

PERCEPTIONS OF OVERSEAS TRAINED DOCTORS ON INTEGRATING INTO THE NEW ZEALAND MEDICAL WORKFORCE

EXECUTIVE SUMMARY

New Zealand (NZ) has become increasingly dependent on overseas trained doctors (OTD) to maintain adequate practitioner numbers. The aim of this study was to identify and explore the major issues of concern for OTDs when first integrating into the NZ medical system. The data was collected using semi-structured interviews and focus groups involving a total of 10 overseas trained doctors who were currently working in a NZ hospital. This study identified 4 key issues that influenced the initial integration of OTDs into the NZ medical system. Work issues include difficulty in finding employment and difficulty in first integrating into their employment role. The bridging programme had considerable impact on the ability of OTDs to gain knowledge and experience of the NZ medical working environment. Financial difficulties were a major impediment to the process of attaining registration and a career pathway in NZ. Bureaucratic barriers which include examinations and information availability were seen as necessary but unsympathetic processes in gaining registration.

INTRODUCTION

Shortage of medical personal is an international problem ^{1,2,3}. This shortage also affects New Zealand (NZ) and has led to a reliance on the inflow of overseas trained doctors (OTD) to maintain an adequate medical workforce. ⁴. In 2003 OTD's comprised 40% of the medical workforce an increase from 29% in 1990 ⁵. In 2003 these doctors came from 82 countries ⁵ and therefore from a variety of cultural and medical training backgrounds. There is much anecdotal evidence that the process of integrating into the NZ medical system is problematic. However, there has been little in the way of formal research carried out in NZ which has investigated the reasons for these difficulties. This study aimed to identify and explore the major issues of concern for OTD's when first integrating into the NZ medical system, but does not attempt to quantify those issues. Greater understanding of the difficulties that OTD's face is the first step to improving their initial integration into the NZ medical system, thus enabling them to practice safe and effective medicine in NZ

METHODS

Ethical approval for the study was sought from the Waikato Ethics Committee and was granted. Due to initial small numbers of respondents, ethical approval was requested to extend the study to Auckland and this was also approved. The criteria for participation in this study was having trained overseas, recently passed NZREX and were currently working in a NZ hospital. The participants were recruited through hospitals in Waikato and Auckland through liaising with the Resident medical officer (RMO) coordinator of Waikato hospital and the Northern Clinical Training Network (NCTN). Those fitting the criteria in Waikato hospital received a phone call requesting participation if interested.

Both semi-structured interviews and focus groups were conducted⁶. Preparation for the focus groups was directed by published qualitative research⁷. A total of 10 people were involved; 4 groups with 2 people and 2 interviews involving a single person. The interviews and focus groups were recorded and transcripts made. The comments made by the participants were then coded, with comments about common topics grouped together under one code. The codes were then organized under common themes. It is now become common practice for qualitative software to assist in the organizing process and the Nvivo software was used for this purpose⁸.

RESULTS

4 key issues were raised as influencing integration into the NZ medical system: (1) work issues, (2) bridging programme, (3) financial difficulties and (4) bureaucratic barriers which include examinations and information.

WORK ISSUES

Work related issues as discussed by the respondents tended to fall into 2 main categories: problems finding employment and problems first integrating into their employment role.

Problems finding employment

It was commonly reported that it was a particularly difficult for OTDs, having passed NZREX, to find employment.

*“I applied to everywhere... and they all replied no jobs, no vacancies”,
“...everyone was willing to go anywhere in NZ just to get a placement just to get a job”.*

This problem was described as affecting a large number of OTDs, with there being a significant time delay between passing exams and receiving a job offer. It was stated that some of those who were unable to find work were moving offshore particularly to Australia. Others were considering areas outside of medicine for employment. Many reasons were mentioned as to why Australia was such a common choice. These included greater job opportunity, being able to work before passing exams as well as better salary, working hours and working conditions.

“I know quite a lot of friends of mine who had passed NZREX who couldn't get a job and they left the country and they all went to Australia and they are all working there. Quite a lot.”

Several of the doctors interviewed commented that as a consequence of the delay in finding employment, information and skill honed for the NZREX exam was losing its edge:

“every single day that I didn't work it was like I was losing some information that I gathered for the exam”.

It was perceived that there were vacancies available within the hospitals but those positions were not being offered to the OTD's.

“I knew that there were vacancies definitely, they didn’t want to give them to us”

Amongst the reasons cited as being responsible for the lack of employment opportunities was the selection methods employed by particular recruitment agencies. Selection methods used by agencies were disputed for their ability to adequately assess OTDs. For example, one recruitment agency assessed OTDs using a 2 week trial placement at a hospital. The critique for such a trial system is two-fold. First, a 2 week trial period was inadequate for OTDs to adjust to working in a hospital. Secondly, a fortnight does not adequately allow the doctor in question to demonstrate his/her true capabilities.

It was commonly expressed notion that a new system for selection should be implemented in the district health boards and recruitment agencies to ensure improved employment opportunities. Ideas for this new system include having a central employment agency which allocates employment for all the hospitals in the country and allocation is carried out according to the length of time an OTD has been waiting for employment. It was seen as necessary that those who had passed NZREX first should be given first priority:

“otherwise how do we know that we are going to get jobs at all, when are we going to get jobs, because I was uncertain whether I was going to get a job at all”.

It was mentioned that the lack of employment opportunity has resulted in the acceptance of employment offers that were beyond level of expertise. An example was given of a run that would normally be filled by a 3rd year house officer being filled by OTDs post – NZREX who was a 1st year house officer. Clearly there is the potential for this kind of situation to compromise patient care and to have serious consequences for the OTDs fulfilling that role.

The lack of job opportunity has also resulted in situations where OTDs are pressured to accept additional duties due to the threat of not being able to secure another run placement:

“like on having long days and additional duties, I could really say no, but ...I have to make a good impression, so I have to do it, even if it is quite difficult, even if it is quite frustrating for me.”

Problems first integrating into their employment role.

One of the barriers to effective integration seemed to be based on an inherent discrepancy between the medical training and medical practice that they had previously been taking part in and the NZ style of medical practice that they are now expected to partake in. They are now having to participate in a different work environment and approach clinical medicine in a different manner. There is a cultural adjustment that needs to take place.

Do you think that because you came from overseas that there were more bad times for you then for NZ graduates? “Oh yes I think so because we used to work in a different medical system, different language...different approaches”.

Cultural differences are present in many aspects of the working life of the hospital.

“There is a very informal approach towards your superior like I would have never dared to call my professor by his first name or the last name its always sir or madam. Whereas here...even the nurses or the orderly can call a doctor by their first name, so it was a big cultural shock for me”.

“There are so many levels of this feeling of inferiority that I can talk about. I think that the biggest problem is being an immigrant, that is the biggest feeling of inferiority to the culture and to the ways of how they do things”.

Further barriers were identified as hindering effective integration when first entering the work place. It was expressed that there is a significant discrepancy in the information which was provided and the information that is actually required to function in a hospital environment. This was applicable irrespective of participation in the bridging programme. The difficulties experienced revolved around three key areas:

- (1) general internal workings of the hospital, such as referrals, paperwork, using the computer;
- (2) practical procedures for example lumber punctures; and
- (3) health system information that applies specifically for NZ (ACC for example).

“From the first minutes its difficult, how to write the notes, how to organize yourself, how to write a referral, how to deal with the... maybe just simple things but for the one who has just started work in NZ, it is a huge, big problem and can stop work”.

“What equipment we use here are different from what I was using for a lumber puncture before. I’ve never seen that”.

There seems to be an expectation within the hospital to be able to function independently and competently as soon as employment commences. It would appear that the current orientation programmes are not adequate in providing the OTDs with the information that is required to function at a level expected by the employer and it would also appear that there is no support network set up within the hospital environment to adequately deal with the issues being faced.

“I guess it adds up to the frustration and because I was expecting at least that for my probationary year...to be really supervised and given the support whilst starting”.

The difficulties experienced in integrating into a NZ hospital are impacting on professional relationships with colleagues:

“problem is with colleagues, because they want everything fast, quick, they are annoyed if you ask twice”.

There was recognition that these difficulties were not only having an impact as personal difficulties but were also impacting on their ability to deliver patient care.

“I’m just not being able to give the quality that I want to give in terms of patient care, but the thing is, it is my limitation, it is what I can do humanly in terms of no one is there to teach me, to at least guide me”.

Another barrier to integration is the use of abbreviated, colloquial or slang words within the hospital which OTDs are not familiar with. For example:

“B.A.B.A. Brought in by ambulance. Mrs so and so, B.A.B.A”.

There is an expectation among colleagues that there is an awareness of these terms:

“sometimes colleagues, doctors, nurses whatever are not patient enough you know. We are OTDs, different culture, different language, different slangs, we know the formal English but not the slangs, some people do not consider these things and get angry and upset”.

It was suggested that a type a ‘buddy system’ be set up which involves partnering newly employed OTDs with a more experienced member of the hospital for a specified period of time. It was thought that such an arrangement would offer the opportunity of exploring the internal workings of the hospital and identify areas of difficulty whilst giving the opportunity to adequately deal with those areas of difficulty before working independently within the hospital.

“Because they don’t give us any support at the beginning, this process of being incompetent extends to 6 weeks, to 7 weeks”.

It was expressed by those who had experienced a similar opportunity as being beneficial:

“and my colleagues told me many stories about how difficult, how they suffered a lot when they started working as house surgeons. But I didn’t get these things because already I got the chance to work with someone for 1 week”.

It was perceived that they had little difficulty in communicating with patients irrespective of cultural or ethnical origin; in particular, questions were addressed concerning Maori and Pacific island patients. However it was expressed that more information about different racial groups would be beneficial for clinical practice.

BRIDGING PROGRAMME

Those who had attended the bridging programme believed that it played an important role in integrating into the NZ medical system. Strong positive feedback was received about the bridging programme overall. It was deemed to be worthwhile both for passing NZREX and also for working in a hospital setting.

“it was useful to help me to pass clinical exam...also it was useful to get familiar with NZ health system so that was easier for me to start to work, I don't know or I can't imagine how people did it without the bridging programme”.

It was deemed to be worthwhile just for easing the adjustment into the hospitals even if there had been no exam.

So for working in a hospital leaving aside the exam the bridging programme would still be good? “yip definantly”.

Although the bridging programme was seen to be worthwhile just for assisting in the adjustment to working in the hospital it was not adequate to provide them with all the information that is required to work in a NZ hospital.

“For sure the bridging programme helped me so much but when I started to work it was completely...the first day was shocking for me”.

“so its different when you watch and its different when somebody tells you write the echocardiology referral, its completely different, suddenly you are stuck here with a referral whom to write, what to put in that referral where are we going to fax it, do you have to phone?, I didn't have these experiences”.

So there was a mismatch between what you were taught on the bridging programme and the day to day work that you are currently doing? *“yes”.*

Aspects of the bridging programme that were identified as being particularly beneficial included the theoretical part A of the programme.

“the theoretical was wonderful”.

“actually part 1 was really good, well organized... part 1 was excellent”.

It was particularly emphasized that the personal development part of the course was beneficial. Areas of personal development that were commonly commented on included communication skills, taking a history and patient centered medicine as opposed to doctor centered medicine.

“We didn't know how to approach or how to take a history, how to handle a patient before going to the bridging programme”.

It was also expressed that the bridging programme was useful in teaching the skills to be culturally appropriate:

“they prepared us how to deal with the different cultures especially Maori culture”.

An area of the bridging programme that was seen to need improvement was the part B hospital placement. It was criticized that it was quite limited in teaching practical skills and it was limited with respect to involvement with patients.

“You could watch but you couldn’t actually put the i.v’s in”.

To improve this area of the bridging programme it was suggested to allow the participants to be more involved in direct patient contact and carrying out procedures under appropriate supervision as well as to involve the participants with the daily routines of the ward.

“I thought at that time that I would like to be more involved in daily routine like for example T.I’s (training interns)”.

FINANCIAL DIFFICULTIES

Financial difficulties faced by the OTDs were experienced throughout the whole process of obtaining registration. During the initial stages of this process – studying for the exams, financially difficulty was largely due to the expenses associated with buying textbooks combined with the inability to undertake employment.

“I knew before hand that I had to pass all those exams so I expected not to work for a couple of years. But it gets you out of the workforce and you are not earning any money during that time and that’s difficult if you don’t have any other income, partner or whoever”.

In addition, other expenses involved the cost of the exams themselves and the associated costs of attending examinations such as flight and accommodation. The cost of sitting the NZREX exams was financially taxing. The combined expenses of the exams and the associated expenses in preparation for them was a factor which can even prevent OTDs from initiating the process of gaining registration in NZ:

“well on a single income you just couldn’t get all the resources...we couldn’t afford for me to sit those examinations”.

The unpredictability of the cost of the exams was also a source of stress. It was perceived that the cost of the exams increased regularly but there wasn’t advanced warning of cost increases. Also associated with the costs of the exams is the cost of accommodation and flights to attend the examination. A strong request was made for much more information to be made available concerning the locations of the exams, dates for the exams and the cost of the exams. The benefit of supplying this kind of information in advance would allow appropriate planning to take place.

“but it would really help to prepare you when...you can have at least a long term plan, that you will be spending this for this examination and the exams for this year will be on these dates and the examination centers will be these places but because we are only given the examination centers a few weeks before the examination so” - you have to arrange flight, accommodation- “yes, accommodation ...so those things all add up in terms of expenses and anxiety”.

The bridging programme which was offered free of charge did contribute to enabling those who had previously been inhibited from initiating the registration process to begin the preparation process for the exams.

BUREAUCRATIC BARRIERS

1. Exams

The NZREX assessment process was difficult and most participants believed that there was a low pass rate:

“the initial pass rate was 60-70% and when I did my exam it was 12-15% and what actually happened was it became very tough, it became one of the toughest exams I was told”.

To an extent, some of this difficulty appears to come from a lack of information about what is required to pass exams and also having to relearn dormant information after having been in a particular specialization overseas for a period of time.

It was also raised that lack of current experience in practical tasks was also contributing to the perceived difficulty and that perhaps there should be opportunity made available for people to relearn those skills. There is also a perception that changing the marking system from a grading system (A, B, C, D), to a less specific pass/ fail system, had lowered the pass rate:

“since they have changed the system the pass rate dropped I think to 20%, before it was 70%...there is a fear now for NZREX because the pass rate is not so good”.

It was commonly expressed that the NZREX exam was reasonably fair from personal experience. However it was perceived that the exam was subjective to an extent and that there was lack of standardized answers. This appeared to be based to an extent on information provided by the Overseas doctors association (ODA) which outlined protocols required by different examiners. It was commented that it would be preferred if a standardized system involving standard questions and answers were in place instead, similar to the system which is believed to be in place in Australia.

It was felt that the USMLE exam required learning unnecessary information, such as organisation of the American health system, and also rare diseases such as rocky mountain spotted fever that are of little or no use to doctors working in the NZ health system. It was commented that it would be more appropriate to have an exam that was more specific to NZ. It was also suggested that perhaps instead of having to sit exams that they were assessed in the area of the medicine that they had previously been practicing in and wanted to continue pursuing.

Another suggestion was to adopt a system similar to what they have in Australia where the OTDs are allowed to work before having to sit exams. It was perceived that

this would give the opportunity to understand the health system before having to sit the exams.

“Comparing with Australia, even without exams one could go and work, start working and then after starting to work then you do the exams, probably that would be easier in the sense you get to the system and you know what is going on and then it would be easier for the person to make sense”.

2. Information

It was clearly expressed that there was an overall lack of information and places to access information throughout the whole process; sitting exams, finding employment and when working itself. In relation to the exams it was conveyed that there was not enough information provided to adequately prepare for the exams. The lack of information related to two particular aspects: lack of information specific to the NZ health scene and lack of information about what is expected to pass the exams. Information which relates specifically to the NZ health scene includes such things as the cervical screening programme and strategies for dealing with asthma. It was reported that the recommended textbooks did not provide this information:

“In gynae take for example the cervical screening programme, you know you will not find it anywhere but without that information you cannot pass NZREX”.

It had been suggested that greater access to the bridging programme notes may be a possible way to alleviate this problem.

“So its like this country has got its own set of problems, it has got its own way of approaching them, its got its own way of managing them and the bridging programme just does that, it gives you very limited but specific information as to what you should be knowing from a NZ point of view”. “the bridging programme textbooks were fantastic, very little in volume, very precise in nature so they were very helpful, but I got it from a friend”.

This quote also emphasizes that availability of these notes is currently limited and requires contact with participants of the bridging programme to obtain them.

It was also expressed that there was a lack of information relating to what is expected from the exams. This was defined as not relating to clinical knowledge but other skills and knowledge as required in the examination situation.

“how to prepare for the exam, the exam is not only knowledge, everyone has a knowledge...but how to deal with the exam, what does he (the examiner) want?”.

It was perceived that a key component of preparing for the exams involved talking with other people who had previously sat the exams and finding out about their experiences.

“most of the information that I got were mostly from colleagues experiences, we were gathering feedbacks for the examination, feedbacks for what to study for certain subjects”.

Many attributed their success in exams to the bridging programme and another important exam preparation technique involved studying in groups with people they had met through the bridging programme. Other strategies employed for preparing for the exams included: obtaining bridging programme notes, studying from the recommended textbooks, information obtained from official websites, and information provided from the ODA. It was reported that the ODA was running seminars which would cover particular topics and go over particular cases.

“they sort of tried to go through cases and topics and those things that were well attended to, it was quite popular”.

There also appears to be a limited possibility of obtaining an observer’s post as well as the possibility of having done an internship at a NZ hospital through previous training. Those who had had the opportunity to participate in these found them particularly beneficial for preparing for the exams.

It was expressed that there was a lack of information about job opportunity. Questions revolved around procedure for applying for employment, and also about expectation about the likelihood of finding job.

“after passing NZREX I didn’t know what to do, so I was talking to a colleague and he said oh you will need to go to NCTN (Northern clinical training agency) and apply... I wonder why they didn’t tell us at the bridging programme”.

3. In place of employment;

As discussed previously barriers were met in terms of lack of information about the internal organisation of the hospital. Other information that was requested to be provided included, information about further educational opportunities;

“the difficulties that I have at the moment is sort of getting into paediatrics is really to understand the system and to know whats available and what community services are available for me to access and I don’t know where to get the information from”

It was suggested that a possible improvement would be to gather information about what overseas doctors needed to know and provide specific education for them around that:

To adequately deal with the amount of information required and to create better access it was suggested that there should be a central place where OTDs can access information:

“every step of the way you would have heaps and heaps and heaps of questions but you really don’t know where to get the answers from”.

LIMITATIONS OF THE STUDY

One limitation on the conclusions of this study includes the small sample size. The results of this study is limited to only the views of those OTDs who had completed examination processes and were currently in a place of employment and does not consider the views of ODA in other positions; the views of whom could in fact be quite different. Other positions OTDs could be in include: (1) in the process of passing examinations and (2) those who have passed exams and are looking for employment.

CONCLUSION

This study identified 4 key issues that influenced the initial integration of OTDs into the NZ medical system; (1) work issues, (2) bridging programme, (3) financial difficulties and (4) bureaucratic barriers which include examinations and information. Suggestions for improving the position of OTDs would include

1. Creating a 'one-stop-shop' that would provide all relevant information concerning registration, NXREX, employment prospects post NXREX etc.
2. Ensuring the NZREX is as transparent as is possible in terms of pass rates, content, methods of examining etc.
3. Maintaining an equivalent of the 'bridging program' or utilizing another method of achieving the same results.
4. Ensuring that work positions are available to OTDS and that these positions are commensurate with their experience.
5. That the transition into hospital medicine is carefully regulated.
6. That the Overseas Doctors Association may provide ongoing information about problems inherent in OTDs successfully integrating into the NZ medical workforce.

References:

1. Mullan F, Politzer RM, Davis CH. Medical migration and the physician workforce. *International Medical graduates and American Medicine*. JAMA 1995; 17: 273(19) 1521-7
2. Health Canada. Paving the way for more international medical graduates. March 2004. Available at: www.hc-sc.gc.ca/english/media/releases/2004/2004_08bk1.htm (accessed April 2005)
3. Hagopian A, Thompson MJ, Fordyce M, et al. The migration of physicians from sub-Saharan Africa to the United States of America: measures of the African brain drain. *Human Resources for Health* 2004; 2:17
4. Miller EA, Laugesen M, Lee SY, Mick SS. Emigration of New Zealand and Australian physicians to the United States and the international flow of medical personnel. *Health Policy* 1998; 43(3):253-70.

5. Education and training for permanent resident overseas trained doctors report August 2003. Report can be ordered through the Medical Council of New Zealand: www.mcnz.org.nz/Default.aspx?tabid=1049
6. Barbour RS. Using focus groups in general practice research. *Family Practice* 1995; 12:328-334.
7. Tang KC, Davis A, Sullivan S, Fisher J. A review of 5 existing guidelines for planning focus groups in GP research. *Aust Fam Physician* 1995; 2:184-186.
8. Northey WF. Using QSR NUD*IST to demonstrate confirmability in qualitative research. *Science Review*. 1997; 10:170–179.