Equal Employment Opportunity: Acculturation Experience of Immigrant Medical Professionals in New Zealand in the period 1995 to 2000

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Abstract

In 1996, there were about six hundred and fifty overseas-trained medical doctors[1] who had immigrated to New Zealand but were unable to practice their profession even though the New Zealand Qualifications Authority (NZQA) had assessed their medical qualifications as equivalent to similar qualifications in New Zealand. These immigrants were subjected to structural discriminator practices of the medical Council of New Zealand (MCNZ) by which qualified medical doctors from non BASIC (Britain, Australia, South Africa, Ireland and Canada) countries were not allowed to register as medical practitioners in New Zealand. The privilege conferred on the MCNZ by the 1968 Medical Practitioners Act allows it to be selective in recognising medical qualifications. As a consequence of this discriminatory practice many of the foreign trained doctors were unemployed while others worked as process workers, taxi drivers, petrol pump dispensers and pizza deliverymen in the period covered in this article (Selvarajah, 1997).[2]

This article provides a case history between 1995 and 2000 on the concerns and conditions of a group of foreign-trained medical professionals (doctors and specialists) whose application to settle in New Zealand was processed by the New Zealand government prior to June 1995.

Introduction

New Zealand is a country of immigrants. Over the years, immigration has had a major impact on the size, economic growth rate, age and sex structures, and ethnic composition of New Zealand. The strength and resilience of a new country has always been in its ability to absorb and utilise new talents and skills in an ever-changing global economy.

New Zealand has traditionally sought its immigrants from the United Kingdom and other European settled nations of the British Commonwealth.

Since the signing of the Treaty of Waitangi in 1840, immigrants from these countries introduced structures and systems and provided administrators to govern the colony. Changes to the immigration policy were introduced in 1986 to accept qualified and skilled immigrants on an open selection basis, which was basically non-discriminatory (Selvarajah, 2004). The points system was introduced in 1991 to assess the suitability of prospective immigrants to gain resident status in New Zealand. The government, to determine the appropriateness and suitability of immigrant's qualifications for employment in the country, established the New Zealand Qualifications Authority (NZQA) as an accrediting body for foreign qualifications.

With the liberalisation of immigration policies in the 1980s and the introduction of the points system, there was a natural swing to accepting skilled workers and professionals from Asia. This resulted in the increase of the Asian population from less than one percent of the total population in 1991 to 4.6 percent in 1996 and 6.1 percent in 2001 (Statistics New Zealand, 2001). The effect of this increase has been measured by the economic benefit the country has received and the benefits created from 'bridging' New Zealand to Asia via this new group of immigrants (Spoonley, et al., 1997; Palat, 1996). These enriching economic and cultural experiences are the positive side of immigration, but what has not been given equal attention is the adaptation difficulties of these immigrants in New Zealand and the response of the host environment in the adaptation process.

This article looks in particular at the acculturation of overseas-trained medical professionals who have predominantly come from countries other than the traditional source countries recognised by the Medical Council of New Zealand (MCNZ).

This research hopes to raise the importance of understanding immigrant acculturation in a new host environment. Apart from intrinsic qualities, the adaptability of immigrants to a new environment is highly dependent on the prospects of gainful employment in the vocation of their training and experience. Specifically, this article looks at the immigrant medical professional's adaptability prospects and concerns, the effect these have on their personality and psychological make-up, and the levels of tolerance they express when faced with perceived discrimination in employment in the new environment. This article analyses, in some detail, the role the Medical Council and the government play in the settlement experiences of overseas-trained medical professionals.

Structural Reasons for Discrimination in New Zealand

As national boundaries become less important in determining the country in which a person is employed, equal opportunities in employment is becoming an increasingly important issue. Discrimination based on race, ethnic origin, age, sex, or religion affects not only the person discriminated against, but also the organisation and the community the organisation serves. This brings with it the realisation that equal opportunity policies and their imple-

mentation are essential if a business or practice is to survive in a changing social and economic environment.

The diversifying ethnic, national and cultural base in New Zealand equally demands a better or a proportionate representation of various groups in the workforce. There are, however, several factors that prevent equal participation of people of different races and ethnicity in the workforce.

Discrimination based on race is unlawful in New Zealand. Nevertheless, discrimination is either directly or indirectly practiced in organisations. Direct discrimination is when a person is treated differently because of their race, colour or ethnic origins, or because of their sex (Coussey and Jackson, 1991:5). Indirect discrimination is a much subtler form and is more difficult to recognise or attribute to any one reason. Indirect discrimination may occur, for example, when equal opportunity is an official policy but job descriptions and selection criteria favour one ethnic group. The commonly-stated employment criterion 'must have local experience' may well fall into this category.

New Zealand's early history shows that skilled labour migration was encouraged from the United Kingdom while Maori and other ethnic minority communities filled unskilled and semi-skilled jobs. The influx of immigrants resulted in a distancing between the host and migrant communities and stereotyped the latter as working class and identified with social ills such as increased crime and unemployment and decreased property values (Spoonley, 1993). Consequently, ethnic minorities faced discrimination in institutions providing employment and basic amenities, such as healthcare, education and housing (Lee, 1976). The Chinese Immigration Act of 1881, the Aliens Act of 1891 and the Asiatic Immigration Restriction Act of 1899 are testimony to institutionalised discrimination based on race perpetuated in organisational practices of professional accrediting institutions such as the MCNZ.

The awareness of previous and continuing discrimination in the workplace led to the establishment of the Equal Employment Opportunity (EEO) programmes in countries such as New Zealand. EEO may be defined as 'a concept related to fairness and justice and a belief that all people, no matter what their age, gender, culture, colour, religion, level of ability or disability, have the right to participate in working life to their fullest potential without being ground down by dogma, narrow mindedness or outright discrimination' (Sayers and Tremaine, 1992:12).

The EEO espouses several benefits that organisations can ideally enjoy by implementing EEO policies. Among this is the 'casting of a wider net' to broaden the choice of candidates for advertised positions, a better public relations image to support the employment of culturally diverse workers, and improved productivity and customer services.

Though people would agree with the EEO policies, the implementation of the policies presents a much more complex issue. The notion that good race relations is a challenge to current management norms is inherent in many institutional policies and practices. An attempt to combat institutional racism may be seen as a denigration of dominant values and institutional practices. Ben-Tovim, et al. (1986:105) suggests that there is a tendency to silence or dismiss claims of racial inequality, especially if the social structure, rather than the individual, is to be held responsible.

Methodology

The research was carried out in late 1997 to early 1998, when the issues, concerns and the plight of the immigrant medical professionals received national importance. The results of the research were reported in New Zealand and Australia (for example the research findings were reported by Bailey, 1997; Birt, 1997; Calvert, 1997; and Inder, 1997).

The research used an investigative process in which documentation freely volunteered by the overseas-trained medical professionals was reviewed, along with written case studies. In addition, a random sample of the overseas-trained medical professionals was sent questionnaires by post (with a stamped return envelope).

The sample was randomly drawn from the names listed as members of the Overseas Doctors Association in 1997. The list had 415 names, of which 150 were randomly selected. Two different questionnaires were posted to the sample population. Questionnaire A was addressed to the immigrant doctor and Questionnaire B was addressed to the spouse. The doctor and spouse were asked not to discuss the questionnaire prior to filling it in and to provide responses independent of the other. The reason for administering a separate questionnaire to the spouse was that the spouse is seen as an important person influencing the acculturation experiences of the immigrant and the views of the spouse, independent of the immigrant, is equally important in the study of immigrant adjustment (Selvarajah and Petzall, 2003). In the study of expatriate acculturation, which has similar acculturation patterns, the spouse's experience is seen as an important factor in the adjustment of the expatriate (Black and Gregersen, 1991; Black and Stephens, 1989; Solomon, 1994).

Of the 150 sets of two questionnaires, 62 sets (41%) were returned undelivered. There may be two reasons for this: one, the overseas-trained medical professionals had moved to another location within New Zealand, and two, the overseas-trained medical professionals had left New Zealand. Both reasons were substantiated on investigation. Of the doctor sample, 30 questionnaires (Questionnaire A) were completed, and 22 completed questionnaires were received from the spouse sample (Questionnaire B). All returned questionnaires were useable, yielding a response rate of 34 percent for Questionnaire A and 25 percent for Questionnaire B. As not all the doc-

tors were married and some of their spouses were not in the country, the spouses' response rate was lower than that of the medical professionals.

In the study, the sample population is the overseas-trained medical professionals; the responses from the spouses are included as support data and to provide independent views on the adaptation process of overseas-trained medical professionals.

Findings

The characteristics of the respondents are presented in Table 1.

Of the respondents in the medical profession, 74 percent were less than 45 years of age, and 73.3 percent were men and 26.7 percent were women. The reverse was reflected in the spouse sample, with men comprising 27.3 percent and women 72.7 percent. About two-thirds of the sample population were medical doctors and the remainder were specialists. The response from the medical professionals also reflected a high proportion of spouses with medical qualifications (45.4 percent).

Most of the medical professionals in the sample were from Asia, and of these 63.4 percent were from the Indian subcontinent. In addition, 52 percent of medical doctors and 60 percent of specialist doctors had more than six years' work experience in their respective fields.

Table 1: Demographic Details

Demographic responses of immigrant doctors (N=30)					
Age		**Sex**		**Professional Status**	
Years	%		%		%
26-35	36.7	Men	73.3	Specialist	36.7
36-45	36.7	Women	26.7	Medical doctor	63.3
46-50	16.6	**Marital Status**		Professional status of spouse (n=26)	
51-55	10.0	Married	86.7	Specialist	15.4
		Not married	13.3	Spouse	30.8
				Other	53.8
Nationality		**Years of Experience**		**Year of Arrival in NZ**	
Country	%	**Years**	%	**Year**	%
India	36.7	Under 2	10.3	1991	3.3
Bangladesh	26.7	2-4	17.3	1992	3.3
Egypt	6.7	4-6	20.7	1993	3.3
Iraq	10.0	More than 6	51.7	1994	16.7

Philippines	3.3	**Specialist experience**		1995	50.4
Malaysia	6.7	Under 2	10.0	1996	23.0
Russia	3.3	2-4	10.0	**Previous immigration experience**	
China	3.3	4-6	20.0	Yes	82.8
Bosnia	3.3	More than 6	60.0	No	17.2
Basic Medical Degree from		**Current Employment**		**Employment of spouse in home country**	
Country	%		%		%
India	36.7	Unemployed	60.0	Yes	84.6
Bangladesh	26.7	In unrelated jobs	26.7	No	15.4
Egypt	6.7	As medical doctors	13.3	**Employment of spouse in NZ**	
Iraq	10.0	**In receipt of Unemployment benefits**		**Unemployed**	73.1
Philippines	3.6	Yes	53.6	Employed other than as a Medical professional	26.9
Malaysia	6.7	No	46.4		
Russia	3.3				
China	3.3				
Bosnia	3.3				
Demographic responses of spouses (n=22)					
Sex		**Occupation category**		**Previous Immigration Experience**	
%			%		%
Men	27.3	Medical doctor	31.8	Yes	87.4
Women	72.7	Specialist doctors	4.5	No	13.6
		House person	18.2		
		Other job category	45.5		

A large number (82.8%) of the overseas-trained medical professionals reported that New Zealand was not their first overseas experience. The previous immigration experience in another country was slightly higher (87.4%) for the spouses. Over 90 percent of the respondents reported that they had come to New Zealand between 1994 and 1996. All respondents reported that their entry visa for settling in New Zealand was issued prior to June 1995.

Employment among the overseas-trained medical professionals and their spouses was extremely low. Unemployment among the medical professionals was 60 percent. Of the total sample, 13 percent had successfully completed their NZREX examinations and were employed as medical doctors. None of the specialists were employed in their field of expertise. Several of the medical professionals (26.7%) were in jobs unrelated to their vocational training. Most of the unemployed medical professionals (53.6%) were receiving unemployment benefits.

The Overseas-trained Medical Professionals

The overseas-trained medical professionals in this study had come from countries whose cultures are different from that of New Zealand. The respondents in the survey were qualified and experienced medical professionals who had been trained under vigorous and stringent medical standards in countries other than New Zealand. One third of the respondents were specialists with many years of experience in their fields of specialisation. One cardiologist, who had received his specialist qualifications from England and Ireland, was denied MCNZ registration because his basic medical qualification was from the National University of Singapore's Medical School.

Almost half (46.6%) of the medical professionals responded that, when their visas were being processed, they were made to understand that they were eligible to practice professionally in New Zealand. Of the 14 respondents who made this comment, six said that NZQA had certified their medical degree to be equivalent to a medical degree from New Zealand. This certification they felt was sufficient for them to practice in New Zealand, and were further informed by NZQA that no other permit or validation was required to work or study in New Zealand. In addition, the respondents felt that the New Zealand Immigration Service (NZIS) awarded them maximum points for qualifications and experience under the points criteria for settlement in New Zealand. This again, they believed, was evidence of the acceptability of their professional skill and experience in New Zealand. A number also responded that government-certified immigration consultants and immigration officials had misled them by not providing sufficient information on their employability prospects in New Zealand.

Most (93.3%) of the medical respondents indicated that, prior to departure, they had received no briefing by NZIS on working conditions in New Zealand. Seventy percent of the medical professionals had come to New Zealand unaware of their bleak employability prospects. When asked

whether they would have immigrated if they had been fully aware of work conditions for foreign-qualified medical professionals in New Zealand, 50 percent responded with a 'definitely not' and another 20 percent would not have considered New Zealand as a country to immigrate to.

The then Minister of Immigration, Mr Roger Maxwell, admitted that many of the unemployed overseas-trained medical professionals would not be able to gain employment in their field of expertise and that it might be necessary for them to consider other vocations (Laxon, 1997). Many respondents have indicated that this was an option they had considered, but they had been unable to secure other jobs compatible with their qualifications. The excuses cited by prospective employers were:

- no local experience
- too highly qualified
- qualifications not suitable.

The Health Industry

New Zealand, like many Western countries, is concerned at the level of government expenditure allocated to the health industry (Laxon, 1997). The New Zealand Government's budget allocation increased from 5.2 percent of GDP in 1984 to 6.0 percent in 1994. In 1994 New Zealand was ranked eleventh (midway) on the list of OECD countries in terms of spending on health (see Table 2).

As Table 2 highlights, New Zealand's ratio of doctors to population is not very impressive in comparison to other OECD countries. The OECD average in 1994 was 2.6 doctors per 1000 people. New Zealand was ranked nineteenth, with 2.1 doctors per 1000 people. The six countries below New Zealand were Ireland, Italy, Japan, Mexico, Turkey and the United Kingdom. To reach the OECD average, New Zealand needed another 1750 doctors.

The distribution of doctors by geographic region in New Zealand in 1994 is given in Table 3. The table reflects an uneven distribution of doctors in the regions of New Zealand. Otago has the highest, with 2.9 doctors per 1000, followed by Auckland with 2.4, and Wellington and Canterbury with 2.3. The other 10 regions are under-represented, with the Southland and the West Coast 29 percent below the national average.

The number of people on survey waiting lists in New Zealand increased dramatically from 4625 people in 1994 to over 18,000 in 1997 (Manning, 1996; Laxon, 1997). This implies that, given that the OECD standards are taken as a benchmark of economic development in its member countries, there is a need to employ more medical professionals.

Table 2: OECD Health Care Figures					
	Health Expenditure as % of GDP		**Doctors per 100 of opulation**		**Doctors in excess of NZ levels***
	1994	1984	1994	1984	350
Australia	5.8	5.5	2.2	2.0	1050
Austria	6.2	5.3	2.4	1.8	560
Belgium	7.2	6.2	3.7	2.7	350
Canada	7.0	6.4	2.2	1.9	2450
Denmark	5.4	5.4	2.8	2.4	2100
Finland	6.2	5.4	2.7	2.0	2800
France	7.6	6.6	2.9	2.3	3850
Germany	6.0	6.3	3.2	2.5	6300
Greece	2.8	2.6	3.9	2.9	3150
Iceland	6.8	6.0	3.0	2.4	-3150
Ireland	5.7	6.1	2.0	1.2	-350
Italy	6.3	5.3	1.7	1.4	-1400
Japan	5.3	4.8	1.8	1.4	-1050
Luxembourg	3.3	2.7	2.2	1.7	350
Mexico	3.1	-	1.0	0.8	-350
Netherlands	6.0	6.0	2.5	2.2	1400
New Zealand	**6.0**	**5.2**	**2.1**	**2.7**	**0**
Norway	5.2	4.3	3.3	2.2	4200
Potiugal	4.1	3.0	2.9	2.4	2800
Spain	5.7	4.7	4.1	3.2	7000
Sweden	6.4	8.5	3.0	2.5	3150
Switzerland	6.8	5.3	3.1	2.6	3500
Turkey	1.4	1.2	1.1	0.7	-3500
United Kingdom	5.8	5.2	1.5	1.4	-2100
United States	6.7	4.3	2.5	2.1	1400
OECD Average	**5.6**	**5.1**	**2.6**	**2.0**	**1750**

Source: Adapted from OECD Health Data 96, Paris, 1996.
* Assumes New Zealand population to be 3.5 million

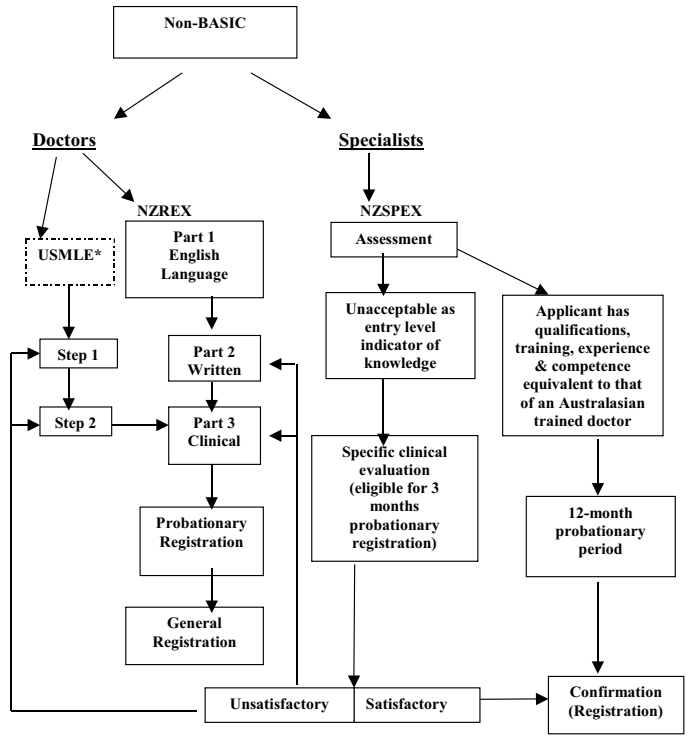
Table 3: Medical Practitioners by Geographic Region	
Geographic Region	**Doctors per 1,000 o population**
Northland	1.6
Auckland	2.4
Waikato	1.9
Bay of Plenty	1.9
Tairawhiti	1.7
Hawke's Bay	1.7
Taranaki	1.6
Manawatu-Wanganui	1.8
Wellington	2.3
Nelson-Marlborough	1.8
West Coast	1.5
Canterbury	2.3
Otago	2.9
Southland	1.5
Total for New Zealand	2.1
Source: Adapted from *The New Zealand Health Workforce*, 1994	

The Registration of Foreign Medical Professionals

The World Health Organisation (WHO) has a list of recognised medical schools that provide a good standard of teaching and training according to established criteria. This list is not limited to doctors qualified in Britain, Australia, South Africa, Ireland and Canada (BASIC). However, the MCNZ allows foreign medical professionals to register and practice in New Zealand only if their initial medical degree was granted in one of the BASIC countries (which are the white member nations of the British Commonwealth). Under this policy, medical doctors who have specialised in one of the BASIC countries but have their first medical degree from a country other than the BASIC countries cannot be registered to practice medicine in New Zealand by the MCNZ. This policy effectively discriminates against medical practitioners from the non-white British Commonwealth countries. In its assessment of qualifications the MCNZ has therefore failed to provide non-discriminatory selection of medical schools based on international standards.

The Medical Council of New Zealand requires medical professionals with foreign qualifications, other than those from the BASIC countries, to sit the New Zealand Registration Examination (NZREX). Figure 1 illustrates the pathways for foreign doctors and specialists. These doctors and specialists have spent on average between six and nine years gaining their qualifications. They are now required to study for another two or three years for general registration and three to four years for specialist registration in New Zealand.

Figure 1 Registration pathways for doctors and specialists



* Part 1 and 2 phased out in 1996 and 1997 and USMLE Steps 1 and 2 or its equivalent to take its place.

** Doctors and specialists from BASIC countries were required to follow the same registration pathways as the medical professionals from non-BASIC countries from June 1998.

The policy change reflected in the changes to the Medical Practitioners Act in 1994 seems to have come about after criticism of the MCNZ's discriminatory practices. Under this policy change all foreign graduates who wish to register with the MCNZ are required to successfully complete the United States Medical License Examination (USMLE). The MCNZ, however, provided an 'amnesty' period, until June 1998, for doctors from BASIC countries. This was extended several times to meet increasing demand for doctors (MCNZ Annual Report, 2003).

The regulatory mechanisms to control the flow of medical professionals from non-BASIC countries, even when postgraduate qualifications have been acquired from medical schools in BASIC countries, are seen as discriminatory. The controls are viewed as mechanisms to keep foreign-qualified medical professionals out of the New Zealand medical system. Many of these unemployed medical professionals are registered to practice medicine in BASIC countries but are denied this in New Zealand.

Prior to 1996 for Part 1, and 1997 for Part 2, MCNZ decided that foreign doctors wishing to practice in New Zealand must pass the English language, written and clinical examinations (Parts 1, 2 and 3 respectively). Table 4 illustrates the pass rates for Part 2 and Part 3 of the NZREC in 1995 and 1996.

Results indicate that all candidates passed Part 1, the English examination, on the first or second attempt (not shown in the table). The pass rates in the written and clinical examinations are however very low. The Clinical examinations can be taken only after passing both the English and the written examinations. Indications are that only a small percentage of the candidates who pass Part 2 will eventually pass Part 3. Estimates given by the respondents on pass rates are between 10 and 12 percent; this is reflected in the number who sit the written examination and who finally pass the clinical examination (Table 4).

The overseas-trained medical professionals responded that the MCNZ, under the 1968 Medical Practitioners Act, had no statutory right to collect fees for the examinations or require specialist doctors to sit the NZREX examinations. The 1995 Annual Report of the Medical Council reported that the examination fees collected from overseas doctors were used to remunerate the staff of the Council.

The three-part examination is, on the surface, meant to be equivalent to the examinations sat by final year medical students in New Zealand. By

Table 4: NZREX Pass Rates – 1994 and 1995

	1995						1996					
	Part 2: Written			Part 3: Clinical			Part 2: Written			Part 3: Clinical		
	Sat	Passed	%	Sat	Passed	%	Sat	Passed	%	Sat	Passed	%
Attempt 1	125	24	19	23	12	52	96	27	28	90	45	51
Attempt 2	24	6	25	8	6	75	59	24	41	36	20	56
Attempt 3	3	0	0	5	5	100	21	14	67	4	2	50
Fees collected	$273,600			$43,200			$316,800			$156,000		
Total fees	English language $122,100 + Part 2 & 3 = $472,800											

Source: Adapted from Director General of Health (1996), p.3.

count alone, the number of examination papers taken by the foreign-qualified doctors is thirteen, compared to six for final year students in New Zealand medical schools. Evidence from the interviews suggests that the pass mark in the NZREC examinations for foreign qualified doctors is between 60 and 65 percent, while the pass mark for local students is 50 percent. The purpose of the clinical examination is to test the practice of medicine within the New Zealand hospital environment. Local students are given access to hospitals to gain this experience but foreign qualified doctors are denied clinical experience but are nevertheless examined on the practical aspects of medicine in New Zealand. Local students are given access to library resources for medical research and study but foreign qualified doctors are denied this. Local students are entitled to student loans and government- subsidised fees but this is not made available to foreign doctors residing in New Zealand. The obstacles placed in the path of the foreign-qualified doctors are numerous, yet the MCNZ has failed to acknowledge that the foreign-qualified medical professionals are disadvantaged. These inequities in resource allocation and policies are perceived by the overseas-trained medical professionals as double standards that make them 'second class citizens' in their adopted country.

About 200 of the overseas medical professionals were specialist doctors. They were told to sit the NZREX examinations if they wanted to practice in New Zealand. These professionals are not in general medicine and many have practices their specialist skills for years. These specialists have been made to feel inadequate and many feel insulted when asked to prove their skills by re-sitting basic qualification examinations after years of specialisation.

The cost of the new pathway for registration (see Figure 1) for doctors and specialists remains fairly similar to the old, pre-1995 system. Parts 1 and 2 of the USMLE each costs $720 (plus $220 for the English examination). The Clinical examination is conducted by MCNZ and costs $1800. Foreign specialist doctors pay $220 on application for an interview, with an additional $1000 for the interview. To complicate matters, specialists who reside in Auckland are expected to have their interviews in Wellington and vice-versa. This increases the cost to the candidate by another $500 to $800. The probationary or supervisory registration cost for specialists is $1800. The criteria for assessment are unknown and the possibility exists of the specialist's asked to sit the USMLE. This adds $3240. The likelihood of this happening is high, as a number of specialists interviewed were told to sit the NZREX after the vocational interview, rather than proceed to probationary specialist registration.

The acculturation of immigrants in a new environment is complex and difficult, both for the immigrant and the family. In addition to problems faced normally by immigrants, the foreign-trained medical professionals also face unemployment, low earning capacity, insecurity, and loss of confi-

dence. It is not surprising that the doctors do not perform well in the examinations.

The Overseas-trained Medical Professionals' Perception of the Medical Council

The Medical Council is the 'gate-keeper' of medical practice in New Zealand. It is mandatory for medical doctors to register with the Council prior to practicing skills in New Zealand. The Council is seen as the guardian of the standards, norms and ethical practice of medicine in the country, and the operation and conduct of the MCNZ is governed by the 1968 Medical Practitioners Act.

Though the Council has no legal authority to restrict the number of doctors seeking registration, in practice it seems to do this. In the first instance, only doctors from recognised BASIC countries have been eligible for registration. Medical professionals (including specialists) from non-BASIC countries have had to pass medical examinations which are meant to be equivalent to the final examinations sat by local medical students.

Based on their relationship and understanding, the overseas-trained medical professionals were asked to rate on a scale of 1 to 5 (1 being low and 5 being high) the performance of the MCNZ on four aspects:

1. provision of equal opportunities
2. guardianship of human rights
3. race relations, and
4. efficiency.

To all four factors, the responses were very low, as is shown in Table 5: 79.3 percent thought that the MCNZ did not provide equal opportunities, 82.8 percent thought that the MCNZ was not a guardian of human rights, 67.8 percent considered the MCNZ to have poor race relations, and 89.7 percent believed that the MCNZ was inefficient.

These negative perceptions may be attributed to the stand taken by the MCNZ in the recognition of overseas-trained medical professionals' qualifications and suitability for employment. Some of the reasons given for not allowing overseas-trained medical professionals to practice in New Zealand are the following (MCNZ 2000 Annual Report):

- to protect the standards of medical practice in New Zealand
- concerns over the overseas-trained medical professionals' competence to practice in New Zealand, and
- poor proficiency in English.

Table 5: Perceptions of the Medical Council and the Government by Respondents

	Low	%			High	Mean	SD
	1	2	3	4	5		
Provider of equal opportunities							
Medical Council	69.0	10.3	17.2	3.4	-	1.55	0.91
Government	34.5	13.8	24.1	13.8	13.5	2.59	1.45
Guardian of human rights							
Medical Council	69.0	13.8	17.2	-	-	1.48	0.78
Government	28.6	10.7	21.4	14.3	25.0	2.96	1.57
Race relations							
Medical Council	57.1	10.7	21.4	-	10.7	1.96	1.35
Government	21.4	21.4	17.9	17.9	21.4	2.96	1.48
Efficiency							
Medical Council	69.0	20.7	6.9	-	3.4	1.48	0.91
Government	34.5	20.7	24.1	13.8	6.9	2.38	1.29

The Overseas-trained Medical Professionals' Perceptions of the New Zealand Government

To many immigrants, the government authorities that assessed their qualifications and work experience and eventually processed their residency visas were the only contact they had with New Zealand prior to departure. It is difficult for immigrants from some parts of the world, such as remote parts of India, to understand the internal employment procedures in New Zealand. The information provided by the embassies is often the only information available to them prior to departure.

Before October 1995, residency status for medical professionals was assessed based on NZQA's recognition of immigrants' qualifications. Relevant qualifications and work skills and experience contributed a major portion of the points required in the assessment by NZIS. Since October 1995, policy changes have taken place and now overseas medical professionals are granted residency only after they have been registered by MCNZ.

All the doctors in this study sample arrived in New Zealand prior to the policy changes of October 1995. These doctors feel that they were misled by the government and by the information, or lack of information, they received before they moved to New Zealand.

The medical professionals in the study were asked to rate the New Zealand government on the four factors on which they had rated the MCNZ (Table 5). The intensely negative feeling expressed towards the MCNZ was not as evident in the responses to the government. Efficiency received the

lowest rating at 55 percent, equal opportunities was assessed at 48.3 percent, race relations at 42.8 percent and human rights at 39.3 percent.

Overseas-trained Medical Professionals' Value Perceptions of Selected Adaptation Factors

The overseas-trained medical professionals responses to adaptation factors in Table 6 suggest that their perceptions have deteriorated since they arrived in New Zealand.

Table 6: Adaptation Factors: Wilcoxon Matched Pair Signed Ranks Test

	On Arrival		Now		Difference	P-value
	Mean	SD	Mean	SD		
Accommodation	2.79	1.01	3.00	1.10	+0.21	0.365
Children's education	3.79	0.96	3.41	1.10	**-0.38**	0.034
Climate	3.07	0.98	3.07	1.11	0	0.948
Cost of living	2.38	1.15	2.31	1.20	**-0.07**	0.616
Distance from home country	2.07	0.96	2.07	1.00	0	1.000
Food	3.57	0.97	3.70	0.88	+0.13	0.305
Goods and equipment	3.10	0.80	3.13	0.94	+0.03	0.739
Understanding spoken local language	3.45	1.21	4.31	0.60	+0.86	**0.000**
Government bureaucracy	2.87	1.31	2.23	1.17	**-0.64**	0.002
Life style	3.20	0.89	3.00	0.83	**-0.2**	0.002
Local culture and customs	3.03	0.85	3.30	0.88	+0.27	**0.046**
Public amenities	3.77	0.97	3.90	0.76	-0.64	0.002
Medical standards and support	2.90	0.86	2.48	1.12	**-0.42**	0.021
Relationships with locals	2.67	1.12	3.30	0.95	+0.63	**0.001**
Religion	3.48	0.83	3.45	0.87	**-0.03**	0.705

Earning capacity	2.17	1.02	2.20	1.00	+0.03	0.949
Technology	3.30	0.70	3.03	0.89	**-0.27**	0.115
Local values and attitude	3.20	0.92	2.86	0.99	**-0.34**	0.085
Productivity at work	2.56	1.42	2.52	1.42	**-0.04**	0.721
Job prospects	2.32	1.42	2.52	1.42	**-0.04**	0.721
0 Self-esteem	3.48	1.27	2.79	1.42	**-0.69**	0.053
Confidence	3.67	1.15	3.17	1.36	**-0.5**	0.120
Equity and fairness in NZ	3.21	1.20	2.33	1.07	-0.88	**0.006**
Financial security	3.00	1.23	2.43	1.04	-0.67	0.059

Interpretation of these results, along with the interviews and the responses from spouses, suggests that perceptions on a number of factors were adversely affected by the post-immigration experience. The respondents' perceptions of children's education, the cost of living, government bureaucracy, life style, medical standards and support, religion, technology, local values and attitudes, productivity at work, job prospects, self-esteem, confidence, equity and fairness in New Zealand, and financial security were poorer at the time of the survey. Perceptions of equity and fairness in New Zealand, financial security, and self-esteem had the largest mean difference between arrival and the present.

The Wilcoxon Signed Ranks Test of the two groups of paired factors measuring perceptions on arrival and at the time of the survey is illustrated in the last column of Table 6.

The factors that seem to have had the greatest effect on the immigrants since arrival and that were highly significant in the Wilcoxon matched pair test were children's education (P-value = 0.034), understanding spoken English in New Zealand (P-value = 0.000), government bureaucracy (P-value = 0.002), local culture and customs (P-value = 0.046), medical standards and support (P-support = 0.021), relationship with locals (P-value = 0.001), equity and fairness (P-value = 0.006). Self-esteem (P-value = 0.053) and financial security (P-value = 0.059), though not highly significant, does imply a change in perception of these factors since arrival in New Zealand. The President of the Federation of Ethnic Councils, Dr Nagalingham Rasalingam, added 'I have seen many sad cases of family break-ups, psychiatric issues and suffering because of misguided expectations'.

The factors causing the greatest difficulty in adaptation to the New Zealand environment are illustrated in Table 7 in order of P-value ranking:

Table 7: Adaptation Factors in Order of P-value Ranking

P-value	Factors
0.000	Understanding spoken local language
0.001	Relationships with locals
0.002	Government bureaucracy
0.006	Equity and fairness
0.021	Medical standards and support
0.034	Children's education
0.046	Local culture and customs
0.053	Self-esteem
0.059	Financial security

Respondents were asked to select five items from a list of 20 that caused the most problems on arrival and in the present (then and now). They were then asked to rank the items from the most problematic to the least problematic in each category, as illustrated in Table 8. Then, accommodation was seen as the most problematic and distance from home as the least problematic. Now, work conditions were ranked the most problematic but distance from home was still ranked the least problematic.

Table 8: Ranking of Problematic Factors

Rank	On Arrival	%	Rank	Now	%
1	Accommodation	33	1	Work conditions	40
2	Cost of living	23	2	Cost of living	30
3	Language/goods & equipment/ Government bureaucracy	30	3	Medical standards & support	20
4	Medical standards & support	20	4	Government bureaucracy/Medical standards & support	50
5	Distance from home	17	5	Distance from home	17

The respondents in the sample estimated that, on average, they had paid $4010 to the Medical Council of New Zealand and a total of $4978 for the purpose of securing registration. Many indicated that they had great difficulty in paying the examination fees.

While waiting to sit for examinations and eventual registration, 60 percent of the medical professionals were on unemployment benefits. The average time spent on unemployment benefits was 23 months. If the sample is representative of the total population of 650 overseas-trained medical professionals, 390 medical professionals were on unemployment support. Based on the level of benefits paid to a married couple with children - $258 per week – the annual payout by the government on unemployment benefits could be as high as $5,232,240.

The overall experience of the professionals in New Zealand had been unpleasant (47%). Only 17 percent said that their experience in New Zealand had been pleasant. Ten percent responded that they would not stay permanently in New Zealand. Thirty-five percent said that they would stay. The remaining 55 percent were not sure what they would do. Of the eight professionals who indicated where they would go if they left New Zealand, four would return to their home country and four said they would go to another host country.

Conclusion

The findings from the sample indicate and suggest trends in the perceptions of immigrants. The research confirmed the frustrations of overseas-trained medical professionals. Their inability to normalise their lives and the frustration of not being able to practice their chosen vocation was causing personal problems such as feelings of inadequacy and hopelessness. This can be both psychologically and physiologically damaging to the immigrant and the family, and in the long term may lead to social problems.

The interview answers and the responses to the open-ended questions in the questionnaires indicate a group of people disillusioned with the system in New Zealand generally and the Medical Council specifically. They were unable to understand why the government had not helped them. They were fearful of the future and the years of study facing them if they were to satisfy the Medical Council's registration requirements. In 1999, eight overseas-trained medical professionals made a collective grievance complaint to the Race Relations Commissioner Dr Rajan Prasad accusing the MCNZ of having breached the Human Rights Act. In July 2000, Dr Prasad dismissed the complaints against the MCNZ.

Since June 1995, all overseas-trained doctors have to register with the MCNZ prior to the issuing of settlement visas. The number of affected doctors seeking to register has dropped, as was reported by the MCNZ's 2001 Annual Report. The Report highlighted that in 2000-2001 the number of

overseas-trained doctors sitting the NZREX examination had dropped from 428 in 1998-1999 to 238 (MCNZ, 2001 Annual Report). This figure included 98 repeats.

Endnotes

1. Director General of Health (1996) *The provision of Tuition for Overseas Trained Doctors Sitting The Medical Council's Registration Examination (NZREX),* 30 August. Released under Official Information Act.

2. The plight of the immigrant medical professionals was reported by the author and received national publicity on television, radio and newspapers in New Zealand and Australia (Bailey, 1997; Birt, 1997; Calvert, 1997; *Evening Standard*, 1997; *Grey Mouth Evening Star*, 1997; Inder, 1997; *Rodney Times*, 1997a; *Rotorua Post*, 1997; *Shore* News, 1997; *The Chronicle*, 1997; *The Dominion*, 1997; *The Ensign*, 1997; *The Gisborne* Herald, 1997; *The Nelson Mail*, 1997; *The Tribune*, 1997; *Westport News*, 1997.

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