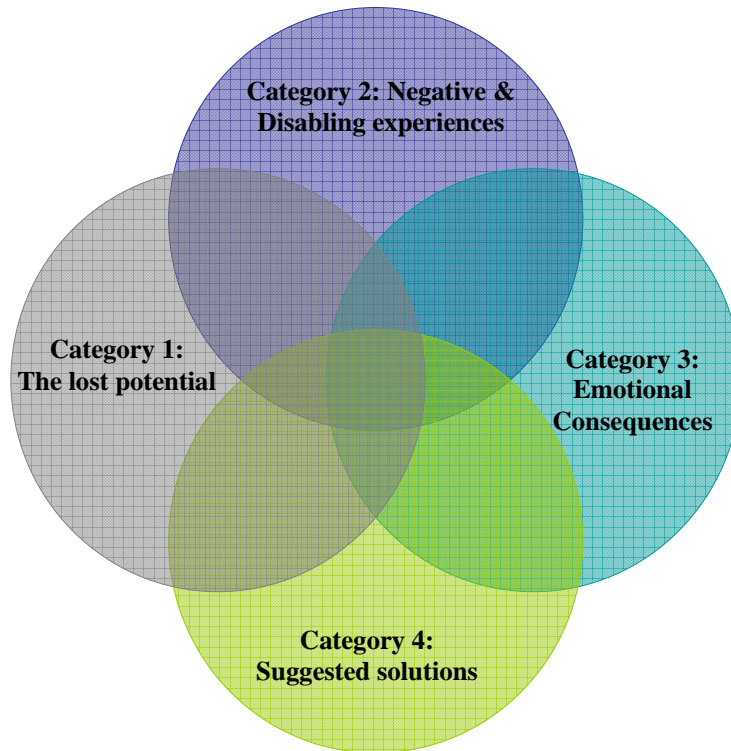
Figure 3.2: Overview of all categories

In the findings chapters the researcher made an effort to present findings as participants said them without being discussed. This was meant to preserve the participants' voices. Discussions and cross-referencing with literature review was done later in the Discussion chapter.

The use of fictitious names was avoided as one participant said that it is against his culture to be called by a fictitious name. He said that the reason was that names have a meaning and they can determine a person's destiny. This was checked with other participants of a similar culture and they told the researcher that they would also prefer numbers to names. This therefore made the researcher to resort to identification of participants using a number followed by either "M" or "F" and then either "DO" or "DE" or "PT". "M" stands for male, "F" for female, "DO" for doctor, "DE" for dentist and "PT" for physiotherapist. For example a speech with "....8-M DO" means "interview 8 male Doctor." The identification of participants as male or female is an acknowledgement that gender is cogent in the experiences of these medical practitioners

as will be seen in the Discussion chapter.

Focus group findings were presented with participants interjecting one another's speech. This was meant to retain context and a sense of flow.

CHAPTER 4:   THE LOST POTENTIAL
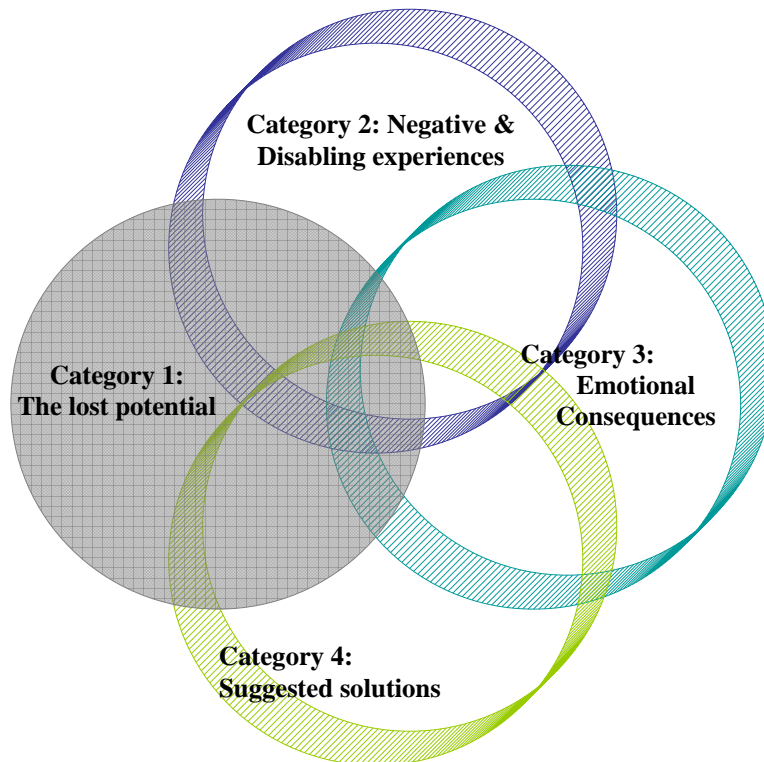
Figure 4.1: Category 1 and 3 other categories

Category 1: The lost potential

During the interviews most of the participants tended not to go up to the end of the interview without mentioning positive attributes about themselves. They also expressed how 'sorry' they were that the New Zealand government was not 'insightful' enough to use their skills. On looking at government Ministerial speeches the researcher noticed that government officials were also acknowledging the potentials of these people (e.g. King, 2000). Some doctors also indicated that a number of their colleagues *"were leaving new Zealand for Australia because they were being better utilised" 4-M DE*. One of the participants even put it this way; " New Zealand sows that plant and when the plant is ripe Australia takes it". After noticing that New Zealand was seen as losing and Australia winning, the researcher with the participants' input decided to look at specific attributes that the participants were saying are not taken into consideration when looking at them as qualified overseas doctors. After identifying the codes that led to the themes pointing to specific attributes the decision was made to form the category of "the lost potential" which is mainly about the skills and strengths of participants

which tend not to be recognised by the responsible authorities in New Zealand as seen in the tables 4.1. and 4.2.

Table 4.1: The lost potential: Subcategories

Category 1	Sub-category number	Sub-category name
	Subcategory (i)	Skills and attributes
	Subcategory (ii)	Positive and enabling factors

Subcategory (i): Skills and attributes

The subcategory was named after the utterances that were made in the focus group by the participants:

> *New Zealand can surely tap our potentials instead of pushing it and throwing it to Aussie [interjection] .....yes you are right my friends left New Zealand and they are registered in Australia [interjection] even Denmark registered a lot of refugee doctors [interjection]...see all the potential but... [Focus group]*

The nature of the potentials voiced are presented below.

Table 4.2: Subcategory (i): Summary of themes

Subcategory	Themes
Skills and attributes	scholarship and publication domain of competence
	Recognition in countries with comparative health systems
	International recognition
	Meeting international standards
	Familiarity with the English system and language
	Transcultural strengths and knowledge
	Resilience
	Diversity and immigrant patient safety competencies
	Economic resource
	New Zealand experience

Scholarship and publication domain of competence - Despite non-recognition

of their qualifications participants reported a history of excelling and scholarship in their countries of origin. This happens against the background of professional bodies and medical colleges emphasising the need for professional to demonstrate scholarship. Professional regulatory authorities like the Medical Council of New Zealand recognise scholarship as a domain of competence.

> *I was active in research at that time I published eight articles. I got eight articles and that pushed on to the top of list … so I got that and it was the training full year's duration and I passed the special exam with highest possible marks so I really felt honored and basically that qualification has enabled me to go straight to a doctorate you know [1-F DO]*

International recognition- Another observation was that despite these applicants failing to be registered here in New Zealand, other countries with comparative health systems did recognise their qualifications. For example the following participant was recognised by a Royal Physician College in Australia yet they could not get recognition in New Zealand.

> *I was recognized by the Royal Australasian College of physicians in December 1996. I'm recognized… my qualification was recognized again. [1-F DO]*

> *One of my postgraduate qualification was awarded in Austria and my other qualifications are from the US [9-M DO]*

It is of particular interest to note that Australian institutes usually have bilateral qualification recognition with New Zealand institutions. Somehow the above scenario can be linked with the issue of qualifications being recognised by the New Zealand qualification authority while the regulatory boards refuse to accept such recognition.

Meeting international standards - similar to the above issue of international standards some participants indicated that they were trained along side the New Zealand benchmarking standards such as meeting the World Health Organisation minimum standards in medical education yet their qualifications were not recognised or even considered for cross-crediting here in New Zealand.

> *and also the curriculum of the university is available for example if someone check the curriculum that we studied under that curriculum that is according to WHO (World Health Organization) curriculum accepted by them so I don't know what's different there[12-M DO]*

> *I don't think human bodies are different in New Zealand and different in Afghanistan. If you from Asia to Africa or America, everywhere human bodies are the same....so they should consider the WHO standards [11-M DO]*

For example the above candidate was required to sit the medical knowledge examinations which are given to IMPs whose qualifications are from institutions that are presumed not to meet New Zealand standards in medical education. In the above scenario it is interesting to note that although this IMP had basic medical qualification from Bangladesh his further qualifications were from US, a country with a health system comparable to New Zealand and in the US the medium of instruction is English. However, still this applicant was being asked to sit English exams. In addition the applicant who trained in US was an interpreter at a hospital here in New Zealand. All these circumstances were not enough for exemption.

Familiarity with the English system and language - As one of their strengths most participants stressed the fact that they were already familiar with the English ways of doing things. To them being in an English system was not culture shock to them. They said this in response to the popular claim that NESB medical and dental graduates have a challenge to adjust to backgrounds in ESB countries. For example the extract below from an interview with a participant from a country in East Europe;

> ..... talking about the language I started English when I was five years old...... working at university I already have communication ....with English speaking clients and ... because I was reading more books in English you know ... because I cant write the book of 2000 pages xxx quickly you know I want new information on updated treatment whatever so when the book arrives in the ward then I read English you know. .... we spoke English and we sang English music ...... in every way, fashion, health, diet, tourism cars you know, air fares.....[1-F DO]

The above extract suggests that the participant did not only learn English at school but also experienced it as part of her culture. A similar sentiment about English not only being a language of instruction was expressed by another participant from North Africa;

> ... the language of instruction at the university where I studied was in English. Its an English built university in Sudan and the language of instruction to do and to study medicine was in English, all textbooks are in English all instructions and everything and lectures are in English. ......, So to start with I studied English when I was in primary school and I understand it's the same with most of other countries and I passed English in the school certificate with a score of A,...... and trained in British system. Training is in English; hospital communication is in English and textbooks in English. And still I am working [in a hospital setting] which I have to speak in English in order to do this job, its demanding but still because we come from non-English speaking countries people talk to us as if we are deaf.... Just from seeing our appearance. [12-M DO]

This participant currently works in a hospital setting as one of the dozens of medical interpreters employed by DHBs yet the same DHBs and the Medical Council does not consider exempting them from English language tests. In the focus group meeting another participant worked in a hospital as a medical interpreter and showed the group a letter of rejection on applying for exemption from the English tests.

Other participants even stated that their language of instruction was English. This happens against the background of the regulatory authorities claiming that one of the major reasons of exempting candidates from some European countries is that they had English as a medium of instruction.

> *… a lot of our teachers in school of dentistry in Iraq were from India, Pakistan, Yugoslavia, so they were teaching in English language not in Arabic language … I already studied dentistry in English language, the Iraq dentistry is English language dentistry. We in Iraq study in English system not just English language but the same system. they look at us and say this Arab who studied in Arabic...no...[4-M DE]*

Transcultural strengths and knowledge -The IMPs also mentioned the importance of their overseas experience as a resource to the health system which can be articulated in the framework of embracing globalisation, multicultural knowledge and the ability to work under diverse medical environments

> *I can deal with any kind of … people in regard to their ethnic group... patients do not speak English only…. a doctor like me who can speak English and speak French, Arabic, etc and who has got a good knowledge of refugee culture from all over the world who have seen or being himself a refugee himself have been to very different parts of the world, I can say I can deal with this globalization. [12-M DO]*

Resilience - Further to that doctors felt that being from the third world countries is a strength which ought to be taken advantage of in the New Zealand health system. However according to the criteria for countries with comparative health systems it is interesting to note that according to the New Zealand regulatory authorities benchmarking standards being from a third world country is mainly viewed as a weakness. To the contrary participants felt that the pressure of work they were subjected to in third world countries made them resilient and therefore this is a strength.

> *…In developing countries we have to see hundreds of patients per day ….. overwork and we are always busy day and night …. we know tropical medicine because we practice it. We practice it not only in the books – textbooks of tropical medicine but we see more conditions developing and because we come from different rural areas or remote areas where people survive in different conditions. So doctors are to be encouraged to say oh*

> *you are working in a very difficult situation you must be very*
> *experienced people and you are welcome to work with us [18-M*
> *DO]*

The above words of the participant is consistent with what one researcher and medical educator said about the strengths and advantages of overseas experience in the UK ;

> *Evidence from research that I have carried out ...... and also*
> *used for evaluating programmes also shows that some refugee*
> *(and I suppose the same would apply to economic migrants)*
> *doctors have a number of skills that are required here such as*
> *working with TB, malaria, HIV/AIDS and gunshot wounds. [one*
> *doctor I know].. who had such an experience ......I was very*
> *impressed with his ability to deal with the gunshot victim very*
> *quickly and effectively. (M. Blarke, Personal communication,*
> *September 15, 2007).*

Immigrant patient safety competencies - Some participants also argued that they are an asset in the New Zealand health system as they could be the answer to the issues of immigrant patient safety. In this way one may conclude that they were acknowledging that communication or language difficulty is a safety issue. In the scenarios given it can be said that patient safety should be viewed also from an immigrant patient's perspective.

> *I found once in clinical, before the operation the doctor and*
> *anesthetist asked the patient if they had any allergies to the*
> *medication and the patient said no but after they finish they ask*
> *me if I can ask them in Mandarin. I asked them if they feel any*
> *sick if they take anything before like food and they said oh yes*
> *pain killer" But to be honest I think a lot of Chinese patients in*
> *New Zealand they need Chinese GPs because even if the GP*
> *gives them some explanation I don't think they can understand*
> *clearly. the Chinese people they trust the GP who is Chinese*
> *.....[10 -F DO]*

> *maybe I think you can arrange some Chinese people and*
> *Chinese dentists to serve some Chinese people a dentist for*
> *Chinese people because you can speak the language Chinese*
> *community maybe some people they don't want to see the local*
> *dentists maybe just because they cant speak English and*
> *sometimes they complain they can't understand the nurse they*
> *cannot communicate properly so they say they can't understand*
> *English as patients so they say they can't understand English as*
> *patients [6-F DE]*

On articulating their language and transcultural strengths participants mentioned how "it is funny" that the government spends a lot of money on clinical interpreters when most of these unregistered doctors can speak the languages of the patients. for the

participants it makes economic sense for the government to integrate immigrant medical practitioners into the health system.

> *The physiotherapists here needs a Korean person to translate. Then the government pays for the translators. Maybe the government can fund the Korean physiotherapists but the New Zealand government is blocking their way. [5-F PT]*

> *The government spends hundreds and thousands of dollars for interpreters for example but they are all doctors who speak the same language as the refugee migrants they do not allow these doctors even to work as volunteer doctors [11-M DO]*

Economic resource - Similar to the above sentiments most doctors mentioned that they are an economic resource which is not well utilized and that by utilizing them the health sector could be saving if it is "insightful."

> *We are well qualified doctors ….mostly experienced not only at their country but in other parts of the world. ….I told you I have a feeling that if DHBs want they can employ these doctors and make a bargain only if they are insightful. I say this coz training a new doctor is expensive …so I feel for the New Zealand Medical Council, I mean I pity the DHBs, they can recognize the people properly, they cant assess the doctors properly but well Australia does it so good on Australia. New Zealand is planting and Aussies are taking the fruits [9-M DO]*

> *Another barrier …for example NZ provided a budget for hundreds of overseas trained doctors for bridging courses in 2000. They… passed and I heard about a large number of them they could not find jobs anywhere in New Zealand for one or one and a half years. Finally they left New Zealand and went to Australia to get a job there and they got a job straight away in Australia so Australia utilized their skills [11-M DO]*

New Zealand experience-The findings also revealed that most IMPs had a rich New Zealand experience ranging from 2 years to 15 years. None of these doctors mentioned the fact that they were exempted from language tests or cultural knowledge competence tests because of their experiences. They thought such things should be factored in considering their slight misses in English Language tests. They said this in the context of a situation where one may be faced with missing the required minimum standard by a slight margin. This is what a dentist had to say;

> *.....and I lived in New Zealand for about four years I am a citizen So well I am actually struggling just to the English language test after my living in Zealand for four years I am able to pass English test that's a requirement [4-M DE]*

> *I don't think you have to get brain surgery or to be a rocket scientist to learn the social health system in New Zealand…. we*

*are created with physical properties or characteristics of living
things you know – adaptability. It is one of the nine physical
properties of living things, we are human beings and we are
living things we adapt to the situation, we adapt to the system
very quickly. This I don't think could be difficult for overseas
trained doctors who are in new Zealand or have been in new
Zealand for at least say the last ten years. ……. services
….available in new Zealand and other things ….can be
mastered… [12 M DO]*

The later quote indicates that the adaptive capabilities were undermined.

This subcategory was about evidence pointing to the theme of the lost potential. This could be interpreted as evidence of the possible professional and clinical assets that these IMPs are to the health system. The economic arguments about helping these doctors to register have also been presented as they were said by IMPs. In the background of all these attributes these IMPs however face a number of obstacles which are both negative and disabling in nature.

Subcategory (ii): Positive and motivating factors

This sub-category, table 4.3, on enabling experiences will present those experiences that signify motivation and goal orientedness of participants. It is also about hope and experiences that are positive about the participants being in New Zealand. In addition this sub-category will include things that are suggested as future goals and aspirations of participants.

Table 4.3: Subcategory (ii): summary of themes

Sub-category	Themes
Positive and motivating factors	**Motivation and challenge**
	Filling-in labour market shortages
	Labour force retention
	Family aspirations
	Appreciating positive things about NZ
	Health and aesthetic factors

Motivation and challenge – Participants stated that feeling challenged and learning new and different things is enabling. Experiencing new ways of doing things was also said to be enabling. This was mostly reported by IMPs from China and South Korea.

I think my English listening and speaking skill is improving This degree it improves your English because I have lot of chances to speak English with my classmates and in tutorials we make group studies, so you can speak English. If you stay at home there is no opportunity. We only speak Chinese at home because I want my kids to speak Chinese. And I think if I finish the study I think I can pass the IELs test with 7.5 [6FDE]

its ok, nursing is ok because I think it's a different experience I don't think in I work as a doctor but now I don't think so because so far I've got more knowledge than before. Before I only focus on the patient's physical health but here I can see the patient as a whole picture. I think I've got more knowledge not only easy for me to work as a nurse it also helps me to do something in life I don't think its really lower or higher than before. It's just different.[10 F DO]

The above utterances show that these IMPs tend to focus on positive things even if they experience negative things as will be seen later.

Filling-in labour market shortages -The IMPs tended to cite shortages in labour market as one the ways of justifying their hope that they will one day be a resource to the new Zealand health system:

…and I know in New Zealand there is a lack of dentists so my goal is to help fill gap...and some of the children cannot get very good dentists services so I think they should give us some opportunities [6-FDE]

It may also be cocluded that the participant has the country at heart as they are talking about labour market shortages.

Labour force retention- Apart from the goal of filling labour market shortages IMPS expressed their awareness of the fact that New Zealand could be losing skilled labour to other ESB countries and they could be one answer to the problem. This was mostly said or echoed by refugee doctors who felt that they are fed up of moving from one country to another and hence they have a motivation or reason to stay in New Zealand.

we are more likely to stay in new Zealand than any other immigrant because we are fed up of moving from one country to another...but not giving us jobs tell us to go.....jobs helps us to settle not to move away...16- M DE

Family inspirations - The need to maintain a family history of excelling in education was also one motivating factor. Some participants mentioned their need to maintain family histories of excelling as a challenge to them.

My sister was a doctor in China, a specialist in fact but when she came here and she couldn't find a job and she went to

university again she did computers and now she is a software
engineer. she designs software, she is ambitious. And my father
was a doctor. So I want to maintain that [6-F DE]

Still on family inspirations some participants cited having to study in order to be good role models to their children. In this case downward mobility in their professions would have led them to think of themselves as poor role models to their children;

Because if I didn't do anything I feel I would have failed in New
Zealand [6-F PT]

……I have a boy, my son I would like to show him my goals and
how I improved myself. I want to prepare my boy so that when
he studies he knows of a future [5-F DE]

Appreciation of positive things about New Zealand - Peace seemed to be the main consolation for IMPs with refugee backgrounds. However it is unfortunate that some authorities and members of the public used this as an excuse for saying at least they are in better situation than they were in their previous countries.

It's a good country, ….we are sleeping better than we used to
when we were political refugees…..If you express negative
feelings they will say well why can't you go back to your country
[12-M DO].

Some IMPS mentioned that they liked the political ideology of the ruling government and its tolerance for a multicultural nation

…politically I think particularly the present government are
very much open and big hearted… it is a multi-cultural country
and multi racial country, many languages and they give the
respect to everybody's feelings everywhere. [9-M DO]

Corruption free environment in the public sector was also mentioned as a positive thing about being in New Zealand. It is quite interesting that although the participants had hurdles getting registered they did not seem to generalize that to the way things are done in New Zealand. Some felt it was only the medical field.

I left my country because of corruption and bureaucracy here in
NZ there are clear processes apart from the tough medical field.
People are easy going here….In my country people tend to be
very formal in their approach to life. [2-F DO]

Health and aesthetic factors about the environment - Some immigrants tended to mention beauty of the environment and the fact that new Zealand was not overpopulated as compared to their source countries

…everybody in China wants to go overseas but many friends
and me and my past friends they went overseas and found good
jobs and were very happy we think coming here we can apply.

You see if we can get a chance of coming overseas. I just think china has a huge number of people and air pollution within the environment was not good so we came here my sister came here earlier and we think ah it's a very good place. [6 F DE]

...... this beautiful country as you know NZ is already voted as the second best known country in the world and fourth best living city was Auckland so everyone is trying to come to this country for a better living, better school, ..but our profession...[9M DO]

The participants who tended to mention issues about beauty of the environment and under population in New Zealand were those mainly from China and South Korea.

Summary of the subcategory

Enabling strategies included feeling challenged and learning new things in New Zealand, feeling challenged to fill the labour market shortages in New Zealand, being in clean environments, being in an uncorrupted and easygoing society and being challenged to be an inspiration to family members.

Summary of the chapter

This chapter has presented two sub-categories one on the skills and attributes of IMPS and the other one on the motivation of the IMPS to stay in New Zealand. In summary the themes made up the category "the lost potential"; the IMPs indicated that their qualifications tended to meet international benchmarking standards, that in terms of cultural competence they were already familiar with the English system and they have already lived in New Zealand to adapt to the societal context of health. They also mentioned that their cross-cultural strengths and the economic sense of employing them should be considered.

In abstract terms it can be said that this category was about motivating intrinsic factors that comprise the potential of NESB IMPs. However this potential is not utilized and therefore lost to other countries or lost in the sense of not being utilized.

CHAPTER 5: NEGATIVE AND DISABLING EXPERIENCES
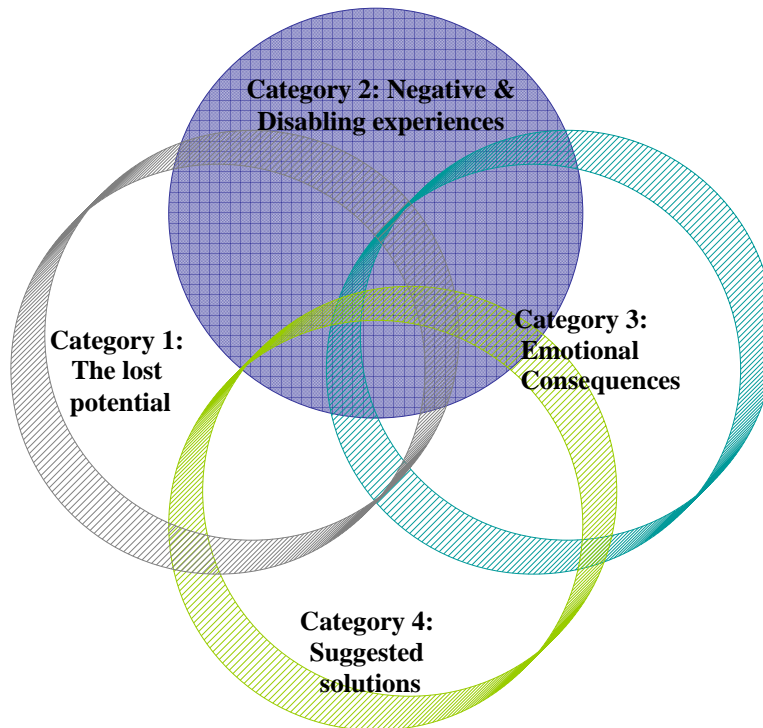
Figure 5.1: Category 2 and 3 other categories

Introduction

The findings in this chapter relate to objective one of the study which is primarily to gain understanding about (i) the experiences of immigrant medical practitioners who come to New Zealand and face the challenges of re-registration in order to continue with their occupations. The emergence of the theme on negative and disabling experiences confirms the goals of a critical investigation in participatory research which are to help the disenfranchised to identify problems about the reality of their environment. In occupational science literature it has been observed that people can experience disability if personal participation in daily life is limited or denied through broader factors than physical or cognitive ones, for example, socio-political and economic conditions (Pollard & Kronenberg, 2005).

As said earlier, themes were identified by identifying and coding recurrent words, phrases and concepts. In all the interviews most of the concepts related mainly to obstacles. See table 5.1.

Table 5.1: Summary of themes

Category	Themes
Negative and disabling experiences	**Language tests**
	Testing models inappropriate and restrictive
	Costs too high
	Multiple social commitments
	Lack of information & guidance
	Issues for refugees
	Prejudice
	Protectionism
	Western elitism
	Injustices and human rights issues
	Neglected and left to burnout

Language Tests: 'an exclusion weapon' -The use of English tests as gate keepers blocking subsequent medical and clinical knowledge tests was seen as the major obstacle by participants. A similar situation was once observed and criticised in Australia (Groutsis, 2003). Language tests seemed to be the main barrier for medical practitioners to get registered in three ways. Firstly the fact that language tests were being used as a pre-requisite or first screening tool meant that most participants spent most of their time 'gambling' instead of focusing on the medical and clinical examinations.

> *.…yes, here in New Zealand there is no opportunity because you have first pass your English before you can attempt any tests. English language tests should not be the first step like you have to pass the English language test first then you can apply for the dental exams. … but now we spend most of the time gambling with English tests instead of working on the real thing [4M DE]*

> *One problem I don't think IELTS should be made to come first. I think people should be given opportunity to do the written medical test and then do the IELTS afterwards because it gives a chance to practice maybe to succeed......its really a big problem [17-M DO]*

In other words while language tests as screening tools for medical tests involving contact with patients can be justified, there seemed to be no clear justification

for the tests to be used as prerequisites for multiple choice medical knowledge tests. This therefore made participants believe that the scenario is an example of closed shop practices of the registration authorities. In some situations concerning the doctors from ESB countries the medical council has bowed down to streamlining its screening criteria. In a speech in 2001 the New Zealand Minister of Health gave the following words.

> *The Medical Council has recently revised its registration processes for doctors who have been eligible for temporary registration (that is, those doctors who qualified in the United Kingdom, Ireland, Canada, USA and South Africa). The aim is to enable them to gain registration more easily to practise here permanently.*

In other words one may conclude that the regulatory authority has admitted the closed shop nature of its regulative mechanism.

Language tests: 'too difficult'- The other thing that the medical practitioners felt was disabling about the English Tests was that they were thought to be too difficult and irrelevant to the medical context in which they practice. The New Zealand Medical Council set the minimum IELTS score at 7.5 and does not recognize any other testing system. The Australian counterpart set the sore at 6.5 and recognizes both the IELTS tests and the OET test. Hence the participants felt that setting a very high score and recognizing only one test is very restrictive.

> *I think the English is the more difficult so that's the one that is a problem? yes more difficult, the great barrier [4-M DE]*
>
> *first of all you have to pass the English test which requires a very high level of English [11-M DO]*
>
> *They are clever they just shut the door using very high standard of English as a barrier [12- M DO]*
>
> *I need to study English because if I sat the exam now and this is a real hard exam and I wonder whether some physiotherapists from Registration Board can pass this exam. [3-F PT]*

The difficulty of the IELTS tests was evident in that even the participants from countries where English is largely spoken felt that English was a main barrier to them. Some of these participants stated that "I converse in English every day with my family because I am married to a Kiwi but these IELTS tests are really difficult". Despite all their previous English experiences they still found tests very difficult.

The main argument was that if these tests are not tools of exclusion why set them too high and not allow alternative tests which could be deemed equivalent in standards.

I had a conversation with one IELTS specialist regarding the difficulty and the relevance of the test to medical practitioners. The response I got was that it has gained popularity mainly because of its reputation for objectivity. The specialist equated "the war of disputing IELTS like that of trying to fight with well established multinational companies and emphasised that there is a lot of 'politics' to overcome in order to win the argument" (Anonymous, Personal Communication).

The above issues about the difficulty of IELTS tests and the fact that some participants used the word "unpredictable" made me to consult further with language specialists on what criteria could be used to judge the difficulty and the restrictive nature of a test. The concept of predictive validity and that of face validity were given to me as ways of standardizing tests. Face validity means that the test should look a good one considering what teachers and students think of it and it should be regarded as a reasonable way of assessing students and not trivial or too difficult. Predictive validity means that the test should accurately predict performance in some subsequent situations. Concurrent validity means that the test gives similar results to existing tests that have already been used. considering the above stated tools one may understand the conclusion by the participants that these tests are too restrictive. The quotes below expand on the evidence of unpredictability.

> *…its very unpredictable …..I am prepared for that but I am not prepared for English test. Its just a no …..and something that is not so easy I'm not prepared to spend more money on this when I don't know if I will score more or not.[4-F PT]*

> *…the IELTS stop many people I heard somebody from Philippine has been sitting for the IELS many times and he couldn't pass and all the time he was getting 7 and you have to get 7.5 …His teachers couldn't predict whether ...will pass or not [6-F DE]*

The other test that was spoken about was the OET which had some aspects deemed by participants as irrelevant to dentists. Some components of the tests were said to be testing dentists general practice knowledge. Examples given included operating on a kidney or upon a pregnant woman .

> *...actually ...OET is ...mainly for GPs the like the listening and reading subjects .We have no idea what that are saying because its really medical subject and we are dentists, we have no idea what they are talking about like last exam of OET the reading part, ...was about the operation to remove the uterus, something like that ... I didn't even understand it, I'm a dentist I've got no idea about removal of the uterus. The speaking and writing, it is*

specialized for your occupation, its good, we have no problem
with that [4-M DE]

I must mention that although the dentists identified negative things about the test they still felt it was good to have it as an alternative to IELTS. The reason given was that having two alternatives is good for people with various family and social commitments. This was because these tests are taken in different times of the year and have different regulations and even the costs of preparing or sitting them are different.

Although some participants felt that there had enough background and practice of English language some participants cited it as their main weaknesses. They felt that on their arrival they devoted most of their time having to learn English. It was interesting that most of these participants admitted that it was an essential requirement that safeguarded patient safety. However, they felt that they were so many stresses associated with learning the language.

In my country I studied in my own language…. yes not in
English I think we had classes in English but not all the time. So
this is a big problem for me here [2-F DO]

Testing models inappropriate and restrictive -The issue of inappropriateness of tests was raised mainly with regards to generic tests that are given to specialists. These specialists included ophthalmologists who did their basic medical training more than 25 years ago and for more than two decades they were working as specialists focusing on eye problems. The tests which they undergo as part of their registration here is that of basic medical training.

…I couldn't proceed anymore. ….because my knowledge is in
the eye for 30 years and to deal with the whole body is very
difficult for me ....only because my experience is based on
the eye only for 30 years not general medicine [9-M DO]

…you have to pass all the basic science exam to the clinical
parts, I mean child health, general surgery, medicine,
psychiatry, pathology, biochemistry and obstetrics and
gynecology and all fields of medicine you have to sit it
especially if you are in one specialty [12-M DO]

The participants also stated that for tests there was no room for special consideration for age and number of years that have lapsed since one has last learnt or practiced general medicine.

…and it might have been a very long time since you have tried it
and you might have forgotten the parts of another specialty [17-
M DO]

Apart from specifically referring to the tests being inappropriate and restrictive

the participants felt that the testing models were very impossible and that inherent in the tests there is an underlying attitude that "they don't want us [immigrants]" 12-M DO. This was mainly stated in the context of the whole picture of difficulties and barriers that immigrants face as doctors and dentists.

> *...those people they are imposing this on us the exam they would fail and they know it that's why I say they don't want us and that is a wall. That is barriers, which means go away, go home. [9-M DO]*

> *From the testing system I can conclude or one can understand there are some barriers that have been put in front of immigrant doctors to stop them from practicing or sort of prejudice. [12-M DO]*

Tests were also thought of as not smart. As a researcher I had a conversation with a colleague who is an educator as well as being a practicing doctor who sated that he doubts very much if he can pass those exams when asked to sit for them.

Costs too high - The participants mentioned costs related to exam sitting and general preparation. These financial costs were mentioned against the background of being in a settling in phase as a new immigrant. The costs included those of preparing and sitting all exams including the registration exams and the English language tests.

> *... it is a waste of few hundred dollars of money if you cannot practice as a doctor. So what is the point of spending the money sending the documents for registration a---- even if you pass that one which needs you to spend a lot of money on and then you have to go to the exams and also all these exams, every paper requires thousands of dollars to spend for the exam [11-M DE]*

> *....you know I'm studying... the fees are too high so I borrow money from study loans. ... and then you do not pass ...thats a waste!!".[4-M DE]*

> *I needed to do these IELTS .... and of course not spending too much money because you know coming to New Zealand or to any country I guess in the world is such a big cost and something that is not so easy [3F PT])*

Multiple social commitments - Some statements that were mentioned by the participants did not necessarily imply high costs. They actually implied multiple social responsibilities and resulted in them having both financial and time constraints. Multiple social commitments included having to work to earn a living , and to devote time for work and study.

> *...I have to work to pay my bills and I have to work hard many hours to do that and I am left with only a couple of hours to do*

my studies, that makes things very difficult and that my studies wont be easy. you have to read sensibly in order to pass the medical licensing exam and you cant do it half heartedly [12-M DO]

Its very hard because I'm a full time mother and I have to do some work. I think doing this way is very hard because you have to go back to the basic knowledge. [5-F PT]

It takes time and money. Now I cant study and support my family at the same time. I am faced with two realities ; the family and the school. I would like to practice again but I don't know how to say it and I am not afraid to start studying again like I am doing but it has effect on my program too its difficult to support your social life? [2-F DO]

On looking at the above theme one may conclude that the government, registration authorities and all those responsible for settlement issues have a tendency to view these immigrants as separate entities whose occupational does not relate to their social and financial dimension.

Lack of information and guidance - The information for new immigrants was either non-existent, discouraging, confusing or misleading.

I would like to get information about what I actually need for my registration whether my education is sort of low, whether they could tell me this and that apart from the English, I know the English part but with like say my education ....[3-F PT]

The following participant was misinformed as an international student and discovered all the realities on arrival here in New Zealand.

I came here with the aim of working as a doctor. : I was not aware of the fact that you still have to do the exam one and two and NZ registration before getting recognized here and I didn't realize that my degree is not even going to be recognized in New Zealand. [13-F DO]

Apart from lack of timely services participants stated that some of the delays were caused by the fact that they took time trying to find out where to go for information about the requirements for registration

I didn't have enough information ...oh lack of information they didn't know at which level I should really go and I didn't know either so that's what I found myself there so they didn't know, I didn't have any information, I just came desperately suddenly [1-F DO]

this way you know overseas doctors just ... come to a strange city and no one knows who is where with no organization to help new professionals...strange city...strange country...no information [8-M DO]

Lack of structures to assist immigrants to retrain was seen as another disabling experience. This was coupled with lack of structured sessions to prepare them for exams. Some participants felt that they even devoted most of their time reading things that were not even going to be examined.

> *…so the standards are too high? ….. but there is no such courses to help us to pass this test actually. There is no OET course And I'm sure it will be more beneficial because you have lectures, you have textbooks and you are attending classes. [4-M DE]*

> *…yes, we need courses; we need courses, not to gamble…..if I want to gamble I can go to the Sky city Tower [4-M DE]*

Issues for refugees - Refugee IMPs mentioned some issues that seemed to be pertinent specifically to them as refugees.

> *.. it is very expensive especially for refugee doctors who have lost all their property in war who came here unprepared, with nothing, with empty pockets. unfortunately I came as a political refugee its involuntary you know ….but lack of employment in profession has left me economically insecure so couldn't live and support family life. [12-M DO]*

> *…the registration in New Zealand for refugee doctors is terrible; it doesn't accommodate the refugee doctors.[11-M DO]*

Prejudice- The issue of prejudicial attitudes also came across from many interviews raising issues about prejudice and these attitudes seemed also to be embedded in the society and many of its formal institutions.

> *….they raise their voice loudly, when we approach them…they say what, what actually? They are not expecting me to talk in English and this is very traumatic and still when I tell them that I can speak English but inside them they can't believe it and they keep on talking to me by signs as if it's a sign language waving their arms and talking loudly and slowly. ……they think that probably English is a heavenly language and difficult language. [12-M DO]*

The discouraging information that the participants got from the stakeholder institutions and members of the society portrayed negative attitudes towards immigrant health practitioners. The following extracts are from participants who were referring to attitudes portrayed by members in social institutions and the society.

> *I contacted physiotherapist association … they said I need test*

*and three interviews and then they say they are too many Asian
people asking about registration. ... but nobody can pass. ....
too many Asians people are applying and they cannot pass...they
discouraged .... you get scared of the interview [5- F PT]*

Western elitism-There was evidence from the participants that the assumptions
and tendencies to elitism among western countries were also reflected in the criteria
used to determine countries with an equivalent health status. New Zealand currently
exempts doctors who come from countries with a health status deemed to be
comparable to that of New Zealand. One of the determinants that exclude most
countries from third world countries is child mortality rate and life expectancy and to
this the following was a view from one doctor:

*.... low life expectancy in third world countries and high infant
mortality in third world countries..... doesn't mean that it is the
failure of doctors or the fault of the system. People are dying
because of war; infancy mortality is high because of
malnutrition because of tropical diseases, which they don't have
in developed countries because this is tropical and tropical
diseases as well as poverty, dictatorial governments. It is a
problem and we don't want to talk about colonialism or
neocolonialism or the problems, which the third world countries
suffer. [12-M DO]*

Citing western elitism participants felt that assumptions and lack of knowledge
about source countries was an obstacle in their registration processes. Assumptions
were said to result in undervaluing capabilities of participants. To this the participants
responded by giving evidence that they are not as backward as what people in Western
countries think. I as a researcher had a conversation with a colleague who had heard
about my research and the colleague thought that the immigrants who accepted
downward mobility and sought non-professional jobs were being insightful as she
"could not imagine a third world doctor being overwhelmed by the abundance of
technology,....stethoscopes, computers etc" (Anonymous, Personal communication,
June 13, 2007).

*...the excuse is now something which is a useless excuse
somebody who comes from the third world country he doesn't
know how to deal with the roots of the system of new Zealand ..It
doesn't mean because we are not born here we are going to be
completely different. [16-M DE]*

*....the instruments which are being used in well developed
countries could be a little bit different from developing countries
but still instruments are posted from England and still we use*

very similar instruments with the same name. They call them MRI and we call them MRI, they call them CT scan and we call them CT Scan … so equipment is the same…[12-M DO]

Protectionism - Protectionism was mentioned as one obstacle. The following are statements said by participants in relationship to protectionism.

…in the name of safety they really act heavy handedly on us. They say they can consider us but if a patient dies politicians have to take the blame because they listen to our problems [9M DO]

…the total attitude of Medical Council of New Zealand is somehow not accepting overseas trained doctors because of mistrust …, I don't know what's going on here.[11M DO]

…as I told you …and as my colleagues told you these people want to prevent what they call foreigners from violent or untrusted communist minds…who want to come and kill patients…

Indeed as seen in the literature review (Totton, 1999) the very concept of self-regulation has some elements of protectionism and assumptions and suspicions about new people joining the profession. It is unfortunate that this kind of protectionism, in this case, is being directed to vulnerable population groups such as immigrants and refugee doctors.

Some participants spoke of suspicions of Western countries about political ideologies in Non-English speaking countries.

..I think the people don't know a lot about…. they always think about communist country or socialist country but we are I tell we are utopic. We never belong to the Eastern block we are independent but western oriented you know more oriented to the west in every line but what we had as a socialist country we had a rewarding health system everyone …. respected and had equal rights ….[1-F DO]

The participants thought that such suspicions made them to fall victim of ideological conflicts between communist and western countries. They thought that the suspicions were that the communist ideals were going to be inherent in their practice.

Injustices and human right issues - The medical practitioners also raised issues about some injustices that they encountered in their attempts to get registered. Some of the encounters were labelled as 'unlawful' and 'unethical' denial of basic

survival needs and human rights as well as lack of consideration for special circumstances in the form of exemptions. At this juncture it is worthwhile to mention that another interviewee felt strongly about the issue of injustices to the extent that s/he asked me to have a look at the file that they have opened with correspondence to human rights organization, the commerce commission and consumer services. Another group (name withheld) of IMPs also showed the researcher a letter with their correspondence to human rights organizations.

> *Their acts are extremely bad, unlawful, and unethical and I believe that WHO and human rights commission would definitely not agree with them e.g. ….a five-minute interview cost me $1000. [9-M DO]*

> *I came here as an international student …I paid my money throughout…. only to find myself worse off than I came here… I did not rely on the government for money. I was given the wrong information and only discovered after graduating that I did what was not exactly what I intended to do [13-F DO]*

Participants also felt it was unjust for them to be subject to lack of consideration for their prior knowledge which made them to be subject to repetitive processes.

> *…if you started again and do another four years in addition to the four years that you did in your country I think its waste of time because I believe the practice area and the study area is something different. I think another four years is waste of time but if they credit my qualification and say I study for two years, I think that one is a good point because I need re-education theory is something that changes and I think two years is good for me and I am not quite sure I can pass all the papers. [5-F PT]*

The other thing that the participants felt were unjust was the negative reporting from the media. This was also expressed in the focus group and participants felt that something must be done.

> *The media is very unjust....terrible reporting about overseas trained doctors...[interjecting].... yeah you remember that headline that said curse or cure and showed the passport of a Chinese doctor!!!.....[interjection] where was that ...when...[interjecting] ....in the Sunday times this year....terrible reporting...[interjecting] ...Yes insulting language and spreading a very negative reputation.... the media is influencing the population....very negative ideas are now shared by the population. We are viewed as killers....I do not know where they take killing, killing from...[Focus group].*

This linked with the experience that I had when I attended a meeting with some immigrant NESB IMPs. They strongly felt that the media community should be taken to

the human rights commission.

The other issue that participants felt was unethical was the fact that the systems were designed in such a disempowering nature such that the result left them unemployed and denying them basic survival and human rights

> *a refugee who comes from very difficult, traumatic or stressful background he comes to a country you are supposed to make them see the light, to have hope to develop, to be encouraged..., to be used as an investment ... not to be pushed or tossed here and there ... pressed down and acquire a low self esteem and become mentally and physically affected..... producing a lot of mentally or physically sick individuals ...[12- M DO]*

> *I have seen refugees here in New Zealand studying and accumulating debts for nothing at the end.....no registration... [16- M DO]*

Some injustices pertained to issues that linked to differential treatment of immigrants from different countries with 'alliances.' The following extracts reveal issues of differential treatment of immigrants from different countries with 'alliances, unlawful and unethical conduct.

> *It's hard to explain. I don't like talking about this what I didn't quite like was the fact that some dentists from other countries alliances of English countries they can get straight to new Zealand registration....*

> *you see until very late South African Doctors were privileged ....may be because it is a nation with many whites and they are afraid that if they place make the registration requirements ......{interjection by another member) yes u right whites will be excluded....[Focus group]*

The above assertion was consistent with the comment that was made by a reporter in New Zealand who said standards could be of concern in the post-apartheid South Africa (Chisholm, 2007).

Neglected and left to 'burnout'. Long breaks because of not practicing seemed to be one of the major problems participants faced. The participants felt that the longer they spent not practicing the harder it was to return back to practice because of the '**burnt out'** or forgetting risk. The other reason was about the regulations that specify that professionals should not be out of practice for a certain period of time

> *This process takes a long time and the long breaks of not practicing technically makes it impossible to re-register. For example regulations say no more than seven years break [1-F DO]*

Its hard when you study and stop and work and then you go back to study again. And studying all the seven years at one go is going to be difficult I have forgotten so much ---I mean burnt out ... this time lapse has made me forget so much I'm almost like starting all over again with my studies so in fact I will be so happy if you connected me with other doctors who are doing this so that we can do a study group of our own. [13-F DO]

Summary of the chapter

The above chapter has presented the negative and disabling experiences. The category of themes was conceptualised as the interplay between ecological factors and individual capacities. In other words this is about interaction between individuals' occupations and their environmental condition of occupational apartheid. While other models which are deficit-oriented look at individuals characteristics as being deficient in the environment the manifestation of this theme shows that the environmental factors can constrain the individuals' natural capacities to adapt to the environment (Abelanda, Kielhofner, Suarez-Balcazar, & Kielhofner, 2005). This chapter has also shown how participants comprehended the social obstacles that stand on their way as they try to achieve social justice.

Out of these experiences were some feelings which were captured and grouped as a separate category. This category is presented in the next chapter.

CHAPTER 6:   EMOTIONAL CONSEQUENCES
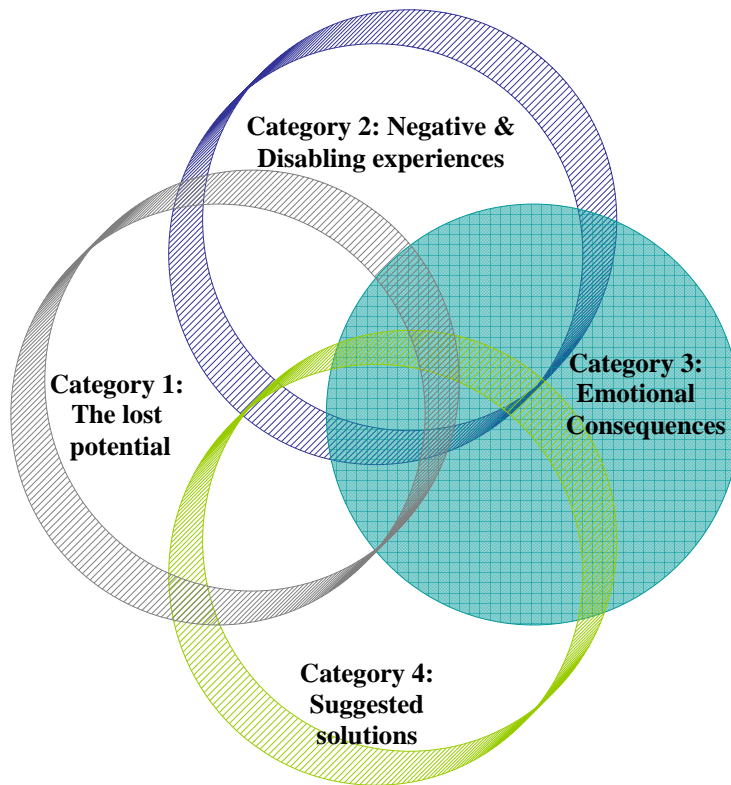
Figure 6.1: Category 3 and 3 other categories

Category 3: Emotional Consequences

Chapter 5 was about findings related to the first objective of the study which was to gain understanding about (i) the experiences of NESB IMPs who come to New Zealand and face the challenges of re-registration in order to continue with their occupations. This chapter is therefore about findings about objective two of the study which is about (ii) how NESB IMPs manage and cope with the experiences. Such experiences are mainly about the consequences of the negative experiences as described in the previous chapter. Conceptually this chapter shows us what happens when individuals and communities are denied access to occupations that appeal to their psychological dimensions of satisfaction, actualisation and dignity (Abelanda et al., 2005) in conditions of social injustice. It has two subcategories. The first sub-category is that of feelings and emotions about the lived experience and the second one is about coping and survival strategies in a marginalized world.

Sub-Category (i): Feelings and emotions

In a research with an emancipatory intent like this one it is vital to honour the

emergence of participants' feelings about phenomena. Issues about participants' negative experiences tended to invoke certain feelings that differed according to the experience encountered. Some participants tended to verbalise their feelings in the course of articulating their negative experiences. It must be noted that some participants exhibited those feelings without verbalising them and where appropriate the interviewer prompted them to verbalise for the sake of capturing in vivo codes in the transcript and for the sake of not misinterpreting what was exhibited. Some participants exhibited their feelings even in conversations with the researcher before the interviews. In such conversations before the interview they tended to express their feelings of being 'very bitter' about their experiences.

The negative experiences faced by the participants as presented in the previous chapter resulted in feelings shown in table 6.1.

Table 6.1: Sub-Category (i): Summary of themes

Sub-category	Themes
Feelings and emotions	**Lost and isolated**
	Disappointed
	Frustrated
	Hopelessness
	Insecure
	traumatised and grieving
	Deprived
	Depressed
	Undervalued/ ridiculed
	Discouraged
	Upset
	Sad feelings
	Agitated

Lost and isolated-The feeling of isolation and not belonging was expressed with reference to failure of commitment by various key stakeholder organizations to provide support and information.

> *I feel as if I don't belong … you don't know who to ask and who is going to support you. You find it very difficult [12-M DO].*

> *we have been lost for so many years and in Canada you cannot be lost …in Australia you cannot be lost…UK you cannot be lost but here we don't belong…Canada makes you feel at*

home...accepted [17-M DO].

It is interesting to note that participants keep on benchmarking New Zealand with other ESB countries especially those with high immigrants of medical practitioners. This is the reason that necessitated the need to look at models of good practice in the discussion chapter and the literature review chapter.

Disappointed- Feelings of disappointment were also expressed. This was with regard to the fact that when some participants came to New Zealand they trusted that the immigration information was given to them in utmost good faith but it turn out to be otherwise when they arrived in New Zealand.

> *I came here with the aim of working as a doctor but I got disappointed when noticed that I was made to do a course that is not even relevant in here in New Zealand. [13-F DO]*

> *its always one step back I feel disappointed....[14-M DO]*

Frustrated - Frustration as a result of being underemployed came out as the most emphasized prevalent feeling in the tones of participants. It is worth noting that in the illustrative quotes below some participants mentioned the word "frustration" a number of times in one speech. The researcher felt that the expression of this feeling endorsed the critical lens used in this research.

> *I mean I am working as a casual physiotherapist assistant but this is definitely not my future coz I'm not working with people who are actually younger physios and education wise I am the oldest physio it is quite frustrating. I am prepared to do this for a year but its really more frustrating if I have to describe it and its funny [3-F PT]*

> *...the fact that you are a doctor but working under [some people].... its frustrating, its actually very frustrating because its almost like you cant make some decisions before you go through someone so that can be quite frustrating...... you had to get people to accept you and not take you as a doctor or as a specialist and they will be asking themselves what new things are you going to tell them [13-F DO].*

Hopelessness - Hopelessness was another feeling expressed by IMPs. In this case one doctor gave an extensive justification for his feeling of being hopeless.

> *I felt hopeless because when I came to New Zealand I met a lot of refugee doctors and I was in an overseas trained doctors association..... for a while and then I go regularly for meetings and then that organization did not grow and it finally collapsed because all the doctors were frustrated, they could not get anywhere here so then I also stopped going to those meetings and I did not send my documents for registration as well*

*because it is a waste of few hundred dollars of money if you
cannot practice as a doctor. So what is the point of spending the
money sending the documents for registration and yes when I
see the doctors who came here before me 10 years or 15 years
and they are all not working in the medical field so I also was
hopeless and I did not want to register [11-M DO]*

Insecure - It was interesting to note that people who are sometimes described as settled refugees described how insecure they were because of not having access to employment:

*…lack of employment in profession has left me economically
insecure so couldn't live and support family life [12-M DO].*

Grieving/ traumatised - Some participants compared the feeling of losing their profession as that of 'grieving' and hence being 'traumatic' as it is not imaginable. The statements below implies that to this person the profession is not only a means of leaving but part of their identity

*I mean I just said goodbye to the profession…and I couldn't
imagine my life without [being a specialist surgeon] you know
so just not being able to go through the process was basically
my time of grieving and saying goodbye to the profession. the
process is quite traumatic…[1-F DO].*

*My community members know me as [Dr "A"] but the
New Zealand society has given me a non-professional title I feel
deprived of my identity and depressed [focus group]*

*you know our children are learning very negative things from
our less identity [interjection] sure they can only want taxi
driving like their father…[interjection] …yeh my children know
I was doctor but kiwi stop me…so they think no Arab can be
doctor. [Focus group conversation]*

Undervalued/ ridiculed - Some participants felt ridiculed and undervalued as they were under-employed in non-professional jobs.

*….having a physiotherapist working as an assistant…..Its funny
…ridiculous………. that's what I have experienced you are just
not the same as you used to be , you are valued minor as an
assistant. …I cant say why I should be an assistant I mean clean
after the physios and put their therapy stuff away, I mean its
really, really ridiculous.[3-F PT]*

Depressed-Feelings of being depressed were also expressed by participants

*…maybe some support maybe from the government both
physical and spiritual. We end up; learning with young people
who hardly mix with us coz of skin colour I feel isolated and
depressed [16-M DE]*

Discouraged- Some feelings came as a result of the negative information about their unlikelihood of success and the hurdles they are likely to go through. This information came from peers, members of the public as well as registration authorities and was seen as discouraging.

> *I mean…when they said too many Asians people are applying and they cannot pass I felt discouraged and you get scared of the interview and writing test and I felt very discouraged*

> *…if I want to use my certificates, its not easy here. Nobody can pass here. Every time I talk to people they say nobody can pass the test. [17-M DO]*

> *you know people tell you so many negative things in this society.….[interjection] and they are not wrong they have seen that overseas qualifications aren't accepted by Kiwi…[Focus group]*

Upset -The other feeling that was expressed was that of being upset. Some participants tended to express that feeling when they had encounters of discrimination or injustices.

> *Actually the second week I came here I had a few places I applied for a dental assistant job but I failed, I failed that I was quite familiar with dental assistant work its very simple but here I got no offer even to be an assistant ….no no offer Felt upset, frustrated [6F DE]*

Sad feelings- The registration process subjects participants to a feeling of being "not happy". These experiences include having to go back to school and learn with people who are not their age. This complicates interaction and communication patterns as can be seen in the comments below.

> *….here like in my class two thirds of them are kiwi girls, they are very young but we are from other countries and we can't speak English fluently and we couldn't communicate with each other [5-F PT]*

> *Its horrible and its hard feeling to be pushed away "don't do this work which you are good at, go and do something else" you will be sad [12- M DO]*

> *In my class there are two parts. First part is kiwi girls and they are very young, and the other part is different countries, different colour of face . sometimes makes me **feel not happy.** Sometimes you come across some other people they don't greet you but teachers here are very nice. They care about you [14- M DO].*

The participant presents two contrasting scenarios which include being faced with an unwelcoming environment and being faced with a welcoming environment where "teachers here are very nice". It can be seen that while there are a few instances of positives still there a lot of negative experiences that they go through.

Agitated-The feeling of being agitated was only interpreted from the IMPs non-verbal communications as they verbalized what their experiences and therefore it is hard to present an invivo here. I therefore present the diary field memos.

> *…..I thought she seemed agitated…why? Because when she mentioned something about being judged by skin color she leaned forward and threw up her hands…[diary notes]*

> *…his skin color turned purple and he was sweating and throwing hands saying this is simple politics and I asked if we could end the conversation as I am not interviewing him but just accepting his letter of consent to be interviewed submitted in person…[diary notes]*

> *I had even to wait for him to cool down and asked if we could discontinue …[diary notes]*

Summary of sub-category (i)

This concludes the presentation about the feelings and emotions. Where uncomfortable feelings and emotions arise one would expect that the affected have some strategies of coping. This does not suggest that these strategies are therefore the solutions to their problems. It only honours the human nature of pursing survival as humans are active beings. Therefore the next category is about solutions

Sub-category(ii): Coping and survival strategies

Participatory research with a critical lens assumes that participants are active beings with potentials which make them self sustaining and therefore having a propensity to survive. In this chapter this kind of thinking was honored by giving the participants a chance to articulate their survival strategies. A presentation that ends with difficulties and feelings of despair does not leave room for optimism. The strategies of survival presented in table 6.2 pertain to those related to dealing with barriers and negative experiences as well as negative feelings.

Table 6.2: Subcategory (ii): Summary of themes

Sub-category	Themes
Survival strategies	**Contentment**
	Forgetting
	"Going back home"
	Emigrating
	"doing this degree"…& "training for nursing"
	"other hospital settings" (transfer of skills)
	"Just being a taxi driver"

Contentment - One way of coping or dealing with the experience of not being registered was to compromise by just being content with whatever the participants were doing as their jobs.

> *Its a question of compromising in order to survive I have said goodbye to my profession. its a grieving process [1-F DO]*

Forgetting- Forgetting was also mentioned as a strategy of dealing with the feelings.

> *I try so hard to make myself and my kids happy and I just forgotten any grieving I had and probably the process was over before I made a decision to move on … then I felt good I had to compromise and then I felt somehow content but there is always a hard thing to accept [2-F DO]*

Going back home - Contemplating returning home seemed to serve as an alternative and a source of hope for some immigrant medical practitioners. However this was only said by IMPs who came as voluntary immigrants and none of the immigrants who came as refugees mentioned this.

> *I basically lost motivation and thought I can go back home and use my studies there, you know if they don't want me here or I just go into a different area you know that's what I thought of at that time..[4-F PT]*

> *Yes its good to struggle but at the same time there is a point where you feel enough is enough….I am now at a stage where I am wanting to leave…[13- F DO]*

Emigrating - The other way of dealing with difficulties that was mentioned by a lot of IMPs was contemplating emigrating to other English speaking countries mainly Australia. The reason given to this was the fact that Australia seems to be less restrictive

than New Zealand. The other reason given was that Australia tends to have some structures in place for assisting immigrants. It is worthwhile to mention that most participants who contemplated going to Australia already had friends or relatives who had left New Zealand for better conditions there.

> *…that's the general opinion it's very common when you say I can't pass the medical exam people just say go to Aussie some people recommend that you go to Aussie and a lot of people went there and they passed, it's a lot easier. Not in New Zealand they are doing the things a lot complicated. And a lot of people went to Australia after getting their citizenship and they got themselves good jobs. It's really true. [4-M DE]*

> *I want to move to Australia if I can…. because they can use their license only English test. They pass the English test. I know one of my mother's friend daughter she is working. she is a physiotherapist there in Australia from here in New Zealand it s hard there is no way, [5-F PT]*

That extract also explains something about complicated structures in New Zealand in contrast with permitting structures in Australia.

"Doing this degree…" and "training for nursing"- Another popular way of managing experiences of not being able to register was that of enrolling in tertiary courses. The courses that these immigrants enrolled in varied from those similar to their profession to courses totally different from those of their previous training. The reasons given were that these courses tended to be good settings for learning English. the other reason was that these courses tended to give them exemption for English language tests . However this exemption rule was not consistent in all regulatory authorities.

> *.. I came for this course so I can learn more terminology and I want to sit a test for dentistry later so after doing this oral health degree ….want to sit the test yes that's it. And that's the reason I came here and also I can skip the IELS test because its 7.5 for the test before taking you. So if you do this course they don't need IELTS **you don't sit IELTS test** if you finish the oral health degree, no IELTS test required? [6-F DE]*

> *Another friend he got medicine training in China 7 years but just now after he came here he got 3 years training for nursing because its shorter and working as a nurse he learn English and did registration examinations and he passed and now he is a GP so there are different ways. [10-F DO]*

"Other hospital settings"/transfer of skills -Another way of dealing with their experiences was through transfer of skills. This means that doctors sought health-related jobs in hospital settings. However this came mainly as a direct suggestion from participants about how they want to deal with the negative experiences. It must be noted

that although IMPs felt it was the best way they could manage their problems most of them even failed to get opportunities for transfer of skills.

> *So these doctors could be involved in public health or health education, other hospital settings where there is no relation with the patient. You know whatever they do as Australians are doing …..[9M DO]*

> *here I think there are some problems for example one of my friends I am so surprised because he is my colleague in hospital in China. He came here 3 years earlier than me but just now he is a builder.[10-F DO]*

"Just being a taxi driver" - Some participants tended to manage their situations by getting employment in non-skilled settings as a way of seeking survival and not out of interest.

> *I survive by just being a taxi driver…[8-M DO]*

> *….I have never done anything sensible…[11-M DO]*

The fact that they were not happy with what they were doing was expressed in the fact that they tended to get agitated when they were talking about the jobs that they were currently doing.

Summary of the chapter

This chapter has presented the consequences of the disabling experience on the human potential with particular reference to the feelings and emotions of NESB IMPs after being faced with negative experiences. At abstract level this was conceptualised in the paradigm of the disabled potential and state of wellbeing. The result of such a state was an attempt among participants to resort to some coping strategies as a means of survival.

CHAPTER 7: SUGGESTED SOLUTIONS
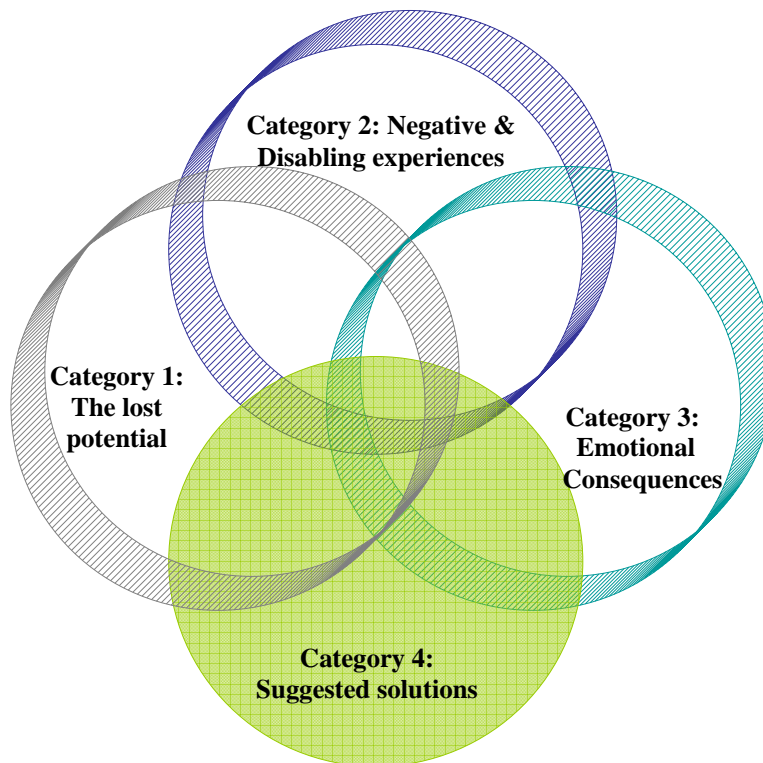
Figure 7.1: Category 4 and 3 other categories

Chapter 5 presented findings that related to objective one of the study. Objective one was about the experiences of immigrant health practitioners who come to New Zealand and face the challenges of re-registration in order to continue with their occupations. Chapter 6 on emotional consequences was about objective two which is about how these IMPs manage and cope with the experiences. This chapter ties well with objective three of the study about raising participants' critical awareness to the shared and individual nature of their experience thereby giving them the opportunity to suggest ways of addressing obstacles they face when they wish to practice in New Zealand. Although solutions were suggested in the individual interviews the focus group was the main arena that provided collective solutions in line with the collective solution orientedness of participatory research.

Table 7.1: Category 4:Summary of themes

Category	Themes
Suggested solutions	**shift in paradigms of thinking**
	key stakeholder forum
	structured tuition for NZREX
	facilitation of tutorials by universities
	transfer of skills
	NESB IMPs for immigrant communities
	centralised information service
	building research evidence base
	introducing a deed of bond

Critical examination of the social causes of participants 'miseries' (Park, 1993) involves appreciation that the causes of the problems are historically rooted in human actions and hence they do not have to remain in their way as permanent obstacles but collective action can transform these. This section of the chapter therefore presents the findings for collective action. See table 7.1.

Shift in paradigms of thinking- Participants felt that the negative attitude and reporting of the media has created a paradigm of thinking that links IMPs with killers. They thought that such kind of thinking is also evident in the regulatory authorities' policies about IMPs:

> *…we are not killers...They are scared they want to stop overseas Doctors from killing New Zealanders....that's the thinking...May be we can show them evidence from doctors who came here 15 years back and they never sat tests and never killed anyone...(interjection) ...sure some of these doctors trained in my college...[Focus group]*

They therefore thought that there should be a campaign against such kind of thinking. They felt that their fellow IMPs who are now registered should be used as examples. They felt that IMPs only get used as examples if they do negative things.

Key stakeholder forum - In the light of universities designing courses that are run but not recognized by the regulatory authorities participants felt that there is no congruency between the key stakeholders. An example given was that the regulatory authorities register some doctors and those doctors fail to get employment in DHBs or even tutoring jobs in health related courses in universities. It was therefore suggested

that a deliberate effort should be made to bring a round table meeting of all key stakeholders.

> *I think there is no congruency or harmony between the DHBs ,
> Medical Council....There should be someone like perhaps the
> Minister of Health brokering a round table discussion on how
> they can make their services link [interjecting]...yes
> streamlining these services...[Focus group]*

In the above discussion the participants were also referring to their experiences of communicating with universities, DHBs, universities and the Dental and Medical Council. In such situations they have noticed that they get told different information and even some responsibilities are disowned by each of these organizations. For example;

> *" ...at one point we get told that our problems need Ministry of
> Health ....Ministry of Health says go to Medical Council.....and
> some say go to politicians..." [Focus group]*

Further on talking about lack of congruency and liaison participants criticized the IELTS tests on the grounds that they were irrelevant to the contextual nature of medical practice. They therefore suggested that universities should liaise with the medical councils and come up with a communication course that does focus even on interaction patterns in medical practice.

> *While they claim that IELTS are the only objective tests we feel
> that they are irrelevant and have little to do with the social and
> contextual aspect of communication. So the solution is for
> universities to collaborate with the Medical Council to come up
> with communication course relevant to medical
> communication.....[interjection]....yes something similar to the
> course offered by AUT.....[interjection] but I hear its no longer
> offered....[interjection].....You see but it seems there is hardly
> any association between universities and medical
> schools....[interjection] ....seems the only association is when
> they accredit courses...[Focus group Discussion]*

The above statements led to the participants wanting to suggest a key stakeholder forum.

Structured tuition for NZREX - Participants also spoke about the need for structured registration courses to prepare them for New Zealand registration examinations (NZREX).

> *There are no structured registration courses or just a system of
> guidance no...no at all...see what Australia and UK does.-plenty
> of such courses...you cannot be lost....interjecting]...but they use
> these countries for benchmarking their standards so they can
> take those good examples...[interjecting] worth taking... [Focus
> group]*

Still on structured registration courses IMPs spoke about the need for opportunities for attachment in clinical settings to be facilitated. A similar scheme happened in the UK where local NHS trusts assisted the doctors to seek clinical placements (BBC Health News, 1998). The Local NHS trusts also reported to have benefited in terms of their staffing needs but in terms of savings too (BBC Health News, 1998). This concurs with what one interviewee said when he stated that "DHBs should be clever because they will benefit" [9M-DO].

Participants felt that lack of registration guidance was an evidence of the authorities' lack of commitment in getting IMPs registered.

Transfer of skills - Participants also felt that there should be some opportunities for them to transfer their skills. When asked what the opportunities could be they mentioned settings like health promotion, health statistics, research and workshops:

> *We could be better utilized in health settings where we do not have to communicate with patients.... the problem is that now I have a tag that label me as a doctor so I can't get any job even health care assistant...(interjection)...yes you get polite excuses like your qualifications are too high... [Focus group]....*

Similar to the issue of transfer of skills the IMPs felt that getting opportunities for transfer of skills will at least help them to feel what it is like to be in the New Zealand health system.

> *Can we have something at least that can get us into the system …[Focus group]*

> *Like myself at least I have put one leg into the system and it gives me an idea of what it might be like if I get registered...[Focus group]*

NESB IMPs for immigrant communities-As have already been said in the earlier chapters participants felt that another way they could be better utilized was being made to work for ethnic communities that are not English speaking. This was rationalized by the fact that effective communication with the patient is a factor in medical practice and hence patients who cannot speak English need practitioners who can communicate in their language.

> *…but to be honest I think a lot of Chinese patients in new Zealand they need Chinese GPs because even if the GP gives them some explanation I don't think they can understand clearly. the Chinese people they trust the GP who is Chinese [10-F DO]*

> *…. physiotherapists here speak English and Korean people can't speak English because they are old so the physiotherapist*

*who goes there needs a Korean person to translate. ...senior
Korean people here can't speak good English So not knowing
English scares. These communities can be seen by physios of
their own cultural people [5-F PT]*

*....maybe I think you can arrange some Chinese people and
Chinese dentists to serve some Chinese people a dentist for
Chinese people because you can speak the language Chinese
community maybe some people they don't want to see the local
dentists maybe just because they can't speak English and
sometimes they complain they can't understand the nurse they
cannot communicate properly so they say they can't understand
English as patients so they say they can't understand English as
patients [6-F DE]*

Centralised information services- The participants felt that the whole system
of integrating overseas professionals needs streamlining. They felt that other
professionals and engineers could be facing the same problem and therefore a
centralised information service should be developed by the government.

*.... Always I was thinking that instead of giving income money
or student allowance to overseas doctors and their families it
would be much better for the government to organize a group of
people who are specialists in their fields and they can gather all
professionals for example they can say all doctors ...., all
engineers ...., all like computer professionals .... These affairs
can be managed or can be directed ..... this kind of organization
would help for information service in all professions ..[8-M DO]*

Centralised information services could also include organised meetings to help
IMPs to share ideas for example, self-development through presentations and
discussions. Internationally in the UK the doctors who were finding it hard to get
registered got organised and made regular contacts where they would make peer
presentations on topics of particular interest (BBC Health News, 1998). Further
communication with registered doctors made comments that concurred with the idea.

*Now there was no way I could have known all these doctors if I
had not attended the focus group [Focus group]*

Building research evidence base - The participants also proposed some follow
up studies on doctors who failed to be successful here in New Zealand but were
successful specifically in Sweden, Denmark and Australia. This was said in the context of
building an evidence base about good practice models of utilising skills of NESB IMPs.

*...again I will ask Mr Mpofu to research about how doctors who
went to Sweden and Denmark managed to make
it.....[interjection] ....I do not think the Swedish people bared
them because they are dangerous....[interjecting] ....I am telling
you they are practicing right now...[interjecting] I pity myself*

for coming to New Zealand then... [FOCUS GROUP]

Introducing a Deed of Bond - In a focus group of a critical research it is recommended that any participant should be a devil's advocate to encourage divergent thinking and viewing issues from all angles. So the researcher made a comment saying that like any other institution the New Zealand government or any funders will not be happy to see IMPS being assisted to register and subsequently leaving the country. The participants said that a deed of bond could be introduced. All beneficiaries in assisted registration could sign before being accepted on to the programme. This deed of bond can serve to bind them to work in New Zealand for a minimum amount of time after registration or a time equivalent to the financial value of the resources committed.

Summary

This chapter also included focus group results where the interactive dialogue, a feature of participatory research resulted in a number of recommendations. The goal of participatory research is to produce practical knowledge. Practical knowledge has therefore been produced in this study. Again this ties well with the goals of participatory research which are to engage individuals in the transformative process thereby changing by becoming aware, more critical, more assertive more creative, and more active.

CHAPTER 8:   DISCUSSION OF FINDINGS AND LITERATURE

Introduction

Chapters 4, 5, 6, and 7 presented findings under the categories of the lost potential, negative experiences, consequences on feelings and strategies of coping and finally on suggested solutions. The theme on lost potential generally serves to illustrate ways by which IMPs are a resource for the New Zealand health system. The theme on negative and disabling experiences illustrate the IMPs' experiences of what they perceive as restrictive policies in the New Zealand medical practice scene. The chapter on survival strategies presented the results of New Zealand's restrictive policies on IMPs' wellbeing while the chapter on solutions presents suggestions that were made in the focus group.

Apart from deciding the overarching theme in this chapter each category will be discussed linking it to theoretical concepts of occupation and social critical theory as well as the overarching theme. An explanation of how each category explains the overarching theme and explore similarities and differences of findings with other studies in literature. A reflection on the limitations of the study and making recommendations for further research as well as application of knowledge generated.

Review of study aims

This chapter involves making sense of the associations between themes with a view to providing explanations for the findings. This process of mapping and interpretation is influenced by the original research objectives as well as by the themes that were created from the data themselves (Pope, 2000). These objectives were: a) primarily to gain understanding about (i) the experiences of immigrant health practitioners who come to New Zealand and face the challenges of re-registration in order to continue with their occupations.(ii) how these people manage and cope with the experiences. b) The secondary aim is: (i) To raise participants' critical awareness to the shared and individual nature of their experience thereby giving them the opportunity to suggest ways of addressing obstacles they face when they wish to practice in New Zealand**.** Also this chapter that will also discuss the overarching theme, which provides the main answer to my research objectives and therefore the title of my study. I will also examine the findings in relation to further literature reviewed to add depth to the understanding of the emancipation issues of immigrant medical practitioners. Underpinning the discussion will be critical theory and occupation and well-being

concepts of which the congruency with the findings of this study will be sought.
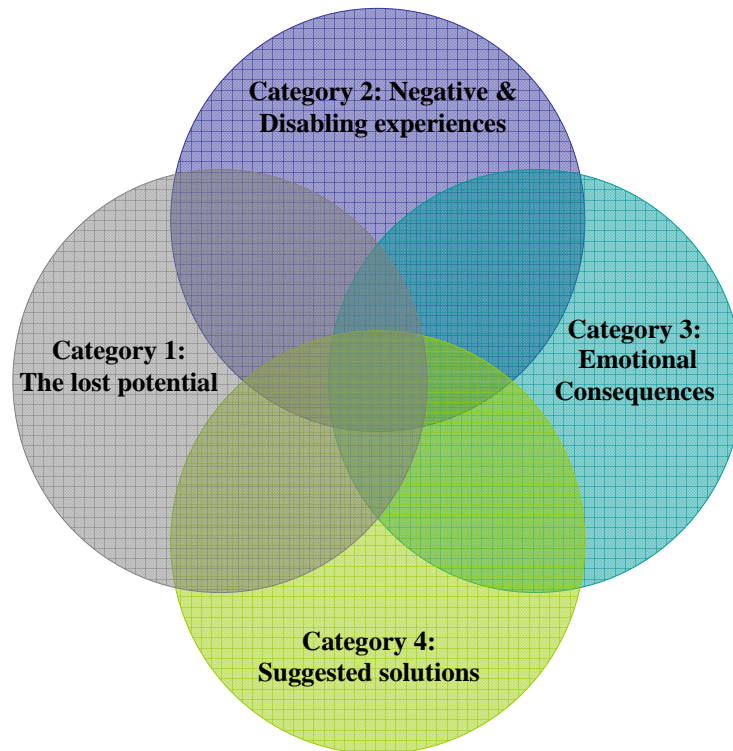
Figure 8.1: Summary of categories- repeated

Figure 8.1 shows a diagrammatical representation of all categories while 8.2 shows a stage by stage representation of how categories were decided.

Transcript←→Code←→Theme←→ Subcategory←→ Category←→Overarching theme

Figure 8.2: Deciding the overarching theme- repeated

The overarching theme (Auerbach & Silverstein, 2003) was decided after having a look at what came out of the categories (major themes). The categories were firstly; **the lost potential** which showed various skills, motivation and positive attributes of the participants. The **second category** was **disabling experiences** which showed how the positive attributes of the participants were disabled by the experiences in New Zealand. **The third category** was **on consequences on feelings and how they cope with their feelings.** The **fourth category** was **suggested solutions** which gives hope that something can be done. On standing and looking back- from the beginning of the journey to the end I have decide that all I have been researching (**the overarching theme**) is about **"Experiences of immigrant medical practitioners seeking**

registration." Therefore the emerging title of my theses will be as follows:

Emerging title:
Immigrant medical practitioners' experience of seeking New Zealand registration: A participatory study

In this discussion the overarching theme will be borne in mind when looking at most issues from the presentation and in comparing the findings with literature. For the sake of organisation, findings will be discussed category-by-category bearing in mind the overarching theme.

From the outset it is important to mention that illustrative examples about the phenomena of study will be drawn from literature on countries such as UK, US , Canada and Australia . there are two reasons for this. The first one is that these are ESB countries with health systems comparable to New Zealand which have been documented to be receiving NESB medical practitioners. The other reason is that these countries are sometimes used by the New Zealand regulatory authorities for benchmarking for example the United States Medical Licensing Examinations (USMLE). The third reason is that these countries tend to have bilateral alliances with New Zealand which imply a number of similarities in the medical system. More examples will be drawn from Australian states as this is the country with strong alliances with New Zealand. For example medical practitioners registered in New Zealand do not have to under go exams when they go to Australia.

There is also a need to give justification of the use of the Model of Human Occupation as a conceptual framework or tool to conceptualise NESB IMPs issues.

A Model of Human Occupation

Abelanda, et al. (2005) have in their critical writings emphasised the need to use a model of human occupation as a conceptual tool for understanding and addressing occupational deprivation and occupational apartheid issues. The relevance of this model on experiences of NESB IMPs is on the fact that it explains occupation by three statuses; volition, habituation and performance capacity. Before proceeding it is essential to define the processes of volition, habituation and performance capacity. Volition entails issues about motivation, choice, enjoyment, satisfaction and finding meaning and importance in 'doing'. Therefore our choices in doing things are based on our unique volitions. This study has explored much about the intrinsic motivation of the NESB IMPs to work as medical practitioners and their lack of job satisfaction in doing

menial jobs. Habituation refers to process where by doing is organised into patterns which order what people do and how they do it. Habituation is therefore relevant in this study that looks at NESB IMPs failing to be engaged in activities they were doing in their countries. Performance capacity refers to the underlying abilities and the lived experience that shape performance whereby performance guides how it feels like to engage in occupation. These three processes interact with the environment to shape who the people are and what they do. In this model the environment therefore provides either opportunities and resources or constraints (Kielhofner, 2004). Constraints can be in the form of the regulatory environment or financial resources needed by IMPS to get registered. This therefore provides a valid argument for employing this model to conceptualise issues of NESB IMPs. In this study the concern is about the intrinsic motivational factors (see category 1) interacting with restricting and constraining environmental conditions (see category 2) leading to consequences of debilitating wellbeing conditions (see category 3).

The model goes on further to say these 3 statuses interact with the environmental factors. In this study category one established the intrinsic strengths of the participants while category 2 presented the environmental constraints. This model was one of the first models to acknowledge the relationship between people's occupations (people's dignified and meaningful participation in daily life (Pollard & Kronenberg, 2005) and their environment (Abelanda et al., 2005). Nowadays it has been used to promote social change in situations where some population face social injustices or are being deprived of their rights and this makes it relevant in emancipatory research like this one. The Model of Human Occupation is relevant in conceptualising these issues as it has been researched and applied to various conditions or situations of occupational problems resulting from social inequities. The model is also relevant as it has been used as an empowerment strategy in overcoming social forces of prejudice and discrimination directed towards persons because of their racial or ethnic status. It has also been used to conceptualise the interactions between occupations of people who are disenfranchised and their environment in conditions where they have no power or control (Abelanda et al., 2005).

Discussion of Category One: The Lost Potential

As has been discussed in the literature review in chapter 2; critical researchers (R Mowbray, 1995; Totton, 1999) have debated on the relationship between licensing

restrictions and the level of consumption of physician services in ESB countries. Research findings have been that restrictions tend to benefit the profession as a "corporate entity" than the public as consumers (Svorny, 1987, 1991). Further contention that professional interests wield influence over the design of regulatory rules is Svorny's (1991) finding that immigration restrictions on entry of foreign-trained physicians into the US have generated substantial gains for American physicians at the expense of consumers (Lowenberg & Tinnin, 1992) . Indeed in New Zealand this kind of scenario can be seen in the context of mass emigration of doctors and long waiting queues for surgical operations while experienced NESB specialists are driving taxis. Although this is not current research such insights can be seen in relationship to the discussion below.

The category on the potential of the IMPs and on enabling factors can be summarised or interpreted to mean that acceptance of the IMPS is a two way deal between them and the New Zealand health system. In the category on strengths it was noted that IMPs claimed to have unique multi-cultural and linguistic strengths which could be of benefit to the new Zealand health system.

In occupational science this can be conceptualised within the model of human occupation which has been discussed above. This model honours the fact that humans are motivated to occupation (a characteristic called volition) and they have internalized roles that give them an outline of what to do in a given environment (habituation). The third construct is called performance capacity and this acknowledges innate skills and abilities of humans which are a product of experiential opportunities.

Globalisation and enriching the medical workforce

Participants presented themselves as having multi-cultural and linguistic strengths. While acknowledging that language usage and disease patterns differ from country and that medical and communication skills obtained from one country cannot necessarily be transferrable to other countries it is important to acknowledge the knowledge they have and their potential to adapt. Although registration authorities and other responsible bodies have evidently not done much to show acceptance of IMPs' skills, some politicians have in their political speeches acknowledged the value of the skills. For example in New Zealand a former Minister of Health reiterated that these immigrants, instead of working as doctors,

> "…they found themselves doing jobs like driving taxis or other occupations that failed to recognize the valuable skills they had to offer this country...... We have the opportunity to tap into a group of people whose talents, experience and knowledge were being largely wasted " (Government of New

Zealand Ministerial Speeches, 2001).

In the context of this era of accelerated globalisation the role of immigrant medical practitioners has been observed to be of crucial significance (Hawthorne, 2001) as "it provides for a sharing of experience and the development of healthcare links in a world where disease is globalised and medicine needs to be" (Borman, 2007, p. 591). Internationally, the substantial and longstanding contribution of IMPs has been acknowledged. For example in Canada, a country with health system comparative to New Zealand, IMPs have been relied on to fill vacancies in under serviced fields of practice and underserved communities. The same thing has been acknowledged in New Zealand and hence there has been a lot of debates about attracting medical practitioners to under serviced communities like rural areas (King, 2002).

Diversity as a resource versus diversity as "danger"

In the background of the IMPs facing restrictions one of the visions of DHBs and the Ministry of Health is to have a diverse workforce which mirrors the multicultural nature of the New Zealand society. This leaves one wondering whether diversification can be achieved with such restrictions which can be interpreted as seeing diversity as a public safety concern and not as a resource. In the UK a local health authority medical advisor once stated that the benefits of having the IMPs is that they can get them "to work with the local population, possibly with members of their own ethnic group" (BBC Health News, 1998). This statement was made following a report that led to the involvement of a district health authority in East London in integrating NESB IMPs. In Canada it has been acknowledged that IMP integration has significantly contributed to the diversification of the medical workforce (Hawthorne, 2001). In Canada another group of health professionals who are overseas trained nurses have been acknowledged to be important in the diversification of the nursing workforce given the fact that Canada has citizens from culturally diverse backgrounds (Canadian Nurses Association- Position Statement, 2002).

The above argument was put by participants when they argued that diversity is a resource and not danger. This leaves one wondering whether the local doctors can likewise be considered unsafe for immigrant patients. This arguments holds unless patient safety is to be viewed only from the side of the dominant western culture. Totton (1999) observed that in such a scenario "At the bottom, [the medical profession is] reflecting the values of capitalist society...." and not the diverse needs of patients. Although participants did not mention gender diversity in terms of positive things

about them, such a variation can be seen in table 3.1. These IMPs vary in terms of gender and hence NESB IMPs could help towards gender balances in terms of diverse workforce supply.

Workforce supply issues

Internationally ESB countries have been noted to rely on NESB IMPS in addressing their workforce supply issues. For example, Canada's reliance on OTDs has been in the range of 20 to 30 per cent of the medical workforce (Canadian Federal Provincial Territorial Advisory Committee on Health Delivery and Human Resources, 2004). In the UK as of October 2007 it is estimated that 36% of doctors registered to practise in the NHS qualified abroad. In Australia a member of parliament once made a comment that:

> *"It is well known that many parts of the country particularly rural and rural regions that have failed to keep and attract "home-grown medical graduates, the local population is heavily dependent on these overseas trained doctors" (Parliament of New South Wales Hansard, November 2007).*

"A win-win situation" in economic sense

The participants also stated that helping doctors to get registered is a two way deal between the government and the concerned IMPs as the New Zealand health system has a shortage of medical practitioners. Participants were also very specific about the situation where the government spends a lot of money hiring interpreters for patients from various ethnic communities. Such a scenario was also once confirmed by a government Minister who stated that "We committed the money because it was a win-win situation both for the overseas trained doctors and the New Zealand health system" (King, 2002). This was in reference to the bridging programme for skilled migrant doctors where about 11 million dollars was committed by the government. Further on economic benefits participants stated that getting IMPs to retrain was a "bargain" when compared to training doctors from scratch. In London this bargain was once admitted by Dr Peter Elliot, a Health Authority medical advisor who once said "For around £3,500 for courses and exams, we could have a qualified GP to work with the local population, ..." (BBC Health News, 1998). Another international example generalising from UK wide doctors' training costs in terms of time and finance was that it costs on average around £25k to train a refugee doctor to be fit for practice in the NHS and takes on average 2.5 years. The cost of training a Medical Student is around £250k and has a 5 years lead-time. This observation was made by the participants and presented in the focus group. When making good use of scarce public resources such an observation is

instructive. Recently at the time of writing this study in UK there was again another argument for the economic sense in integrating IMPs where it was found that … "Such a system is cheaper [doctors coming from abroad bring their qualifications to the UK for free], it is more amenable to changing needs (recruitment of trained doctors within a year, rather than having to wait for them to graduate),......" (Borman, 2007, p. 591).

Further on the economic sense of assisting NESB IMPs to integrate participants also felt that it was an irony that the government was not facilitating their transition into employment but instead made them rely on social benefits. A similar case was observed in UK where it was found that if doctors are not helped to transit into employment they are then forced to rely on social security benefits instead of contributing their skills and knowledge to the National Health Service (The BMA Refugee Doctor Initiative, 2007).

IMPs and their aspirations

Further on strengths, the category on the lost potential illustrated that these IMPs are motivated and they have goals to achieve. An example is an instance whereby some participants mentioned their motivations as being derived from the need to keep family histories of excelling and the need to be an inspiration to their children. The drive for some IMPs to maintain the family tendencies of excelling is part of their identity and hence they want to maintain it. In the field of occupational science it is said that a person is defined, to some extent, by the occupations in which he or she engages in. Occupations have social and symbolic dimensions because they are associated with socially identifiable roles in a society (Fidler & Fidler as cited in American Occupational Therapy Association, 1995). Occupations reflect the unique characteristics of the person. The IMPs are therefore motivated to maintain their identities despite the hurdles that they face. Such keenness was once echoed and acknowledged by a government minister who said "Most importantly of all, they are [IMPs] desperately keen to work in New Zealand as doctors"(Government of New Zealand Ministerial Speeches, 2001).

Insights from discussion of category one

Given the above facts it can be concluded (Hawthorne, 2001) that such insufficient stakeholder attention that the issue of immigrant medical practitioners is facing has a profound effect on workforce cohesion and supply. It is therefore suggested that there must be deliberate effort by the government and the medical community to seek stakeholder commitment to streamlining campaigns for a shift to paradigms that view NESB medical practitioners as enriching workforce diversity and a resource for

meeting workforce needs as opposed to paradigms that link them with safety and competence concerns. The media community would be one such stakeholder. This is because it has been observed by participants to portray the negative societal attitudes in its reporting as seen in chapters six and seven. It is also suggested that the key stakeholders should consider implementing a New Zealand national strategy for integrating the medical workforce. As a foundation to such effort it is suggested that deliberate research commitment should be made on issues of integrating NESB IMPS in line with workforce development initiatives. The issues about occupation and social identity raised above also signify the importance of the social and human services ministries such as ethnic affairs Ministry to be involved in the issues about immigrant health practitioner integration. Hence any effort seeking key stakeholder commitment should look beyond the medical community.

Discussion of category two: Disabling Experiences

The evidence about disabling experiences pointed to negative attitudes, flawed examination processes, and lack of guidance, tuition and information services, prohibitive financial and psycho-social costs and some acts of injustices. It is important to mention from the outset that the participants tended to mention that conditions are better in Australia than in New Zealand, yet below there are examples of negative experiences in Australia. This does not invalidate the participants' claims. as it can be taken to mean that Australia has had a long period with this problem hence as of now most issues to some extent being actively pursued while in New Zealand it appears there has been no known resolution.

As the interviewing process developed it was apparent that participants tended to point fingers to the examination processes. Literature at international level dating back as far as1975 has been pointing to the flawed and discriminatory nature of examinations and the processes:

> *That has been the conclusion of a number of diverse bodies, including the Doherty report, the Fry report and even an AMC working party report. The examination process was heavily criticized by a report of the Human Rights and Equal Opportunity Commission entitled "The Experience of Overseas Medical Practitioners – An Analysis in the Light of the Racial Discrimination Act 1975 (Parliament of New South Wales Hansard, November 2007).*

It has been observed that in Australia different organisations have made a call in support of the fact that the examination processes are discriminatory. While the regulatory authorities may argue that the examinations have been moderated and meet

international standards from a critical point of view one may ask the questions such as who does the moderation? And when they say they meet international standards still the question of which countries determine the international standards will follow.

The nature of intervention and organisations that have taken the issue on board is evidence that there is discrimination of some sort. For example in New South Wales civic and ethnic community organizations like the Ethnic Community Council of New South Wales, the Federation of Ethnic Councils of Australia, the Doctors Reform Society have worked with universities and government to specifically address the issue of discrimination by examination (Parliament of New South Wales Hansard, November 2007).

Apart from the nature of organisations the nature of captions of official documents and action plans also suggest elements of inequity or discrimination. For example in Australia, The House of Representatives Standing Committee on Family and Community Affairs, had a report entitled "A Fair Go For All: Report on Migrant Access and equity - January 1996", which called for tolerance and need to integrate overseas doctors into the system. The House of Representatives committee report stated:

> *Sadly, the only criteria by which the general population of patients can judge the competence of a doctor are the criteria they can see and hear - in other words the doctor's skin colour, physiognomy and accent. Most of the medical practitioners whom the board informs us were "deregistered" or censured were Australian-trained graduates" (Wijesinha, 2005)*

Most participants cited the English language tests as a "weapon of exclusion" or delaying them from proceeding to registration. It was felt that this weapon of exclusion tends to come as a result of discrimination. In critical occupational science literature it has been observed that the weapons of restricting people from participating in their occupations can be legal, economic, social or political (Kronenberg et al., 2006). Similar observations have been made internationally. For example, in Australia a study by Hawthorne and Toth (as cited in Hawthorne, 2001) discovered that the Occupational English Test had three effects on IMP progression :1) that it was a tool of excluding health professionals at a point of entry by between 333- 67% ; 2) a tool for barring health professionals to proceed to pre-registration courses; 3) a tool for selective delay professional re- entry for health professionals including those with exceptional competence levels of English.

> *In conclusion, the Committee believes that the current system of accreditation of overseas trained doctors is neither easy nor comprehensible; that its very complexity is deliberate and*

designed to protect various vested interest groups; that it is unfair and discriminatory and designed to exclude trained doctors from non-English speaking countries.(Parliament of New South Wales Hansard, November 2007).

In New Zealand English is a pre-requisite for all registration examinations. Apart from being made a pre-requisite, among the participants there were some who have lived in New Zealand for many years and have studied up to postgraduate levels but still had been rejected for English test exemptions by regulatory bodies. Some were even working in hospital settings in non-professional jobs that still involved extensive communication with patients.

Again in New Zealand it has been found that doctors from Australia, the United Kingdom, and North America are exempt from sitting the English examination as the medium of instruction in the medical schools at which have trained is English (Narasimhan et al., 2006). However, such an exemption is not extended to doctors who trained in countries other than those mentioned. Again New Zealand residence experience as a way of advocating for flexibility in English tests requirements is not valued by regulatory authorities. In the findings participants had stayed for years ranging between two years and 10 years in New Zealand and none of the participants mentioned that years spent in New Zealand were acknowledged as years of experience. A former Minister of Health acknowledged such an experience with the following words "These doctors have lived in New Zealand for five to seven years, they speak good English, and they are becoming increasingly familiar with the New Zealand way of life and cultural differences"(Government of New Zealand Ministerial Speeches, 2001). The implication here is that regulatory bodies should be inclusive enough to extend the definition of New Zealand experience to not only work experience but practical life experience. The other deduction that can be made from the scenario where New Zealand experience is not factored in is that such regulations undermine the human potential of being adaptive.

Complicated procedures/closed shop practices

Strict policies have been blamed for delaying or restricting registration of immigrant medical practitioners. In critical literature policy is defined as "the authoritative allocation and legitimation of values commonly expressed by a politically dominant group in order to effect substantive or procedural, distributive or re-distributive, or regulatory ends" (Smith, 1993, p. 86). Tight and complicated examination processes and registration policies and procedures were suggested by

participants as limiting their access to registration. For example one specific issue raised by participants was that recognition of Overseas Trained Specialists is also flawed. Doctors with several years of specialist experience find it hard to go back to the basics especially when asked to sit general practice exams (Department of Health, 1999). For example among the participants of this study some IMPs were specialists who have worked in their specialities for more than two decades but they were subject to registration tests that test basic medical or knowledge that is mainly of a general practice nature.

In the UK it was acknowledged that the procedures that the IMPs need to follow in order to resume their medical careers are extremely complicated, and most refugee doctors need support at all stages if they are to succeed (BMA, 2007). One scholar commenting on such complications felt that it is an abuse of doctors lured from overseas to compete for non-existent jobs (Borman, 2007).

The following was a contribution to a parliamentary debate in Australia's longstanding debate about the issue of medical practice being a closed shop:

> *The AMA is a closed shop; professional bodies protect each area. People often talk about trade unions being closed shops, but professional organizations are also closed shops. The House of Representatives committee is in no doubt that the complexity of the accreditation process is applied not only to ensure the highest possible standard in medicine but also to maintain a closed shop (Parliament of New South Wales Hansard, November 2007)*

Talking about issues of occupational apartheid in occupational science literature it has been observed that opportunities can be created, restricted or denied. Hence what we do is dependant on the social opportunities and resources available to us to facilitate our participation in and the exercise of occupational rights. It therefore appears that the exercise of NESB IMPs occupational rights is restricted by the regulatory policies in New Zealand.

Attitudes- "acting heavy handedly …in the name of safety"

The issue about negative attitudes towards NESB IMPs has also been documented in international literature. Negative attitudes about qualifications and experience were also raised by participants. In international literature there is already evidence of utterances about presumed inferiority of qualifications and experience of doctors from third world countries. For example one scholar commenting about standards in medical education said:

> *In Cape Town, Max Price had convinced me that highly*

academically trained US residents might not be suited to rural
African health care, with its scanty and primitive facilities, and
that African doctors would be equally poorly equipped for
service in the American health care system (ten Cate, 2002) .

Considering the fact that most of these regulations were enacted recently it is interesting to note that it is hard to find documented evidence of the adverse safety effects of some periods in history where NESB IMPs flooded ESB countries in large numbers. In the study participants gave examples of instances where NESB IMPs are currently practicing because they came before the restrictive policies were in place. They said this to show that there is no clear ground for restricting them on safety grounds especially given the exaggerated media scare campaigns about NESB IMPs. By making such arguments these IMPs were not suggesting that safety competences should not be in place. Instead, they were talking about the need for consideration of exceptional circumstances. In New South Wales one member of Parliament once gave a similar scenario such as the one suggested by participants in this study.

Before the AMC was created in 1979 to stop migrant overseas-
trained doctors from practising in Australia, how many migrant
doctors - no different to the ones protesting outside Parliament
House at the moment - caused harm to their patients? What is
the difference between them and the doctors protesting outside?
They are from the same countries and universities; they have the
same training and experience (Parliament of New South
Wales Hansard, November 2007)

Scare campaigns have also been noted and criticised in Australia especially in relation to what the Australian Medical Council did in opposition to the entry of post-war East European medical refugees (Blacket, 1990b). The following extract is reveals what some nursing applicants from NESB countries experienced in Australia:

I have been told at an interview for an assistant charge nurse
position, 'We don't know what sort of bush nursing you've done
in India' [Indian nurse] (Hawthorne, 2001, p. 225)

We encountered some racism, treated as inferior, ignorant
beings…very condescending attitudes. [Sri Lankan nurse]
(Hawthorne, 2001, p. 225)

"Dark skin. Many think we are dumb" Indian nurse
(Hawthorne, 2001, p. 225)

The above issues are therefore issues of occupational apartheid. Occupational apartheid are political and system wide forces that segregate people for cultural, racial, religious or socioeconomic reasons and restrict access and change meaningful daily occupations (Kronenberg & Pollard, 2006). This is in the sense that in the cited

situations people faced negative experiences in pursuing their occupations because of their ethnicity or their countries of origin. The explicit aim of participatory research as in this study is therefore to bring about a more just society in which no groups or classes of people suffer from deprivation of life's chances. Deprivation from life chances leads to "denial of basic needs like as food, clothing, shelter, and health and in which all enjoy basic human freedoms and dignity" (Park, 1993, p. 2) .

The statement below gives another evidence of a situation of occupational apartheid with regard to the employment experiences of immigrants:

> *This does not apply only to doctors. I attended a meeting of engineers in Sydney whose professional qualifications were recognized, who did a bridging course, yet still could not obtain employment. The usual answer from employers was that local experience was necessary and that they needed to work in this country to become familiar with the working practices here. If those doctors were not given a chance, when would they ever gain that level of experience? (Parliament of New South Wales Hansard, November 2007)*

This is consistent with the assertion by the participants who stated that there seems to be no light at the end of the tunnel. For example some participants stated that they were discouraged by the fact that their colleagues in New Zealand who attended the bridging course did not get employment even though they were registered. Some participants even stated that those who managed to get employed are still facing many difficulties in getting upgraded. However this issue was outside the scope of this study.

Best interest of the public or protection of professional self-regulation?

The practical, philosophical and technical reasons for doubting that registration or licensing protects the client has been extensively documented by Mowbray (1995). Totton (1999) supports the authenticity of his agument by stating that his critique draws on a wide range of sources, including Hogan's (1979) reputable magisterial four-volume work. Other scholars (Stacey, 1992, 1994) have also cited evidence from the abusive behaviour in the tightly regulated medical legal professions. Totton further argues that "What is more, every experienced practitioner knows that practitioner abuse occurs in the most respectable and senior areas of the field, not just on the wild fringes" (p.320). An example cited by Totton is that of one well-documented example of the past-president of the American Psychiatric Association and the American Psychoanalytic Association, and honorary life president of the World Association for Social Psychiatry, who was found to have raped patients whom he injected with amytal (Noel & Watterson, 1992).

Lack of guidance and information services

Participants also mentioned often the lack of information and guidance services in New Zealand. At some point of time else where in first world countries such as Canada and the US opportunities and lack of support to understand the licensure process has been observed to be a major problem (Lochhead, 2003). Internationally guidance issues have been resolved through bridging programmes as they have been observed to be the key to skill recognition (Hawthorne, 2001). In the UK one organisation that offers guidance is Reache North West, which is a purposefully built centre in Hope Hospital in Manchester. This centre delivers a comprehensive package of support and training particularly to refugee health professionals from English language and communications support through to professional registration examination classes and clinical attachments. Another programme called the Refugee and Overseas Doctors Organisation based within a large medical school provides a study club, PLAB (professional registration exams for doctors) and careers advice and support [Focus group discussion].

Socio-economic difficulties/ expensive exams

One theme that was noted in the study was that of difficulties in committing time to study as participants have to work in order to live. This theme reflected that examinations tended to be very expensive especially considering the fact that some participants were in their settling in phase in New Zealand. At this stage they will be trying to establish themselves socially. These difficulties have also been observed (North, Trlin, & Singh, 1999) in a study that sort to find out the characteristics of difficulties of unregistered doctors in New Zealand. This study found that doctors paid as much as NZ$3,500 excluding study materials. The same study observed that these are the costs the doctors bear with against the background of having sunk their financial resources into migrating to New Zealand. Internationally this theme about socio-economic difficulties has been alluded (Cole-Kelly, 1994) in studies of IMPs in the US and in Australia (Sullivan, Willcock, Ardzejewska, & Slaytor, 2002). In the UK it was also observed that this group of IMPs are very keen to establish themselves professionally as quickly as possible, but are frequently frustrated by financial and practical obstacles to registration and often find it very difficult to integrate into the UK medical system (The BMA Refugee Doctor Initiative, 2007). A district health authority in the UK once resolved this by helping to pay for mentors and course fees for language tests (BBC Health News, 1998)

It was disturbing to note that the high costs of examination fees even affected

IMPs who are refugees and came here with no financial base. This seemed to be an issue of moral ethics. In countries like the UK and Australia IMPs who are refugees are exempted from paying exam fees and registration fees. In the UK they can even attempt registration tests up to twice without paying. In 2002 employers in the Canadian health care system initiated a programme for financial assistance for refresher courses for nurses and this proved to be a positive step in easing the registration processes. It can be argued that probably in New Zealand the reason why such exemptions are not in place is because the issue has not been articulated. However, it must be noted that exemptions made by the General Medical Council in the UK might be difficult to implement in New Zealand as the Medical Council of New Zealand operates as an independent commercial enterprise which does not receive funding from the government.

Issues that raised moral concerns- refugee doctors

In occupational science literature it has been observed that refugees and asylum seekers are at a higher risk of developing occupational deprivation (Verschuur, 2006). In the study issues of refugees were seen to be even more complex as they are a special group of immigrants whose occupational lives have been disrupted and therefore requiring occupational justice and enablement. One way by which the occupations of refugees has been disabled or disrupted is the fact that they moved between number countries as temporary immigrants and have not been eligible to practice. In this case they have been observed to be facing difficulties when trying to explain gaps in their Curriculum Vitae (BMA, 2007). In addition, when they come to settle in New Zealand one of the technicalities that they have to meet is that among the registration regulations there is a requirement that the candidate must not be out of practice for a certain number of years. Another issue with refugee doctors is that in some cases they do not even know what their final destination will be and hence they come not prepared for practical obstacles that they face in their new countries of settlement.

Insights from discussion of category 2

The discussion on category 2 has demonstrated the fact that the complexity of occupational problems faced by NESB IMPs has been acknowledged internationally. To some extent the complexity has also been acknowledged in academic literature. Countries such as the UK, Canada and Australia have also seen NESB IMPs going through the complex problems stated above. However the main difference with the New Zealand situation is that in New Zealand there has been no commitment to address such problems.

Discussion of category 3: Emotional consequences

The consequences of being faced with disabling experiences identified in category 2 have been noted to include health and wellbeing complications to the participants. This will be discussed below.

Occupational needs, wellbeing and health

In this category occupational deprivation and occupational apartheid of NESB IMPS has been shown to be resulting in debilitating health outcomes. These negative health outcomes include depression, stress, neglect, as well as, social cohesion and settlement outcomes of being frustrated and being financially insecure. Researchers (Hawken, 2005; North et al., 1999) on NESB IMPs have also indeed noted considerable stressors on NESB IMPs' lives which results in deterioration of mental health evidenced by their poor scores on the General Health Questionnaire. Indeed in literature it has been observed that occupational deprivation over extended periods has been shown to have a detrimental effect on health, well-being and adaptation (Wilcock, 1998). Concurring Yerxa et al (1989) suggest that "individuals are most true to their humanity when engaged in occupation" (p. 7).

The primary assumptions of linking occupation with wellbeing are that of the occupational nature of human beings. The occupational nature of human beings is reflected in that human beings have a basic motive for occupation and occupation is a primary source of meaning in life. Since occupation is a basic human need, people who are denied access to occupations or are restricted in their occupations may suffer a reduction in quality of life (Christensen, 1994; Kielhofner, 2004).

It has been found in literature that population groups at risk of occupational deprivation are: people living on or below the minimal income scale; immigrants; refugees/asylum seekers; prisoners; addicts and the unemployed (Verschuur, 2006). The IMPs fall into this group in the respect that they are immigrants, some are refugees, some are either underemployed or fall below the minimal income scale. It is therefore understandable that participants spoke of feelings of financial insecurity, being neglected and feeling frustrated. This is therefore a settlement issue; a labour department issue and a social services issue. It is interesting to note that in the interviews some participants stated that different government departments were disowning the responsibility of looking into the problems of IMPs.

Further understanding of the phenomenological aspects of the issues of NESB IMPs can be deduced by having a closer look at the definition of occupational

deprivation. Occupational deprivations is defined as " a state of preclusion from engagement in occupations of necessity and / or meaning due to factors that stand outside the immediate control of the individuals (Whiteford, 2000, p. 201)." Because of its emphasis on meaningfulness of occupation the concept of occupational deprivation is therefore useful in comprehending issues of NESB IMPS who are finding it harder or impossible to continue with the occupations they have been doing meaningfully in their countries. This could be the cause of negative feelings like being frustrated and undervalued as mentioned by participants in the study. In occupational science terms these individuals have been denied access to occupations that appeal to their psychological dimensions of satisfaction, actualisation and dignity (Abelanda et al., 2005).

Articulating the model of human occupation Kielhofner (2004) stated that "when people's identities do not fit with their possibilities for enacting them or when they become frayed by life circumstances, occupational adaptation is threatened" (p.153).

Insights from discussion of category 3

It has been seen from the above discussion that taking occupation as just a question of getting jobs is trivializing. The experience of not being able to continue with one's usual occupation should be considered in a holistic way; that is a total look at a person and their wellbeing. According to Wilcock (1998) wellbeing components include the physical, social, spiritual, emotional, and financial. It can therefore be seen that issues of depression, isolation, frustration, and being neglected are linked to these wellbeing components. The fact that some doctors manage their situation by ending up emigrating to other countries indeed shows that occupations are the fabric of human lives. It will therefore be interesting to research and find out how the wellbeing components of the IMPs who failed to make it here in New Zealand are met when they finally went to countries like Sweden and Australia and got registered there. The process of migrating takes a lot of courage, reflection and energy. Hence this means that immigrants end up resorting to unimaginable ventures in order to meet their occupational needs.

Discussion of category 4: Collectively suggested solutions

This section which includes recommendations caters for the secondary aim of the study which is to raise participants' critical awareness to the shared and individual

nature of their experience thereby giving them the opportunity to suggest ways of addressing obstacles they face when they wish to practice in New Zealand. This aim honours the critical emancipatory paradigm of this study as emancipatory research sees the participants as active and reasoning beings who engage in critical reflection to generate practical knowledge which can be applied to real life situations.

Learning from the UK initiatives

This section has been included to provide an insight that New Zealand can learn from international good practice models. This also followed recommendations by participants who consistently spoke about their friends or family members whose situations improved when they went to other countries. Some international programmes certainly represent a model of good practice and participants thought it would be very useful to make links with or learn from their practice. This is in terms of the numbers of health professionals they have assisted back into employment. A specific organisation in London, that has successfully obtained funding from the London Strategic Health Authority is the Refugee and Overseas Doctors Programme at Barts and the London Medical School. Their director, Dr Sheila Cheeroth, has been working with refugee and overseas doctors for over ten years and was recently honoured by the Queen for her work in this sector [Focus group discussion].

A co-ordinated database of overseas IMPs

A national co-ordinated database of overseas-trained medical practitioners was another suggestion to a problem of lack of co-ordinated database with information from overseas doctors. In New Zealand it was observed that at one point of time the government needed to act on the issue of overseas doctors but

> *No one seemed quite sure how many overseas-trained doctors came into the country between November 1991 and October 1995 when the problem existed, ...even the hundreds who want to take part in this Government's bridging programme probably only reflect a portion of the total number (King, 2002).*

Making a national centralised database was one strategy that was carried out in the UK as a solution.

An example internationally is that of the BMA which holds and maintains the Refugee Doctors' Database. This voluntary database currently holds the details of 1144 refugee and asylum-seeking doctors. All information provided is strictly confidential.

Doctors are regularly contacted on behalf of refugee doctor programmes to ensure that they are aware of the services available in their area (BMA, 2007).

> *[A database] is an invaluable resource, which has enabled help for refugee doctors to be more accurately targeted. The BMA produces bi-monthly statistics on numbers, nationalities, progress towards UK registration and needs, and.... send all the doctors on the database a regular newsletter informing them of recent developments and the availability of assistance through local projects (BMA, 2007)*

It was also suggested that there should be a deliberate effort by the government to capture some data about immigrant medical practitioners entering the country through means other than recruitment agencies. A review of the medical council website indicated that the doctors who are in their database are those that came through agencies. This was consistent with the assertion that was made in Canada they observed that:

> *In addition to skilled work permit category immigration IMPS tend to pass immigration as refugees, on spousal visas or other family reunification programmes [and this] has been observed to drive some MDs "underground" by not declaring that they were MDs and hence not been catered for in the databases of numbers of OTDs getting into the country, yet wishing to be once here. It has been found therefore that the characteristics of this group of physicians are not fully known. Hence this makes them not known by various stakeholders as group with particular grievances in their attempts to use their potentials (Canadian Federal Provincial Territorial Advisory Committee on Health Delivery and Human Resources, 2004)*

The collective effort in seeking solutions resulted in the recommendations listed below. These recommendations are both a result of participants' collective suggestion and insights learnt from international models of good practice.

Recommendations

The outcomes of this collaborative process as well as literature review led to the following recommendations. The recommendations were also based on evidence of successful international good practice projects in countries with health systems that comparative to New Zealand.

- Recommend the commissioning of a report to look into the issues of NESB IMPs wishing to practice in New Zealand
- Propose structured tuition and guidance for NESB IMPs wishing to be integrated
- Propose that this research endeavor should continue by following the doctors who

failed to make it here in New Zealand and finally went to countries like Sweden and Australia and got registered there.

- Recommend a follow up on international good practice examples integration and build evidence base to inform practice.

- There is need for a campaign for a shift to paradigms that view NESB medical practitioners as enriching workforce diversity and a resource for meeting workforce needs as opposed to paradigms that link them with safety and competence concerns

- Propose the idea of funded and accessible registration processes for refugee medical practitioners as a special group of immigrants.

- There is need for commitment from key stakeholder employers to accommodate NESB IMPs in their recruitment policies

- There is need for funding for providers of tuition programs

- There is need for accreditation of approved support courses by regulatory authorities

- Recommend the development of a centralized information service and a point of information on reception services for NESB IMPs

- Recommend clinical exam tutorials for NESB IMPs sitting registration examinations

- There is need for consideration of alternative career pathways for NESB IMPs

- Recommend the development of strategies to assist NESB IMPs to access student loans.

- Develop a national research agenda for evaluating implemented projects and how the integration project align with workforce development policies of different agencies

Significance of the study

In terms of concept development this study is one of few studies that have extended the purpose and scope of the Model of Human Occupation beyond impairment issues to social issues of injustice and occupational apartheid. This study has therefore added to the literature on the potential of the enabling professions (like Occupational Therapy) to extend their understanding of social inequity issues. In the social field this study is of significance as it has shown a broader understanding of issues about IMPs being deprived of continuing with their chosen occupations. Such issues can be the basis for understanding the complexity of problems that immigrants in higher professional grades face when they immigrate to new countries. This study has also highlighted some implications on health and wellbeing of these immigrants and this is

important in policy development.

 In the medical field this study has implications for diverse workforce development initiatives that can be done by medical practitioner employing authorities like DHBs and the Ministry of Health. This is because the study has shed light on the characteristics and attributes of NESB IMPs. Hence the employing bodies can capitalise on the strengths of NESB IMPs that have been articulated in this study. For the NESB IMPs this study is of special significance as it has brought to the table some injustices and discriminatory issues that IMPs might face even after registration. As seen in this study the registered NESB IMPs felt that even after registration there are still some challenges that NESB IMPS may face. This study has resulted in the establishment of research networks nationally and internationally which could be of use in developing a research evidence base about issues of NESB IMPs and diverse workforce development initiatives in the medical field.

For the participants this study was of special significance as it afforded the participants to share their experiences with others with similar problems. The opportunity to have someone who listens and identifies with the participants' experiences was also of special significance especially in individual interviews. Through the participatory for a like focus group discussion this study might have to some extent empowered the participants by boosting their self-esteem. This is because participants had a forum to reflect on their strengths as opposed to their experiences of being told about their inadequacies.

Directions for future research

This study partly has implications for diverse medical workforce development and the Treaty issues are of particular importance when looking at medical workforce issues. Future studies could look at how the NESB IMPs impact on upholding the aspirations of the Maori health partners and even the minority ethnic communities. Future studies could also follow up on NESB IMPs who managed to be registered and find out more about their survival strategies and how they cope in their present jobs. It has been claimed anecdotally that NESB IMPs tend to face communication competence issues in practice. It would therefore be interesting if there could be some studies looking at the specific nature of the communication issues and ways of redressing them. Statistical representation of these IMPs in disciplinary tribunals and even among cases heard by the HDC could be analysed with a view of finding solutions.

NESB IMPs mentioned that their coping strategies also included changing

professions and at times going for menial jobs. Since the scale of the problem has been shown to be wide internationally it would be useful to find out how these people cope in their carriers chosen out of desperation.

Another area of research suggested by participants in the focus group was that of international good practice examples of tolerance. In the light of doctors failing to get registration and moving to other countries, it was proposed that this research endeavor should continue by following the doctors who failed to make it here in New Zealand and finally went to Countries like Sweden and Australia and got registered there. In the same discussion it was proposed that follow-up research should include doctors who instead of coming to New Zealand went to countries like Australia, Sweden and Denmark and got registered. These doctors are said to have trained and had very similar experience with the NESB IMPs who came to New Zealand. It is interesting that while the focus of this study was on comparing the integration procedures of doctors in ESB countries the participants kept emphasizing Sweden and Denmark. This could be because the participants have relatives and friends who have already gone there. Such a research endeavor might have an advantage in that the NESB IMPs who participated in this study expressed willingness to help the snowball sampling of specific participants that they already know.

Limitations of the study and reflexivity

The researcher is aware that his experience as an immigrant professional from an NESB country might have affected the critical analysis of discussions of participants' issues. However, in participatory research such an experience is valuable is it is acknowledge that the researcher is not an independent objective observer, as in positivist research paradigms.

The study also relied on participants' use of language to code data and come up with themes. This therefore assumed participants competence in articulating their experiences. Limitations in language expression might be reduced by spending more time with participants instead of working in a confined timeframe like one hour for interviews as was the case in this study. Additional limitations to the study were posed by the limit in numbers of participants to be sampled. This was done to stay within the time and financial resources consisted with the level of a Masters thesis.

Conclusion

It has been seen that there is a need for a better understanding of people's deprivation from their chosen occupations from a holistic view. Qualitative research paradigms that

seek to find deeper meaning allow for the holistic view of such phenomena. This has been partly achieved in this study as the wider aspects of the phenomena of being deprived from one's usually job / occupation has been explored in a broader view. The findings presented showed that whenever the participants were mentioning their experience of being deprived of their chosen occupations they mentioned broader implications of the experience rather than narrowing it to just a question of earning income. These findings were consistent with the theoretical tradition of social critical research and occupational science concepts informing this study. It was also found that that the participants have a range of skills and experience that can be valuable to the New Zealand health system but the dominant discourses about them are those that view them with a deficiency lens. Moreover, the researcher noted that different researchers found that some regulatory authorities in ESB countries are not too comfortable about facilitating NESB IMPs integration since they perceive that inclusion will demand them to move away from their traditional status of self-regulation and control which ideally should benefit the public. However, in conclusion the success of the integration of NESB IMPs would depend on dedication and collaboration among stakeholders. Furthermore, all stakeholders should be prepared to accept the responsibility and start to create opportunities that address the negative experiences discussed in this study. This could help the public and the New Zealand health system and afford the concerned IMPs to be responsible citizens of this country. The study revealed that, there is no doubt that successful integration of IMPs is long overdue in New Zealand and has already resulted in negative health and settlement outcomes of the concerned immigrants.

Postscript

The follow up on international examples of good practice is currently being done mainly with some Health Authorities in England. The researcher is still working on seeking funding to strengthen such collaboration. Here in New Zealand a key stakeholder forum is being planned for May 2008. Invitations have been sent to the Medical Council and the Dental Council of New Zealand, government Ministries, the District Health Boards and medical schools in New Zealand. Most of these key stakeholders have already expressed interest.

The forum that is being explored is outside the scope of a Master of Health Science thesis and will be an on-going endeavour to strengthen multi-stakeholder approaches of integrating NESB IMPs.

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APPENDICES

Appendix A- Ethics approval

MEMORANDUM
Auckland University of Technology Ethics Committee
(AUTEC)

To:	Anthony MacCulloch
From:	**Madeline Banda** Executive Secretary, AUTEC
Date:	8 February 2007
Subject:	Ethics Application Number 06/228 **Occupational transition outcomes of immigrant medical graduates from non-english speaking backgrounds: a participatory study.**

Dear Anthony

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 11 December 2006 and that the Chair AUTEC has approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 12 March 2007.

Your ethics application is approved for a period of three years until 8 February 2010.

I advise that as part of the ethics approval process, you are required to submit to AUTEC the following:

- A brief annual progress report indicating compliance with the ethical approval given using form EA2, which is available online through *http://www.aut.ac.nz/research/ethics*, including when necessary a request for extension of the approval one month prior to its expiry on 8 February 2010;

- A brief report on the status of the project using form EA3, which is available online through *http://www.aut.ac.nz/research/ethics*. This report is to be submitted either when the approval expires on 8 February 2010 or on completion of the project, whichever comes sooner;

It is also a condition of approval that AUTEC is notified of any adverse events or if the research does not commence and that AUTEC approval is sought for any alteration to the research, including any alteration of or addition to the participant documents involved.

You are reminded that, as applicant, you are responsible for ensuring that any research undertaken under this approval is carried out within the parameters approved for your application. Any change to the research outside the parameters of this approval must be submitted to AUTEC for approval before that change is implemented.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this. Also, should your research be undertaken within a jurisdiction outside New Zealand, you will need to make the

arrangements necessary to meet the legal and ethical requirements that apply within that jurisdiction.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at charles.grinter@aut.ac.nz or by telephone on 921 9999 at extension 8860.

On behalf of the Committee and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Madeline Banda

Executive Secretary

Auckland University of Technology Ethics Committee

Cc: Charles Mpofu Charles.mpofu@aut.ac.nz

Appendix B- Approval to increase participants

M E M O R A N D U M
Auckland University of Technology Ethics Committee
(AUTEC)

To: Anthony MacCulloch

From: **Madeline Banda** Executive Secretary, AUTEC

Date: 02 July 2007

Subject: Ethics Application Number 06/228 **Employment outcomes of immigrant medical practitioners from non-English speaking backgrounds: a participatory study.**

Dear Anthony

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 11 December 2006 and as the Executive Secretary of AUTEC I have approved minor amendments to your ethics application, altering the project title, increasing the number of participants, and including focus groups. This delegated approval is made in accordance with section 5.3.2 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 13 August 2007.

Your ethics application is approved for a period of three years until 8 February 2010.

You are reminded that as part of the ethics approval process, you are required to submit to AUTEC the following:

- A brief annual progress report indicating compliance with the ethical approval given using form EA2, which is available online through *http://www.aut.ac.nz/about/ethics*, including when necessary a request for extension of the approval one month prior to its expiry on 8 February 2010;

- A brief report on the status of the project using form EA3, which is available online through *http://www.aut.ac.nz/about/ethics*. This report is to be submitted either when the approval expires on 8 February 2010 or on completion of the project, whichever comes sooner;

It is also a condition of approval that AUTEC is notified of any adverse events or if the research does not commence and that AUTEC approval is sought for any alteration to the research, including any alteration of or addition to the participant documents involved.

You are also reminded that, as applicant, you are responsible for ensuring that any research undertaken under this approval is carried out within the parameters approved for your application. Any change to the research outside the parameters of this approval must be submitted to AUTEC for approval before that change is implemented.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this. Also, should your research be undertaken within a jurisdiction outside New Zealand, you will need to make the

arrangements necessary to meet the legal and ethical requirements that apply within that jurisdiction.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at charles.grinter@aut.ac.nz or by telephone on 921 9999 at extension 8860.

On behalf of the Committee and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Madeline Banda

Executive Secretary

Auckland University of Technology Ethics Committee

Cc: Charles Mpofu Charles.mpofu@aut.ac.nz

Appendix C-Advertisement

AUT
UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Project Title:

Employment outcomes of immigrant Medical practitioners from non-English speaking backgrounds: A participatory study.

An Invitation

To: Immigrant Medical practitioners who are medical doctors, physiotherapists, dentists, or nurses of a non-English Speaking background.

Would you:

Be interested in participating in a research that seeks to further our understanding of employment experiences of immigrant health practitioners of non-English speaking backgrounds? And hopefully can contribute to improving policies and processes that a affect immigrants' quest to find suitable employment in New Zealand?

Do you meet these criteria:

1. Are you:
   a) an immigrant legally residing in New Zealand?
   b) an immigrant health practitioner who is a medical doctor, physiotherapist, or dentist..
   c) studying, seeking a job or already in employment?
   d) able to speak English in such a way that you will be able to understand and answer questions in a conversation without needing interpretation
   e) able to spare approximately between 1 and 2 hours of your time to be interviewed and 1-2 hours of your time in focus group discussions?
   f) not a student of the researcher, Charles Mpofu

If you answered 'Yes' to the above questions:

Please contact me so we can arrange a meeting to discuss more.

You can contact me via email at charles.mpofu@aut.ac.nz to request a copy of the participant information sheet and other relevant documents or to arrange a time to meet and discuss the project. You can also leave a message on 09-9219999 EXT 7893.

Appendix D- Participant information sheet

Participant Information Sheet

AUT
UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Date Information Sheet Produced:

15 October 2006

Project Title

Employment outcomes of immigrant medical practitioners from non-English speaking backgrounds: A participatory study.

An Invitation

You are invited to participate in a research project that explores the experiences of immigrant health practitioners from non-English Speaking Background who come to New Zealand and face hardships in continuing the occupations they were doing in their countries. It will also explore how such health practitioners manage the transition experience and possibly find collective resolutions to the problem. This study is part of my Master of Health Science qualification at AUT University, Auckland. I am a lecturer working in the Division of Public Health and Psychosocial Studies. The media stories about shortages in the medical workforce and about immigrant doctors being underemployed in low skilled work prompted me to research on employment outcomes of immigrant medical practitioners from non-English speaking backgrounds. My studies on professional practice and health law inspired me in this research. Your participation is voluntary and you can withdraw entirely at anytime during the study.

What is the purpose of this research?

To achieve a greater understanding of the stresses and pressures faced by immigrant medical practitioners in New Zealand as they experience and manage hardships in continuing with the occupations they were doing in their countries. It is anticipated that the published findings of this study may contribute to improvements in various policies involved and to achieve greater awareness of the difficulties faced by such immigrants. For the initiating researcher this study will lead to a qualification of a Master of Health Science Degree. As part of my professional and ethical obligations the results of this research are likely to be published in professional journals or presented in professional

conferences and workshops.

How was I chosen for this invitation?

This project needs 8-12 participants. Participants have been selected via computer notice board advertisements and other places where immigrant medical practitioners are likely to be found. The advertisements will target immigrant health practitioners who are in the process of finding jobs or career advancement and those who are already in employment. These should be:

a) immigrants legally residing in New Zealand.

b) health practitioners who are medical doctors and dentists.

c) studying, seeking a job or already in employment.

d) able to speak English in such a way that you will be able to understand and answer questions in a conversation without needing interpretation.

e) able to spare approximately between 2 and 4 hours of their time to be interviewed and to participate in a focus group.

f) not involved as a student of the researcher.

By responding to these advertisements you show interest but you will not be bound to participate. You have further opportunities to have the interview and focus group procedures explained to you. You might be invited to help to find other participants and the same consent procedures will apply.

What will happen in this research?

We will agree on a convenient place to meet. Prior to the interview I will send you a copy of questions we are likely to address. They will though not be strictly predetermined and ordered. Whatever you say will be useful and this will be recorded and transcribed. You will receive a copy which you can comment on and return to me. Prior to the focus group you will have an opportunity to view and comment on the preliminary data analysis. Copies of transcripts will be kept in a locked filing cabinet.

What are the discomforts and risks?

The nature and process of this research is not expected to cause any distress or discomfort. However immigrants leave their countries to settle in New Zealand for many reasons. Sometimes discussing such things may cause discomfort.

How will these discomforts and risks be alleviated?

The interview will be conducted in a gentle and respectful manner. Participants will be advised that they may decline to answer any of the questions presented. Participants

may terminate their participation in the interview or focus group at any stage should they so wish without giving any explanation or facing prejudice. Should the participant show or experience any signs of discomfort or distress the interview can be suspended and recommenced when and if the participant is agreeable. Should any discomfort arise free counselling is available at AUT University. However participants should be ware of the limitation that AUT University counselling service is a brief intervention which at times makes referrals to other long term counselling service providers.

What are the benefits?

This research is intended to increase our understanding of the stresses and pressures experienced by immigrant medical practitioners seeking appropriate employment in New Zealand. As a participant you will contribute and have access to the findings of the research. You may read my bound thesis and I will offer you a simplified overview of the findings. The findings may be used by government agencies to inform immigration policy and by medical practitioner credentialing bodies to increase awareness about concerns in managing employment seeking experiences.

How will my privacy be protected?

In accordance with the research guidelines and ethical conduct I will endeavour to protect your privacy and confidentiality. This will primarily be by using fictitious names in the interview and removing all identifying details in any writing that will be seen by any other person other than yourself. As already stated the interview transcript will be kept in a locked filing cabinet.

What are the costs of participating in this research?

I thank you for voluntarily giving your time which is expected to amount to approximately 1-2 hours for the interview and a maximum of 2 hours of focus group discussions.

What opportunity do I have to consider this invitation?

You have many chances to consider the invitation. You can contact me at any stage to ask further questions, and you will be given a consent form before the interview process begins. It will be appreciated if you respond to this invitation within three weeks.

How do I agree to participate in this research?

You will be expected to sign a consent form after reading the participant information sheet.

Will I receive feedback on the results of this research?

As stated above you will have access to my bound thesis which will be available in the library on completion of my masters qualification. I will also contract to provide you

with a summary of the findings and you can indicate in the consent form whether you want to receive it or not .

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor.

Tony MacCulloch

Faculty of Health and Environmental Sciences

Division of Health Care Practice,

AUT University

Private Bag 92006, Auckland.

Tel. (09)921-9999, extn 7116

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, madeline.banda@aut.ac.nz , 921 9999 ext 8044.

Whom do I contact for further information about this research?

Researcher Contact Details:

Charles Mpofu

Faculty of Health and Environmental Sciences

AUT University, Private Bag 92006, Auckland.

Tel. (09)9219999 EXN 7893

Approved by the Auckland University of Technology Ethics Committee on, 8/02/2007

AUTEC Reference number 06/228.

Appendix E-Transcriber confidentiality

Confidentiality Agreement	AUT UNIVERSITY TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

For someone typing/ transcribing data, e.g. audio-tapes of interviews.

Project title*:*   Employment outcomes of immigrant health practitioners from non-English speaking backgrounds: A participatory study.

Project Supervisor*:* Tony MacCulloch

Researcher: Charles Mpofu

○   I understand that all the material I will be asked to transcribe is confidential.

○   I understand that the contents of the tapes or recordings can only be discussed with the researchers.

○   I will not keep any copies of the transcripts nor allow third parties access to them while the work is in progress.

Typist/ Transcriber' signature:

.....................................……………………………………

Typist/ Transcriber's name:

.....................................……………………………………

Typisyt/ Transcriber's Contact Details (if appropriate):

…………………………………………………………………………

Date:

Project Supervisor's Contact Details (if appropriate):

Tony MacCulloch

Faculty of health and environmental sciences

Division of Health Care Practice,
AUT University
Private Bag 92006, Auckland.
Tel. (09)921-9999, extn 7116

Approved by the Auckland University of Technology Ethics Committee on 08/02/2007 AUTEC Reference number 06/228 *Note: The Transcriber should retain a copy of this form.*

Appendix F- Consent form (interviews)

Consent Form **For use when interviews are involved.**	AUT UNIVERSITY TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Project title: Employment outcomes of immigrant health practitioners from non-English speaking backgrounds: A participatory study.

Project Supervisor: Tony MacCulloch

Researcher: Charles Mpofu

○   I have read and understood the information provided about this research project in the Information Sheet dated ....

○   I have had an opportunity to ask questions and to have them answered.

○   I understand that the interviews will be audio-taped and transcribed.

○   I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

○   If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.

○   I agree to take part in this research.

○   I wish to receive a copy of the report from the research (circle one): Yes/   No○

     Participant's signature:....................……………………………………..

     Participant name: ....……………………………..

     Participant Contact Details (if appropriate):

     ………………………………………………………………………………

     ………………………………………………………………………………

     ………………………………………………………………………………

Date:

Approved by the Auckland University of Technology Ethics Committee on 08/02/2007 AUTEC Reference number 06/228.
    Note: The Participant should retain a copy of this form.

Consent Form For use when focus groups are involved.	AUT UNIVERSIT TE WĀNANGA ARONUI O TAMAKI MAKAU

Appendix G- Consent form (Focus group)

Project title: Employment outcomes of immigrant medical practitioners of Non-
English speaking backgrounds: A participatory study.

Project Supervisor: Tony MacCulloch

Researcher: Charles Mpofu

○ I have read and understood the information provided about this research project in
the Information Sheet dated ……………………………………….

○ I have had an opportunity to ask questions and to have them answered.

○ I understand that identity of my fellow participants and our discussions in the focus
group is confidential to the group and I agree to keep this information confidential.

○ I understand that the focus group will be video/audio-taped and transcribed.

○ I understand that I may withdraw myself or any information that I have provided for
this project at any time prior to completion of data collection, without being
disadvantaged in any way.

○ If I withdraw, I understand that while it may not be possible to destroy all records of
the focus group discussion of which I was part, the relevant information about
myself including tapes and transcripts, or parts thereof, will not be used.

○ I agree to take part in this research.

○ I wish to receive a copy of the report from the research (please tick one):

Yes○   No○

Participant's signature:

..................……………………………………………………

Participant's name:

....…………………

Participant's Contact Details (if appropriate):

…………………………………………………………………………………………….

…………………………………………………………………………………………….

Date:

Approved by the Auckland University of Technology Ethics Committee on 08/02/2007 AUTEC Reference number 06/228

Note: The Participant should retain a copy of this form.

Appendix H-Interview guide

Project Title: Employment outcomes of immigrant health practitioners from non-English speaking backgrounds: A participatory study.

Semi-structured interview questions guide

Background profile information

Overseas Qualification / occupation &

experience.. ……………

Current occupation/ studies..

Country of origin ……………………………………………………………………

Anticipated questions

1.Tell me about your experience of finding work in the health field in New Zealand.

2. Tell me about your experiences of being an immigrant of Non-English Speaking Background (NESB) in New Zealand, a predominantly English Speaking Background (ESB) country.

3. Tell me about your views about the accreditation procedures.

4. What do you think makes your health/ medical practice training different or similar to the New Zealand system?

5. What reasons have you been given for refusing you job offers/ training opportunities? / or if you easily found employment; what made it easier for you to get recognition/ employment.

6. What have you been told about your qualifications by the immigration, credentialing bodies, potential employers etc.

7. What do you do in the process of finding jobs?

8.What do you think or feel about the kind of jobs that you do at the moment?

9. If you had the opportunity, what would you change about your Employment experience?

10. What made you leave your country of origin? How does living in New Zealand make your life different?

11. If you remained in your country at what level will you be in your career journey?

Appendix I- Focus group schedule and questions

Project Title:

 Employment outcomes of immigrant medical practitioners from non-English speaking backgrounds: A participatory study.

Focus group schedule

1. Welcome and introductions.

2. Briefings & explanation of intent of focus group.

3. Ground rules, confidentiality and confirming the agenda.

4. Feedback and discussion following preliminary analysis review.

5. Discussion of tabled and contributed focus group questions.

6. Summary of discussions and concluding thoughts.

7. Closing and thanking participants

8. Refreshments and informal mingling.

Specific questions

1. What are the group perspectives/ views about the issue?
2. What could be done to address the issue (solutions)?

Appendix J-Counselling support for participants

AUT UNIVERSITY **STUDENT SERVICES**

MEMORANDUM

To	**Charles Mpofu**
CC	**Tony MacCulloch**
FROM	**Stella McFarlane**
SUBJECT	Counselling support for the participants in AUT research
DATE	

Dear **Charles**

As manager of AUT Health Counselling and Wellbeing, I would like to confirm that we are able to offer confidential counselling support for the participants in your AUT research project…………………………. The free counselling will be provided by our professional counsellors for a maximum of three sessions and must be in relation to issues arising from participating in your research project.

Please inform your participants:

- They will need to drop into our centres at WB219 or AS104 or phone 921 992 City Campus or 921 9998 North Shore campus to make an appointment
- They will need to let the receptionist know that they are a research participant
- They will need to provide your contact details to confirm this
- They can find out more information about our counsellors and the option of online counselling on our website
http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing

Yours sincerely

Stella McFarlane

Manager

Health, Counselling and Wellbeing