The Quality of Life and Social Needs of International Medical Graduates: Emerging Themes in Research

Daniel Terry[1], Quynh, Lê[2], Jess, Woodroffe[3], Kathryn, Ogden[4]
[1, 2, 3] *University Department of Rural Health, University of Tasmania*
[4]*Launceston Clinical School, University of Tasmania*

ABSTRACT

A literature review was conducted to identify the experiences, challenges and acculturation of International Medical Graduates (IMGs) living and working throughout rural and remote Australia. As such recently published literature highlighted key factors impacting IMGs living and working in rural and remote areas which informed the acculturation process in western society. IMGs acculturation throughout Australian rural settings occurs rapidly among these higher educated migrants. Those IMGs with Australian spouses or who have practiced in rural settings prior to migration also experience a new phase of acculturation. However, maintaining cultural and religious connectivity continues to be challenging in these settings. Community awareness and an ability to embrace IMGs and cultural differences remain crucial for identity and cultural retention. Nevertheless, few studies recognised quality of life and social needs of IMGs and their family's impact on the rural acculturation and settlement success. Previous research has focused primarily on employment integration, satisfaction and practice support. The identified literature is in no way extensive as it focuses on IMGs in the Australian context, which may impact on transferability. A gap exists where quality of life and social needs of IMGs and their families have been overlooked. These are crucial factors impacting rural acculturation, retention and IMGs health and wellbeing. The literature highlights insights into IMGs acculturation as they migrate and reside in Tasmania, a less culturally diverse population, remains absent with very little comparable research conducted.

Keywords: acculturation, international medical graduates, Australia, rural community, settlement success, quality of life

BACKGROUND

Recruitment of International Medical Graduates (IMGs), also known as overseas trained doctors, continues to be central to global workforce planning. This is to meet the demand produced by a worldwide shortage of doctors. Australia is no exception as it has the highest rate of IMGs per capita in the world (Alexander & Fraser, 2007; Audas, Ross, & Vardy, 2005; Han, 2010; Iredale, 2009; Lim, 2010; Rabinowitz, Diamond, Markham, & Paynter, 2001; Spike, 2006). Australia's IMGs recruitment efforts are borne out of a necessity to redress rural health disparity and previous government policy reaction to speculative high doctor-to-population ratio and misdistribution. These assumptions led to sustained underproduction of medical graduates in Australia and increased reliance on IMGs recruitment. Compulsory schemes were implemented to ensure IMGs filled rural and remote positions to sustain

ISSN 1839-9053

access to health services due to higher rates of illness and poor access to health services in these communities (Birrell, 2004; Hawthorne, 2006; Hawthorne & Birrell, 2002; Van Der Weyden & Chew, 2004).

In a global era of increasing urbanization, rural communities have undergone health workforce shortages (Brooks, Lapsley, & Butt, 2003). This coupled with an increasing level of competition for IMGs between developed countries as an ageing population increases patient demand for medical services (Alexander & Fraser, 2007; Brooks, et al., 2003; Lim, 2010; Spike, 2006). It is therefore appropriate to evaluate the processes which aid IMGs to practice and remain in Australia. This will ensure Australia remains competitive in a global IMGs market. As part of this process it is imperative IMGs acculturation in rural contexts be better understood (Rural Health Workforce Australia, 2011). To understand IMGs acculturation, a literature review was conducted to comprehend the placement and retention issues faced by IMGs in Australian rural practice and how these and other complex issues impact on rural community acculturation.

INTERNATIONAL MEDICAL GRADUATES: CONCEPTUALISATION AND DEFINITION

International medical graduates have been called many names over the past few decades, some respectful, others derogatory and offensive. With these names, comes imagery, connotations and inferences to stimulate public and political debate and fear. These names have also shaped public and personal views of IMGs (Harvey & Faunce, 2005). The name and definition of an overseas trained health professional remains problematic. Much of the literatures use names such as displaced persons doctor, alien doctor, foreign doctor, and foreign graduate of an accredited medical school (FGAMS) with the most common title of overseas trained doctor (OTD) (Laurence, 2008). The term 'International medical graduate' still remains challenging as much of the literature has defined an IMG as a doctor who has acquired their primary medical qualification in a country other than Australia and New Zealand (Harvey & Faunce, 2005). Yet, section 19AB of *The Health Insurance Act 1973*, identifies New Zealanders as IMGs. This is to ensure IMGs who become New Zealand citizens are under the same restrictions as other IMGs when migrating to practice in Australia (Birrell, 2004; Laurence, 2008).

IMG AS AN AUSTRALIAN MEDICAL LABOUR FORCE

In 2008, there were n=68,689 employed medical practitioners with 76.0% (n=51,200) trained in Australia, 8.3% (n=5709) trained in New Zealand and UK with the remainder 15.25% (n=10,477) consisting of other IMGs from other countries (Australian Institute of Health and Welfare, 2010a). In addition 40% of the rural GP workforce in 2009 were IMGs (Australian Institute of Health and Welfare, 2010a; Han, 2010; Lim, 2010; Rural Health Workforce Australia, 2011). IMGs continue to be the backbone of the workforce in regional, rural and remote settings where there has been an inability to recruit Australian trained medical graduates. Therefore, the medical workforce remains heavily dependent on IMGs (Durey, 2005; Han, 2010; Han & Humphreys, 2005; Han & Humphreys, 2006; Liaw & Kilpatrick, 2008). In spite of the large numbers of IMGs in rural and remote areas, their retention remains difficult. IMGs relocate into more metropolitan areas once they have completed their compulsory scheme obligations (Harvey & Faunce, 2005; Lim, 2010). Yet, the continued recruitment of IMGs is an implausible long-term solution for the rural doctor shortage (Han, 2010; Han & Humphreys, 2005; Lim, 2010; Van Der Weyden & Chew, 2004).

ISSN 1839-9053

International Medical Graduates constitute over 30% (n=500) of registered medical practitioners in Tasmania (Department of Health and Ageing, 2011; Health Recruitment Plus Tasmania, 2011). However, there is limited knowledge and research concerning the acculturation process of these IMGs as they reside in Tasmania, a less culturally diverse area (Han & Humphreys, 2005; Lê & Kilpatrick, 2008). The literature highlights previous research on IMGs in other areas of rural Australia focusing primarily on employment integration, satisfaction and practice support as a measure of acculturation and retention (Alexander & Fraser, 2007; Carlier, Carlier, & Bisset, 2005; Durey, 2005; Han & Humphreys, 2005; Han & Humphreys, 2006; Hawthorne, Birrell, & Young, 2003; Heal & Jacobs, 2005; Rural Health Workforce Australia, 2011). Nevertheless, only a small number of these study recognised quality of life and social needs of IMGs and their families as crucial factors impacting acculturation (Alexander, 1998; Colic-Peisker, 2009; Stanley & Bennett, 2005).

ACCULTURATION AND SETTLEMENT SUCCESS

The concentration of previous research follows the policy view that obtaining paid employment and adequate income to support a migrant and their family are two central indicators of successful settlement in Australia (Colic-Peisker, 2009; Richardson et al., 2004). This focus on integration and settlement success remains detached with the psychosocial indicators of successful integration, settlement and life satisfaction. This includes establishing social networks within communities, quality of life, wellbeing and happiness of migrants (Colic-Peisker, 2009). These issues of acculturation and settlement success are highlighted through the psychosocial characteristics of acculturation, rather than solely employment satisfaction alone (Colic-Peisker, 2009). The literature although focused on employment integration, satisfaction and practice support did highlight a number of other subtle factors which influenced successful employment integration. These are discussed below.

Professional support

Professional support for IMGs, although studied comprehensively remains critical as it contributes to IMGs inevitable integration and retention in a rural community (Han & Humphreys, 2005). This includes colleagues' clinical support and supervision which remains a vital factor to assist IMGs integration in the practice and connectivity with the community. A lack of assistance impedes professional integration and may stem from the medical profession who has been divided by the employment of large numbers of IMGs to abate the rural doctor shortage (Gilles, Wakerman, & Durey, 2008; Han & Humphreys, 2005).

IMGs joining rural settings may be faced with Australian Doctors with animosity toward IMGs recruitment which can then challenge workplace relationships. It may create an environment which is less conducive for both parties (Han, 2010). A number of contrasting experiences have been voiced by IMGs. These include being welcomed by colleagues and their families, to discrimination and professional isolation from others. Other examples include hospital managers and nursing staff building strong and lasting professional relationships, to the provision of refurbished practices in close proximity to the hospital as a means of retaining IMGs in the community (Durey, 2005; Lim, 2010). The support provided by a practice whether positive or negative assists in the camaraderie or isolation experienced and the ultimate acculturation of IMGs in the community (Durey, 2005).

A study of community integration of IMGs in rural Victoria had identified migrants who were better-educated adapted more easily in a new community. Additionally, those IMGs with knowledge of compulsory scheme requirements prior to migration were more inclined to integrate within the

ISSN 1839-9053

community. This occurred regardless of cultural, religious and urban background (Han & Humphreys, 2006). In addition, length of stay in Australia positively correlated to a IMGs ability to cope with life as a migrant particularly in rural settings. Furthermore, IMGs with an Australian spouse or who practiced rural medicine prior to migration were more familiar with and accepting of rural life (Han & Humphreys, 2006). A number of other key themes were identified throughout the literature and are discussed in greater detail.

Community support

Professional support for IMGs is crucial within a practice, yet personal, family and community needs are more essential to be met to ensure acculturation of IMGs and their family occurs in rural communities (Han & Humphreys, 2005). Community support can facilitate the integration of IMGs and their families into the community, yet discrimination and other obstacles can accelerate poorer outcomes (Han & Humphreys, 2005). Addressing prevailing barriers through community orientation and knowledge of IMGs cultures and differences can assist integration and acculturation within the community. Whereas, indifference, cultural prejudice and disparaging comments can create lasting and profound apprehension and anxiety (Han & Humphreys, 2005).

Positive community support may extend from renting a car, providing housing, to being provided with information about the community and the available facilities (Durey, 2005; Han & Humphreys, 2005). In other instances, a number of central Queensland communities have purchased a practice facility and provided generous lease-back arrangements to IMGs. Other communities built, equipped and staffed surgeries to ensure IMGs felt welcomed. In addition, a mid-northern community in South Australia constructed a new house to support and make the incoming IMGs feel welcomed (Han, 2010). Those IMGs which were positively supported by capacity building and community ownership have been observed to be increasingly loyal with aspirations to remain longer in these communities than required (Fleming, McRae, & Tegen, 2001; Han, 2010).

Conversely, IMGs in rural Victoria did not require a lot of support from the community. These IMGs cited the welcoming culture and community awareness, which embraced difference. This was crucial to their integration and feeling accepted in the community (Han & Humphreys, 2005). Those communities which cultivated relationships with migrants assisted the formation of migrant identity within the new community. Also the community's connectivity with an IMGs family was cited to be the most significant factor to influence integration in rural settings (Carlier, et al., 2005; Han & Humphreys, 2006). Lastly, social and community events also aided acceptance and wellbeing. The inclusion created a sense of belonging and support, which reduced the cultural dislocation many felt from family and friends (Durey, 2005).

Family needs

A lack of accessible or adequate schooling for children and employment for a spouse is pivotal to retain IMGs in rural communities (Frehywot, Mullan, Payne, & Ross, 2010; Han & Humphreys, 2006; Heal & Jacobs, 2005; Stanley & Bennett, 2005). With the simple provision of information about facilities and resources in the new town such as schools, employment possibilities for spouses and where to shop will assist IMGs and their families to flourish (Carlier, et al., 2005). In contrast, the spouses of IMGs in Durey's (2005) study had greater difficulty adjusting to rural life. They recognised the limitations of rural life were challenging because of such things as limited lifestyle and employment opportunities.

ISSN 1839-9053

Nevertheless they had stated 'the advantages of staying outweighed those of leaving and returning to their countries of origin' (Durey, 2005, p. 44).

Cultural and religious needs

Individual needs were identified to be highly important. These needs included the maintenance of cultural and religious values and connectivity with the respective culturally and linguistically diverse (CaLD) community. In the case of Carlier, Carlier and Bisset's (2005) rural South Australian study, they found providing information on how to obtain cultural foods, linking IMGs with families from the same cultural or religious background or providing a local mentor family assisted IMGs acculturation. In contrast, IMGs in a Western Australian study found the move to rural life a little more challenging due to cultural, language and religious differences. This included a lack of extended family or friends, however in these circumstances they were more than happy to travel hundreds of kilometres to see others from their CaLD background (Durey, 2005).

Dissimilarity exists between Victoria, South Australia, Western Australia and areas such as Tasmania. Many IMGs from these rural communities still had relative ease of access to metropolitan cities such as Melbourne, Adelaide and Perth where they took advantage of large CaLD communities (Durey, 2005). CaLD communities in large Australian cities are dense and cohesive ethnically distinct populations that allow cultural traditions, beliefs and experiences including socio-cultural norms to be maintained (Bécares, Nazroo, & Stafford, 2011; Chou, 2007; Gray, Harding, & Reid, 2007; Stafford, Bécares, & Nazroo, 2010b). Migrant communities in Tasmania often do not exist or are much smaller and arguably less cohesive than those found in larger Australian cities. Tasmania may offer less cultural diversity than other areas of Australia. This may make cultural and religious connectivity and identity for IMGs challenging in some areas of Tasmania. (Stafford, Bécares, & Nazroo, 2010a; Stafford, et al., 2010b).

In addition to CaLD communities in large cities, there are a number of large CaLD populations which reside in rural areas, for example Cobram in Victoria has a large Iraqi population. These communities can create a greater level of satisfaction when living and working in rural settings for IMGs and their families (Han & Humphreys, 2005). However, living within large CaLD communities may also hinder social integration into a host country irrespective of years of residence (Chin, Neilands, Weiss, & Mantell, 2008). Regardless of place of residence, the effects of sub-optimal integration on physical and social outcomes are not always positive (Osypuk, Diez Roux, Hadley, & Kandula, 2009). In contrast in a number of areas where greater ethnic density occurs, an increased ability exists for new migrants to understand and access public services. This includes cultural specific social, shopping and health care services which can assist in retaining cultural identity, health beliefs, traditions and lifestyles (Chan & Quine, 1997; Gray, et al., 2007; Tang & Easthope, 2000).

Living in CaLD communities has been shown to facilitate successful migrant adaptation by increasing social networks, social capital, improved communication for those unfamiliar with local languages and accessing cultural goods including familiar food (Osypuk, et al., 2009). Migrant community institutions such as local places of worship also play a vital role in perpetuating traditional cultural values and facilitating community cohesion and acculturation (Han & Humphreys, 2005). These institutions increase access to resources which assist migrants adjusting to life in their new country and continue many familiar aspects of their lifestyle and culture. However, this does not always occur in rural settings, such as Tasmania, where physical and social isolation is encountered (Chin, et al., 2008; Chiswick, Lee, & Miller, 2008; Stanley & Bennett, 2005).

ISSN 1839-9053

IMPLICATIONS FOR FUTURE RESEARCH DIRECTIONS

As IMGs migrate to Australia, whether as displaced persons, political refugees or economic migrant's one common theme emerges. This is to attain a 'better life' for themselves and their family. However what is evident, IMGs over the decades have been and continue to be faced with large lobby groups and complex legislation. This creates obstacles such as expensive examinations and compulsory schemes to overcome and work through to be able to practice their chosen profession in Australia. These obstacles and schemes remain heavily debated as a breach of an individual's human right to choose the location of employment. Yet they have conversely been called instruments of social justice to ensure health equity occurs (Frehywot, et al., 2010).

The amount of social and professional isolation that may be experienced in rural practice and the challenges of placement can be an issue for IMGs and their families. In addition, a number of rural communities may have had little experience with people from different cultures and may be less welcoming when cultures, customs and religious beliefs are unfamiliar (Crompvoets, 2010; Durey et al., 2008; Han, 2010; Han & Humphreys, 2005; Harvey & Faunce, 2005). These challenges experienced by IMGs and their families after meeting legislative requirements, including compulsory schemes may be inhibitory to the retention of IMGs in rural communities as they greatly impact the acculturation process.

Australia continues to experience a shortage of doctors caused by inadequate numbers of Australian medical students graduating over several years. This has led to an increased dependence upon IMGs to meet this demand (Han & Humphreys, 2005). A literature review was conducted to understand the history of IMGs in Australia, the legislation and policy which guides IMGs to enter and practice in Australia. It identified workplace placement and retention issues faced by IMGs in rural practice and how these complex issues impact on rural community acculturation. Yet only a small number of studies recognised quality of life and social needs of IMGs and their families (Alexander & Fraser, 2007; Carlier, et al., 2005; Durey, 2005; Han & Humphreys, 2005; Han & Humphreys, 2006; Hawthorne, et al., 2003; Heal & Jacobs, 2005; Rural Health Workforce Australia, 2011). Nevertheless, Alexander and Fraser (2007) argued in their research, no assumption can be made regarding IMGs non-professional needs in rural contexts are any different to their Australian Medical Graduate counterparts unless further research is conducted.

CONCLUSION

A number of key findings have emerged from the literature, which remains unanswered. This includes the identified gap of the quality of life and social needs of IMGs and their families, which has been previously overlooked (Alexander, 1998; Colic-Peisker, 2009; Stanley & Bennett, 2005). A number of studies have highlighted future research remains open to investigate IMGs survival strategies and how they manage in their present employment. In addition, research remains open to how these doctors lives can be improved in rural settings, particularly those from a Non-English speaking background (Mpofu, 2008). It is essential to identify the key characteristics of IMGs who have the capacity to acculturate within practice and community (Han & Humphreys, 2006). These questions to a certain extent will be answered in the current research. The research aims to explore the experiences and challenges which informs the acculturation process. This ultimately impacts IMGs health and wellbeing as they live and work in rural and remote Tasmania, where very little comparable research has been conducted (Han & Humphreys, 2005; Lê & Kilpatrick, 2008).

REFERENCES

ISSN 1839-9053

Alexander, C. (1998). Why doctors would stay in rural practice in the New England health area of New South Wales. *Australian Journal of Rural Health, 6*(3), 136-139.

Alexander, C., & Fraser, J. (2007). Education, training and support needs of Australian trained doctors and international medical graduates in rural Australia: a case of special needs. *Rural and Remote Health, 7*(681).

Audas, R., Ross, A., & Vardy, D. (2005). The use of provisionally licensed international medical graduates in Canada. *Canadian Medical Association Journal, 173*(11), 1315.

Australian Institute of Health and Welfare. (2010a). Medical Labour Force Survey 2008. Canberra.

Bécares, L., Nazroo, J., & Stafford, M. (2011). The ethnic density effect on alcohol use among ethnic minority people in the UK. *J Epidemiol Community Health, 65*(20), 20-25.

Birrell, R. J. (2004). Australian policy on overseas-trained doctors. *The Medical Journal of Australia, 118*(11-12), 635-639.

Brooks, P. M., Lapsley, H. M., & Butt, D. B. (2003). Medical workforce issues in Australia: "tomorrow's doctors-too few, too far". *Medical Journal of Australia, 179*(4), 206-208.

Carlier, N., Carlier, M., & Bisset, G. (2005). Orientation of IMGs: a rural evaluation. *Australian Family Physician, 34*(6), 485.

Chan, Y., & Quine, S. (1997). Utilisation of Australian health care services by ethnic Chinese. *Australian Health Review, 20*(1), 64-77.

Chin, J., Neilands, T., Weiss, L., & Mantell, J. (2008). Paradigm shifters, professionals, and community sentinels: Immigrant community institutions' roles in shaping places and implications for stigmatized public health initiatives. *Health & place, 14*(4), 866-882.

Chiswick, B., Lee, Y., & Miller, P. (2008). Immigrant selection systems and immigrant health. *Contemporary Economic Policy, 26*(4), 555-578.

Chou, K.-L. (2007). Psychological distress in migrants in Australia over 50 years old: A longitudinal investigation. *Journal of Affective Disorders, 98*(1-2), 99-108.

Colic-Peisker, V. (2009). Visibility, settlement success and life satisfaction in three refugee communities in Australia. *Ethnicities, 9*(2), 175.

Crompvoets, S. (2010). In Search of an Alternative Discourse on International Medical Graduate Issues. *People and Place, 18*(3), 27.

Department of Health and Ageing. (2011). General Practice Workforce Statistics Retrieved 7 June, 2011, from http://www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

Durey, A. (2005). Settling In: Overseas Trained GPs and Their Spouses in Rural Western Australia. *Rural Society, 15*(1), 38-54.

Durey, A., Hill, P., Arkles, R., Gilles, M., Peterson, K., Wearne, S., et al. (2008). Overseas trained doctors in Indigenous rural health services: negotiating professional relationships across cultural domains. *Australian and New Zealand Journal of Public Health, 32*(6), 512-518.

ISSN 1839-9053

Fleming, J., McRae, C., & Tegen, S. (2001). *From the ground up—Successful models of community capacity building to address recruitment and retention of GPs in rural South Australia.* Paper presented at the 6th National Rural Health Conference, Canberra, Australian Capital Territory.

Frehywot, S., Mullan, F., Payne, P. W., & Ross, H. (2010). Compulsory service programmes for recruiting health workers in remote and rural areas: do they work? *Bulletin of the World Health Organization, 88*(5), 364-370.

Gilles, M. T., Wakerman, J., & Durey, A. (2008). If it wasn't for OTDs, there would be no AMS": overseas-trained doctors working in rural and remote Aboriginal health settings. *Australian Health Review : A publication of the Australian Hospital Association, 32*(4), 655-663.

Gray, L., Harding, S., & Reid, A. (2007). Evidence of divergence with duration of residence in circulatory disease mortality in migrants to Australia. *The European Journal of Public Health, 17*(6), 550-554.

Han, G. S. (2010). International medical graduates in Australian news: a media narrative analysis. *Journal of Health Organization and Management, 24*(3), 237-257.

Han, G. S., & Humphreys, J. S. (2005). Overseas trained doctors in Australia: Community integration and their intention to stay in a rural community. *Australian Journal of Rural Health, 13*(4), 236-241.

Han, G. S., & Humphreys, J. S. (2006). Integration and retention of international medical graduates in rural communities. *Journal of Sociology, 42*(2), 189.

Harvey, K., & Faunce, T. (2005). A Critical Analysis of Overseas-trained Doctor (OTD) Factors in the Bundaberg Base Hospital Surgical Inquiry. *Law in Context, 23*(2), 73-90.

Hawthorne, L. (2006). *Labour Market Outcomes for Migrant Professionals: Canada and Australia Compared*. Ottawa: Citizenship and Immigration Canada.

Hawthorne, L., & Birrell, B. (2002). Doctor shortages and their impact on the quality of medical care in Australia. *People and Place, 10*(3), 55-67.

Hawthorne, L., Birrell, B., & Young, D. (2003). *The retention of overseas trained doctors in general practice in regional Victoria* (No. 0958183589). Melbourne: University of Melbourne.

Heal, C., & Jacobs, H. (2005). A peer support program for international medical graduates. *Australian family physician, 34*, 277-278.

Health Recruitment Plus Tasmania. (2011). GP Recruitment. Retrieved June 29th, 2011, from http://www.healthrecruitmentplus.com.au/gp-recruitment/choose-tasmania.htm

Iredale, R. (2009). Luring Overseas Trained Doctors to Australia: Issues of Training, Regulating and Trading. *International Migration, 47*(4), 31-65.

Laurence, C. O. M. (2008). *Overseas trained doctors in rural and remote Australia: do they practise differently from Australian trained doctors?* Unpublished PhD, University of Adelaide Adelaide.

Lê, Q., & Kilpatrick, S. (2008). Vietnamese-born health professionals: negotiating work and life in rural Australia. *Rural and Remote Health, 8*(4).

Liaw, S.-T., & Kilpatrick, S. (2008). *A textbook of Australian rural health*. Canberra: Australian Rural Health Education Network.

Lim, C. K. D. (2010). *Prescibing Practices of Austrlian Dispensing Doctors.* Unpublished PhD, Curtin University, Perth.

ISSN 1839-9053

Mpofu, C. (2008). *Immigrant medical practitioners' experience of seeking New Zealand registration: a participatory study.* Auckland University of Technology, Auckland.

Osypuk, T., Diez Roux, A., Hadley, C., & Kandula, N. (2009). Are immigrant enclaves healthy places to live? The Multi-ethnic Study of Atherosclerosis. *Social Science & Medicine, 69*(1), 110-120.

Rabinowitz, H. K., Diamond, J. J., Markham, F. W., & Paynter, N. P. (2001). Critical factors for designing programs to increase the supply and retention of rural primary care physicians. *JAMA: the journal of the American Medical Association, 286*(9), 1041.

Richardson, S., Stack, S., Lester, L., Healy, J., Ilsley, D., & Horrocks, J. (2004). *The changing labour force experience of new migrants*. Canberra: The National Institute of Labour Studies, Flinders University.

Rural Health Workforce Australia. (2011). *Parliamentary Inquiry into Overseas Trained Doctors*. Melbourne: Rural Health Workforce Australia.

Spike, N. A. (2006). International medical graduates: the Australian perspective. *Academic Medicine, 81*(9), 842.

Stafford, M., Bécares, L., & Nazroo, J. (2010a). *Racial Discrimination and Health: Exploring the Possible Protective Effects of Ethnic Density - Research Findings*. Leeds: Economic and social research council.

Stafford, M., Bécares, L., & Nazroo, J. (2010b). Racial Discrimination and Health: Exploring the Possible Protective Effects of Ethnic Density. *Ethnicity and Integration, 3*, 225-250.

Stanley, M., & Bennett, C. (2005). *Supporting Doctors' Families in Rural and Remote Practice: Policy Position Statement*. Carlton South, Victoria: Australian Rural and Remote Workforce Agencies Group

Tang, K. C., & Easthope, G. (2000). What constitutes treatment effectiveness? - the differential judgements of Chinese Australian patients and doctors. *Complementary Therapies in Medicine, 8*(4), 241-247.

Van Der Weyden, M. B., & Chew, M. (2004). Arriving in Australia: overseas-trained doctors. *The Medical journal of Australia, 181*(11-12), 633-634.

ISSN 1839-9053