The experiences of overseas-trained medical doctors in adjusting to the Australian rural context

Submitted by

Aye Aye Gyi, PhD, MMed Sc, MBBS

A thesis submitted in total fulfilment of the requirements for the degree of

Master of Philosophy

The Joanna Briggs Institute, Faculty of Health Sciences

The University of Adelaide

July 2011
Thesis declaration

This work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution to Aye Aye Gyi and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

I give consent to this copy of my thesis, where deposited in the University Library, being made available for loan and photocopying, subject to the provisions of the Copyright Act 1968.

I also give permission for the digital version of my thesis to be made available on the web, via the University's digital research repository, the Library catalogue and also through web search engines, unless permission has been granted by the University to restrict access for a period of time.

Signature

Date: 30 July 2011
Table of contents

Table of contents ..............................................................................................................4
Acknowledgements ...........................................................................................................7
Abstract .............................................................................................................................8
  Background .....................................................................................................................8
  Objectives ......................................................................................................................8
  Search strategy and selection criteria ..........................................................................8
  Results and discussion ..................................................................................................8
  Conclusion .....................................................................................................................9
  Keywords ......................................................................................................................10

Chapter 1. Introduction to the Study ............................................................................11
  Situating the Study ........................................................................................................11
  Structure of Thesis .......................................................................................................12

Chapter 2: Background to the Study ..........................................................................13
  Factors contributing to the shortage of medical professionals .................................13
  Migration of health workers .........................................................................................14
  Emerging evidence of medical workforce shortage in Australia .............................15
  Rural doctors shortage and retention ..........................................................................16
  Visa pathways, programs and practicing restriction OTDs in Australia ....................16
  Australia’s OTDs registration and training processes ...............................................17
  Discussion ....................................................................................................................19

Chapter 3. Study Design and Methods ......................................................................24
  Review Objective .........................................................................................................24
  Operational definitions.................................................................................................24
  Inclusion criteria ............................................................................................................25
    Type of participants ....................................................................................................25
    Phenomena of interest ...............................................................................................25
    Type of outcome .........................................................................................................26
    Type of studies ............................................................................................................26
    Exclusion criteria .......................................................................................................26
  Search strategy .............................................................................................................26
  Assessment of methodological quality ........................................................................28
  Data collection ..............................................................................................................29
  Data synthesis ..............................................................................................................29
  Conflicts of interest ......................................................................................................29

Chapter 4. Results ........................................................................................................30
  Search Results ............................................................................................................30
  Main findings ..............................................................................................................30

Chapter 5. Synthesis 1: Adequate support systems to ease fear of entrapment are required ........................................................................................................32
Studies.............................................................................................................................32
Themes................................................................................................................................34
Synthesis.............................................................................................................................39
Discussion.............................................................................................................................39
QARI-view of Syntheses 1....................................................................................................41

Chapter 6. Synthesis 2: Transparent standards for determining the eligibility of OTDs is required ......................................................................................................................42
Studies...................................................................................................................................42
Themes...................................................................................................................................43
Synthesis...................................................................................................................................48
Discussion.................................................................................................................................48
QARI-view of Syntheses 2.......................................................................................................53

Chapter 7. Synthesis 3: National standards of English language assessment would maximise the effectiveness of clinical communication ........................................................................54
Studies...................................................................................................................................54
Themes...................................................................................................................................56
Synthesis...................................................................................................................................60
Discussion.................................................................................................................................60
QARI-view of Syntheses 3.......................................................................................................62

Chapter 8. Synthesis 4: Social integration and community support would contribute significantly to the settling in process ............................................................................................63
Studies...................................................................................................................................63
Themes...................................................................................................................................64
Synthesis...................................................................................................................................69
Discussion.................................................................................................................................70
QARI-view of Syntheses 4.......................................................................................................71

Chapter 9. Synthesis 5: Meeting OTDs professional needs is crucial to retaining rural GPs ........................................................................................................................................73
Studies...................................................................................................................................73
Themes...................................................................................................................................74
Synthesis...................................................................................................................................81
Discussion.................................................................................................................................81
QARI-view of Syntheses 5.......................................................................................................83

Chapter 10. Synthesis 6: Cultural transition training programs for OTDs in rural areas are required .......................................................................................................................................84
Studies...................................................................................................................................84
Themes...................................................................................................................................85
Synthesis...................................................................................................................................88
Discussion.................................................................................................................................88
QARI-view of Syntheses 6.......................................................................................................91

Chapter 11. Synthesis 7: Government funding assistance to implement and strengthen locum support for OTDs in rural and remote areas is required ................................................................92
Acknowledgements

I want to thank the following people who have helped support, encourage and motivate me to achieve this goal over the last two years. With their help I was able to turn an interesting question into a research study.

My special thanks to Professor Alan Pearson for getting me started and supporting me in various ways. His encouragement and support were instrumental in my finishing the study.

Professor Heather Gibb was my principal supervisor and mentor during the preparation of this thesis. I greatly appreciated her encouragement, discussions and support.

Dr Zoe Jordan, as my associate supervisor, provided important input at key times during the study. She helped me with valuable media information on overseas trained medical doctors. Without her support and encouragement, I would never have persevered.

Thankyou also to Mr Craig Lockwood for assessing methodological validity of the papers as a secondary reviewer prior to inclusion them in the review.

My special thanks to Dr Sanjiva Wijesinha, Associate Professor of General Practice at Monash University who has helped me with valuable media information on overseas trained medical doctors. I greatly appreciated his willingness to respond my quires at any time despite his very busy schedule.

Finally, I'm deeply grateful to my only immediate family, my 10 years old daughter, who understood and listened to me throughout the process, and makes everyday worthwhile and encourages me at all times.
Abstract

Background
Due to difficulties attracting Australian trained medical practitioners to work outside metropolitan areas, many rural communities are recruiting OTDs to provide medical services. Consequently health services in rural and remote areas are heavily dependent on OTDs to maintain their complement of medical practitioners. The experience of overseas trained medical doctors working in rural areas may be culturally and professionally highly challenging with wide-ranging implications for personal, familial and social life.

Objectives
The objective of this review was to identify the experiences, views, attitudes, and perceptions of OTDs or international medical graduates (IMGs) towards working and living in an Australian rural context.

Search strategy and selection criteria
Published studies from the electronic databases such as PubMed, CINAHL, JBI Library of Systematic Reviews, ERIC, AUSTROM, ProQuest, Scopus, Current Contents, PsychINFO and unpublished studies from Dissertation Abstract International, and Australian Government/Rural and Remote Professional bodies or association web sites were searched between 1990-2010. Qualitative studies examining OTDs’ experiential accounts of working in rural and remote communities in Australia were sought. Participants were OTDs or general practitioners from non-English speaking backgrounds regardless of duration of working experience in rural areas. The review includes the views and perceptions of OTDs and does not specifically consider the views of their spouses and other stakeholders. Two reviewers independently assessed study quality and extracted data using the Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI-QARI).

Results and discussion
A total of 72 papers were identified based on the title and abstract. Of these, 58 studies were excluded as they did not match the review objectives. One study was excluded because of duplicate publication. As a result a total of 59 studies were excluded. Subsequently, 13 papers
were selected for full paper retrieval, and critically appraised. All the selected studies pass the quality appraisal process. As a result all the 13 studies were included. However the overall quality of the all included studies were by and large poor.

While the generic themes generated were about a number of areas of concern reported by OTDs, the review did also identify some positive comments. A common theme running through all of the identified studies was that OTDs, regardless of their visa category and the pathways they used to enter the rural practice, interact with, and are affected by, dimensions of rural place.

A total of 115 findings were analysed into 45 categories which were grouped into seven synthesized findings that related to rural doctors’ subjective experience as follows: 1) Adequate support systems to ease fear of entrapment are required; 2) Transparent standards for determining the eligibility of OTDs is required; 3) National standards of English language assessment would maximise the effectiveness of clinical communication; 4) social integration and community support would contribute significantly to the settling in process; 5) Meeting OTDs professional needs is crucial to retaining rural GPs; 6) Cultural transition training programs for OTDs in rural areas are required; and 7) Government funding assistance to implement and strengthen locum support for OTDs in rural and remote areas is required. Out of these synthesized findings eight specific needs that relate to improving the recruitment rate to rural practices, the retention rate of rural doctors; ensuring high-quality, coordinated actual health care provided by rural practitioners were identified.

**Conclusion**

Qualitative data is not always widely accepted in the research community as a form of evidence. However qualitative findings can provide insights and explanations of a different depth and perspective to quantitative data. Whereas quantitative data are causal, or examine associations, qualitative data are insightful, and offer individualised perspectives on a person’s experiences.

The review identified a number of professional and psychosocial concerns in regards to rural doctors’ experiences associated with adaptation to rural practice and the increasingly complex environment in Australia’s health care system. Analysis resulted in both positive and negative experience themes. These may provide a viable platform for developing the most effective strategy for OTDs to better integrate into the Australian health care system. Based on these results it is important for government and professional organisations, rural General Practice supervisors, regional training providers, divisions and rural workforce agencies to work together to
ensure OTDs are provided with information and support to alleviate their unwanted negative experiences, while confirming warranted positive experiences. Negative experiences should also be discussed to plan strategies for management and further improvement. If the findings are used in this way, an improvement in overall rural placement experience could be expected.

**Keywords**

Chapter 1. Introduction to the Study

Situating the Study

This study examines the extant literature on Overseas Trained Doctors (OTDs) or International Medical Graduates (IMGs) experiences of working in rural and remote Australia. My interest in pursuing this phenomena relate to my own experiences as a migrant medical doctor from Myanmar (formerly known as Burma). In the mid 1990s, doctors who had qualified and trained in other countries migrated to Australia for many reasons. Some arrived as refugees as a result of troubles and turmoil in their original homes where they may have worked for many years, bringing with them years of medical experience. Some came for economic reasons - such as one of my cousins who migrated to Australia in the early 90s because at the time he completed his internship, doctors in Australia were being remunerated for their service at a much higher level than in their native country.

Historically, there has long been the question of the non-acceptance or non-recognition of medical qualifications of doctors from non-Western training backgrounds, where the standards and relevance of knowledge and skills to Australian patient needs are uncertain. This has been variously attributed to the non-transferability of qualifications and skills due to the lack of knowledge about the quality of training in non-Western countries the absence of adequate language and effective communication skills required in Australia; and discrimination and xenophobia based on race and/or gender. Despite being involved in cutting-edge research and having arrived in Australia to undertake post-doctoral research, some doctors trained overseas, still have to sit for the Australian Medical Council qualifying exam to prove they are clinically competent and can treat patients safely.

Because of the reluctance of Australian-trained doctors to work in rural and remote areas, OTDs are required to work in underserved areas in rural and remote Australia. Many doctors who come to Australia from non-Western countries use English as a second language and the educational equivalency to Australian-trained doctors is variable. Given the different experiences of professional and social integration into medical practice, it is likely that the additional demands of adaptation to Australian health services (particularly to rural and remote health areas) may compound the stress experienced by OTDs. In addition to challenges such as fulfilling immigration and medical registration requirements, meeting costs incurred in relocation, and insufficient orientation to local practice and community, OTDs report difficulties with the remoteness of the
area, the degree of morbidity and mortality encountered, the “culture of service”, and relationships with colleagues.

Over the years, OTDs have made an essential and valuable contribution to Australian healthcare. While the majority of native people respect their contribution, discrimination and negative attitudes towards OTDs from local communities are often reported particularly from those who have arrived at a time when they were not particularly welcome in Australia. Many rural communities may have had little exposure to people from other cultures and may not initially welcome OTDs with different customs and beliefs.

Many qualitative studies and a number of scholarly theses by higher degree by research students in Australia have provided detailed accounts of OTDs’ motivations, challenges and rewards in rural practice with honest and forthright descriptions. However, to date there has been no synthesized body of evidence on the subjective experience of this diverse medical workforce working in rural areas. This study set out to redress this gap.

**Structure of Thesis**

The thesis comprises twelve chapters. The first chapter presents the Introduction to the study. Background to the study is presented in Chapter Two. It examines the extant literature on the international and Australian medical workforce, the political nature of the Australian medical system, international trends highlighting the importance of the labour market integration of OTDs to rural areas, and a description of pathways and visa requirement for OTDs to practice in rural Australia. This background information provides the framework for the secondary analysis of the international research literature following the Joanna Briggs Institute methodology for the systematic review of evidence.

Chapter 3 includes the secondary analysis of the international evidence followed the conventions associated with the systematic review process adhered to by the Joanna Briggs Institute. Chapter 4 presents search results and main findings. Chapter 5 to 11 presents the synthesized evidence generated from the analysis. Also included in these Chapters is a discussion of each theme and synthesis and what all these syntheses contribute in terms of appropriate support. Chapter 12 summarizes the study and, based on the synthesis, suggests areas for future research. The chapter ends with an outline of the limitations of the study and of the additional studies included in the review beyond the Australian context.
Chapter 2: Background to the Study

Among the key components of a well functioning health care system, the complementary supply of medical practitioners is the centre of attention in the international literature. The delivery of an appropriate quantity and quality of health care in an efficient way requires matching the supply with the demand for services of medical practitioners over time. Many countries are running into shortages in this area.

As a result of direct outcome of the strict criteria for the education and registration of medical practitioners, the shortage of medical practitioners in England in the 1880s was such that there was “imminent danger” that qualified medical care might become “quite inaccessible to vast numbers of people”. Now the dilemma of Victorian England has become a global problem.¹

It has been estimated by the World Health Organization that whilst there are nearly 59.2 million full-time paid health workers worldwide, there is currently a critical shortage of healthcare provider's equivalent to a global deficit approaching 4.3 million health workers.¹ The greatest numerical deficit occurs in South-East Asia, dominated by the needs of Bangladesh, India and Indonesia, while the greatest proportional shortfalls exist in sub-Saharan Africa, where the WHO estimates an increase in health workers of almost 140% is necessary to meet the health needs of its population.¹ Furthermore, the African Region has "24% of the burden (of global disease) but only 3% of health workers commanding less than 1% of world health expenditure".¹ Conversely, the Americas have "10% of the global burden of disease has 37% of the world's health workers spending more than 50% of the world's health financing".¹

Factors contributing to the shortage of medical professionals

Australia, like many other developed countries, has faced medical workforce shortages.² A number of factors have contributed to our doctor shortage, including increasing demands from an aging population and a decline in the hours worked by medical practitioners.² Prominent among these is federal government policy in the 1990s, which limited the number of medical school places in Australia.¹ Compounding this policy is the government's restriction on entry to general practice based on the 1996 legislation requiring all future medical graduates who wished to practice as general practitioners to complete a postgraduate family medicine course first. The annual number of training places allocated for those wishing to enter the program was initially limited to 400. This restriction on entry to general practice sharply cut the number of new entrants to the general
practice field and contributed to a widening shortage in the supply of GPs, making it harder for regional areas to attract locally trained GPs.

Australia’s population is concentrated in the coastal region and OTDs are often required to service the more sparsely populated rural and remote areas, which find it difficult to attract and retain local medical graduates. As a result, rural and remote areas are designated “Areas of Need” and are heavily dependent on OTDs to maintain their complement of medical practitioners. This has led to an Australian labour market increasingly dependent on OTDs.³

It has been argued that Australia’s extensive reliance on OTDs stems from “faulty planning”.⁴ During the late 1980s and early 1990s, the prevailing policy view was that there was an oversupply of health professionals in Australia.⁴ Various “remedial” steps were taken, such as capping the number of medical school places, restricting the number of doctors entering certain sectors of the medical profession and constraining the number of OTDs entering the Australian medical workforce.⁴ Noble argues that the cutting of medical student places overlooked two critical issues. First, that Australians’ views of work were changing and that employees were opting for greater work-life balance. This meant that doctors were choosing to work less. Secondly, Noble contends that the feminisation of the medical workforce (he reports that more than half of medical graduates are female) has meant that female medical professionals work significantly less hours than their male colleagues, primarily because of their child-rearing role. These factors contribute to the shortage of medical professionals. Australia’s extensive utilisation of OTDs has been referred to as a “shorter term policy lever” and is said to avoid the “considerable time lag involved in educating and training a doctor in Australia”⁵

Migration of health workers

Globalization has helped to drive international migration. Many medical doctors migrate to high-income countries where demand for health workers is ever increasing to enable them to earn more money, to increase job satisfaction and career or training opportunities. Others move away from political instability, war, and the threat of violence in the workplace.

In an era of globalization, all the population in the world has the legitimate right to migrate; accelerated doctor migration and mobility have resulted in increasing numbers of doctors from different parts of the world working together.⁶ The immigration of doctors has historically occurred by their inclusion in the general migration or refugee intakes of countries such as Canada, New
Zealand, USA and the UK. Reflecting international trends, the total number of OTDs in Australia is steadily increasing.  

Emerging evidence of medical workforce shortage in Australia

In the Australian context, an overseas trained doctor is a doctor who obtained their primary medical qualification in a country other than Australia or New Zealand. The point of entry into the workforce for most of them is through selective intake to designated rural and remote areas of unmet need, with corresponding location-restricted provider numbers. The Australian labour market is increasingly dependent on international medical graduates. This situation is particularly obvious in rural General Practice. While nationally they comprise at least 25% of the general practice workforce, more than a third of rural general practitioners are OTDs (37% in 2005–06). Thus, these two workforce strategies geographically overlap in Australia’s vast under-served outback. According to the Department of Health and Ageing, there were 2447 OTDs practicing in Australia in April 2005. This figure represented an increase of 21.6 per cent over the previous 12 months. In its submission to the Productivity Commission, the Australian Medical Association (AMA) claimed that in 1993 - 1994, 670 OTDs were granted visas. In 2003 - 2004, that number is alleged to have increased to 2249.

The background of OTD migrating to Australia has changed dramatically in recent years. These doctors come from a range of professional and cultural backgrounds. In 1997, the majority were from the United Kingdom (UK) (70 per cent), which has a comparable health system to Australia’s. However, by 2002-2003, this figure had fallen to 43 per cent. Figures presented at the 9th International Medical Workforce Collaborative Conference in Melbourne in 2005 indicated that the largest single group of OTDs practicing in Australia was from the United Kingdom, closely followed by the Indian subcontinent, Malaysia and Singapore, followed by the rest of Asia.

OTDs practicing in Australia are sometimes disadvantaged through being educated, trained and having usually practiced in cultural settings where disease patterns, levels of technology, treatment options, forms of health care delivery, workplace hierarchies and etiquette differ markedly from those in Australia.
Rural doctors shortage and retention

The number of OTDs filling general practice training positions in Australia has been steadily increasing, particularly in rural areas of need. However, retention of OTD in rural and remote areas appears to be difficult. OTDs often seek to relocate to cities and metropolitan areas after completing their initial period of service in An Area of Need or a District of Workforce Shortage. Another difficulty is the increasing global competition to recruit health professionals. The AMA Position Statement on OTDs emphasizes Australia's global responsibility to ensure that it expands its own pool of Australian-trained doctors to ensure that it has an adequate medical workforce to meet the future health needs of the population.

Our increased dependence on OTDs is reflected by recent bureaucratic activity attending the government's announced Strengthening Medicare package, with its additional 725 OTDs working in Australia by 2007. One consequence has been the generation of a report on OTDs submitted to the Medical Training Review Panel of the Australian Department of Health and Ageing in February 2004. It outlines a bewildering array of Australian policies and guidelines, and differing surveillance and stewardship of OTDs programs. The report identifies: enormous inconsistencies in terminology; lack of national coordination in collection of data on OTDs; inadequacy of data held by different agencies and departments; and differing entry points of OTD controlled by different jurisdictions.

Visa pathways, programs and practicing restriction OTDs in Australia

While OTDs can take up practice in Australia under a variety of schemes, the main pathway by which they have entered Australian medical practice are as temporary resident OTDs, occupational trainees or permanent resident OTDs.

Under the current federal system of government in Australia, the states and territories are responsible for the licensing of medical practitioners. This process is administered by the State and Territory Medical Boards using the individual Medical (Practitioners) Acts. Although in 1991 all states and territories agreed to a national standard of non-specialist registration for Overseas trained medical doctors (the AMC examination followed by 12 months of supervised practice), each state and territory has discretionary powers under its relevant legislation to register individual practitioners who do not meet the agreed national standard where it is in the public interest to do so. This provision is commonly used for what is called the Area of Need category.
does not qualify an applicant for full registration and usually carries with it a time limitation, a geographic limitation, or some limitation on the scope of practice. In brief, OTDs must complete the Australian Medical Council's Multiple Choice Questionnaire and clinical exams and 12 months of supervised Australian hospital training unless they are considered suitable to work in an 'Area of Need'.

While an ‘Area of Need’ is defined as a geographic area that has a lack of medical practitioners, similarly, a District of Workforce Shortage is defined as a geographic area in which the general population's need for health care is not met. As such, the majority of OTDs are allocated to positions in rural or remote locations, under ‘Area of Need’ and District of Workforce Shortage schemes. However, regrettfully, in such (often remote and culturally isolated) locations, the support structures, supervision and training available to doctors practicing in major cities and metropolitan areas are often lacking. These categories of registration are not subject to the same, stringent requirements that apply to Australian trained doctors.

For most OTDs, ‘Area of Need’ certification is a condition of obtaining medical registration. ‘Area of Need’ requirements apply to both public and private sector positions. Furthermore, the Australian Government requires who wish to access the Medicare Benefits System to be registered with a State or Territory Medical Board and to practice in a District of Workforce Shortage. This practicing restriction usually applies to OTDs who gain permanent residency for a minimum of 10 years, and it applies to temporary resident OTDs indefinitely.

Those without permanent residency may join the Victorian OTDs Rural Recruitment Scheme or equivalent in other states/territories, which offers them a Medicare provider number after working in the rural community and obtaining the Royal Australian College of General Practitioners (RACGP) Fellowship within two years. Between 2000 and 2003, 1176 OTDs were approved to work in Victorian ‘Areas of Need’.

**Australia's OTDs registration and training processes**

Overseas trained medical doctors may be granted permanent residency status predominantly by entering Australia as a New Zealand citizen (most of whom were third-country entrants), as a spouse sponsored by an Australian citizen, or as an accompanying spouse of a migrant. However, these doctors possess medical qualifications from an overseas university that are not recognized by the AMC.
From the 2004 Australian Medical Workforce Advisory Committee (AMWAC) report, the numbers of OTDs entering Australia with permanent residency status have been increasing. Given the continuing workforce shortages in particular areas, it is expected that these numbers will continue to escalate in the foreseeable future, or at least until more recent local graduate strategies take effect.

The Medical Boards of the Australian States and Territories are responsible for the registration and regulation of all health workers, including OTDs. Australia’s OTDs registration and training processes differ significantly to those of other developed countries with comparable health systems. In Canada, the United States and the United Kingdom, an OTD’s English language; medical knowledge and clinical skills must be proven before they are allowed to practice. Canada and the United States also require OTDs to initially serve in a probationary hospital residency position.

While the Medical Boards of the Australian States and Territories are responsible for the registration and regulation of all health workers, there is no national standard for the assessment and registration of OTDs in Australia and each Medical Board prescribes its own standards. Although a national accreditation process for OTDs exists, many of them are recruited directly to Australian hospitals and community practices without adequate assessment of their qualifications or language and clinical skills. The consequence of this is that the overseas trained medical doctors’ registration processes are “fragmented, inconsistent and confusing”. Birrell argues that there is rarely any systematic evaluation of the medical knowledge and clinical skills of overseas trained medical doctors before they are permitted to practice, particularly in the case of temporary resident doctors. Birrell also reported that “until recently most Medical Boards did not require overseas trained medical doctors to pass an English language proficiency test”.

In Australia, OTDs accredited by the Australian Medical Council (AMC) are considered to possess qualifications equivalent to those of Australian doctors. However, the majority of OTDs practicing in Australia are temporary resident doctors and, unlike permanent resident OTDs with unconditional practicing rights, do not require AMC accreditation.

Upon arriving in Australia, OTDs do not have to undergo mandatory orientation or training programs. However, some OTDs orientation programs are in operation. Sullivan et al describe a four-week, voluntary program undertaken in New South Wales, which consisted of core group teaching and a hospital clinical attachment. The curriculum included communication, health and
workplace skills, culture shock sessions and the role of junior doctors. The program is said to have enabled the OTDs to have a more equitable entry into the public hospital system, resulting in a more integrated, confident and functional workforce.

The Australian Government’s Strengthening Medicare package has attempted to address some of the aforementioned shortcomings and includes measures designed to enhance the opportunities for OTDs to practice in Australia. These include opportunities to extend stays or obtain permanent residency, listing medical practitioners on the skilled occupations list used for the General Skilled Migration Program (consequently medical practitioners no longer require a sponsor to migrate to Australia), improving the identification, assessment and counselling of potential OTDs’s support programs for OTDs in Australia and reducing red tape.

However, OTDs, especially from Asia and the Middle East, are likely to encounter difficulties to meet the performance targets, adjusting to life in a Western culture and reactions to separation from extended family and friends. In addition, OTDs have to cope with practicing medicine in an English-language environment and adjusting to the “medical culture” or way that medicine is practiced in Australia. OTDs need to quickly grasp the protocols of the medical practices to which they are attached and the organisation of state and federal health systems. In addition, they have to cope with changes in self-esteem, differences in learning styles, new patterns of disease, and communication issues. Moreover, due to their disparate and often non-Western medical training and experience, some OTDs practicing in Australia may not have previously been exposed to comparable clinical governance mechanisms.

Because OTDs are regarded as a very important part of the rural Australian medical workforce, understanding the nature of the personal experience, views, attitudes, and perceptions towards working and living in an Australian rural practice can assist in anticipating the challenges they may face. Such an understanding can also provide more culturally sensitive support programs for OTDs so that they can make a more substantial contribution to Australian rural health care practice.

Discussion

Throughout Australia the demand for healthcare has increased but currently there are not enough healthcare workers who can provide that care for the population. This is particularly the case in
rural and remote areas. Recruitment of healthcare professionals and specialists to rural and remote areas is proving difficult due to factors such as unfamiliarity with rural life, lack of facilities and resources, cultural isolation and ‘the tyranny of distance’, family commitments, lack of spouse employment opportunities, lifestyle and fear of unknown environments.  

In the face of Australian-trained doctors often being reluctant to work in rural and remote areas, it has been suggested that the shortage of healthcare workers in rural and remote areas be dealt with by employing International Medical Graduates, previously known as OTDs. Health services in rural and remote areas have consequently been designated ‘Areas of Need’, and they are heavily dependent on OTDs holding temporary resident visas to maintain their complement of medical practitioners. For example, the number of the OTDs filling general practice training positions in Australia has been steadily increasing since the end of the 1990s, particularly in rural ‘Areas of Need’. While assessment standards vary according to state and field of medicine, most OTDs holding temporary resident visas are appointed without a formal assessment of their medical knowledge and clinical skills; registration to practice is conditional only on their working in hospitals and ‘Areas of Need’. Currently, OTDs occupy more than 25% of Australia’s medical workforce, with about 65% of them working in locations outside capital cities. In rural and regional areas during 1995-96 to 2003-4 there was an 8.8% increase in Australian-trained GPs compared to an 80% increase in overseas-trained GPs. The proportion of medical registrants who are conditionally registered as temporary resident doctors increases with remoteness, particularly in Western Australia and Queensland.

Australia has historically been a culturally diverse nation with migrants coming from a wide variety of societies and countries. This has led to a greater sensitivity regarding intercultural awareness and respect through people from different cultures interacting with each other. While this enriching interaction is evident in large cities like Sydney and Melbourne, this situation is very different in the Australian rural or remote context. Living in an isolated rural area is challenging for health professionals who were brought up and worked in urban areas, particularly those born overseas as they experience two types of cultural and social adaptation: from urban to rural and from native culture to new culture. The literature on this topic has reported recurring themes which are as follows: culture shock, homesickness, communication difficulties, social isolation, anxiety and accommodation issues.

The Commonwealth Department of Health, with the assistance of the Rural Doctors Workforce Agency (RDWA), has attempted to maintain the quality of healthcare delivered to Australia’s rural
communities by ensuring strategies in place for the effective placement, and skills matching for OTDs. For example, in 1999 the Commonwealth Department of Health and Aged Care and RDWA announced a scheme to help address, in the short term, problems of general practice workforce shortages in rural and remote Australia.

A strategy to deal with general practitioner workforce shortages in rural and remote areas of Australia was developed, now known as the 5 year Overseas Trained Doctor Scheme. The name of this scheme may vary across the States and Territories (such as the ‘Doctors for the Bush’ scheme). OTDs joining the scheme have to work in a position that has been difficult to fill, otherwise known as an Area of Need position, for a minimum of 5 years and gain permanent residency during this time. It is also a requirement of the scheme that the OTDs have adequate and appropriate supervision for the duration of their employment. However, these programs do not meet all the expectations and needs of health professionals who were born and trained overseas and now working in Australia. Their experiences in fact are quite different from those of Australian graduates. This claim is supported by the research conducted by McGrath, who wrote in 2004 that, "Australian healthcare is greatly enriched by its overseas trained medical doctors. However there is no national approach to support the integration of OTDs into the workforce. The problem areas need to be well-defined".

OTDs are increasingly being recruited from countries with variable English language and educational equivalency compared to Australian trained doctors. While the largest single group of OTDs practicing in Australia came from the United Kingdom, closely followed by the Indian subcontinent, Malaysia and Singapore, followed by the rest of Asia, those OTDs who are likely to encounter difficulties adjusting to life in a Western culture and reactions to separation from extended family and friends, are coming from Asia and the Middle East.

In 2003 a Steering Committee from the Australian Federal Government, State and Northern Territory departments of health undertook a postal survey of OTDs participating in Australia’s 5-Year Overseas Trained Doctor Scheme. While this report did not seek to draw conclusions about the effectiveness of the program, it did provide a quantitative scientific approach that highlighted issues emerging from the findings and information useful to rural and remote communities, the Australian Federal Government, State and Territory governments, RDWA and current and future doctors participating in the scheme. In short, rural and remote communities have experienced difficulties recruiting doctors. However, this quantitative survey could not articulate in-depth intensive information or document the participants’ experiences in the complex area of recruitment.
Qualitative research is interested in finding answers to questions that involve human consciousness and subjectivity, and values people and their experiences in the research process. Consequently the experience of OTDs working in rural areas may be culturally and professionally highly challenging with wide-ranging implications for personal, familial and social life. An investigation of OTDs’ experiences of how to overcome the difficulties or challenges, and how to adjust to life in a rural culture would be greatly enriched by implementing a qualitative interpretive approach.

Current qualitative studies examining the life experiences and acculturation of OTDs from Asia working in rural remote Australia discovered that working in rural and remote Australia is culturally and professionally highly challenging. These studies described the OTDs experience, views and attitudes towards working in an Australian rural context along with the process/strategies they used to adapt to a new rural environment. Essential strategies the OTDs to adapt to a new workplace reported in the literature varied from collaborating, distancing, adjusting, repairing and accommodating.

Gilles (2008) recently examined the factors affecting OTDs professional, cultural and social integration along with their training and support needs. Interviews were done with spouses/partners, professional colleagues, co-workers, and Aboriginal and Torres Strait Islander community members associated with the health service. The following key themes emerged: addressing recruitment, orientation and cross-cultural issues and the importance of effective communication and building community and institutional relationships, both with the local health service and the broader medical establishment.

In addition, a recent study explored the differences between the practice patterns of OTDs and Australian Trained Graduates (ATGs) working in rural and remote Australia. The analysis involved a comparison of Medicare services provided by OTDs and ATGs practicing across a number of GP demographics. While the quantitative data indicated some differences between the two groups across certain Medicare items, OTDs’ subjective accounts of main factors contributing to these differences was explored by a qualitative focus group interview. Also investigated in the focus group interview were: the OTDs’ experience and views regarding the most helpful types of assistance and support, the most important facilitating factors and the most important barriers. This study highlights the issues required to improve the recruitment of OTDs to work in areas of workforce shortage.
Clinicians and recruitment agencies responsible for supporting and training OTDs need a thorough understanding of the range of issues confronting OTDs. Trainers should be aware that OTDs are not a homogeneous group and those culturally diverse medical practitioners bring multiple perspectives to issues. As a result, the diversity and complexity of the cultural interfaces in health service provision in rural Australia must be synthesized so that health care policy makers can improve the living and working conditions of OTDs in order to attract them to rural Australia.

The systematic reviews of Konno (2006) and Pillotto (2007) attempted to summarise the best available evidence supporting overseas nurses’ adjustment to Australian nursing practice, and OTDs’ communication-related issues during their training in clinical practice in Australia. While they focused on issues concerning overseas nurses and medical doctors adjustment to the Australian healthcare system in terms of program evaluation in the education sector, these reviews did not provide any real insight into the lived experience of OTDs working in rural and remote areas. Furthermore, the literature in Konno’s review included work published only up to 2003 and in Pillotto’s study, published research up to 2006. In addition, Konno’s work only focused on nurses experiences. Consequently, more recent views and qualitative evidence emerging from the studies undertaken in the latter part of 2006 were not incorporated in these reviews.

Because OTDs are regarded as a very important part of the rural Australian medical workforce, understanding the nature of the personal experience, workforce agencies and current existing programs can anticipate their problems. Such an understanding can also provide more culturally sensitive support programs for OTDs so that they can make a more substantial contribution to Australian rural health care practice.

This review aims to explore the diversity and complexity of the cultural interfaces by OTDs working and living in rural Australia. Synthesized findings will inform the healthcare policy makers with how to improve the working and living conditions of OTDs in order to attract them to rural Australia.
Chapter 3. Study Design and Methods

The secondary analysis of the international evidence followed the conventions associated with the systematic review process adhered to by the Joanna Briggs Institute.

Review Objective

The objective of this review was to identify OTDs’ experiences, views, attitudes, and perceptions towards working and living in an Australian rural context.

Operational definitions

Rural and Remote Area classification (RARA)\textsuperscript{21}

Metropolitan – Signifies a major city. In Australia, these are usually the state capitals, although some major coastal towns, such as Wollongong, Geelong, Newcastle and Tweed Heads are also metropolitan areas. Larger towns in the far north of Australia – namely Darwin, Cairns and Townsville – may be regarded as metropolitan areas but are often treated as rural, due to their isolated location.\textsuperscript{21}

Urban – Signifies any built-up area and not entirely interchangeable with metropolitan. An urbanised area may still be considered rural, in the case of a large country town for instance.\textsuperscript{21}

Outer Metropolitan – Refers to areas on the outskirts of major cities that, while either too densely populated or too close to the city to be considered rural, have fewer services and resources than most city suburbs. May also include satellite towns of major cities (e.g. Geelong, Ipswich) and small communities with structure similar to rural towns but within easy access of the city.\textsuperscript{21}

Area of Need – Refers to any area where a particular service (usually a health service) is under-supplied. While rural areas are almost always Areas of Need, not all Areas of Need are in rural areas.\textsuperscript{16}

Regional – Refers to any area outside the capitals. Most commonly used with reference to larger centres and less remote areas.\textsuperscript{21}
Rural – Refers to all non-metropolitan regions, but may have a specific definition in some contexts (e.g. the RRMA, as above). Rural towns are smaller and have different socio-economic and service structures to major cities. 24

Remote – Refers to any town or area that is significantly removed from major service centres. Usually these are smaller towns, though Australia also has some larger remote centres. 21

ARIA (Accessibility/Remoteness Index of Australia) classification25

ARIA classification consists of five ARIA classes (Highly Accessible, Accessible, Moderately Accessible, Remote and Very Remote). Each ARIA class is defined by a range of ARIA index values that refers to a continuous variable (with values ranging from 0 to 12) assigned to populated localities.25

ASGC (Australian Standard Geographical Classification) Remoteness Areas classification17

ASGC Remoteness Area classification consists of six ASGC Remoteness Area classes (Major Cities, Inner Regional, Outer Regional, Remote, Very Remote and Migratory).17

Inclusion criteria

Type of participants

While the current pathways that assist OTDs to enter medical practice in Australia are broad, this review primarily considered publications that include temporary resident OTDs from English versus non English speaking backgrounds recruited into rural and remote areas through Australia’s 5-Year Overseas Trained Doctor Scheme regardless of duration of their length of experience in Rural Australia. In the absence of this information this review considered all the studies describing OTDs’ experience in rural practice.

Phenomena of interest

This review considered studies that investigate the difficulties OTDs face in the process of adapting to a rural health service (such as cultural shock, difficult working conditions, isolation, and family issues). In addition, their positive experiences in terms of factors or strategies that help them to adapt to their new working and living rural environment (such as social and cultural capital, local community awareness, health resources), were also investigated.
Type of outcome

The types of data incorporated OTDs’ experiential accounts of working in rural and remote communities in Australia.

Type of studies

This review considered interpretive studies that draw on the experiences of OTDs and include, but not be limited to, designs such as phenomenology, cultural theory, grounded theory, ethnography, action research and feminist research.

Exclusion criteria

Subjective experience of spouse, work colleagues, local community, professional associations were excluded. Program evaluation studies, quantitative studies, surveys, and government policy papers were also excluded.

Search strategy

Since the late 1990s Australian employers have recruited an increasing number of OTDs to ‘Areas of Need’ positions through the 5-Year Overseas Trained Doctor Scheme. As such the search strategy aims to find both published and unpublished studies for a period of 1990-2010. A three-step search strategy was utilised in each component of this review. Firstly, an initial limited search of PubMed and CINAHL was undertaken followed by an analysis of the text words contained in the title and abstract, and of the index terms used to describe the article. A second search using all identified keywords and index terms were then undertaken across all included databases. Thirdly, the reference lists of all identified reports and articles were searched for additional studies.

The search strategy used was as follows:

1. Databases

PubMed, CINAHL, JBI Library of Systematic Reviews, ERIC, AUSTROM, ProQuest, Scopus, Current Contents, PsychINFO

2. Journals

Medical Journal of Australia
Australian Journal of Rural Health
The New Zealand Medical Journal
Australian Health Review
Rural and Remote Health Journal
The Canadian Journal of Rural Medicine
Rural workforce special issue of WHO Bulletin

3. Unpublished studies or Grey Literature

Australian Digital Thesis Program
Dissertation Abstracts International
Mednar
Conference Proceedings

4. Australian Government/Rural and Remote Professional bodies or association web sites

Department of Health and Ageing
Australian Medical Council
Royal Australian College of General Practitioners
Area of Need Program (New South Wales)
Medical Board of Queensland
Medical Board of South Australia
Medical Board of Victoria
Medical Board of Western Australia
Medical Board of New South Wales
Medical Board of Tasmania
Postgraduate Medical Institute of Queensland
Postgraduate Medical Institute of Victoria
Postgraduate Medical Institute of Western Australia
Postgraduate Medical Institute of New South Wales
Postgraduate Medical Institute of Tasmania
Rural Health Workforce Australia
Rural and Remote Health Workforce South Australia
Rural and Remote Health Workforce Queensland
Rural and Remote Health Workforce Victoria
Rural and Remote Health Workforce Western Australia
Rural and Remote Health Workforce New South Wales (Areas of Need)
Rural and Remote Health Workforce Tasmania

Initial keywords used are:


Assessment of methodological quality

Qualitative papers selected for retrieval were assessed by two independent reviewers for methodological validity prior to inclusion in the review using standardised critical appraisal
instruments from the Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI-QARI). No disagreements arose between the reviewers.

Data collection

Qualitative data were extracted from papers included in the review using the standardised data extraction tool from the Joanna Briggs Institute Qualitative Assessment and Review Instrument JBI-QARI (Appendix 3). The data extracted included specific details about the interventions/phenomena of interest, populations, study methods and outcomes of significance to the review question and specific objectives.

Data synthesis

Qualitative research findings were pooled using the Qualitative Assessment and Review Instrument (JBI-QARI). This involves the aggregation or synthesis of findings to generate a set of statements that represent that aggregation, through assembling the findings (Level 1 findings) rates according to their quality, and categorising these findings on the basis of similarity in meaning (Level 2 findings). These categories were then subjected to a meta-synthesis in order to produce a single comprehensive set of synthesised findings (Level 3 findings) that can be used as a basis for evidence-based practice.

Conflicts of interest

There were no conflicts of interest associated with this systematic review.
Chapter 4. Results

Search Results

A total of 72 papers were identified based on the title and abstract. Of these, 58 studies were excluded, as they did not match the review objectives. One study was excluded because of duplicate publication. As a result a total of 59 studies were excluded. Subsequently, 13 papers were selected for full paper retrieval, and critically appraised. All the selected studies pass the quality appraisal process. As a result all the 13 studies were included. (Refer to Figure 1; Appendix 1). However the overall quality of the all included studies were by and large poor. A list of the excluded studies and the reasons for exclusion are set out in Appendix 4.

Main findings

While the generic themes generated are about a number of areas of concern reported by the OTDs, the review did identify positive and aspiration comments. A common theme running through all of these studies is that OTDs regardless of their visa category and the pathways they used to enter the rural practice, interact with, and are affected by, dimensions of rural place.

The review identified a number of professional and psychosocial concerns in regards to experiences associated with adaptation to rural practice and the increasingly complex environment in Australia’s health care system. Analysis resulted in both positive and negative experience themes. These may provide a viable platform for developing the most effective strategy for the OTDs to better integrate to Australia health care system. Based on these results it is important for government and professional organizations, GP supervisors, regional training providers, Divisions and rural workforce agencies to work together to ensure OTDs are provided with information and support to alleviate their unwanted negative experiences, while confirming warranted positive experiences. Negative experience should also be discussed to plan strategies for managing and further improvement. If the findings are used in this way, an improvement in overall rural placement experience could be expected.

In brief, a total of 115 findings are analysed into 45 categories which are grouped into seven synthesized findings that related to rural OTDs’ subjective experience of: (1) relocation to practice in rural and remote Australia; (2) going through the pathways to rural employment and endeavouring recognition of overseas degree); (3) interaction with rural communities comprising
distressing and voices of racism; (4) social integration with aspiration on community support that contributed significantly to the settling in process; (5) professional integration revealing stirring emotion on limited professional support and career opportunities; (6) interaction with rural patients: extremely worrying voices on doctor patient communication; and (7) government funding assistance to implement and strengthen some for locum general practice activities.
Chapter 5. Synthesis 1: Adequate support systems to ease fear of entrapment are required

Six themes were identified that capture the subjective experience of OTDs' about factors that have attracted them to rural areas; those which keep them there; and the factors which might prompt them to leave.

While the first theme "a sense of entrapment" focussed on negative expectations it was also viewed positively by OTDs because it kept them there. The second to fourth themes inclusive are related to positive experiences regarding factors that have attracted OTDs to rural areas. Circumstances under which OTDs arrived in Australia and New Zealand were addressed in the fourth theme. Astonishingly the final theme typified OTDs' ability to successfully resolve professional concerns through a process of moving from loss, through disorientation, to adaptation, which completes the transition to becoming a rural doctor.

Studies

Four studies were included under this section; two studies were conducted in Australia, one in New Zealand and one from Canada as follows:


In 2008, McFayden explored potential barriers preventing large numbers of permanent resident OTDs from working as general practitioners (GPs) in rural New South Wales (NSW).26 The study focused specifically on doctors from non-English speaking backgrounds who were permanent
residents of Australia or Australian citizens, and who migrated to Australia for reasons other than employment. This thesis explores the views and perceptions of permanent resident OTDs and does not specifically consider the views of other stakeholders. While the researcher used a mixed method approach, themes and rich data related to the qualitative approach are only extracted and used in the review.

New Zealand, like many First World countries, has become increasingly dependent on OTDs. The location of rural communities in New Zealand presents particular challenges in the context of primary healthcare delivery. A qualitative study conducted in 2006 identified and explored issues of concern to OTDs when first integrating into the New Zealand medical system through the rural recruitment pathway.\textsuperscript{27} The data were collected using semi-structured interviews and focus groups involving 10 medical doctors graduated from overseas medical schools and Institute who were working in a New Zealand hospital, presumably in a rural area. Five of the participants were from Eastern European countries, four from Asian countries, and one from the Middle East. Transcripts were subjected to thematic analysis.

Another study, also conducted in 2006, investigated what keeps doctors ‘in place’ in New Zealand rural communities and what prompts their departure from practice.\textsuperscript{28} The study was based on in-depth interviews conducted with nine overseas-trained medical practitioners within rural areas in New Zealand during 2004. The OTDs interviewed had qualified in countries including the United Kingdom, South Africa and Australia, and were working in a range of diverse rural communities throughout New Zealand. The authors confirmed the rurality of all the Practices on the basis of Rural ranking scale scores (ranged between 35 and 80). The majority of participants were likely to be from non-English speaking backgrounds.

The work of Wong & Lohfeld 2008 \textsuperscript{29} aimed to describe the views and experiences of OTDs certifying to practice medicine in Ontario, Canada. A phenomenological (qualitative) research approach (utilising Van Manen and Cohen et al proponents of interpretive phenomenology) was undertaken for this study. There were 12 study participants involved in the interview: 5 women and 7 men, were from Asia, Latin America, the Middle East, the Caribbean and Eastern Europe.
Each of the themes identified are discussed below.

**Themes**

**Theme 1: A sense of being trapped**

The theme of entrapment is a common consideration among OTDs’ and policy concerning rural doctors. Some OTDs have noted the distance from main centres as promoting a sense of being trapped while others reported feelings of social and financial entrapment. One OTD reported a sense of entrapment arising from physical isolation and distance from main urban centres.

The key illustrations of these situations are presented below:

Finding 1: Distance from main centres as promoting a sense of being trapped. (C)

Illustration 1: I feel physical entrapment … The nearest centre is 2 and whether or not to leave town to make that journey on any given occasion has to be a major decision. (p537)

Finding 2: Overseas trained medical doctors reported feelings of social and financial entrapment. (C)

Illustration 2: I live elsewhere [from where I work] and I know the common theme of entrapment often comes from a sense of responsibility to the people. I feel trapped in a professional sense … I am unable to do much but practice medicine, and I have little control over my work conditions … I have no control over how hard I work because I need to provide a service and I need to earn enough money to sustain my family. (p537)

Finding 3: The difficulty to on-sell the practice and the house. (C)

Illustration 3: The inability to find someone to take over is a huge problem… I have been working with one of the doctors here for 27 years … it's like a marriage … There is no way I could walk out on that. (p537)
Theme 2: Appreciate the continuity of care

Respondents commonly expressed that the delivery of healthcare in a rural settings can start in the doctor’s office and end up in the local hospital, whereas the GP’s role in an urban setting is largely finished when they refer a patient to hospital care. Two of the respondents saw this continuity of care as a major 'pull' factor: Overall rural doctors were satisfied with their current medical practice.

The key illustrations indicative of these experiences are presented below:

Finding 4: Continuity of care is recurring findings voiced by all OTDs as what they most enjoyed about rural practice or what rural practice offers them. (C)

Illustration 4: The things I most enjoy are the close relationships with the patients and the ability to care for them beyond the practice into the hospital.(p537) ¹

Theme 3: Intention to live and work as a doctor in rural Australia

While opportune circumstances brought many of these OTDs to Australia, New Zealand and the particular rural community they currently serve, the attractions of a rural, over an urban, lifestyle were explicitly acknowledged. Several respondents commented on the more relaxed lifestyle they enjoy in their rural area. Despite the fact that some OTDs found the transition more difficult than others, most had made the decision to come to Australia with the intention of staying. Overall rural doctors were content with their life as a rural doctor intended to remain in rural practice.

The illustration to support this evidence is presented below.

Finding 5: All participants wanted to work as a doctor in Australia, the majority in general practice. (C)

Illustration 5: It's a goal and a dream in Australia to work as a GP. That's my dream and my goal. (p 207)²⁶

Finding 6: The attractions of a rural, rather than an urban, lifestyle were explicitly acknowledged. (C)
Illustration 6: A rural lifestyle offers a relaxed environment, fewer traffic problems and access to activities on one’s doorstep. (p537)

Finding 7: The influence of the natural environment in Overseas trained medical doctors’ initial decision to practice in the rural New Zealand. (C)

Illustration 7: The biggest thing for me would be the ready access to the beautiful outdoors. (p537)

Finding 8: The natural peace and quiet lifestyle enable overseas trained medical doctors to accept the offer of the post in rural areas. (C)

Illustration 8: It offers us peace and quiet and easy living. Wide open green spaces. (p537)

Finding 9: While majority of participants concern about rural practice varied, a few of the overseas trained medical doctors were willing to consider working in rural general practice. (C)

Illustration 9: I like rural areas. I don't know why they have a bad reputation. (p196)

Theme 4: Loyalty to their patients and community in rural areas

The trustworthy nature of patients in rural communities supported the intention of OTDs to remain in rural under-served areas. Rural doctors believed the satisfaction they got from the job outweighs the problems. They felt very fortunate being able to make a difference in some small way. Far from the facilities and comforts of the city, a small but highly dedicated group of rural doctors work to ensure the people of the outback have access to quality medical services. With ingenuity and commitment, being a GP in a rural or remote area can be infinitely more satisfying than life in the city where much of the time they never really get to know their patients.

Finding 10: Most Overseas trained medical doctors said that it was the people that they worked with who brought most enjoyment. (C)

Illustration 10: There is a certain loyalty I feel … but deep down, I do really enjoy it … I would not want to work anywhere else. When you spend 12 years anywhere, there is an element of loyalty involved. (p537)

Finding 11: Some doctors commented favourably on living and working in rural NSW in regard to professional, social and financial benefits. (C)
Illustration 11: The other thing about rural general practice is that people appreciate what you do. I'm enjoying my time in rural area very much ... if I find a position here I will stay here for ever. (p 199)

His teenage son do very well. He's very good. He's no problem at all... and since he’s come, and the next day, and two or three days I asked him, no problems. They're happy more than Sydney. (p 199)

Theme 5: Easy access of overseas trained medical doctors to positions in areas of workforce shortage in Australia and New Zealand

Unintended circumstances under which respondents often arrived in their rural communities were well explained. Recognizing the limited employment opportunities in urban areas most OTDs reveal that they accepted they would need to move to a rural area in order to work outside the hospital system. As such the circumstances under which OTDs arrived in Australia and New Zealand by and large tended to be unplanned, so too was the decision to favour rural general practice setting. Taking up a position was often simply a result of an available opportunity.

The key findings of each study and the illustration to support those findings are presented.

Finding 12: Overseas trained medical doctors recognised the limited opportunities in urban areas and most accepted that they would need to move to a rural area in order to work outside the hospital system. (C)

Illustration 12: May be it's good for me to just transfer to the bush so that I can have my provider number quicker than just, you know, staying here in Sydney. (p 198)

Finding 13: It was difficult for OTDs to find medical employment in the city and urban Australia. (C)

Illustration 13: I applied 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. (p 2)

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. (p2)

I knew that there were vacancies definitely, [but] they didn't want to give them to us. (p2)
Finding 14: Opportune circumstances brought many OTDs to New Zealand. (C)

Illustration 14: I happened to be working in the area and the general practice opportunity came up. (p536)

Finding 15: Taking up a rural position was often simply a result of an available opportunity. (C)

Illustration 15: I saw an ad advertising the practice here and thought it was a good opportunity. (p 536)

Theme 6: Positive experience of professional integration in later years of residency training programs (rural Canada)

In Australia, the main means of accessing primary health services, through general practitioners (GPs), is more difficult in rural and remote areas because of the relative shortage of doctors and nurses. The evidential basis underpinning these issues in the Australian literature is largely mirrored in the Canadian literature. Physically, Canada and Australia are geographically large continents with dispersed populations, particularly the former. Both have sizeable rural and remote populations, and proportionately less rural doctors serving in rural or remote areas.

Canadian provincial and federal governments are taking steps to increase the number of Canadian trained physicians; however; like Australia, the provision of health services in rural and remote Canada is widely recognized to be inadequate and the recruitment and retention of general practitioners (GPs) in rural communities continues to be of concern. As a result, many rural communities are recruiting OTDs to provide medical services in Canada.

Globalisation and severe doctor shortages in many countries have resulted in increased numbers of OTDs in medical training programmes prior to rural placement in major recipient countries such as Canada. While medical training programmes per se are not the subject of this review one study from Canada described the subjective experiences of OTDs in the province of Ontario and addressed training positions in isolated or under-serviced areas of Canada.

Finding 16: A lot of commitments take place in OTDs’ professional domain, which was often expressed in optimistic terms. (C)
Illustration 16: The transition from practicing Third World medicine to practicing First World medicine is one of the biggest jumps that I have made in terms of my practice career! (P5)

Finding 17: Despite their initial difficulties, overseas trained medical doctors often referred to their later years of residency training in very positive terms. (C)

Illustration 17: "If I had a choice, I would have preferred to be accepted at the PGY2 level rather than the 6-month [practice-ready assessment] because at the end of 2 years, you will be very comfortable and ready for practice... whereas [in] the 6 months! Time and because medicine is so complex, I think it's... too short! (P57)

Synthesis

There was considerable conversation within the interviews regarding various aspects of rural placement in Australia and New Zealand, supported by optimistic experiences of training programmes to placement in rural Canada. Apart from OTDs experiencing a sense of entrapment, the majority of the themes reflect a positive perception. These relate to an appreciation of the continuity of care, intention to live and work as rural doctor in Australia, loyalty to patients and families in rural area, positive experience about last year of residency training program, the apparent relatively easy access of OTDs to area of workforce shortage positions in Australia and New Zealand.

A total of 17 findings were grouped into six categories and then further derived into a synthesized finding that relates to providing adequate support mechanisms to ease the fear of rural entrapment.

Discussion

Temporary resident OTDs come from a wide variety of countries. Workforce demands are such that OTDs are employed in positions of medical need. They are often sent to the most desperate areas of need where support, both educational and cultural, is minimal. OTDs are an essential component of the Australian rural medical workforce. Their decision to come to rural underserved areas is, by and large, unplanned. The result is that the most under-serviced regions of the country continue to be under-serviced by less qualified doctors for reasons of political expediency.
However the wealth of personal feelings of devotion to rural practice, loyalty to rural communities and patients, and the decision in favour of a rural general practice setting needs to be recognized and valued. Medical practitioners in the cities have a sense of satisfaction, but it's clear from the findings that it is more powerful and more intense, in a small, isolated community. They all have their own special contribution to make.

Weyden 2004 stated that, OTDs make a valued and essential contribution to our society and to the provision of healthcare to Australians. We should respect their contribution with the attention and care it deserves.
### QARI-view of Syntheses 1

<table>
<thead>
<tr>
<th>Findings</th>
<th>Categories</th>
<th>Synthesized Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance from main centres as promoting a sense of being trapped.</td>
<td>A sense of being trapped.</td>
<td>A national strategy that is cognizant of factors associated with ODTs' dissatisfaction and better integration into the Australian rural areas should be implemented. Rural GPs have deeply symbolic and practical contributions within rural communities. There is a need to provide adequate support mechanisms to ease their fear of rural entrapment.</td>
</tr>
<tr>
<td>Overseas trained doctors reported feelings of social and financial entrapment.</td>
<td>Appreciate the continuity of care.</td>
<td></td>
</tr>
<tr>
<td>The difficulty to on set the practice and the house</td>
<td>Intention to live and work as a doctor in rural Australia.</td>
<td></td>
</tr>
<tr>
<td>Continuity of care was mentioned by all of the respondents when asked what they thought about rural practice or what rural practice offered.</td>
<td>Loyalty to their patients and community in rural areas.</td>
<td></td>
</tr>
<tr>
<td>All participants wanted to work as a doctor in Australia, the majority in general practice.</td>
<td>Positive experience of professional integration during later years of residency training programs (rural Canada).</td>
<td></td>
</tr>
<tr>
<td>The attractions of a rural over an urban setting were explicitly acknowledged.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The influence of the natural environment in ODTs initial decision to practice in the rural New Zealand.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The natural peace and quiet lifestyle enable ODTs to accept the offer of the post in rural areas.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>While majority of participants concern about rural practice varied, a few of the ODTs were willing to consider working in rural general practice.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most ODTs said that it was the people that they worked with who brought most enjoyment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some ODTs commented favourably on living and working in rural NSW in regard to professional, social and financial benefits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A lot of commitments take place in ODTs' professional domain which was often expressed in optimistic terms.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Despite their rural difficulties, ODTs often referred to their later years of residency training in very positive terms.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It was difficult for ODTs to find medical employment in the city and urban Australia.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opportune circumstances brought many ODTs to New Zealand.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ODTs recognised the limited opportunities in urban areas and most accepted that they would need to move to a rural area in order to work outside the hospital system.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking up a rural position was often simply a result of an available opportunity.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Chapter 6. Synthesis 2: Transparent standards for determining the eligibility of OTDs is required

Coping with bureaucratic procedures and the threat of litigation were frustrating for OTDs working in rural communities. Their frustrations related to a lack of coordination and synchronization of the recruitment and employment process in relation to obtaining visas, being granted access to Medicare for their own family’s health needs, their assessment and their registration.

Fifteen (15) findings were identified within this synthesis: seven (7) findings are related to anger towards the Government and its bureaucratic requirements to practice medicine in rural Australia, including strict criteria for Medicare benefit for their families; an anxiety on threat of medical litigation of clinical governance issue and eight findings typified OTDs’ difficulties in securing and maintaining medical registration to work in general practice in rural NSW as a result of bewildering array of enormous inconsistencies in visa requirements and registration pathways. These findings were categorized into two main themes.

Studies

There were 5 references to these themes as follows:

3. Gilles M, Wakeman J, Durey A. "If it wasn't for OTDs, there would be no AMS": OTDs working in rural and remote Aboriginal health settings. Aust Health Rev. 2008 32(4):655-63.21
Among five included studies, three studies were conducted in Australia\textsuperscript{21, 23, 26} one in New Zealand\textsuperscript{27} and one from Canada.\textsuperscript{29} Among the three Australian studies, one study was conducted in a rural and remote Aboriginal health setting.\textsuperscript{21} Three studies\textsuperscript{26, 27, 29} were also included under section one. The description of the studies here reflects only those not already described above.\textsuperscript{21, 23}

Han (2005) identified factors that influence foreign doctors' community integration and examined how these affect their intention to stay in the rural community.\textsuperscript{23} This qualitative study used a life-history perspective and was conducted in rural communities throughout Victoria. Participants were fifty-seven OTDs working throughout rural Victoria, Australia. The main outcome measures were key factors of community integration influencing OTDs' decision to stay in or leave a rural community.

Gilles 2008 focused on factors affecting OTDs' professional, cultural and social integration and examined their training and support needs. Ten case studies were conducted throughout Australia with OTDs, which also included interviews with spouses/partners, professional colleagues, co-workers, and Aboriginal and Torres Strait Islander community members associated with the health service. However the subject of this review was confined to the specific experiences of OTDs only therefore data related to the experience of other stakeholders was not included.

Themes

**Theme 1: Frustration to Bureaucratic requirements and the threat of litigation for medical malpractice**

OTDs showed considerable concern regarding bureaucratic structures, which they thought were more likely to be “top down” and focused on policy making and setting performance targets for OTDs than for Australian-trained doctors. It may be that as a result of their disparate and often non-Western medical training and experience, some OTDs practicing in Australia in general with rural in particular, may not have previously been exposed to comparable clinical governance mechanisms.
Most overseas trained rural GPs were frustrated at bureaucratic requirements and the threat of litigation for medical malpractice in rural areas. The amount of red tape encountered by OTDs was more than they were used to and often caused frustration.

The key findings of each study and the accompanying illustrations are presented below.

Finding 18: Government regulation and control over work practice, and the risk of litigation for professional malpractice were seen as time consuming distractions from the real work. (C)

Illustration 18: It was incumbent on me to try and save a life rather than to phone an insurance company and say will you give me cover while the patient deteriorates. So I don't care what the insurance or government does. I just handle situations as they arise. (p 48)27

Finding 19: Overseas trained medical doctors are very critical of the policy and practice of accepting them into Australia and leaving them to fend for themselves - especially in their early years in Australia. (C)

Illustration 19: What a waste of this educated people who only need either a bit of communication skills, ... or something to this country, they're left on a door, nobody taking care of them and nobody doesn't want to know. (p 204)26

Finding 20: Overseas trained medical doctors in rural area are very anxious about the risk of litigation for professional malpractice. (C)

Illustration 20: I was mad coming here because of the litigation. (p 49)27

Finding 21: One overseas trained GP commented on the stress related to the threat of litigation. (C)

Illustration 21: Cost and fear of litigation will influence everyone who is practicing medicine. You don't necessarily change how you practice medicine and continue to practice the best of your ability but the fear of stress is that there is no guarantee to protect you from litigation and that is a stress. It is the fear of the threat of litigation. If it not your fault, someone can sue you and that is your concern. You feel powerless. (p 49)27

Finding 22: OTDs’ inability to access Medicare for themselves and their family exacerbated their anger towards the Government. (U)
Illustration 22: Yes [Medicare] is very costly. Since we are living here, we are living in this community, we are working, we should be counted as part of the community especially as we are contributing our fair share to the community. I think the foreign doctors and their families should be able to have access to Medicare. (p 661)^21

Finding 23: Several overseas trained GP thought bureaucratic requirements to practice medicine in rural WA, including taking the RACGP exam, were a one size fits all approach. Such requirements did not take into account the diversity in experience and skills between GPs with some having worked as procedural doctors for over 30 years in their country of origin. (C)

Illustration 23: It came as a hell of a shock when I started here because I had never pushed around so much paper. And a lot of the paperwork is really irrelevant. It's not doing anything. We are gradually getting used to it. You can't get away from it with Health Insurance Commission and all the bloody hoops you have to jump through there. A good example is Practice Incentive Payments. A lot of hog wash. Why do we have to do care plans? We are doing them anyway. I think all doctors do it wherever you have trained. For diabetics we check their sugars, cholesterol and send them to a direction. That is a care plan in any case. So why call them enhanced primary care items and then get PIP for having a practice nurse or doing so many asthma checks or so many immunizations?? It is a load of bullshit. We are not going to achieve anything by doing that. We are doing it to please the bureaucrats. (p 48)^27

Theme 2: Overseas trained medical doctors’ registration processes are fragmented, inconsistent and confusing

A number of the temporary and permanent resident OTDs were critical of the role of recruiting agencies in not providing accurate information about the job and feeling misled about the expectations for the job. This prompted decisions to return to their countries of origin. They felt unwelcome in Australia and suggested that permanent residents in particular were not wanted in the Australian medical workforce.

The AMC examinations are designed to assess, for registration purposes, the medical knowledge and clinical skills of OTDs whose basic medical qualifications are not recognised by State and Territory Medical Boards, that is, doctors trained in medical schools that have not been formally reviewed and accredited by the AMC. AMC manages a multi-stage policy and process that assesses applications for recognition against specific criteria and standards. The examinations
are designed as a comprehensive test of medical knowledge, clinical competence and performance. Both MCQ and clinical assessments are multidisciplinary and integrated. Doctor-patient communication is considered critical to patient care. The ability of doctors to communicate effectively with patients in the Australian community in general and with the rural community in particular is very crucial. As such, in addition to passing the MCQ and the clinical examinations, each practitioner must meet the Occupational English Test (OET) set by Language Australia or sit the IELTS.

While AMC is one of the mandatory requirements for OTDs who want to get their registration in Australia, according to the findings from four studies, most of the OTDs regrettfully commented the assessment system for OTDs was found to be racially discriminatory and manifestly unfair. Most of the voices on discriminatory aspects of the assessment and registration of overseas doctors holding a permanent resident visa in NSW have been derived from McFeyden's study. The research was conducted from 2001 to 2006. In the seven years it has taken to complete this research, the policies and practices governing the registration and appointment of these OTDs in NSW in the late 1990s appeared to be discriminatory and unnecessarily restrictive.

The key findings of each study and the accompanying illustrations are presented below.

Finding 24: Completion of admission process for acceptance into medical practice was made difficult, and stressful as a result of ambiguous selection criteria and lack of feedback. (C)

Illustration 24: The [most] frustrating part of the [application] process was that they give general guidelines of what is required, but they don't clearly state how they determine & who they select! (P56)

Finding 25: Even when overseas trained medical doctors had identified the key organisations governing medical practice in Australia, they had considerable difficulty obtaining the information they required. (C)

Illustration 25: Just a guess, everything is a guess. There's no guidelines. (p 200)

Finding 26: Overseas trained medical doctors stressed that permanent resident doctors need access to accurate and relevant information on their arrival to Australia and information specific to rural practice. (C)
Illustration 26: By the end of the process they do put on a website some information, but its still like, we had citizenship, its most information were relating to Overseas trained medical doctors who had a temporary visa. (p 202)

Finding 27: Overseas trained medical doctors were confused by the different requirements and opportunities for temporary and permanent visa. (C)

Illustration 27: Some of the people say don't take citizen because if you are a citizen... it's more difficulty to get the work because if you are on a temporary visa you can get the work because it's in an Area of Need. (p 201)

Finding 28: Overseas trained medical doctors were not given enough information required for registration. (C)

Illustration 28: Most of the information that I got were mostly from colleagues experiences, we were gathering feedback for the examination, feedback for what to study for certain subjects. (p5)

Finding 29: Medical registration was sometimes problematic. Some medical organisations were criticised for not recognising prior medical experience, often leaving OTDs feeling undervalued. (C)

Illustration 29: During this whole process I have been feeling controlled, totally not empowered in my career and my life... It is an extremely frustrating, depressing and never ending story of proving myself over and over again. (p 660)

Finding 30: Most of overseas trained medical doctors had a very poor understanding of the specific requirements for medical practice in rural Australia. (C)

Illustration 30: When I come first in Australia ... I just didn't know how to get to, to apply for some work or how to get, ah recognise my qualifications by Australian Medical Council. (p 200)

Finding 31: Permanent resident overseas trained medical doctors complaining about the AMC examination system. (U)

Illustration 31: The system is not fair and transparent. (p245)

Finding 32: Unclear pathway, and inconsistent advice from multiple recruitment agencies make OTDs confused regard to how to get to the Australia health care system in general with rural remote areas in particular. (C)
Illustration 32: All OTDs communicated with multiple private and public agencies and professional groups, often resulting in no clear pathway, inconsistent advice and too much confusion. (p 658)\textsuperscript{21}

**Synthesis**

These findings identified OTDs’ disappointment on a multitude of recruiting agencies distributing inaccurate and confusing information about migration requirements and registration pathways; doubts about the adequacy of assessment and supervision of OTDs entering Australian medical practice by medical boards and the adequacy of the AMC examination.

A total of 15 findings were grouped into two categories and then further derived into a synthesized finding that relates to the requirement of a national source of relevant and current information for OTDs to access on available positions, prerequisites, and procedures.

**Discussion**

The Australian Government requires OTDs who wish to access the Medicare Benefits System to be registered with a State or Territory Medical Board and to practice in an area of District Workforce Shortage.\textsuperscript{9} This practicing restriction usually applies to international medical graduates who gain permanent residency for a minimum of 10 years, and applies to temporary resident OTDs indefinitely. These were well articulated in the open dialogue generated from the work of McFayden\textsuperscript{26} in which permanent resident OTDs in rural WA identified a lack of transparency, provision of limited information, and different policies and opportunities as being a key component driving failure of OTDs to work in rural practice.

While OTDs are often sent to the most desperate areas of need where support, both educational and cultural, is minimal, the Government remains concerned that the most under serviced regions of the country continue to be under serviced by less qualified doctors for reasons of political expediency. While there is growing importance for utilising OTDs to maintain basic health services in under-served areas of Australia, there is the difficulty of teasing out genuine quality and safety problems in this context from possible racial or xenophobic concerns.
Some of the regulatory problems associated with the increasing use of OTDs to provide basic health services in under-served areas of Australia is largely explored in a number of case studies.\textsuperscript{30, 31}

For example concerns were raised in one Australian state (Victoria) that doctors who had not completed their AMC assessments were working in the public hospital system. In 2005 a doctor from the temporary resident pathway was also the focus of a formal government inquiry (Royal Commission) following his alleged involvement in more than 80 deaths in a provincial hospital.\textsuperscript{30} Moreover, one of the most intriguing and hitherto largely unexplored aspects of healthcare quality and safety investigations in Australia is explicitly articulated in the case of a United States trained Indian doctor who was accused of gross incompetence leading to the deaths of many patients in Queensland, Australia. In this case, a surgeon was accused of gross incompetence while working at Bundaberg Base Hospital in Queensland, Australia in 2005. In June 2010, Dr Patel was convicted of 3 counts of manslaughter and one case of grievous bodily harm, and sentenced to seven years in jail.\textsuperscript{30} The unfortunate example of “Doctor Death”, as he has been labelled in the media, is evidence that the qualifications of OTDs with temporary residency status are not accurately checked, as it appears this doctor had previously had his license withdrawn in the United States.\textsuperscript{30}

Such sensational headlines unfortunately reflect poorly on the OTD workforce, which is unwarranted. Sadly, these stories serve to reinforce instinctive narrow-minded prejudices and long-held stereotypes. As a result, many OTDs, regardless of providing a vital service in rural Australia have been facing a situation described by Dr Wijestinha and Dr Haikerwai in The Age 2005.\textsuperscript{31} Wijestinha and Haikerwai state that “Because of the mal-practice cases, doctors with funny names, accents, coloured skin and different backgrounds are getting a hard time... They are generally disturbed by the “medical racism” towards overseas trained medical doctors practicing in Australia and its seeming exacerbation by reported malpractice cases conducted by from Overseas trained medical doctors from a number of sources. They are under scrutiny for getting a medical degree from overseas. OTDs do not practice inferior medicine. Nor are they less committed to patient care.”

As a result, a series of new measures to evaluate and certify OTDs were announced. For example, The Medical Board of Queensland has since introduced extensive measures for registration of OTDs, including receiving a certificate of good standing from each and every jurisdiction where a doctor has practiced and getting the primary medical degree, registration and
transcripts of applicants verified by the Educational Commission for Foreign Medical Graduates International Credentialing Service.30

Large numbers of the temporary resident medical doctors and permanent resident medical doctors complained about the AMC examination system.26,27 These doctors strongly contended that, “the system is not fair and transparent.” Among the list of complaints were “the cost of the examinations, poor customer service, and the waiting period of 18 months to two years to sit for the clinical exam.

Appropriate recognition of overseas qualifications has always been a contentious issue in most professions not only in Australia but also in other countries. The maintenance of medical standards is of critical importance for the medical profession as it has direct implications for the provision of the best healthcare for the Australian public. This makes the process of developing appropriate recognition of overseas medical qualifications difficult.

Moreover, permanent resident OTDs were highly critical of the NSW medical registration board.26 They felt that the different policies for registration of postgraduate training applied by the NSW Medical Board were unfair and unreasonable. They expected the government to relax its policies on recognizing OTDs’ qualifications. They also expressed concern about the lack of accountability of various medical bodies and also considered that policies that impede the return of overseas trained specialists to their professional field are racially discriminatory in that they provide greater opportunities to temporary residents, the majority of whom come from the United Kingdom, and restrict opportunities for permanent resident OTDs, who statistically are predominantly from other racial backgrounds. 26

It was reported that OTDs might be willing to pursue their personal and professional goals, they are only able to achieve them under given opportunities and the particular regulatory framework of the Australian government. However, their aspirations may at times be somewhat restrained by professional guidelines that they face in Australia.32

When considering the discourses centred on what has happened to many capable and well-qualified OTDs, the Australian governments commitment to medical standards does need to be justified. Concerns about the quality of medical care provided by OTDs is required to be addressed by a more open, transparent, national standardized system of registration. Any differences in the professional experiences of OTDs working in rural areas could not be teased out
according to country of training, occupational visa category or language or cultural distance. The Department of Health and Ageing believes that the future recruitment of OTDs to Australia is contingent upon Australia remaining an attractive destination for health professionals from other countries, and on their acceptance by the Australian community.9

In brief, while the AMC is one of the mandatory requirements for OTDs who want to get their registration in Australia, according to the findings from four studies, most of the OTDs regretfully commented the assessment system for OTDs was found to be racially discriminatory and manifestly unfair. Sadly Han (2005) reported that although Australia has to rely on OTDs to fill posts in rural Australia medical premiums discourage doctors to work in small communities.32

Studies from a number of government sources have identified a range of issues that must be considered as part of a national strategy on resolving the OTDs workforce concerns. Since 2004 Australian clinical governance structures fully acknowledge OTDs specific regulatory problems, including monitoring and assessment of, and potential institutional legal liability for, minimum level of competence.12

“Standards” is the key criterion in recognising foreign medical qualifications, but “standards” deems to be used to keep OTDs out. Coupled with the “standard” set up by the medical profession, OTDs might find it too difficult to overcome these unfavourable climates, thus remaining professionally disadvantaged.

While the maintenance of high medical standards is most important, the processes used to set up “standard” are required to be transparent and publicly accountable and comply with anti-discrimination legislation and the principles of equal opportunity.

Rural and remote areas rely on OTDs to maintain services. Institutional practices disregarding OTDs’ prior knowledge, experience and skills cause tension and constrain their professional integration. This is not going to improve until a transparent national system of medical accreditation is implemented.

There are many complex issues around the registration and assessment of OTDs in Australia. There are no national standards in Australia for assessing OTDs before they are permitted to practice. Assessment standards also vary by state and area of medical practice. This may be partly explained by the division of health responsibilities between Federal, State and Territory, with each state and territory establishing its own medical board under its states’ legislation, leading to a
fragmented processes with varied requirements for registration. With a few exceptions, OTDs are permitted to practice without having to pass a test of medical knowledge and clinical skills like that required in the UK, Canada and the USA.

The number of OTDs employed in Australia's medical workforce has increased sharply since the mid-1990s. This dependence will grow in the near future as a consequence of recent measures to facilitate the recruitment of OTDs. Until the mid-1990s, most OTDs came from the UK and Ireland. However, most now come from a diversity of backgrounds. Because the number of OTDs working in rural areas each year has increased, it was suggested that a system is needed to help permanent residents who have medical training and skills make the transition from non-health occupations and from supervised medical practice into general practice if they are suited. This could be achieved through a more intensive case-management approach to OTDs. This will require additional resources for mentoring, supervision and support.
### Findings

1. Government regulation and control over work practice, and the risk of litigation for professional malpractice were seen as very stressful to work in rural Australia.

2. One overseas-trained GP commented on the stress related to the threat of litigation.

3. OTD's are very critical of the policy and practice of accepting them into Australia and leaving them to fend for themselves especially in their early years in Australia.

4. OTD's in rural area are very anxious about the risk of litigation for professional malpractice.

5. OTD's inability to access Medicare for themselves and their family resulted in a strain towards the Government.

6. Several overseas-trained thought bureaucratic requirements to practise medicine in rural WA, including taking the RACGP exam, were a one-size-fits-all approach. Such requirements did not take into account the diversity in experience and skills between GPs with some having worked as procedural doctors for over 30 years in their country of origin.

7. Completion of admission process for acceptance into medical practice was made difficult, and stressful as a result of inefficient service delivery and lack of feedback.

8. Even when OTD's had identified the key organisations governing medical practice in Australia, they had considerable difficulty obtaining the information they required.

9. Medical registration was sometimes problematic. Some medical organisations were criticised for not recognising prior medical experience, often leaving GPs feeling undervalued.

10. Most of OTD's had a very poor understanding of the specific

### Categories

1. Frustration to bureaucratic requirements and the threat of legislation for medical malpractice

2. OTD registration examinations pathways and processes are fragmented, inconsistent and confusing

### Synthesized Findings

The processes used to determine eligibility for registration are required to be transparent, publicly accountable and comply with anti-discrimination legislation and the principles of equal opportunity. "Standards" (the key criterion in recognising foreign medical qualifications, but "standards" seems to be used to keep OTD's out.)
Chapter 7. Synthesis 3: National standards of English language assessment would maximise the effectiveness of clinical communication

It is well known that in many parts of Australia, particularly in rural and remote regions that have failed to attract and keep "home-grown" medical graduates, the local population is heavily dependent on OTDs. Medical racism is particularly concerning given the extent of Australia’s current dependence on OTDs to supplement the Australian medical workforce. Even if they have passed the Australian Medical Council’s qualifying exam, which patronisingly recognises them to be "of a standard equivalent to that of an Australian trained doctor". Unfortunately, these doctors do not wear a badge stating their qualifications or experience. Pessimistically, the only criteria by which the general population of rural 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.

A total of 15 findings generated from seven studies were grouped in to three categories. The information below includes description of the included studies and description of the categories used to support the final synthesis in this section.

Studies

There were seven references to these themes. Of seven studies included under this section, six studies were conducted in Australia, one from Canada.


The following description of studies reflects only those that have not been described in the previous sections.

Caroline Laurence from the Discipline of General practice, the University of Adelaide undertook a PhD study in 2007 in which service provision and quality of care provided by OTDs a under 5 year OTDs scheme was investigated. The thesis basically aims to determine if OTDs working in rural and remote Australia practiced differently from Australian Trained Doctors working in similar locations. A mixed method approach was used. The thesis initially presented quantitative data highlighting a number of differences in the provision of service between ATDs and OTDs, however, this is not the subject of this review and therefore only data related to OTDs’ subjective experiences on how and why their service differed from those of Australian doctors were utilized. These include a number of subjective explanations regarding the OTDs’ differences in patterns of service including language and cultural differences; training; community attitudes to OTDs; understanding of the Australian health care system; and access to services.

To examine aspects of the acculturation of overseas-born and Australian-trained health professionals in the Australian health discourse; and to identify key coping strategies used by them when working in the rural context, Le Qe 2008 examined the life experiences and acculturation strategies of Vietnamese-born health professionals working and living in rural Australia. Six overseas-born, Australian-trained health professionals were invited to participate in this qualitative study using a snowball sampling technique. The participants were all born in Vietnam and had experienced working in rural Australia. They included three medical doctors, a dentist, a physiotherapist and a nurse. Topics and themes that emerged focused on the issues and strategies of acculturation to the rural health context.

Dorgan 2009 conducted a qualitative study to examine OTDs’ perceptions of the barriers to their communication with patients in rural Canada. A convenience sample of 12 OTDs participated in
interviews that lasted 1 to 1.5 hours. Residents from the Caribbean, Colombia, Denmark, India, Iran, Pakistan, and Peru participated in individual interviews conducted on-site at one of three clinics. Interviews were transcribed and then coded independently and jointly. The authors used a qualitative analysis of interview transcripts to identify primary and secondary themes.

Themes

**Theme 1: Communication challenges as a result of limited proficiency in spoken English, particularly accents and idiom**

Communication was identified as a major problem despite the participants being fluent in English. The use of local Aussie slang by some local town speakers presented a large obstacle to comprehension. Participants often had to ask them to repeat the saying many times, and this could undermine their confidence in their own English and even their professional competence. Participant voices supporting this statement are presented below.

Finding 33: Communication was sometimes a problem despite the participants being fluent in English when some local town speakers use local Aussie slang. (C)

Illustration 33: Most town people tended to speak Aussie English with a broad accent, particularly the males. For example, it can be difficult to distinguish words such as nice/noise, sure/shore, day/die. (p6) I think we have to learn how to confront the situation. 20

Finding 34: Developing decent relationships was made difficult by the discriminatory attitudes and actions encountered from the patients in rural practice. (C)

Illustration 34: I can feel they try very hard to find a way they think I can accept or they can't find a way because they don't know my background, they don't know which ways I can accept. (p239)23

Finding 35: Overseas trained medical doctors experienced difficulty in understanding abbreviated, colloquial, or slang words used by work colleagues’ native speakers. (C)

Illustration 35: Sometimes colleagues, doctors, nurses, whatever, are not patient enough you know. We are doctors from overseas University, 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. (p4)²⁷

Finding 36: Participants felt uncomfortable people from different cultural and linguistic backgrounds used words with embedded cultural meanings. (C)

Illustration 36: I was rather uncomfortable when a person at work addressed me as love, as in 'Yes, love, a new chair will be here shortly'. First I felt very annoyed but later I understood the casual way in their communication at work. (p6) ²⁰

Theme 2: Communication challenges as a result of regionally unique dialect, colloquial expressions and accents (rural Canada)

Acceptance by the local rural community is a key factor influencing a positive view of work location. Supportive communication can positively influence OTDs’ appreciation of what the rural community can offer them and how they might overcome any difficulties that they face with their rural practice and life. However; apparent discrimination is an obvious deterrent to integration and desire to stay in a community. Many rural communities may have had little exposure to people from other cultures and may not initially welcome OTDs with different customs and beliefs. Some patients are reluctant to consult OTDs, both in the hospital emergency room and the practice setting. OTDs were aware of discriminating comments and behaviours of the local community. They had also experienced confusion at new communication training and residency assessment programs, because they had never experienced such pedagogical techniques.

Participant voices related to this theme are represented below:

Finding 37: Overseas trained medical doctors had experienced confusion at new communication training and assessment residency programs, because they had never experienced such pedagogical techniques. (C)

Illustration 37: I mistakenly thought the interaction was only about “whether I [was] able to diagnose the patient and come up with a good differential.” I realized only after faculty feedback, “Maybe I did the wrong thing,” adding that the interaction with the SP was supposed to be about “communication skill and how you talk with the patient, how you listen to the patient.” (p 1569)³³
Finding 38: A few overseas trained medical doctors identified their own dialect as a source of problematic communication with their patients. (C)

Illustration 38: Understanding ‘hillbillies’ is really hard," but I admitted that my patients initially did not like me because they could not understand me… some patients “have a problem understanding my accent." “I have an accent, and they have an accent, and at first I had to slow down and [try] to figure out what they’re saying. There [are] a lot of colloquial terms for this area, [and] I don’t know what some mean." (p 1571) 33

Finding 39: Most reported having had extensive formal training in the English language; however, the overall U.S. dialect, and particularly the regional dialect in southern Appalachia, seemed to present challenges in their interactions with patients. (C)

Illustration 39: Somebody who has not lived here, how would you expect that person to know what Jenny Craig is and the Atkins Diet is or what the South Beach Diet is?”(pg 1570) 33

Finding 40: Participants indicated overall that their speaking standard (formal) English as a second language was not a communication barrier. Rather, what they did cite as a barrier was their patients’ spoken dialect, including the colloquial expressions and accents unique to this region of the United States. (C)

Illustration 40: “I learned my English just from a book. When I first came here, the first couple of months, I had a problem understanding. (p 1570) 33

Finding 41: Regionally unique expressions complicated physician–patient encounters, apparently requiring residents to negotiate even achieve understanding.(C)

Illustration 41: How are my testes?” [the patient asked]. I say, “What is that? No, no—you mean [to ask what are your tests], what is the report? You want to know about your test [emphasis added], not testes, because you are a female.”(p 1571) 33

Finding 42: Several overseas trained medical doctors stated that they had experienced communication barriers related to colloquial language use; these challenges seemed to be magnified by the regional dialects encountered in their residency programs. (C)

Illustration 42: My challenge was to understand the South eastern dialect. It was very difficult. The first week was a nightmare.” (p 1570) 33
Theme 3: Overseas trained medical doctors who look different or speak differently are targeted for racial slurs or abuse.

As in theme 1 and 2 it was found that the rural population of patients judged the competence of a doctor based on the doctor’s skin colour, physiognomy and accent which resulted in the classification of theme 3. Participant voices supporting this statement are presented below.

Finding 43: A number of OTDs had experienced racism in Australia. (C)

Illustration 43: Since I came to here, for it's as if they like punishment. They hate overseas doctors. (p 205)²⁶

Finding 44: Overseas trained medical doctors felt that being labelled OTDs amplified any mistakes they made. (C)

Illustration 44: He doesn't want to take chances. If a small mistake is done by an Australian doctor and some mistake is done by an OTD, the way it has been looked is totally different. This is fact. Okay. It may be a small thing an OTD doing something that is magnified, exaggerated so you can't expect them to afford to take chances. And in what I have seen of these things (here) you see now the senior Australian doctors and the way they practice... they have a problem. They are totally different. (p 122)¹⁹

Finding 45: One GP from a different racial background experienced discriminatory behaviour from local health professional. (C)

Illustration 45: The other problem I had was because I came from Africa and they thought I would be pretty backward. So whenever I asked for drugs that were not available in Australia at the time, but have subsequently been made available, I was told that we didn't have those primitive drugs in Australia. Two and a half years after I was here I was introduced to the Medical Director by a senior member of staff as " the locum from Africa". I wasn't very impressed. This attitude was washed off into the community. It does make it difficult sometimes. (p 49)²¹

Finding 46: Participants were feeling discriminated by the patients in rural practice. (C)
Illustration 46: I don’t want to see that yellow doctor. (p239) 23 ... This attitude was washed off into the community. It does make it difficult sometimes. (p 49) 21

Finding 47: Racial considerations were voiced and led two African OTDs to work in an Aboriginal community. (C)

Illustration 47: As soon as we were told it was an Aboriginal community, we knew they were black, we thought that would be a good place to work, just you know, being black. (p 660) 21

Synthesis

A total of 15 findings were grouped into three categories and then further derived into a synthesized finding that relates to requirement of a national uniform standard of English language assessment to maximise the effectiveness of clinical communication and preventing poor outcomes and complaints.

Almost all OTDs identified communication as an issue. Communication and language are vital to clinical medical practice. Understanding accents and different cultural norms were important for OTDs’ successful professional integration and their acceptance by the rural community: Language and communication training for all OTDs from non-English speaking background would help overcome language barriers.

Discussion

The continued reliance on OTDs in the Australian health care setting is well documented, and the problems of the existing system become more and more evident as time passes. For the majority of OTDs entering Australia and Canada, English is not a first language, but many OTDs will have completed their undergraduate medical training using English as the medium of instruction. They would also have been familiar with medical textbooks and journal articles printed in English.

However, some of them experienced language difficulties when communicating with patients, and colleagues. Language is the vehicle of communication and weaknesses in language can act as a barrier to learning. This review has demonstrated poor communication, resulting from language barriers, is a real concern to OTDs. While communication and language are vital to clinical
medical practice, it is obligatory for OTDs from non-English speaking backgrounds to have an operational command of the language, otherwise inaccuracies and inappropriateness may cause misunderstandings in some situations. More importantly they are required to handle complex language well and to understand detailed reasoning. Currently the language requirement for OTDs entry into Australia specified by the Department of Education, Science and Training is a minimum International English Language Testing System score of 7. With the exception of those from the UK and Ireland, OTDs are required to meet the entry language requirement into Australia specified by the Department of Education, Science and Training. Language and communication training for all medical doctors from non-English speaking backgrounds would help overcome language barriers.

OTDs are an essential component of our medical workforce, and a national strategy that is mindful of past mistakes and has a clear focus on quality health care should be implemented to better integrate these doctors into the Australian community. A national consistent assessment process would need to include a clinical assessment to evaluate OTDs clinical competencies, communication skills within the clinical setting and English Language proficiency tests. The assessment process would need to provide recommendations on the appropriate placement setting for OTDs to match the level of decision-making, clinical profile, available e-support and supervision. This will ensure effective placement, skills matching and supervision to the specific vacancy.
QARI-view of Syntheses 3

Findings

- Communication was sometimes a problem despite the participants being fluent in English when some local town speakers used local Ausable slang.
- Developing robust relationships was made difficult by the discriminatory attitudes and actions encountered from the patients and their families.
- UTCs experienced difficulty in understanding abbreviated, colloquial, or slang words used by work colleagues native speakers.
- Participants felt uncomfortable people from different cultural and linguistic backgrounds used words with embedded cultural meanings.
- A few UTCs identified their own dialect as a source of problematic communication with their patients.
- Most reported having had extensive training in the English language; however, the overall U.S. dialect, and particularly the regional dialect in southern Appalachia, seemed to present challenges in their interactions with patients.
- UTCs had experienced conflict in new communication training and management residency programs, because they had never experienced such pedagogical techniques.
- Participants indicated awareness that their speaking standards within English as a second language was not a communication barrier.
- Rather, what they did use as a barrier was their patient’s spoken dialect, including

Categories

- Regional unique expressions encountered, apparently requiring residents to negotiate even more understanding.
- Several UTCs stated that they had experienced communication barriers related to colloquial language that these challenges seemed to be magnified by the regional dialects encountered in their residency programs.
- A number of UTCs had experienced racism in Australia.
- One overseas trained OT from a different racial background experienced discriminatory behavior from local health professionals.
- UTCs felt that being labeled an UTC/MC or anything mistakes they made.
- Participants were feeling discriminated by the patients in rural practice.
- Racial considerations were voiced and had difficulty UTCs to work in an Aboriginal community.

Synthesized Findings

- Communication challenges as a result of limited proficiency in spoken English, particularly accents and idiosyncrasy.
- Communication challenges as a result of regional dialect, colloquial expressions, and accents (rural Canada).
- A national uniform standard of English language assessment is required to maximize the effectiveness of clinical communication and present poor outcomes and complaints. Almost all UTCs identified communication as an issue. Communication and language are vital to clinical medical practice. Language and continence training for all UTCs from non-English speaking background would help overcome language barriers.
Chapter 8. Synthesis 4: social integration and community support would contribute significantly to the settling in process

While some OTDs found the transition more difficult than others, most had made decisions to come to Australia with the intention of staying. While bureaucratic procedures and the threat of litigation were frustrating in the course of work practice, they were not factors underpinning a decision to leave. Some solo GPs found the pressures and isolation stressful, particularly racial insults and discriminatory behaviours from the local community directed at some doctors resulted in a sense of isolation. However, these negative thoughts were cushioned for others by the welcome they received from the local community. By and large doctors working in rural and remote locations found acceptance by the local community as one of the key factors associated with satisfaction with practice location.

Studies

There were 8 references to these themes.


3. Laurence C. Overseas Trained Doctors in rural and remote Australia: do they practise differently from Australian trained doctors?. [Thesis (Ph.D.) ]: University of Adelaide, School of Population Health and Clinical Practice; 2008.19


5. McFayden L. An examination of the structural and political barriers preventing permanent resident overseas-trained doctors from working as general practitioners in rural New South Wales: University of Newcastle. Faculty of Business and Law; 2008.26

7. Wong A, Lohfeld L. Recertifying as a doctor in Canada: international medical graduates and the journey from entry to adaptation. Medical Education. 2008;42:53–60. 29

8. Gilles M, Wakerman J, Durey A. "If it wasn't for overseas trained medical doctors, there would be no AMS": overseas-trained doctors working in rural and remote Aboriginal health settings. Aust Health Rev. 2008 32(4):655-63. 21

Description of the studies here reflects only those not described in the previous sections. 34, 35

The aspirations, challenges and experiences faced by a small group of rural GPs from diverse cultural and linguistic backgrounds was examined as part of a doctoral research project. 35 It examines their perspectives on living and working in rural or remote locations in rural Western Australia with a view to understanding factors affecting their settling in process, which may influence their decision to stay or leave. Fourteen overseas trained GPs were interviewed, 12 male and two female with ages ranging from 33-63 years. The majority had trained in South Africa, with others trained in the United Kingdom, Eastern Europe, Africa and Asia. Their spouses were also interviewed; however, this was not the subject of this review.

To highlight the institutional and cultural challenges OTDs face in rural and remote Indigenous health settings one study focused specifically on case studies of 49 overseas trained GPs in Queensland, the Northern Territory and Western Australia rural and remote Indigenous health settings. 34 OTDs included sub-continental Indians, Europeans, Afrikaners, South Pacific Islanders, Africans and Chinese.

Themes

Theme 1: Community support and personal support

While coping with life in new culture in a remote location is often compounded by a sense of isolation, OTDs truly appreciate and highly value the friendliness welcome and support they received from the rural local community. Community support and belonging contributed significantly to the settling in process and overall enjoyment of overseas trained rural GPs who initially experienced the sense of isolation adjusting to a new culture and location.

Finding 48: A GP working in a solo practice enjoyed feeling part of the community where he was invited regularly. (C)
Illustration 48: There are fantastic people around here. I'm part of the community. That is the only way you can survive in a community like this. You have to be one of them. If there is a party they call me. If they go to the pub they drag me out. I'm part of it. (p47)

Finding 49: Overseas trained medical doctors felt part of a community and appreciated by the community, which contrasted with their previous practice location. (C)

Illustration 49: People are very supportive, here… very friendly, they treat you very well and they enjoy talking to you and it's like a family. There are supportive people in the community when you go out with the family… different from our country, nobody would bother with you, they go to the doctor and want to know what is the problem and what you can do and not care after that, but in this country people are very social … still is a good relationship. (p 117)

Finding 50: The sense of isolation was cushioned for others by the welcome they received from the local community. (C)

Illustration 50: I didn't expect this friendliness, open-arms welcome from everybody that we have experienced so far. I haven't had a bad experience yet. (p 38)

Theme 2: Family issues (Family/spouse/Children)

Favourable conditions for children's education, work opportunities for their spouses, easy access to essential goods and social services, and a combination of favourable circumstances or situations to mix with others from their own cultural background provide OTDs with sense of belonging and support.

Systematic and organized professional support mechanisms, as well as good educational facilities for their children and work opportunities for their partners, were identified as significant factors contributing to OTDs remaining in rural practice.

Finding 51: Access to good educational facilities for their children has a bearing on whether currently practicing doctors will remain in rural areas. (C)

Illustration 51: Primary schooling here is adequate, but we will have to think hard about secondary school for the kids if we are still here. (p537)
Primary schooling here is fine, but secondary, on the other hand, is very poor (p 538)

Finding 52: If successful retention of rural doctors is to be attained, and of course, employment opportunities are one of the issues to consider. (C)

Illustration 52: My wife has never looked for work here ... but if she did, she would find it very difficult to find a job. (p 538)

Finding 53: A number commented favourably on their children's life in Australia. (C)

Illustration 53: After I gave up in 2003 I was very frustrated, very depressed even. For a period took an antidepressant and then I left it because I say silly ... and I persuade myself that I am seeing my children growing up and having a good future this is my investment I say. (p 206)

Finding 54: Emotional support of families when they accompanied participants to a rural area was an important factor. (C)

Illustration 54: I felt very lucky that my parents moved along with us to the town when I got the job. Actually we were much closer when we moved there. We spent a lot of time together. As our house was a short walk from where I worked, I occasionally came home to have a quick chat with my parents. It's a big advantage. (p 5)

Finding 55: Experience of losing the personal domain in the form of personal sacrifices impact on family members and marital relations. (C)

Illustration 55: You felt dehumanised, in a sense, as if you had lost something that you had already achieved) that [your profession] had been taken away from you. You had to sort of work to get it back! (P 56)

Finding 56: Lack of opportunities for children's education and spouse adjustment were factors impacting on rural integration and their reluctance to live and work in rural practice. (C)

Illustration 56: There isn't a job for my husband that'd be one [reason], and moving schools for my kids is difficult. (p 238) ... paying about $15 000 per year for tuition. If you put [my child in a college] you need about $25 000. (p 238)
Finding 57: OTDs were usually recruited to a specific rural town, though no identified strategies matched location to social needs such as religious amenities, ethnic group, spouse employment or children’s education. This adversely affected retention in a rural AHS. (C)

Illustration 57: One of the difficulties that I got was the schools for the kids and I eventually had to move my family to [a regional centre 500 km away] and put my children in better schools. (p 658)²¹ The break up of my family in that respect is not very good. (p 658)²¹

**Theme 3: Transcultural challenges as a result of life style difference**

Overseas trained medical doctors provide a necessary and much needed service in rural and remote communities, despite facing specific challenges in their transition to the professional and social aspects of rural culture. Supportive community integration arrangements in remote area settings are particularly important to address the unique problems of geographic, social and ‘cultural’ isolation in underserved areas of Australia.

Finding 58: Adapting to the new culture in rural Australian context, some still yearned for their country, family and friends. (U)

Illustration 58: I ache deep down but still hang onto those things that reflect a better life you miss the smells, the smells of Africa and South Africa. (p45)³⁵

Finding 59: Overseas trained medical doctors are frustrated with socio-cultural differences in Australia. (C)

Illustration 59: I come from a culture where it’s a virtue to be modest and humble... whereas here, that can easily be misinterpreted as ignorance or worse - stupidity! (p56)²⁹

Finding 60: Overseas trained medical doctors experienced the sense of isolation in rural community. (C)

Illustration 60: Isolated, like a man in prison. (p 46)²⁷

Finding 61: Isolation provided challenging (U)
Illustration 61: Ten minutes after I came here I wanted to leave. Maybe it was ten seconds. But I had made a commitment to come and I thought it was unfair to leave. The previous GP from (overseas) stayed for six weeks and left ... If I had looked around and decided what I was going to do in Australia I would not have come to a rural area ... A lot of people who come over here don't realise how isolated it is. (p40)35

Finding 62: Loneliness added to the difficulty in adjusting to a new life. (U)

Illustration 62: I had no one not one person to talk to. I was desperately unhappy. I would stop people on the road and say good morning and start talking to myself in case I forgot how to talk. (p45) 35

Finding 63: One female medical doctor highlighted cultural difference when invited to dinner by local Australian families. (U)

Illustration 63: few people would invite us over for dinner and even that would be different the kind of food they serve. You only realise what your culture is once you leave it, the way you eat, the way you do things different. We missed our food our own kind of food terribly. Our best times have been going to visit South African friends where we eat as we usually do and talk our language. (p45) 35

Finding 64: Parents of the participants felt unhappy because older patients in nursing homes and hospitals had few visitors. (C)

Illustration 64: One thing that my parents were very scared when they visited a nursing home. They saw old people on wheel chairs and no one to talk to. For them, these old people were abandoned and left there to die. They wanted to go back home to live when they were at that age. (p5)20

Finding 65: Participants experienced a clash of cultures when handling health issues and problems.

Illustration 65: When my mother had a nasty cold or flu, she asked my father to use a coin to scratch her back to take away the bad wind from her body. After about 40 minutes of wind scratching, my mothers back looked horrible. It was like being tortured in a prison. When an
Finding 66: Participants experienced cultural shock when they moved from a crowded Asian city to a small Australian city. (C)

Illustration 66: I couldn't believe it when someone in the town told me that they needed to go to a quiet place on the weekend, away from the town. To me, it’s already too quiet and I wanted to spend weekends in a city, but these people want to live with nature and to run away from the town's crowded population! How ironical! (p4)

Finding 67: The adjustment to a new culture and location was difficult for one male OTD's wife. (U)

Illustration 67: My wife couldn't cope and returned to country of origin. There was nothing for her to do. She had trained in her chosen profession and she was bored here with nothing to do. She had always worked and had never stayed at home before (so this was) a big difference. (p4)

Finding 68: The participants observed a number of differences between the rural communities where they were practicing and their own family life in both Australia and Vietnam. The concept of acculturation normally applies when people. (C)

Illustration 68: For me, the obvious cultural shock that I experienced in the first few weeks in this rural town was what to do in the evening and particularly on the weekend. I used to hang out with friends in the city, spending a lot of time shopping, visiting friends, and our house was always filled with visitors on the weekend. We cooked together Asian foods and chatted about things. In a small rural town, there was not much for me to do after work. I felt rather lonely. Thus I spent a lot of time talking to my friends on the phone. (p4)

Synthesis

A total of 21 findings were grouped into three categories and then further refined into a synthesized finding that related to the requirement of supportive community integration arrangements in remote area to address the unique problems of geographic, social and 'cultural' isolation in underserved areas of Australia.
Discussion

OTDs provide a necessary and much needed service in rural and remote communities, despite facing specific challenges in their transition to the professional and social aspects of rural culture. Supportive community integration arrangements in remote area settings are particularly important to address the unique problems of geographic, social and ‘cultural’ isolation in underserved areas of Australia. It is important to ensure that high-quality doctors are available and that Australia maintains a welcoming approach to OTDs and that we provide the necessary support and quality checks. Australia’s placement within the international medical recruitment market is important and any restrictive and potentially bureaucratic barriers will immediately reduce the number of well-qualified doctors wishing to move to Australia. There needs to be a balance between welcoming OTDs and measures that ensure that Australia recruit high-quality OTDs.
### QARI-view of Syntheses 4

<table>
<thead>
<tr>
<th>Findings</th>
<th>Categories</th>
<th>Synthesized Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>A GP working in a solo practice enjoyed feeling part of the community where he was invited regularly.</td>
<td></td>
<td><strong>Community support and personal support</strong></td>
</tr>
<tr>
<td>OTUs felt part of a community and appreciated by the community, which contrasted with their previous practice location.</td>
<td></td>
<td><strong>Meeting OTUs’ non-professional needs is crucial in retaining rural GPs.</strong></td>
</tr>
<tr>
<td>The sense of isolation was cushioned for others by the welcome they received from the local community.</td>
<td></td>
<td>Work opportunities for partners, access to good educational facilities for their children, availability of good housing, social and cultural facilities also have a bearing on whether currently practising doctors will remain in our rural area.</td>
</tr>
<tr>
<td>Access to good educational facilities for their children has a bearing on whether currently practising doctors will remain in rural areas.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If successful retention of rural doctors is to be attained, and of course, employment opportunities are one of the issues to consider.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A number commented favourably on their children's life in Australia.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional support of families when they accompanied participants to a rural area was an important factor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience of #loss in the personal domain in the form of personal sacrifices impact on family members and marital relationships.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of opportunities for children’s education and spouse adjustment were factors impacting on rural integration and their reluctance to live and work in rural practice.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTUs were usually recruited to a specific rural town, though no identified strategies matched location to social needs such as religious amenities, ethnic group, spouse employment or children’s education. This adversely affected</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Family/spouse/Children)
Adapting to the new culture in rural Australian context, some still yearned for their country, family and friends. Isolation provided challenging.

Loneliness added to the difficulty in adjusting to a new life.

One female OTD highlighted cultural difference when invited to dinner by local Australian families.

OTD's are frustrated with socio-cultural differences in Australia.

OTD's experienced the sense of isolation in rural community.

Parents of the participants felt unhappy because older patients in nursing homes and hospitals had few visitors.

Participants experienced a clash of cultures when handling health issues and problems.

Participants experienced cultural shock when they moved from a crowded Asian city to a small Australian city.

The adjustment to a new culture and location was difficult for one male OTD's wife.

The participants observed a number of differences between the rural communities where they were practising and their own family life in both Australia and Vietnam.
Chapter 9. Synthesis 5: Meeting OTDs professional needs is crucial to retaining rural GPs

Issues affecting retention of OTDs in rural and remote areas are common, in particular, concerns relate to children’s schooling and work opportunities for spouses. Additional hurdles, particularly for conditionally registered OTDs, such as lack of flexibility in practice conditions, and inadequate supervision and educational support, have been noted as constraints to professional integration. Many OTDs face significant professional and personal difficulties in seeking to practice medicine in Australia and other comparable Western countries. OTDs largely agree on key education, training and professional support needs. Continuing professional development, training opportunities, professional support and networking, as well as financial support are the doctors’ shared top priority issues. The ability to retain links to their own cultural and religious communities has a positive effect on levels of life satisfaction, although this varies in importance for doctors from different ethnic and cultural backgrounds.

Thirty two (32) findings are categorized into three themes related to significant life stressors involved in the adjustment to rural placement. They provide insight into the types of problems doctors experience with relocation to a new rural country setting and to how these problems impact on the work practice.

Studies

There were seven references to these themes.

1. Gilles M, Wakerman J, Durey A. "If it wasn't for overseas-trained medical doctors, there would be no AMS": overseas-trained doctors working in rural and remote Aboriginal health settings. Aust Health Rev. 2008 32(4):655-63. 21
5. Laurence C. OTDs in rural and remote Australia: do they practise differently from Australian trained doctors? [Thesis (Ph.D.)]: University of Adelaide, School of Population Health and Clinical Practice; 2008.19


Themes
Theme 1: Challenges of rural general practice

It was reported that although country doctors in general love their job, they are frustrated with work conditions, long hours and a conflict with family desires and responsibilities. It is difficult to anticipate whether OTDs would have better methods of coping with the difficulties of working in the country than locally trained doctors.

Finding 69: Overseas trained medical doctors faced with cultural and communication issues, and working in a new paradigm, took longer to build the relationships with the service and its patients in rural Aboriginal setting. (C)

Illustration 69: Well it takes a longer time to be confident in the AMS for most doctors than it might be in another practice, because in another practice the patients are educated upon the value of doctors. Here the doctor is just someone who is going to treat my sickness. So you see we have to build the trust and the confidence in patients, which takes longer, much longer than in another practice. (p 661)21

Finding 70: Overseas trained medical doctors felt pressured to accept additional duties to secure another rural placement. (C)

Illustration 70: …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. (p 3) 27
Finding 71: Overseas trained medical doctors in rural GP practice found the initial weeks very challenging and may not have remained in rural practice had there been any adverse outcomes. (C)

Illustration 71: Maybe in the beginning a little bit ah, difficulty with some patient ... especially when I work at night times ... and when I was alone by myself in the medical centre and some emergency cases come in and I manage all the times but at least sometimes are scary ... It was only us in the first two or three weeks ... After that I didn't have any bad things or bad experience. (p 197)

Finding 72: OTDs' notions of their status as a doctor were not met in rural Aboriginal Health Service.

Illustration 72: Something's wrong ... it must be something that I am doing wrong here or maybe it is because of the orientation was not put in place properly that is making me appear funny to them and that gives me some stress. (p 661)

Finding 73: One overseas trained GP working in rural practice several years found to keep clear boundaries between professional and private lives, working, but not socialising in the community. (C)

Illustration 73: I found such boundaries become increasingly blurred as friends took liberties wanting after hours consultations. (p 47)

Finding 74: Participants used a problem-solving strategy that was used when there was something wrong which needed correction. (C)

Illustration 74: When a problem occurred at work, naturally I felt bad but I had to be honest with myself, reminding me that I had a lot to learn and avoiding the blame game. I wanted to sit down with my colleagues to talk openly about the problem, and how to improve. (p 7)

Finding 75: Several of the OTDs discussed the stress related to working in rural practice in Australia due to the attitude towards OTDs by certain groups in Australia. (C)

Illustration 75: Basically you're concerned about the litigation issues all the time so that means that again it comes under the criteria of patient's attitudes. You are always thinking you haven't left something. (p 122)
Finding 76: Some overseas trained medical doctors were frustrated at limited opportunities for training in local computer systems before taking on a heavy clinical load in an Aboriginal health setting.

Illustration 76: One day, you know, I was told about computer literacy for about fifteen minutes and then from the next day I was supposed to see the patients. (p 659)²¹

Finding 77: This lack of assistance for longer term career planning, and sometimes collegiate support hampered professional integration. (C)

Illustration 77: Really they don’t look after you well, they don’t orientate you well and then there is a lot to be said about the doctors. We are not there to steal anything off them. I have come here for a better life and I think after a few years they should mellow to us but they don’t. (p661)²¹

Theme 2: Limited professional support

OTDs working in rural health services reported complex communication issues and variable support with respect to training and career advice. Rural doctors are at a serious training disadvantage compared with their metropolitan counterparts.

Finding 78: There are insufficient support networks in the rural hospitals to assist overseas trained medical doctors in gaining sufficient information to work. (C)

Illustration 78: I guess it adds up to the frustration because I was expecting at least that for my probationary year…[I would be] supervised and given support whilst starting. (p 3)²⁷

Finding 79: Challenges in the placement compounded by lack of support from work colleagues affected overseas trained medical doctors ability to deliver effective patient care.

Illustration 79: 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 (p 4)²⁷

Finding 80: Overseas trained medical doctors commented the lack of practical component of the RACGP preparation program, and stressed the need for them to have help and guidance to prepare.(C)
Illustration 80: When I came and I didn't know anything about the AMC ... it is just ah studying Davidson's, Harrison's, the text books, the big text book or what should I do all day.. I didn't know the system, I didn't know what to do, what to study, how to study. That's the problem (p 193)

Finding 81: Overseas trained medical doctors were very critical about the lack of practical support and assistance available to them and a perceived lack of opportunity for them to obtain clinical experience. (C)

Illustration 81: Not leaving them at home ... and just studying and sit the test. Oh no, you didn't pass the test, come next time and you leave them another year or six months and sit another test. Ah you didn't pass, what, where's the learning plan? What do they need? (p 192)

Finding 82: Limited access to continuing medical education (CME) is a point of concern. (C)

Illustration 82: We have access in a way, but it is difficult. Base Hospital is 2 away, which makes access very difficult. Not only does travel cost, but the time that I am away from the practice costs even more. To decide to leave town then is a big decision. There is most certainly access, but it is not made easy in that there are regular sessions held in Nelson, but that's the best part of 2 h away, which makes it very difficult to justify. (P 538)

Finding 83: One GP commented that, after several years, his medical colleagues had not introduced him to some of the visiting specialists.

Illustration 83: There was no attempt made by anyone to introduce me to any of them. And if you make attempts to try and meet them you are considered a bit pushy. (p 47)

Finding 84: Participants would have liked information about further educational opportunities. (C)

Illustration 84: the difficulties that I have at the moment is sort of getting into paediatrics is really to understand the system and to know what's available and what community services are available for me to access and I don't know where to get the information from (p 5)

Finding 85: The majority of registrars were concerned about dealing with emergencies when they are on-call and not having appropriate support from their supervisors. (C)
Illustration 85: I guess being in the middle of nowhere with a big sort of motor vehicle accident and wondering how I’ll survive trying to manage that all by myself. I guess more the extreme examples, where it’s more or less I guess you’re sort of solo in managing the situation. (p7)

Finding 86: Some rural GPs felt they were not welcomed by their medical colleagues. (C)

Illustration 86: That sense of welcome is lacking in Australian medical circles where they are well-established doctors and wives. They don’t think there is a newcomer from a different part of the world. I don’t think they think. (p 47)

Theme 3: Transcultural challenges (knowledge and confidence)

Overseas trained medical doctors discussed issues related to their integration into another culture, particularly from a work perspective. Many OTDs felt inadequately prepared for practice in rural areas including Aboriginal health settings where social and historical issues, and the model of health care differed from their previous experience.

OTDs need to understand the complexity and diversity of rural health cultural and political issues; different structures of services; and the different status that doctors hold within rural health services. Orientation to the Australian health care system, Aboriginal health services, cross-cultural matters and information technology was generally found to be inadequate. Some voices of racism were also echoed around the OTDs.

Finding 87: Conflict between expected work roles and culturally accepted roles that they adopted at native countries were large cause of stress. (C)

Illustration 87: In my culture, we have the same religion, so . . . it will be easy . . . how you approach these people [in situations of conflict] . . . Here you have to be more practical . . . some of them [male residents] do not want women to work. Some of them think women should stay at home. We have an internal struggle that we should say we are here, we exist and a male making you feel that you should go home . . . (p123-4) . . . people in my culture, they don’t want to know a lot about their problems, especially if they are dying . . . Tell the family! (p122)

Finding 88: Confusion arose over the contextual areas of practice, such as the organisational features of the Western medical system, and the scope of practice.
Illustration 88: ... we don't have enough information about how your system is run ... We don't have social workers ... We don't have to spend time doing [paperwork] ... We just discharge people and that's it ... (p123)

Finding 89: Emotion-focused coping strategies (efforts to regulate the emotional consequences of their circumstances) were evident. (C)

Illustration 89: In Vietnamese, we have a popular saying: The journey is difficult not because of huge mountains and wild rivers blocking the journey, but because of the fears of mountains and rivers. Thus I had to accept the new working and living conditions and learn how to accommodate them. (P7)

Finding 90: Overseas trained medical doctors commented on the differences in health conditions seen in Australia compared with their previous practice. (C)

Illustration 90: The other thing I would say; because it was a little bit of a problem, was mental health especially when it comes to the violence in Australia. (p 115)

Finding 91: Overseas trained medical doctors experienced challenges in general internal workings of the hospital, such as referrals, paperwork, using a computer; practical procedures such as lumber punctures; and health system information specific to New Zealand rural health system. (C)

Illustration 91: From the first minutes it's difficult, how to write the notes, how to organise 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 New Zealand, it is a huge, big problem and can stop work What equipment we use here are different from what I was using for a lumbar puncture before. I've never seen that. (p3)

Finding 92: Overseas trained medical doctors felt that adaptation to a new health care structure and environment is very stressful. (C)

Illustration 92: In terms of that, over time, most OTDs begin to practise like Australian trained doctors, not in terms of the pure medicine or the subject medicine itself, which is the small overall, but the culture of practice. If someone walks in and starts talking about fishing and things like that, you will be able to say "Have you been fishing lately?" or something like that- the cultural aspect and the services available to you and you being able to get used to that. That's what measures are
put in place to train you or to probably orientate you for what is the practice, just like in an Australian doctor. It does happen, many people wait three, four or five years. (p 123)\textsuperscript{19}

Finding 93: Overseas trained medical doctors felt that in Australia patients were seen to have a greater awareness of their condition and expect more from their GP.

Illustration 93: The second thing, which I find a bit difficult, is people here are well aware of their illness. They are very up-to-date with the latest technology, bringing all of the information, so you have to be really up-to-date and know your stuff very well. (p116)\textsuperscript{19}

Finding 94: Overseas trained medical doctors highlighted differences in disease pattern between developed and developing countries. (C)

Illustration 94: One difference is the kind of illness and conditions in our country.. very different here (Australia) to what is in our country-completely different from what is here- there are more chronic diabetes, chronic illness, hypertension. In our country we don't see asthma and so on. So the kind of illness that we see here, although we are trained in similar medical schools, what we are familiar in one country is different from here. (p115)\textsuperscript{19}

Finding 95: Overseas trained medical doctors were reluctant to acknowledge any weakness that they thought could jeopardise their reputation or their registration. (C)

Illustration 95: General practice is different from country to country there's difference. I mean the names of drugs, diseases and many aspects different, so in order to get used to the certain ways, some training is required before we start. (p 192)\textsuperscript{26}

Finding 96: Overseas trained medical doctors working in rural GP had become felt that they had been forced to modify their approach to adjust the cultural difference while examining patients.(C)

Illustration 96: For instance we had a case, 70 year old lady, and we supposed to take history because it, she's 70 years old. She wouldn't be, that's the mentality, that's then, how we, the cultural background think. (p 191)\textsuperscript{26}

Finding 97: Issues of discrimination at the workplace, and during the training programs was commonly found.
Illustration 97: ... if you cut this, I will send you back to Saudi ... (p122) I didn’t feel that I am different except when people treat me different ... (p123)37

Finding 98: Many OTDs felt inadequately prepared for practice in Aboriginal health settings where social and historical issues, and the model of health care differed from their previous experience. (C)

Illustration 98: What I wasn’t quite trained for was just the despair of the patient and sometimes the lack of compliance ... or the disinterest of patients in their own conditions and self care. (p 658)21

Finding 99: Some Overseas trained medical doctors thought the programme did not, however, provide them with all the information required to work in a New Zealand rural hospital. (C)

Illustration 99: 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 (p 4)27

Finding 100: The difficulties in integrating into a New Zealand rural hospital also impacted on relationships with colleagues. (C)

Illustration 100: ...problem is with colleagues, because they want everything fast, quick, they are annoyed if you ask twice. (p 3)27

Synthesis

A total of 32 findings were grouped into three categories and then further refined into a synthesized finding that relates to the provision of adequate support mechanisms so that OTDs can practice safe and satisfactory medicine as Australian medical professionals.

Discussion

Analysis of overseas-trained doctors' understanding of the roles that they are to play in rural and remote health — particularly in Aboriginal communities — and their projections for their personal and professional lives in Australia is essential for further development of policy in this area.
Key themes emerging from the data across all studies included under this section reflect OTDs receiving minimal orientation and training before commencing in rural practice. All emphasized the need for local orientation to rural and Indigenous health, culture and diversity. The variability of experience regarding orientation indicates a need for consistency across different jurisdictions, especially when better orientation, induction and support systems do exist.

Health service management systems need strengthening to include formal performance review and career planning (including an Indigenous health pathway) for all OTDs. Explicit arrangements should exist between the recruiting agencies, employers and medical boards clearly specifying responsibilities prior to arrival, upon arrival and in the period following their arrival to ensure that OTDs who do not have appropriate skills are properly assessed and given relevant supervision, training, orientation, mentorship and support. Work-based and GP Division-led professional development should include OTDs’ ongoing medical education and fellowship training needs. Because of the difficulties OTDs in rural areas experience in accessing training and assessment programs, the delivery of training needs to be made more flexible and additional support mechanisms should be provided. Training providers need to expand the suite of distance learning tools to assist OTDs in rural and remote locations to develop their skills on an ongoing basis, and as far as possible deliver skills assessment programs in the workplace.

Access to basic services such as health care and education is an important part of ensuring that an OTD and their family are able to enter the community successfully. Access to these services needs to be expanded.
# QARI-view of Syntheses 5

<table>
<thead>
<tr>
<th>Findings</th>
<th>Categories</th>
<th>Synthesized Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>The OTDs working in rural practice sixteen years found to keep clear boundaries between professional and private lives, working, but not socialising in the community.</td>
<td></td>
<td>Meeting OTDs' professional needs is crucial in retaining rural GPs.</td>
</tr>
<tr>
<td>OTDs faced with cultural and communication issues, and working in a new paradigm, took longer to trust the relationships with the service and its patients in rural Aboriginal setting.</td>
<td></td>
<td>To enable them to practice in the manner that Australia have come to expect, there needs to be opportunity for integration, orientation, and re-training.</td>
</tr>
<tr>
<td>OTDs felt pressured to accept additional duties to secure another rural placement.</td>
<td>Challenges of rural general practice</td>
<td></td>
</tr>
<tr>
<td>ODTs in rural GP practice found the initial weeks very challenging and may not have remained in rural practice had there been any adverse outcomes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ODTs noted of their status as a doctor were not met in rural Aboriginal Health Service.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participants used a problem-solving strategy that was used when there was something sitting within their role.</td>
<td>Limited professional support</td>
<td></td>
</tr>
<tr>
<td>Several of the ODTs discussed the stress related to working in rural practice in Australia due to the attitude of ODTs by certain groups in Australia.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some ODTs were frustrated at limited opportunities for training in local computer systems before taking on a heavy clinical load in an Aboriginal health setting.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The lack of assistance for longer term career planning and sometimes colleagues support hampered professional integration.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are insufficient support networks in the rural hospitals to assist ODTs in gaining sufficient information to work.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Challenges in this placement compounded by lack of support from work colleagues affected ODTs ability to deliver effective patient care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited access to continuing medical education training is a point of concern.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One overseas trained GP commented that, after several years, her medical colleagues had not introduced him to some of the visiting specialists.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ODTs commented the lack of practical component of the RACGP preparation program, and stressed the need for them to have hands-on guidance to prepare.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ODTs were very critical about the lack of practical support and assistance available to them and a perceived lack of opportunity for them to obtain clinical experience.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participants would have liked information about further educational opportunities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some ODTs UPS felt they were not welcomed by their medical colleagues.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conflict between expected work roles and culturally accepted roles that they adopted at native countries were large cause of stress.</td>
<td>Transcultural challenges (knowledge and confidence)</td>
<td></td>
</tr>
</tbody>
</table>
Chapter 10. Synthesis 6: Cultural transition training programs for OTDs in rural areas are required

All medical professionals require good communication skills to develop effective physician–patient relationships. A review of the extant literature confirms that by and large patients and families expect doctors to provide reliable information in an effective and compassionate way with priority given to the bioethical principles of patient autonomy. OTDs, however, receive very little formal training in these skills. They cannot be fully competent if they don’t communicate effectively with their patients. OTDs showed deficiencies in communication skills, which were not remedied in current training programmes when compared with Australian-trained residents.

It is suggested that English-language skills as one component of the challenges encountered by OTDs coming to Australia. OTDs working in rural health services reported complex communication issues between doctors and patients, particularly interaction with rural patients. Many OTDs from non-Western cultures may not have had prior experience in dealing with such a range of people and may lack the communication skills to deal with all people meaningfully and effectively.

In many cultures the status of medical doctor is highly regarded and the doctor operates from a position of considerable power within the community. Thus, difficulty arises when OTDs change country to a culture in which the doctor–patient relationship is more equitable.

Thirteen findings are categorized into two main themes.

Studies

There were 2 references to theses themes.


Theme 1: Communication challenges as a result of cultural difference impacting on doctor-patient relationships

The consumer-oriented view of patient care prevalent in developed countries may pose problems for OTDs as patients often challenge them. The concept of a patient questioning a doctor is quite alien to many OTDs because, in their home countries, the patient's role is one of compliance, trust and cooperation, and any other behaviour is not tolerated.

The key findings of each study and the accompanying illustrations are presented below.

Finding 101: Overseas trained medical doctors described that they had to change from using tell approach they used in their cultures of origin to using an explain approach in the US. This largely involves discussion, negotiation and explanation. (C)

Illustration 101: The good thing is [that] the [U.S.] patient knows what is happening to him. This is a very good thing. In my country, most of the time, the patient didn't want to know [the diagnosis]. They just wanted to get better. (p 1572)

Finding 102: Overseas trained medical doctors from a different cultural background and a separate residency program also reported changing her interaction styles when it came to connecting with her Appalachian patients. (C)

Illustration 102: Here I try to be more friendly, more approachable. When you enter the room, say who you are and shake hands. Say, Good morning, and ask, How are you doing today? Not just barging in and saying, What's wrong with you? I have seen my colleagues doing that in India. (p 1574)

Finding 103: Other Overseas trained medical doctors described patients in their cultures of origin as being “uneducated,” which requires physicians to “be a little strong” when telling patients what they need to do. (C)

Illustration 103: Our patients don't argue with their doctors, and whatever the doctor says is the word. (p 1571)
Finding 104: Participant described that she had experienced “a bit of frustration” because her Appalachian patients would “take offense” at the frank talk she was used to with patients in her culture of origin. (C)

Illustration 104: I have to “explain all the details” to U.S. patients, I think it is because “the knowledge of the patient about the disease is higher than” that of patients in my culture of origin. (p 1571)³³

Finding 105: Participant mentioned several times that she had to work harder and be more cautious in her communications with her Appalachian patients than was necessary at home. (C)

Illustration 105: Back home, we could tell our patients anything. We talked to them [freely], and we’re just so relaxed with each other. Here, you have to be careful about what you say.”(p 1571)³³

Finding 106: Several overseas trained medical doctors reported that patients in their cultures of origin believed that physicians were godlike. (C)

Illustration 106: Several overseas trained medical doctors reported that patients in their cultures of origin believed that physicians were godlike. (p 1571)³³

Theme 2: Transcultural challenges (interactive communication) (rural Canada)

Overseas trained medical doctors need to be able to read the non-verbal cues in an interaction and respond with cultural appropriateness. Establishing rapport with patients and responding to patients’ emotions can be challenging for medical graduates trained in non-Western countries. Many OTDs expressed frustration with their inability to show caring and empathy towards patients and did not know how to express empathy in a different culture, both by word choice and non-verbal actions. This resulted in OTDs feeling they had been unable to support the patients and their families in a caring way. OTDs reported that they received little or no training in specific doctor–patient communication skills and experienced difficulties with question formation, understanding informal colloquial language and negotiating treatment plans.
Finding 107: Communication techniques taught during residency program also were not fully understood by “the rest of the foreign grads.” Others expressed frustration over the use of standardized patient (SP), and videotaping. (C)

Illustration 107: Such training produced artificial physician–patient exchanges. I’m frustrated about the finding it “invasive.” (p 1569) 33

Finding 108: Education tended to be defined in a specific way as a focus on the hard science. (C)

Illustration 108: Education is very important in my culture and my educational background targets the science. (p1569) 33

Finding 109: Overseas trained medical doctors also struggled with certain communication training and assessment residency programs, because they had very limited facilitating skills such as using open-ended questioning. (C)

Illustration 109: The patient wants to speak a lot. The patient [says], “But I remember that pain I had two years ago because I ate something, da, da, da.” You say, “Okay, how is that pain?” Sometimes you have to interrupt that patient. But it’s because, in our culture [of origin], the patient speaks a lot, a lot, a lot. But, here, the patient normally gets to the point. (p 1570) 33

Finding 110: Overseas trained medical doctors come from a culture where a focus almost solely on science and there is a general lack of study of communication. (C)

Illustration 110: We have 3 years of basic science, which is anatomy and physiology and after that we have one year… where we learn about the disease and diagnosis. (p 1569) 33

Finding 111: Most Overseas trained medical doctors reported developing their communication skills through experiential means before entering their residency programs. (C)

Illustration 111: You have to learn on your own. You have to observe how this doctor is approaching the patient. We were not taught by specific lectures. (p1569) 33

Finding 112: Participants noted discrepancies (between the culture of medicine in their country of origin compared to New Zealand) in many aspects of the working life of the hospital. A cultural adjustment had to take place. (C)
Illustration: 112: 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. (p 3)

Finding: 113: Several Overseas trained medical doctors stated that they had experienced communication barriers related to colloquial language use; these challenges seemed to be magnified by the regional dialects encountered in their residency programs. (C)

Illustration 113: My challenge was to understand the South-Eastern dialect. It was very difficult. The first week was a nightmare."(p 1570)

Synthesis

A total of 13 findings were grouped into two categories and then further refined into a synthesized finding that relates to the development of training programmes that would facilitate the cultural transition.

Discussion

Communication is a universal activity that varies greatly across cultures. An individual’s cultural background has been shown to affect various communication-related factors, including willingness to communicate, notions of communication competence, and interpersonal request-making behaviours and beliefs. Entering a new and unfamiliar culture can profoundly affect communication, producing anxiety and resulting in greater avoidance of and less satisfaction with interpersonal interactions.

However, in cross-cultural encounters between physician and patient, neither party may have the option of withdrawing from the encounter. Rural doctors must be prepared to treat diverse patient populations, including some that have experienced health disparities; patients from various cultural backgrounds. More importantly, it was suggested that they also need to explore and understand the impact of their own multilayered cultural backgrounds (e.g. aspects of the dominant culture, religious culture, and socioeconomic status) while adjusting to their patients’ needs.
The analysis in this section helps shed some light on the complex, multidimensional nature of physician patient communication, particularly cross-cultural communication challenges. These data also enabled the identification of education-related barriers. For example, the analysis showed that the previous medical education of many of OTDs focused largely on the “hard” sciences. Moreover, there was a distinct lack of education in physician–patient communication. Every communicative interaction requires a change in the choice of medical terminology (e.g. limiting the use of jargon); the way of explaining; the register (i.e. appropriate tone and word choice to match the audience and situation); the amount of information given; and the element of empathy. Overseas trained medical doctors need to be made more conscious of the subtle and pragmatic changes within a communicative interaction.

Specifically, OTDs identified challenges with dyadic interactions due to encountering new dialects, changes in physician–patient power, and different expectations with regard to physician–patient rapport building when they began to adapt to their rural patients. Orientation programs must also focus on the latent features of cultures, such as the differences in norms, values, beliefs, attitudes, and expectations. While language - or, more specifically, dialect, vernacular, and accent - was one barrier to communication, new and unfamiliar cultural norms and expectations were more often cited by OTDs as sources of problematic communication with patients. Perhaps more importantly, OTDs had difficulty explaining the complications they were facing, often broadly and generically attributing those complications to “cultural differences”.

These OTDs have spent their lives being influenced by their cultures. Some of their behaviours, attitudes and values, which have been culturally defined may cause some misunderstandings. For example, a number of participants in these studies indicated that they had been raised and educated in cultures that programmed patients to elevate physicians to a godlike status and programmed physicians to be directive during medical interviews, and programmed both physicians and patients to see the physician as having the power to decide the fates of patients without being questioned or challenged.

In contrast with such experiences, interactive, relationship-centred doctors patient communication caused several problems for OTDs. Nonverbal communication, such as that around different cultural norms of eye contact, use of physical space, and touch, challenged their interactions with
patients. These highlight the need for communication skills development and orientation programs that helps them understand the cultural norms, beliefs, and values of their host culture and their residency program, as they would affect communication expectations. In addition to this a key area for improvement is the need to improve patient-centred interviewing skills, as well as the skill of giving and receiving feedback.

Understanding the barriers related to their English-speaking skills, interventions in this area may require OTDs to spend time (outside of the medical office) interacting in the local vernacular, rather than returning home to a spouse, friend, or family members who may prefer to speak in their primary language or who may also struggle with unfamiliar dialects.
QARI-view of Syntheses 6

Findings

| OTDs described that they had to change from using the approach they used in their cultures of origin to using an explain approach in the US. This required more discussion, negotiation, and education. |
| OTDs from a different culture background and a separate residency program also reported changing their interaction styles when it came to connecting with their Appalachian patients. |
| OTDs described patients in their culture of origin as being "unapproachable," which required physicians to "be a little strong" when telling patients what they needed to do. |
| Participant described that she had experienced a bit of frustration because her Appalachian patients would "take advantage" of the train talk she was used to with patients in her culture of origin. |
| Participant mentioned several times that she had to work harder and be more cautious in her communications with her Appalachian patients than was necessary at home. |
| Several OTDs reported that patients in their cultures of origin believed that physicians were godlike. |
| Communication techniques taught during residency program were also not fully understood by the rest of the foreign trainees. They expressed frustration over the use of standardized patient (SP) and videoaging. |
| Education tended to be defined in a specific way as a focus on the hard science. |

Categories

| Communication challenges as a result of cultural difference impacting on doctor-patient relationship |
| Transcultural challenges (intercultural communication) (rural Canada) |

Synthesized Findings

| Training programmes for rural practice are required to facilitate the cultural transition. |
| NTAs from non-English speaking cultures are often confronted by a series of transcultural challenges including language, culture, lifestyle, sex-role differences, discrimination, and changes in status. |

Most OTDs reported developing their communication skills through experiential means before entering their residency programs. |
OTDs also struggled with certain communication training and assessment residency programs, because they had very limited facilitatory skills such as using open-ended questioning. |
OTDs come from a culture where a focus clinical specialty on science and there is a general lack of study of communication. |
Participants noted discrepancies between the culture of medicine in their country of origin compared to New Zealand in many aspects of the working life of the hospital. A cultural adjustment had to take place. |
Several OTDs stated that they had experienced communication barriers related to colloquial language use; these challenges seemed to be magnified by the regional dialects encountered in their residency programs. |
The communication training within many of the OTDs' cultures of origin was scant and limited in scope. |
Chapter 11. Synthesis 7: Government funding assistance to implement and strengthen locum support for OTDs in rural and remote areas is required

In addition to the challenges of settling in to a new and sometimes isolating environment, learning to communicate and interact with new communities, and adjusting to different cultural norms and practices, OTDs were also faced with the challenge of not being able to find locum support. This, in turn, affected recruitment and retention of OTDs to these areas and the quality of care received by rural and remote communities.

There is only one reference in this last section.


Themes

Theme 1: Government support through establishing a rural locum service

In 2002 NZD$32 million was pledged over 3 years to support the recruitment and retention of rural primary healthcare workers through establishing a rural locum service and paying extra rural premiums to GPs. A mixed response to this policy was received. While no respondents were entirely positive, some of the OTDs reported benefits from the policy over the last year.

Problems finding locums in primary healthcare is one of the other additional disadvantages of working in a remote rural practice, which has implications for the care of the rural population. Locum-starved South Island GPs were very pleased with the rural premium policy to support the recruitment and retention of rural primary healthcare workers, however, some expressed doubts regarding the sustainability of the policy.

Finding 114: Policy is improving; however; it is hard to fully address the problem. (C)

Illustration 114: … Currently it is a mixed bag. A year ago, the new funding packages are what kept me here. Now, in its second year, we have all these strings attached. Either they are going to
say, ‘Here you go, you are a rural doctor, have this funding and down it what you will,’ or they are going to say, ‘You are a rural doctor, there is funding here, but there are strings attached.’ It has now left me more unimpressed than impressed. (p538)

Finding 115: While most overseas trained medical doctors reported at least some benefit from the 2002 funding announcements, one respondent claimed that none of the promised funding has so far been seen. (C)

Illustration 115: The government has promised wonderful things, but the situation is simply not getting any better at the coalface. They [the Government] have put millions of dollars into locum schemes and I just have not seen it. For example, I took a break in September for two weeks … I had to find my own locum and it cost me NZD$4200 for 2 provide them with accommodation … We gave up our house to them in the end.(p 538)

Synthesis

Two findings were assembled into one category and then further refined into one synthesis regarding government support for locum cover in rural and remote areas.

Discussion

A good professional support system was a requirement for rural doctors who have made an important contribution to the rural health workforce by filling the gaps. It is clear that disadvantages of working in a remote rural practice include: inescapable on-call commitments, distant (and subsequently expensive) professional development opportunities coupled with a need to keep up with a wide range of new skills (especially trauma and emergency medicine), problems finding locums, isolation, and loss of anonymity. Furthermore, problems finding locums in primary healthcare is one of the additional disadvantages of working in a remote rural practice, which has implications for the care of the rural population.

As part of the Government policy for the recruitment of rural GPs, in the 1990s, the New Zealand government attempted to support the retention and recruitment of the rural primary healthcare workforce through establishing a rural locum service and paying extra rural premiums to GPs.
However, this program has not been successful. Sustainable government funding is required to facilitate locum cover for rural practitioners.
QARI-view of Syntheses 7

Findings

Policy is improving; however, it is hard to fully address the problem.

While most CRs reported at least some benefit from the extra funding announcements, one respondent claimed that none of the promised funding has so far been taken.

Categories

Government support through establishing a Rural Locum Service

Synthesized Findings

There is a need to facilitate locum cover for rural practitioners. Problems finding locums in primary healthcare is one of the additional disadvantages of working in a remote rural practice.
Chapter 12. Discussion and conclusions

Meta-synthesis enables the reinterpretation of qualitative data in order to capture the essence of the phenomenon of interest. The current review identified a number of qualitative research papers related to the topic under investigation. However, only 13 of these were considered to fall within the inclusion criteria. Critical appraisal of these was conducted using JBI-QARI and as a result, 115 findings are analysed into seven synthesized findings that related to rural doctors’ subjective experience as follows: 1) Adequate support systems to ease fear of entrapment are required; 2) Transparent standards for determining the eligibility of OTDs is required; 3) National standards of English language assessment would maximise the effectiveness of clinical communication; 4) Social integration and community support would contribute significantly to the settling in process; 5) Meeting OTDs professional needs is crucial to retaining rural GPs; 6) Cultural transition training programs for OTDs in rural areas are required; and 7) Government funding assistance to implement and strengthen locum support for OTDs in rural and remote areas is required.

While the majority of the experiences identified in this review are idealistic and very challenging, the review also identified some positive aspirations of OTDs working in rural and remote settings. On the whole, these experiences may be utilised to develop a national strategy to resolve the rural doctors workforce crisis.

Based on the results of this systematic review it is asserted that there are eight specific areas related to improving the experience of OTDs who are recruited to work in rural and remote Australia; and that if these are met, the quality of care provided in these regions would be improved.

1. Provide adequate support mechanisms to ease the fear of rural entrapment

The first synthesized finding related to OTDs experiencing a sense of entrapment during their transition to a geographically, socially and ‘culturally’ isolated and underserved area of Australia. OTDs provide a necessary and much needed service in rural and remote communities. Supportive community integration arrangements in remote area settings are particularly important to relieve the concern of rural entrapment.
2. Instigate a transparent national registration system for all OTDs, regardless of visa status, to avoid exploitation and discrimination

The second synthesized finding incorporates OTDs’ stress related to the threat of litigation; lack of clear transparent consistent advice on entry and registration pathways. Furthermore, it also encompasses what has been referred to as political barriers reported by rural OTDs who had migrated to Australia before 1997 (a time when OTDs were not particularly welcome in Australia and immigration became difficult). Current policies and practices governing the appointment and registration of OTDs in Australia are a significant barrier.

Appropriate recognition of overseas qualifications has always been a contentious issue in most professions not only in Australia but also in other countries. The maintenance of medical standards is of critical importance for the medical profession as it has implications for the provision of the best healthcare for the Australian public. This makes the process of developing appropriate recognition of overseas medical qualifications difficult.

Policies and practices governing the registration and appointment of permanent resident overseas doctors in NSW in the late 1990s appeared to be discriminatory and unnecessarily restrictive. Communities in rural NSW were struggling to attract GPs and many rural residents could not access adequate or appropriate medical care. It was suggested that perhaps regulation of the medical profession had gone beyond what was necessary to protect patients from incompetent doctors and was being used as a device to restrict competition within the medical profession. This ‘closed shop’ professional culture was preventing OTDs from obtaining medical registration in Australia. OTDs were usually recruited to a specific rural town, although no strategies were identified that matched the location to the social needs of the OTD (such as religious amenities, ethnic group, spouse employment or children’s education). This adversely affected retention in a rural Area Heath Services.

Accreditation of OTDs in late 1990s provided greater opportunities to temporary residents, the majority of whom came from the United Kingdom, and restricted opportunities for permanent resident OTDs, who statistically are predominantly from other racial backgrounds. Permanent resident OTDs critiqued the system of accreditation in the late 1990s, stating that it was neither easy nor comprehensible; that its complexity was deliberate and designed to protect various vested interests; and that it was unfair, discriminatory and designed to exclude doctors trained in non-English speaking countries.
The AMC now has its examinations independently evaluated to ensure that the format of the examinations, and the wording of the questions, does not unduly disadvantage OTDs from non-English speaking backgrounds.

When considering the discourses centred on what has happened to many capable and well-qualified OTDs, the Australian’s government commitment to medical standards does need to be justified. Concerns about the quality of medical care provided by OTDs needs to be addressed by a more open, transparent, national standardized system of registration. Any differences in the professional experiences of OTDs working in rural areas could not be teased out according to country of training, occupational visa category or language or cultural distance.

3. Develop a national source of relevant and current information for OTDs to access on available positions, prerequisites, and procedures

There is ample evidence that OTDs are poorly prepared for the AMC examinations, including understanding what the AMC examiners are looking for and what is required to pass. Participants had difficulty obtaining accurate information relevant to their circumstances and struggled to afford the AMC examination fees. OTDs commonly identified difficulties such as preparing for and passing the AMC examinations as barriers to medical registration.

An overarching finding was that OTDs might be willing to pursue their personal and professional goals, however, they were only able to achieve them under given opportunities and the particular regulatory framework of the Australian government. However, their aspirations may at times be somewhat restrained by professional guidelines that they face in Australia.

While it is important to ensure that the processes for the assessment and registration of Area of Need positions are identical for permanent and temporary resident OTDs, it is also imperative to develop a national source of relevant and current information for OTDs to access on available positions, prerequisites, and procedures for exams.
4. A national comprehensive assessment process that requires demonstration of appropriate communication skills, medical knowledge, and clinical skills to a level of fitness for safe practice

The third synthesized findings relates to distressing and emotional voices of racial discrimination while interacting with rural communities. The current review revealed that only a few OTDs reported that their formal English-speaking skill was a barrier to their communication with rural patients. In contrast with such experiences, the majority of them noted their problems with understanding regional dialects, which can also be a challenge in communication with rural patients who often judge the competence of a doctor on the basis of what they can see and hear - in other words the doctor’s skin colour, physiognomy and accent.

Available evidence suggests that language and communication skills were identified as important issues to address as part of the settling in process and the integration process with rural communities. However, more importantly, it is essential for OTDs from non-English speaking backgrounds to have a first-rate operational command of the English language, because they are required to handle complex language well and to understand detailed reasoning to avoid significant problems and miscommunications. Language and communication training for all OTDs from non-English speaking backgrounds would help overcome language barriers.

It is clear, both from literature and from our current review that there needs to be a fuller assessment of OTDs learning needs before they enter a rural practice. For example, the English proficiency standard should be higher than it is currently, and appropriate to medical training. Before commencing work, it is important to clarify OTDs language needs. English is their second language and proficiency varies. Indeed, lack of proficiency, including accents and idiom can affect both the potential to learn and later effectiveness in clinical communication. To enable them to practice in the manner that Australians have come to expect, there should be opportunity for integration, orientation and re-training.
5. Facilitate supportive community integration arrangements in remote area settings

Doctors working in rural and remote locations reported acceptance by the local community as one of the key factors associated with satisfaction with practice location.

The fourth synthesis related to the positive impact that acceptance by the local community and favourable supportive community integration arrangements can have on OTDs settling in process in isolated rural areas. Favourable conditions for children’s education, work opportunities for their spouses, easy access to essential goods and social services, and a combination of favourable circumstances or situations to mix with others from their own cultural background can provide OTDs with sense of belonging and support. The need for socio-cultural support and proximity to ethnic community has been shown to be important for doctors from different ethnic and cultural backgrounds. Successful community based initiatives welcoming OTDs and their families, and assisting in their integration, have been reported to be one of the most important factors associated with satisfaction with remote area settings.

6. Institute and strengthen better rural continuing medical education establishing a unique rural career pathway supporting appropriate professional development for rural practitioners

The fifth synthesis related to OTDs' need for growth in rural academic programmes with respect to training and career advice, information about the complexity and diversity of rural health, cultural and political issues, and different structures of health care services.

It is difficult to anticipate that in comparison with locally trained doctors, OTDs would have better methods of coping with the difficulties working in the country. The availability and accessibility of education and training support programs for OTDs provided a sense of security and certainty in an otherwise complex, challenging and diverse situation. The presence of appropriate support from supervisors and colleagues was also reported to be one of the most important resources for country doctors who love their job in general but are frustrated with work conditions, long hours and a conflict with family desires and responsibilities. This will require additional resources for mentoring, supervision and support.
7. Implement a national standard for orientation programs for OTDs that addresses the Australian health care system, specific doctor-patient communication skills as well as cultural awareness.

The sixth synthesis incorporated what was referred to as complex communication issues. OTDs from non-Western cultures, who did not have had prior experience in dealing with a range of people, lacked the communication skills required to deal with all people meaningfully and effectively. Establishing rapport with patients and responding to patients' emotions can be challenging for medical graduates trained in non-Western countries. Many OTDs expressed frustration with their inability to show caring and empathy towards patients and did not know how to express empathy in a different culture, both by word choice and non-verbal actions. This resulted in OTDs feeling they had been unable to support the patients and their families in a caring way. OTDs reported that they received little or no training in specific doctor-patient communication skills and experienced difficulties with question formation, understanding informal colloquial language and negotiating treatment plans.

In many non-Western cultures the status of a medical doctor is highly regarded and the doctor operates from a position of considerable power within the community. Thus, difficulty arises when OTDs move to a new country with a culture in which the doctor-patient relationship is more equitable. The consumer-oriented view of patient care prevalent in developed countries may pose problems for OTDs, as patients often challenge them. The concept of a patient questioning a doctor is quite alien to many OTDs because, in their home countries, the patient's role is one of compliance, trust and cooperation, and any other behaviour is not tolerated. Thus, while these OTDs may be knowledgeable and able to diagnose and manage disease profiles, they may not have developed adequate communication skills to deal with all people meaningfully and effectively. Invariably they had received little or no training in specific doctor-patient communication and needed to equip them with techniques to contend with communication challenges.

In Australia, assessments of competence of communication skills (as distinct from linguistic proficiency) and cultural awareness are not included in current assessments of OTDs. The Review of Cultural Training for GPs working in Aboriginal and Torres Strait Islander Health found that cultural training is limited for GPs working in Aboriginal and Torres Strait Islander health.
8. **Initiate, facilitate, reinforce and implement national funding of locum cover for rural practitioners**

The seventh synthesized finding related to finding locums in primary healthcare as one of the additional disadvantages of working in a remote rural practice, which have implications for both the care of the rural population. The medical profession in Australia is largely self-governed and is therefore able to control the market and create the conditions in which selective recruitment is possible.

Rural doctors can make deeply symbolic and practical contributions within rural communities; for instance, offering a sense of security to those living within sparsely populated areas. Despite experiencing disadvantages of working in a remote rural practice they are dedicated to working in underserved areas. Funding support from governments through establishing a rural locum service and paying extra rural premiums to GPs may enhance recruitment and retention of rural primary healthcare workers.

**Summary**

The quality of medical care for the Australian community depends on a willingness and commitment from governments (federal, state, and territory), immigration officials, educators, accreditation organizations, health care providers, and professional bodies to reform the current system.

Through its Rural Workforce and Training Program, the Royal Australian College of Physicians already undertake a number of initiatives in support of Fellows and trainees in regional and rural Australia. Funding assistance has been received from the Commonwealth Department of Health and Ageing and various State government health departments to implement some of these activities. A steering committee that includes relevant professional bodies and the medical boards has recently been established to address the issues of the complex and inconsistent systems of overseas qualification recognition that perpetuates ongoing inadequate workforce planning and international equity concerns. The committee implemented a new uniform standard for English tests in each of four categories (reading, writing, listening, and speaking). This is considered an initial step in the right direction. Many more complex issues identified above are still to be resolved.
to develop a fair and equitable mechanisms for assessing and employing OTDs in underserved rural areas.

There is also need for a regular audit of those who are currently practicing as OTDs, whether on temporary visas, with conditional accreditation in areas of need, or unrestricted GPs. This will help guarantee safe practice and enable targeted support to be provided.

The results of this study illustrate that being able to successfully meet the identified education, training and professional support needs will contribute significantly to all rural region’s doctors, and not just GP OTDs, being retained in rural practice. The findings support the notion that, wherever possible, a fully integrated strategic approach, focusing on meeting the doctors’ professional needs should guide the development and implementation of relevant, comprehensive retention strategies for the region’s rural doctors.

The results point to the existing lack of a national approach supporting the integration of OTDs into the workforce. Areas that require urgent policy attention are identified as:

- Information access
- Orientation to Australian health care systems and specific workplaces
- Communication between rural patients and healthcare professionals
- Nationally consistent standards for skills assessment and education and training support
- The capacity of the system to support ongoing initiatives.

*Additional studies incorporated in analysis*

Although primary objective of this review was to examine the experiences of OTDs working and living in sparsely populated isolated rural areas, it also generated an additional synthesis based on the included studies that were slightly outside the boundaries of the main review objective. It was thought that this information might enhance understandings of rural doctors experiences from other developed countries with comparable health systems such as Canada, and New Zealand. The health care needs of many rural communities in New Zealand and Canada are also challenged by under-servicing and the recruitment and retention of general practitioners (GPs) in
rural communities continues to be of concern. These countries share the same challenge of ‘doctoring’ in rural areas that Australia is facing.

The first example is the synthesis on requirement of training programmes for rural practice to facilitate the cultural transition. This synthesis incorporates what has been referred to as doctors and patient's complex communication issues faced by many OTDs from non Western cultures, who may not have had prior experience in dealing with a range of people and may lack the communication skills to deal with all people meaningfully and effectively. Although this synthesis did not fall neatly into the Australian rural setting, there was sufficient evidence within the included Canadian study that suggested that cultural awareness orientation and a doctor–patient communication skills training program may be a preferred option for many OTDs and also that they need to be considered when planning for induction programs. Synthesis 6 shows how the synthesis is underpinned by the categories and the relationships between them.

The theme that typified experience of OTDs from non Western cultures successfully resolving professional concerns through a touch process of moving from loss, through disorientation, to adaptation throughout the rural placement training programs in rural Canada and ultimately becoming a rural doctor in Canada is included under the synthesis on “national strategy that is cognizant of factors associated with OTDs' satisfaction and better integration into the Australian rural areas”. Although not in Australia this theme provided an example of one of the remarkable aspirations from the Canadian experience regarding OTDs' dedicated hard work towards professional destination. Synthesis 1 shows how the theme is integrated into synthesis and the relationships between them.

Again communication challenges experienced by OTDs during communication training and assessment residency programs as a result of regionally unique dialect, colloquial expressions and accents of rural Canadian also enriched the synthesis on the requirement of language and appropriate communication skills, medical knowledge, and clinical skills to a level of fitness for safe practice. Synthesis 3 shows how the synthesis is underpinned by this category and the relationships between them.

One of the supporting theme underpinning under synthesis towards “factors associated with OTDs’ satisfaction and better integration into the Australian rural area” is theme describing Overseas trained medical doctors appreciating the Natural scenic attractions of a rural New Zealand lifestyle. Despite being deemed to be outside the boundaries of the main review objective, we thought this
theme would be useful to enhance understanding about OTDs’ intention to wholeheartedly stay in quiet and peaceful rural area. Synthesis 1 shows how the theme is integrated into synthesis and the relationships between them.

Also generated from the same study from New Zealand is the synthesis on “Rural premium policy”. Although this funding did not fall neatly into Australian state and federal government funding scheme, there was sufficient evidence within the included study that suggested that funding support of governments through establishing a rural locum service and paying extra rural premiums to GPs may enhance retention and recruitment of the rural primary healthcare workforce. Synthesis 7 shows how the theme is integrated into synthesis and the relationships between them.

Limitations

Qualitative data is not always widely accepted in the research community as a form of evidence. However qualitative findings can provide insights and explanations of a different depth and perspective to quantitative data. Whereas quantitative data are causal, or examine associations, qualitative data are insightful, and offer individualised perspectives on a person’s experiences. Nevertheless, because of the qualitative nature of this review, the generalisability of the findings are limited.

This review identifies enormous inconsistencies in defining rural areas reported in the included papers. It has become increasingly difficult to draw the line between urban and rural because the majority of the included studies did not define rural practice according to the Rural, Remote and Metropolitan Areas (RRMA) classification or by the postcode of the primary practice. Indeed, all the included studies described it as a ‘vague and ambiguous term’.

Many qualitative studies do not explicate their philosophical position. In addition, many studies are poorly reported, resulting in issues of muddling, blurring and slurring.

All the studies did not articulate clearly whether the OTDs interviewed were involved in the Australia’s 5-Year Overseas Trained Doctor Program. This required the author of the review to include all the articles regardless of the training program to develop the best available evidence.
Much of the literature into OTDs addresses recruitment and employment in rural and remote areas with no detailed description of distance, and lack of description on involvement in the Australia's 5-Year Overseas Trained Doctor Program.

There appears to be limited literature articulating the specific experiences of OTDs working in Aboriginal and Torres Strait Islander Health, despite the fact that improving the health of Aboriginal and Torres Strait Islander people is one of Australia’s highest health priorities. Further research into this cultural context may advocate for culturally appropriate health delivery systems and doctors who would improve health outcomes for Indigenous Australians.

**Implications for research**

The limitations of this review constitute a good starting point for further direction for future research in this area. There is a need for good quality qualitative studies carefully designed with a rigorous qualitative approach.

There is also need for a regular audit of those who are currently practicing as OTDs, whether on temporary visas, with conditional accreditation in areas of need, or unrestricted GPs. This will help guarantee safe practice and enable targeted support to be provided.
Appendices

Appendix 1: Flow diagram of the studies
# Appendix 2: QARI Appraisal instrument

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Yes</th>
<th>No</th>
<th>Unclear</th>
<th>N/A Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) There is congruity between the stated philosophical perspective and the research methodology.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>2) There is congruity between the research methodology and the research question or objectives.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>3) There is congruity between the research methodology and the methods used to collect data.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>4) There is congruity between the research methodology and the representation and analysis of data.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>5) There is congruity between the research methodology and the interpretation of results.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>6) There is a statement locating the researcher culturally or theoretically.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>7) The influence of the researcher on the research, and vice-versa, is addressed.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>8) Participants, and their voices, are adequately represented.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>9) The research is ethical according to current criteria or, for recent studies, there is evidence of ethical approval by an appropriate body.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>10) Conclusions drawn in the research report do appear to flow from the analysis, or interpretation, of the data.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
</tr>
</tbody>
</table>
Appendix 3: QARI data extraction instrument

<table>
<thead>
<tr>
<th>Extraction Details: Extraction - Name (2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>* denotes field which will appear in report appendix</td>
</tr>
<tr>
<td>Methodology:</td>
</tr>
<tr>
<td>Method: *</td>
</tr>
<tr>
<td>Phenomena of Interest: *</td>
</tr>
<tr>
<td>Setting:</td>
</tr>
<tr>
<td>Geographical:</td>
</tr>
<tr>
<td>Cultural:</td>
</tr>
<tr>
<td>Participants: *</td>
</tr>
<tr>
<td>Data Analysis:</td>
</tr>
<tr>
<td>Authors Conclusion: *</td>
</tr>
<tr>
<td>Reviewers Comments: *</td>
</tr>
<tr>
<td>Complete: Yes</td>
</tr>
</tbody>
</table>

Appendix 4: List of excluded studies and reason for exclusion


   Reason for exclusion: not related to review objective.


   Reason for exclusion: not related to review objective.


   Reason for exclusion: not related to review objective.


   Reason for exclusion: not related to review objective.


   Reason for exclusion: not related to review objective.


   Reason for exclusion: not related to review objective.


   Reason for exclusion: not related to review objective. not related to rural area. Only for overseas nurses.

Reason for exclusion: related to review objective. however setting is not in rural area.


Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective.


Reason for exclusion: Duplicate publication. This is confernece paper.


Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective.

Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective. Quantitative study


Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective.

Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective.

28. Lisa M. An examination of the structural and political barriers preventing permanent resident overseas-trained doctors from working as general practitioners in rural New South Wales University of Newcastle. Faculty of Business and Law, School of Business and Management; 2008.

Reason for exclusion: not related to review objective.

Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective. not related to rural area.

33. Playford D, Maley M. Medical teaching in rural Australia: should we be concerned about the international medical graduate connection? MJA 2008;189(2):125-7.

Reason for exclusion: not related to review objective.

34. Royal Australian College of General Practitioners. Review of cultural training for GPs working in Aboriginal and Torres Strait Islander Health.2004.

Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective.

Reason for exclusion: not related to review objective.

Reason for exclusion: not related to review objective.

Reason for exclusion: not related to review objective.

Reason for exclusion: not related to review objective.

Reason for exclusion: not related to review objective.

42. Health CDo, Ageing. Information for Overseas-Trained Doctors.
Reason for exclusion: not related to review objective.

43. Immigration CDo. Immigration Advice for Skilled Workers.
Reason for exclusion: not related to review objective.

44. Immigration CDo. Temporary Business Visa Information.
Reason for exclusion: not related to review objective.

Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective. Not related to rural area.


Reason for exclusion: not related to review objective.


Reason for exclusion: not related to review objective.

   Reason for exclusion: not related to review objective.


   Reason for exclusion: not related to review objective.

55. Wijesinha S. Australians see Dr Death in every overseas-trained doctor. June 14, 2005 [cited 2011 20 Feb].

   Reason for exclusion: not related to review objective.


   Reason for exclusion: not related to review objective.


   Reason for exclusion: not related to review objective.


   Reason for exclusion: not related to review objective.
References


26. McFayden L. An examination of the structural and political barriers preventing permanent resident overseas-trained doctors from working as general practitioners in rural New South Wales: University of Newcastle. Faculty of Business and Law; 2008.


31. Wijesinha S. OMG! Do we really need the terms overseas-trained medical doctors and overseas trained medical doctors? 2010.


