

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.



MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

“Broken” Pathways: Understanding the Licensing Experiences of Overseas-Trained Medical Doctors in Aotearoa New Zealand

*A Thesis Presented in Fulfilment of the Requirements for the
Degree of
Doctor of Philosophy in Development Studies at Massey
University, Palmerston North, Aotearoa New Zealand*

By Johanna Thomas-Maude

2024

Abstract

More than 40% of registered medical doctors in Aotearoa New Zealand received their primary medical qualifications overseas. Within this landscape, the pathways that international medical graduates (IMGs) must follow to achieve professional licensing depend on their background. This research explores IMG experiences of these processes using a capabilities approach to mobility justice, finding that although pathways to registration exist on paper, many are broken, unpredictable, and often unattainable in practice.

General registration is available to doctors who completed their primary qualifications, or have worked for a minimum time period, in 24 high-income, Global North countries known as Comparable Health Systems (CHS). Other IMGs must apply for registration by taking a medical knowledge examination from the United Kingdom (U.K.), Australia, Canada, or the United States of America (U.S.A.), demonstrating English language competency, and taking the New Zealand Registration Examination (NZREX), which evaluates context-specific clinical skills. While completing these steps is time-consuming and costly, IMGs on the NZREX pathway are also required to complete two years of supervised work in local hospitals. First year positions, known as Postgraduate Year One (PGY1), are limited and prioritised for New Zealand medical graduates (NZMGs). As a result, a bottleneck has delayed or prevented many of these IMGs, typically originating from Global South countries, from finding PGY1 employment.

This research addresses a knowledge gap by exploring the relationship between IMG experiences, professional outcomes, and their designated pathway to registration. An exploratory sequential mixed methods research design was employed, consisting of semi-structured interviews of IMGs ($n = 24$) and local experts ($n = 9$), an online questionnaire of IMGs ($N = 80$), and a document analysis of historical policies, grey literature, and media reports ($N = 370$), across three phases. The project was framed by a capabilities approach to mobility justice that evolved alongside the research design, data collection, and analysis. This theoretical approach considers what IMGs in Aotearoa New Zealand are able to “be” and “do” as migrant professionals, through four key components known as the 4Ps. The 4Ps comprise *professional* mobilities and capabilities, *(inter)personal* mobilities and capabilities, mobilities and capabilities in *practice*, and mobilities and capabilities *power* regimes.

Combining empirical data with this theoretical lens highlights how medical registration pathways and policies contribute to uneven mobilities and capabilities among IMGs in Aotearoa New Zealand. Injustices are produced through misrecognition and the arbitrary exclusion of individuals who did not train in CHS countries. Such arbitrary exclusions, in turn, produce brain waste, whereby some IMGs already residing in Aotearoa New Zealand were unable to work as doctors, or experienced significant delays in registration, even during the COVID-19 pandemic. This situation is detrimental not only to these IMGs, but also to the chronically under-resourced local medical workforce and, consequently, the broader population in need of healthcare. Furthermore, colonial vestiges can be seen to have contributed to a recurring cycle of policy changes, which have culminated in contemporary licensing policies strongly resembling those from 1905. To create more just pathways for registration for IMGs in Aotearoa New Zealand, this (post)colonial cycle needs to be examined, evaluated, and broken, paving the way for more equitable medical regulation.

Keywords

medical migration; international medical graduates; mobility justice; capabilities; brain waste; postcolonialism; Aotearoa New Zealand

Acknowledgements

It's hard to know where to start when thinking about who to thank for all the incredible support that has led me to this point, but I suppose there is some sense in going back to the beginning of my postgraduate research journey: Sharon and Vicky, you've been there as my supervisors since I was first starting my at Masters' research in 2018, and I'm so appreciative for your ongoing encouragement, guidance, and expertise over the past six years. Your mentorship, adaptability to my evolving research interests, and commitment to both my academic and personal growth have left an indelible mark on my journey as a researcher and as an individual. Thank you also to Beth, who has joined my supervisory team from 2021 – your insightful contributions have added depth to my reflections and research approach, always encouraging me to extend my way of thinking.

On a more personal note, I would like to express my deepest gratitude to Sebastian for your unwavering support, encouragement, and understanding throughout this journey. Your inspiration, whether directly influencing my research topic or providing the gentle nudge I needed, has always motivated to keep moving forward. I'm also grateful to my family and friends, whose belief in me never wavered. Your constant encouragement and reassurance has been invaluable throughout this process – from listening to practice presentations, helping me talk through ideas, or even volunteering to proofread a 400-page thesis, I couldn't have done it without you.

Special thanks are also due to the medical doctors and local experts who generously shared their time, expertise, and experiences as research participants in this project. It has been a privilege to hear your stories and perspectives, and I have striven to incorporate these as best I can in this thesis.

Gratitude is also extended to Massey University for their financial support through the Vice-Chancellor's Doctoral Scholarship, without which this research would not have been possible.

Finally, thank you to all those whose names may not appear here but who, in various ways, have contributed to this research. Your collective support has been instrumental in the completion of this thesis.

CONTENTS

1	Introduction: “Broken” Pathways.....	1
1.1	Towards a Capabilities Approach to Mobility Justice.....	3
1.2	Research Questions and Approach	4
1.3	Migration and Medicine.....	5
1.4	Thesis Structure.....	6
2	Policy and Institutional Context of Medical Licensing in Aotearoa New Zealand.....	9
2.1	Introduction	9
2.2	Institutional Mapping.....	9
2.2.1	National Actors.....	12
2.2.2	The Australian Influence	13
2.3	Pathways to Medical Registration.....	15
2.3.1	Specialist Registration.....	17
2.3.2	General Registration Without Examination	18
2.3.3	General Registration With Examination	21
2.4	Competent and Comparable: Analysis of the CA and CHS Pathways	27
2.4.1	The Competent Authority (CA) Pathway.....	28
2.4.2	The Comparable Health System (CHS) Pathway.....	28
2.4.3	Analysing Comparability.....	29
2.4.4	What is Being Measured?	34
2.5	Medical Licensing as a Colonial Legacy	35
2.5.1	A Timeline of Medical Licensing History	37
2.5.2	The Colonial Era.....	40
2.5.3	An Influx of IMGs	42
2.5.4	The Origins of NZREX	43
2.6	Conclusion.....	46
3	Coming and Going: Medical Migration Patterns and Othering in Aotearoa New Zealand	48
3.1	Introduction	48

3.2	Migration and Medicine: “Modern Medicine is Global”	48
3.2.1	Addressing Medical Brain Drain.....	50
3.2.2	Understanding Brain Gain.....	51
3.2.3	Brain Waste of IMGs	52
3.3	Brain Drain, Gain, and Waste: A Workforce in Crisis.....	53
3.3.1	IMGs and Brain Gain	54
3.3.2	Brain Drain and Workforce Shortages.....	57
3.3.3	Brain Waste and Bottlenecks.....	64
3.4	Medicine, Migration, and Othering in Aotearoa New Zealand.....	67
3.4.1	“Alien” Medical Practitioners.....	69
3.4.2	Medical Licensing and the Other	71
3.4.3	Medicine and Identity	74
3.4.4	Communication and Language.....	76
3.4.5	Culture and Integration.....	76
3.5	Conclusion	80
4	The 4Ps: Towards a Capabilities Approach to Mobility Justice	82
4.1	Introduction	82
4.2	Key Characteristics and Concepts of Justice.....	83
4.2.1	Recognition and Respect	83
4.2.2	Context and Pluralism.....	85
4.2.3	Scales of Justice	86
4.3	Mobilities and Capabilities.....	87
4.3.1	The New Mobilities Paradigm	87
4.3.2	Mobility Justice	89
4.3.3	The Capabilities Approach.....	91
4.3.4	Capabilities and Justice.....	92
4.4	A Capabilities Approach to Mobility Justice	93
4.4.1	Existing Overlaps Between the Capabilities Approach and Mobility Justice	94
4.4.2	Mobility Justice, Capabilities, and Notions of Scales	95

4.4.3	Towards a Capabilities Approach to Mobility Justice	97
4.5	Development of the 4Ps.....	99
4.5.1	P1: Professional Mobilities and Capabilities.....	101
4.5.2	P2: (Inter)Personal Mobilities and Capabilities	102
4.5.3	P3: Mobilities and Capabilities in Practice	103
4.5.4	P4: Mobilities and Capabilities Power Regimes	104
4.6	Conclusion.....	105
5	Researching Medical Migration in Context: A Mixed Methods Approach	107
5.1	Introduction	107
5.2	Research Questions and Paradigms	107
5.2.1	Mixed Methods	108
5.2.2	Research Paradigms.....	108
5.3	Overarching Research Design	110
5.4	Phase 1: Semi-Structured Interviews	113
5.4.1	Research Participants and Selection Strategies	113
5.4.2	Data Collection.....	117
5.4.3	Interview Structure	118
5.4.4	Thematic Analysis	119
5.5	Phase 2: Online Questionnaire	119
5.5.1	Research Participants and Selection Strategies	120
5.5.2	Questionnaire Structure	121
5.5.3	Descriptive Analysis.....	123
5.6	Phase 3: Integration and Analysis.....	125
5.7	Ethical Considerations	127
5.7.1	Privacy and Confidentiality.....	128
5.7.2	Potential Harm.....	128
5.7.3	Researcher Positionality	129
5.7.4	Cultural Concerns.....	130
5.7.5	Research Location and COVID-19	130

5.7.6	Knowledge and the Global North	131
5.8	Conclusion	131
6	Ticking Boxes: Professional Mobilities and Capabilities.....	133
6.1	Introduction	133
6.2	Uneven Mobilities and Recognition of Professional Capabilities	133
6.2.1	NZREX Pathway Participants.....	138
6.2.2	Specialist Participants.....	140
6.2.3	Competent/Comparable Pathway Participants.....	143
6.2.4	Professional Recognition and Human Dignity.....	144
6.3	Differential Burdens: Conversion Factors Contributing to Uneven Mobilities and Combined Capabilities	145
6.3.1	Delays and (In)efficiencies.....	145
6.3.2	Financial Considerations	148
6.3.3	Timing.....	150
6.3.4	COVID-19.....	152
6.3.5	Uneven Mobilities	155
6.4	Impacts of Uneven Mobilities, Capabilities, and Recognition	156
6.4.1	Pull and Push Factors.....	156
6.4.2	Unrealised Potential	160
6.4.3	Brain Waste	163
6.5	Conclusion	167
7	Identity, (Mis)recognition, and Culture: (Inter)personal Mobilities and Capabilities	169
7.1	Introduction	169
7.2	Identity and (Mis)recognition	170
7.2.1	Personal Conversion Factors	170
7.2.2	Identity and Status Injuries	172
7.3	Discrimination and Othering.....	175
7.3.1	Citizenship and Fear of the Other	176
7.3.2	Othering and Systemic Processes	179
7.4	The (In)direct Impact of Gender and Family on Medical Licensing.....	182

7.4.1	Family and Gender Roles	182
7.4.2	Gender and Medical Registration	184
7.4.3	Invisibility as Misrecognition	192
7.5	Language, Communication, and Culture	193
7.5.1	English Language Requirements	193
7.5.2	Communication and Cultural Safety.....	196
7.5.3	Licensing Pathways and Differential Subjects	200
7.6	Conclusion.....	202
8	Working (in) the System: Mobilities and Capabilities in Practice.....	204
8.1	Introduction	204
8.2	Transparency and (In)consistency	205
8.2.1	Understanding Registration Processes	205
8.2.2	NZREX Examination Processes.....	209
8.2.3	NZREX Employment Processes	211
8.2.4	Systemic Barriers and Enablers	214
8.3	Enhancing Combined Capabilities	217
8.3.1	The Significance of Context	217
8.3.2	Formal Strategies for Enhancing Professional Network Capital.....	220
8.4	Subversive Mobilities: Seeking Workarounds and Change	223
8.4.1	Peer Support: Collaboration Versus Competition	224
8.4.2	Connecting with Employers: Networking Versus Nepotism	227
8.4.3	Advocacy and Political Engagement.....	229
8.5	An Ideal Future.....	231
8.5.1	Governance and Institutions	231
8.5.2	NZREX Pathway	232
8.5.3	Online Questionnaire	232
8.6	Conclusion.....	235
9	Comparability, Ambiguity, and Colonialism: Mobilities and Capabilities Power Regimes....	237
9.1	Introduction	237

9.2	Comparability, Geopolitics, and Arbitrary Exclusions	238
9.2.1	Country of Primary Qualification	238
9.2.2	Comparability and Arbitrary Exclusions	241
9.2.3	Systemic (Mis)recognition	244
9.3	Institutional Ambiguity and Uneven Accountability	246
9.3.1	The “Ping Pong” Phenomenon.....	249
9.3.2	Institutional Absences	253
9.3.3	In Whose Best Interests?	255
9.4	Reinventing the Wheel: The Cyclical Nature of Medical Licensing	258
9.4.1	Labels Matter	258
9.4.2	Colonial Legacies.....	259
9.5	Conclusion	261
10	Conclusions.....	262
10.1	Theoretical Reflections.....	263
10.1.1	Theoretical Distinctions in Practice.....	264
10.1.2	Other Possible Theoretical Applications.....	266
10.2	Breaking the Wheel	267
10.3	Implications for Further Research.....	270
10.4	Final Thoughts.....	272
11	References.....	274
12	Appendices.....	315
12.1	Appendix A: Timeline of Medical Licensing History in Aotearoa New Zealand.....	315
12.2	Appendix B: Region of PGY1 Employment for NZREX Candidates	324
12.3	Appendix C: PRENZ and NZREX Clinical Examination Pass Rates	325
12.4	Appendix D: Country of Primary Qualification of IMG Workforce.....	327
12.5	Appendix E: Mixed Methods Rationales for This Research	331
12.6	Appendix F: Phase 1: Social Media Advertisement	333
12.7	Appendix G: Phase 1: Participant Information Sheet (IMGs).....	334
12.8	Appendix H: Phase 1: Participant Information Sheet (Local Experts).....	336

12.9	Appendix I: Phase 1: Participant Consent Form (Online Interview)	338
12.10	Appendix J: Phase 1: Participant Consent Form (In-person Interview)	339
12.11	Appendix K: Phase 1: Final Interview Schedules	340
12.12	Appendix L: Phase 2: Social Media Advertisement for Online Questionnaire	344
12.13	Appendix M: Phase 2: Online Questionnaire	345
12.14	Appendix N: Phase 2: Information Blurb for Online Questionnaire	355
12.15	Appendix O: Summary of Questionnaire Findings According to Licensing Pathway	356
12.16	Appendix P: Summary of Questionnaire Findings According to Gender	362
12.17	Appendix Q: Full Spectrum of Agreement With Suggestions for Change Among Questionnaire Participants.....	366
12.18	Appendix R: Summary of questionnaire findings according to income level of country of primary qualification.....	368

Table of Figures

Figure 1	<i>Overview of Institutional Relationships and Policies Shaping Medical Licensing for IMGs in Aotearoa New Zealand (Source: Created by Author)</i>	11
Figure 2	<i>Pathway 1: Vocational 3 (VOC3) (Source: Created by Author)</i>	18
Figure 3	<i>Pathway 2: Locum Tenens (LOC) (Source: Created by Author)</i>	18
Figure 4	<i>Pathway 3: Australian (and New Zealand) Medical Graduates (AUS) (Source: Created by Author)</i>	19
Figure 5	<i>Pathway 4: Competent Authority (CA) (Source: Created by Author)</i>	19
Figure 6	<i>Pathway 5: Comparable Health System (CHS) (Source: Created by Author)</i>	20
Figure 7	<i>Pathway 6: General Registrants (GR) via Australia (from 2017) or the U.K. (from 2023) (Source: Created by Author)</i>	21
Figure 8	<i>Pathway 7: New Zealand Registration Examination (NZREX) (Source: Created by Author)</i>	22
Figure 9	<i>Status of Candidates Who Passed NZREX Between March 2014 and September 2023 (as of October 2023)</i>	23
Figure 10	<i>Total PGY1 Annual Hires Across Aotearoa New Zealand Between November 2013 and May 2022</i>	25
Figure 11	<i>Historical Overview of Key Policies Indicating who was Eligible For Medical Licensing in Aotearoa New Zealand Since 1849 (Source: Created by Author)</i>	39
Figure 12	<i>“Active” Medical Workforce in Aotearoa New Zealand Between 1956 and 2023</i>	55

Figure 13 <i>Percentage of Medical Workforce Who Trained Overseas in 2021, in Countries With Data Available on the OECD Database (OECD, 2023)</i>	56
Figure 14 <i>Annual Estimated Number of New Registrants With MCNZ, From 1968-2022, According to Status as Locally (NZMG) or Overseas-Trained (IMG) Doctors</i>	59
Figure 15 <i>Provisional (or Equivalent) Registrations Granted to IMGs Between 1997 and 2023 According to Licensing Pathway</i>	62
Figure 16 <i>Retention Rates for Doctors in Aotearoa New Zealand According to Registration Pathway, 2013-2023 (as of October 2023)</i>	63
Figure 17 <i>Constellations of Mobility and Social Formations (Source: Created by Author)</i>	88
Figure 18 <i>Scales of Mobility Justice, Based on Sheller (2018a, 2018b), Diagram Created by Author</i>	91
Figure 19 <i>Visual Representation of the 4Ps Framework (Source: Created by Author)</i>	101
Figure 20 <i>Procedural Diagram for Research Design (Final Iteration, March 2024)</i>	112
Figure 21 <i>Questionnaire Respondents According to Global Subregion of Primary Medical Qualification (N = 80)</i>	121
Figure 22 <i>Total Questionnaire Respondents According to Their Medical Licensing Pathway Eligibility (N = 80)</i>	124
Figure 23 <i>Development of Theoretical Framework Alongside Data Collection, Integration, and Analysis (Source: Created by Author)</i>	127
Figure 24 <i>Questionnaire Responses to “Have You Ever Achieved Provisional or Full Registration to Work as a Medical Doctor in New Zealand?” by Respondent Licensing Pathway (N = 80)</i>	134
Figure 25 <i>Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “My Overseas Training and Qualifications Are Valued in New Zealand” (N = 67)</i>	136
Figure 26 <i>Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “My Overseas Clinical Experience Is Valued in New Zealand” (N = 68)</i>	137
Figure 27 <i>Responses From Phase 1 and Phase 2 Research Participants Regarding Whether Their Overseas Specialist Qualifications Are Recognised in Aotearoa New Zealand, by Region of Specialist Qualification (N = 36)</i>	141
Figure 28 <i>Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “The Time it Takes to Register as a Medical Doctor in New Zealand Is Reasonable” (N = 68)</i>	146
Figure 29 <i>Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “The Cost of New Zealand Medical Licensing for Doctors who Trained Overseas Is Reasonable” (N = 68)</i>	149
Figure 30 <i>Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “COVID-19 Has Made It More Difficult to Register as a Doctor in New Zealand” (N = 67)</i>	155

Figure 31 Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “I Would Recommend That Other Doctors, With a Similar Background to Me, Migrate to New Zealand” (N = 67)	159
Figure 32 Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “I Am Able to Utilise my Full Potential as a Medical Professional in New Zealand” (N = 67)	162
Figure 33 Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “My Overall Experience of Registering as a Doctor in New Zealand Has Been Positive” (N = 68)	163
Figure 34 Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “As a Medical Professional, I Feel Welcome in New Zealand” (N = 67)	180
Figure 35 Proportion of Questionnaire Respondents of Each Gender According to Their Responses to “My Gender Has Played a Role in My Medical Licensing Experiences in New Zealand” (N = 66)	185
Figure 36 Questionnaire Responses to “Have You Ever Achieved Provisional or Full Registration to Work as a Medical Doctor in New Zealand?” by Respondents’ Indicated Gender (N = 79)	186
Figure 37 Proportion of Questionnaire Respondents of Each Gender Group According to Their Responses to “As a Medical Professional, I Feel Welcome in New Zealand” (N = 67)	187
Figure 38 Proportion of Questionnaire Respondents of Each Gender According to Their Responses to “I Would Recommend That Other Doctors, With a Similar Background to Me, Migrate to New Zealand” (N = 67)	188
Figure 39 Proportion of Questionnaire Respondents of Each Gender According to Their Responses to “My Overall Experience of Registering as a Doctor in New Zealand Has Been Positive” (N = 68)	189
Figure 40 Relationship Between Respondents’ Gender and Licensing Pathway Eligibility (N = 79)	190
Figure 41 Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “Medical Licensing Processes in New Zealand Are Clear and Easy to Follow” (N = 68)	206
Figure 42 Disclaimer for NZREX Candidates, as of January 2024 (MCNZ, 2024n)	208
Figure 43 Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “All Necessary Resources and Materials Are Readily Available for Overseas-Trained Doctors to Navigate the Medical Licensing Process in New Zealand” (N = 68)	209
Figure 44 Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “Networking with Other Doctors Who Trained Overseas Has Been Important to My Licensing Process in New Zealand” (N = 67)	227
Figure 45 Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “Networking With Potential Employers has Been Important to My Licensing Process in New Zealand” (N = 67)	228
Figure 46 Suggestions for Change According to the Extent of Agreement of Questionnaire Respondents (N ≈ 59 to 62)	233

Figure 47 Relationship Between Income Level of Country of Primary Qualification and Responses to “Have You Ever Achieved Provisional or Full Registration to Work as a Medical Doctor in New Zealand?” (N = 80)	239
Figure 48 Extent of Agreement Among Respondents With the Given Statements, by Income Level of Country of Primary Qualification (N ≈ 66 to 68)	240
Figure 49 Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “In Terms of Immigration Processes, It Was Easy to Move/Migrate to New Zealand” (N = 67)	250
Figure 50 Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “Immigration New Zealand and Medical Council of New Zealand Processes Work Together to Make Medical Licensing Easier” (N = 68)	251
Figure 51 Total NZREX, ACE/CA and ACE Matching System PGY1 Hires Between 2014 and 2022, by Region (Formerly Known as District Health Boards)	324
Figure 52 IMG Clinical Examination Attempts Between 1984 and 2023 (PRENZ and NZREX)	326
Figure 53 Proportion of Registered IMG Workforce by Country or Region of Primary Qualification, 1992-2022	327
Figure 54 New IMG Registrants by Country of Primary Qualification, 1977-2022	329
Figure 55 Proportion of IMGs With Current Annual Practising Certificates (APCs) in 2004, 2006, 2011, 2016 and 2021, by Region of Primary Qualification	330
Figure 56 Mean Agreement of Questionnaire Respondents on Different Licensing Pathways With a Series of Statements (Where 1 = Strongly Disagree; 2 = Disagree; 3 = Somewhat Disagree; 4 = Neither Agree nor Disagree; 5 = Somewhat Agree; 6 = Agree; 7 = Strongly Agree)	361
Figure 57 Mean Agreement of Doctors of Different Genders With a Series of Statements (Where 1 = Strongly Disagree; 2 = Disagree; 3 = Somewhat Disagree; 4 = Neither Agree nor Disagree; 5 = Somewhat Agree; 6 = Agree; 7 = Strongly Agree)	365
Figure 58 Suggestions for Change According to the Extent of Agreement of Questionnaire Respondents (N ≈ 59 to 62)	366
Figure 59 Mean Responses to a Series of Statements in Relation to Income Level of Their Country of Primary Qualification (Where 1 = Strongly Disagree; 2 = Disagree; 3 = Somewhat Disagree; 4 = Neither Agree nor Disagree; 5 = Somewhat Agree; 6 = Agree; 7 = Strongly Agree)	372

Table of Tables

Table 1 Glossary and List of Abbreviations	xiv
Table 2 Specialist Pathways to Medical Registration	15
Table 3 General Pathways to Medical Registration	16
Table 4 Comparable Health System Countries According to Key Health Indicators, Compared With Aotearoa New Zealand	31

Table 5	<i>Summary of Percentage Difference of 18 Non-CHS Countries to Aotearoa New Zealand's Health Indicators (Using Data From 2019-2021)</i>	33
Table 6	<i>Comparison of General Registration Pathways in 1905 and 2023</i>	41
Table 7	<i>Key Concepts and Distinctions Made Between Justice Theories</i>	87
Table 8	<i>Key Characteristics of a Capabilities Approach to Mobility Justice</i>	99
Table 9	<i>Phase 1 IMG Research Participants and Their Registration Status at Time of Interview</i>	114
Table 10	<i>Phase 1 Local Expert Research Participants</i>	116
Table 11	<i>Forms of Advocacy From Questionnaire Respondents Who Indicated They Had Been Involved in Advocacy Efforts (N = 19)</i>	230
Table 12	<i>Key Characteristics of a Capabilities Approach to Mobility Justice</i>	263
Table 13	<i>Historical Overview of Key Policies Indicating Who Was Eligible for Medical Licensing in Aotearoa New Zealand Since 1849</i>	316
Table 14	<i>Pass Rates for PRENZ and NZREX Clinical Examinations Between 1984 and 2023</i>	325
Table 15	<i>Mixed Methods Rationales for This Research</i>	331
Table 16	<i>Interview Schedule for International Medical Graduates (IMGs)</i>	340
Table 17	<i>Interview Schedule for Local Experts Group 1: Policymakers and/or Policy Advisors</i>	341
Table 18	<i>Interview Schedule for Local Experts Group 2: Employer</i>	342
Table 19	<i>Interview Schedule for Local Experts Group 3: Other Expert (Such as Māori Health Expert, Politician, Commentator)</i>	343
Table 20	<i>Cohen's f Effect Sizes</i>	356
Table 21	<i>Extent of Agreement From Respondents According to Three Licensing Pathway Groupings (Where 1 = Strongly Disagree; 2 = Disagree; 3 = Somewhat Disagree; 4 = Neither Agree nor Disagree; 5 = Somewhat Agree; 6 = Agree; 7 = Strongly Agree)</i>	358
Table 22	<i>Extent of Agreement From Respondents According to Gender (Where 1 = Strongly Disagree; 2 = Disagree; 3 = Somewhat Disagree; 4 = Neither Agree nor Disagree; 5 = Somewhat Agree; 6 = Agree; 7 = Strongly Agree)</i>	362
Table 23	<i>Cohen's d Effect Sizes</i>	368
Table 24	<i>Extent of Agreement From Respondents According to Income Level of Country of Primary Qualification (Where 1 = Strongly Disagree; 2 = Disagree; 3 = Somewhat Disagree; 4 = Neither Agree nor Disagree; 5 = Somewhat Agree; 6 = Agree; 7 = Strongly Agree)</i>	369

USE OF TE REO MĀORI AND ENGLISH LANGUAGE

While New Zealand is the legal name of the country where this research was carried out, Aotearoa was the name given to the country by the Indigenous Māori people before European colonisation in the 19th century. It is common to refer to New Zealand as Aotearoa New Zealand in recognition of Māori as *tangata whenua* (first people of the land) and this thesis uses both the *te reo* (Māori language) and English names to describe the country.

Please also note that some organisations are named both in English and in te reo Māori. For example, the Medical Council of New Zealand (MCNZ) refers to the full name of their organisation as Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand. This is also the case for Te Whatu Ora | Health New Zealand.

GLOSSARY AND LIST OF ABBREVIATIONS

Table 1

Glossary and List of Abbreviations

Term / Abbreviation	Description
<i>ACE</i> Advanced Choice of Employment	This online portal allows New Zealand and Australian medical graduates to apply for first-year, supervised positions (PGY1) in public hospitals Aotearoa New Zealand by entering a pool of eligible candidates all saved in the same database.
<i>AHPRA</i> Australian Health Practitioner Regulation Agency	Also known as the Medical Board of Australia, AHPRA is responsible for overseeing medical registration for medical doctors and other health practitioners seeking to work in Australia.
<i>AMC</i> Australian Medical Council	Responsible for setting the standards required for medical practitioners to work in Australia, but not overseeing registration processes. AMC works with the Medical Council of New Zealand (MCNZ) to jointly accredit medical training institutions in both Australia and Aotearoa New Zealand.
<i>AMC MCQ</i> Australian Medical Council Multiple Choice Question Examination	This refers to the first examination required by overseas-trained doctors seeking to work in Australia; a multiple choice, medical knowledge examination. AMC MCQ is one of four international medical knowledge examinations accepted for IMGs seeking registration in Aotearoa New Zealand on the NZREX pathway.
<i>APC</i> Annual Practising Certificate	Introduced in the 1930s (Sainsbury, 2015), APCs require medical doctors to pay a fee to the Medical Council of New Zealand (MCNZ) each year to allow them to practise medicine in Aotearoa New Zealand.
<i>AUS</i> Australian medical graduates licensing pathway	This term refers to the pathway for medical licensing in Aotearoa New Zealand that is available to doctors with primary medical qualifications from Australian medical schools.
<i>ASMS</i> Association of Salaried Medical Specialists	This is a union for medical specialists working in Aotearoa New Zealand.

Term / Abbreviation	Description
<i>BMA</i> British Medical Association	A trade union and professional body for medical doctors in the U.K. The NZMA was originally founded as an overseas branch of the BMA when Aotearoa New Zealand was a British colony in the 19 th century.
<i>Bridging Programme</i>	Bridging programmes are courses for IMGs to learn about and adapt to the health system of Aotearoa New Zealand that usually involve working under supervision and some degree of compensation.
<i>CA</i> Competent Authority licensing pathway	The CA licensing pathway is available for medical doctors whose primary medical qualification was received in the U.K. or Ireland.
<i>Capabilities</i>	Capabilities are the potential opportunities for individuals to choose and act in pursuit of things they have reason to value (Robeyns, 2017).
<i>Capabilities approach to mobility justice</i>	This is the theoretical framework that guides this research (see Chapter 4).
<i>CHS</i> Comparable Health System licensing pathway	The CHS pathway for medical registration in Aotearoa New Zealand is available for overseas-trained doctors who have worked for at least 20 hours per week, for 33 of the last 48 months in the same or similar area of medicine as they are applying for in Aotearoa New Zealand, in either: Australia, Austria, Belgium, Canada, Czech Republic, Denmark, Finland, France, Germany, Greece, Hong Kong, Iceland, Ireland, Israel, Italy, the Netherlands, Norway, Portugal, Singapore, Spain, Sweden, Switzerland, the U.K., or the U.S.A.
<i>Colleges</i>	See <i>Specialist Colleges</i> .
<i>Combined Capabilities</i>	The interaction between an individual's abilities and the opportunities afforded to them by their environment (Robeyns, 2017).
<i>Conditional Registration</i>	See <i>Provisional Registration</i> .
<i>Constellations of Mobility</i>	Interwoven patterns, representations, and ways of practising movement (Cresswell, 2010, p. 17)
<i>Conversion factors</i>	Conversion factors refer to the ability to translate capabilities into functionings or outcomes (Robeyns, 2017)
<i>DHB</i> District Health Board	This term that referred to the boards that managed public healthcare in 20 different regions of Aotearoa New Zealand, before the DHBs were dissolved with the formation of a centralised organisation, Te Whatu Ora Health New Zealand, in July 2022.
<i>Dignity</i>	Based on Nussbaum (2006, 2011), dignity is understood as a fluid and intuitive concept related to respect, agency, and equality.
<i>Doctor</i>	In this thesis, it should be assumed unless otherwise stated that <i>doctor</i> refers to a medical doctor. A medical doctor is understood as someone who has been awarded a Bachelor of Medicine and Bachelor of Surgery (MBChB) or an overseas equivalent, such as a Bachelor of Medicine and Bachelor of Surgery (MBBS) or Doctor of Medicine (MD), among other titles. This term is used to refer both to doctors who trained in Aotearoa New Zealand (NZMGs) and those who trained overseas (IMGs).
<i>Functioning</i>	An outcome resulting from the conversion of a capability as a potential outcome, to the active realisation of this capability (Robeyns, 2017).
<i>General Registration / Generalists</i>	Practitioners who have not completed postgraduate specialisation, or whose specialist qualifications are not recognised in Aotearoa New Zealand, are considered <i>generalists</i> and are eligible for <i>general registration</i> , under the <i>general scope of practice</i> (see <i>Scope of Practice</i>).

Term / Abbreviation	Description
<i>Global North / South</i>	While these terms are imperfect geographically, this terminology is used in this thesis to distinguish between countries that are classified as “high-income” by the United Nations (2019), and countries which are considered “middle-income” or “low-income” (pp. 4-5). This language has been selected to avoid problematic terms such as developed or underdeveloped (McEwan, 2019).
<i>GMC</i> General Medical Council	The GMC is the medical licensing authority of the U.K.
<i>GP</i> General Practice or General Practitioner	General Practice is the medical field focused on general medicine, also known as primary care or, in countries such as the U.S.A., Family Medicine. A General Practitioner is a medical doctor who works in General Practice.
<i>GR (GR – AUS or GR – U.K.)</i> General Registrants (via Australia or the U.K.)	This refers to the General Registrants pathway for medical registration in Aotearoa New Zealand, which is available to overseas-trained doctors who have completed licensing examinations and at least one year’s supervised work in either Australia or the U.K.
<i>Healthcare Assistant</i>	See <i>Medical Assistant</i> .
<i>House Officer / House Surgeon</i>	See <i>PGY1 / PGY2</i> .
<i>HPCA Act 2003</i> Health Practitioners Competence Assurance Act 2003	Pass in 2003, this is the current policy that provides the mandate for the Medical Council of New Zealand (MCNZ) to oversee medical regulation, accreditation, and registration in Aotearoa New Zealand, for the overall purpose of ensuring the public has access to safe healthcare.
<i>Human Dignity</i>	See <i>Dignity</i> .
<i>HWNZ</i> Health Workforce New Zealand	HWNZ was established in 2009 to provide national guidance and leadership in planning and developing the health and disability workforce, before being disestablished in 2018.
<i>IAMRA</i> International Association of Medical Regulatory Authorities	IAMRA comprises members from global medical councils and regulatory bodies, including MCNZ.
<i>IMG</i> International Medical Graduate	This term refers any doctor who graduated outside of Aotearoa New Zealand, independent of their subsequent clinical experience (the term does not refer exclusively to recent graduates). While IMG is the preferred term in this thesis, similar terms include Foreign Medical Graduate (FMG) or Overseas-Trained Doctor (OTD). An IMG is any medical doctor “who obtained their primary medical qualification in a country other than New Zealand” (MCNZ, 2022c, p. 5) and they may or may not be practising as a doctor in Aotearoa New Zealand.
<i>Justice</i>	<i>Justice</i> , in its broadest sense, is intricately linked to the treatment of individuals, often has an enforceable nature, implies impartiality and consistency in application, and typically requires an agent to modify relevant circumstances according to their will (Miller, 2017).
<i>Kiwi</i>	People from Aotearoa New Zealand are often referred to colloquially as “Kiwis”. This term relates to the country’s national bird (the kiwi).
<i>Licensing Pathway</i>	<i>Licensing pathways</i> and <i>medical registration</i> are used interchangeably in this thesis, per the literature and policy documentation. These terms refer to the processes a medical doctor must undertake in order to have

Term / Abbreviation	Description
	their qualifications and/or experience officially recognised so they are able to legally practise medicine within a defined context and scope.
<i>LOC</i> Locum Tenens licensing pathway	The LOC pathway for medical registration in Aotearoa New Zealand is available to specialists from a select range of countries and fields, with a minimum threshold of clinical experience, for a maximum of 12 months.
<i>MBBS</i> Bachelor of Medicine and Bachelor of Surgery	See <i>Doctor</i> .
<i>MBChB</i> Bachelor of Medicine and Bachelor of Surgery	See <i>Doctor</i> .
<i>MCCEE</i> Medical Council of Canada Qualifying Examination	MCCQE Part I is a medical knowledge examination designed for IMGs applying for medical registration in Canada. It is one of four international medical knowledge examinations accepted for IMGs seeking registration in Aotearoa New Zealand on the NZREX pathway.
<i>MCNZ</i> Te Kaunihera Rata o Aotearoa Medical Council of New Zealand	MCNZ is the regulatory authority for medical standards, accreditation of institutions, and registration of doctors in Aotearoa New Zealand.
<i>MD</i> Doctor of Medicine	See <i>Doctor</i> .
<i>Medical Assistant</i>	<i>Medical Assistants</i> , also known as <i>Physician's Assistants</i> , are related to the role of <i>Healthcare Assistants</i> , and are generally targeted towards IMGs whose medical qualifications are not yet recognised in Aotearoa New Zealand. Typically employed in General Practice (GP) settings, Medical/Physician's Assistants tend to undertake administrative tasks that require clinical knowledge.
<i>Mobilities</i>	Mobilities are the movements of goods, people, and resources, including more-than-human aspects such as ideas or information. Mobilities tend to refer not only to physical movement, but the structures and systems that shape these movements (Sheller, 2021). See also <i>New Mobilities Paradigm</i> and <i>Mobility Regimes</i> .
<i>Mobility Justice</i>	An “overarching concept for thinking about how power and inequality inform the governance and control of movement” (Sheller, 2018a, p. 14)
<i>Mobility Regimes</i>	Structures of power that dictate who does and does not have the right to move (Sheller, 2018a, 2021).
<i>Motility</i>	The potential, or capability, for movement (Kaufmann et al., 2004, p. 745). See also <i>Network Capital</i> .
<i>MP</i> Member of Parliament	An MP refers to one of the 120 members of Parliament who are responsible for political decision-making in Aotearoa New Zealand.
<i>Network Capital</i>	Mobility capacity and capability (Elliott & Urry, 2010, p. 11). See also <i>Motility</i> .
<i>New Mobilities Paradigm</i>	The flows of people and goods to, from and within spaces creates spaces; social worlds do not exist in a sedentary state and mobilities should be viewed as an integral aspect of human life and society (Sheller & Urry, 2006).
<i>NZ</i> Aotearoa New Zealand	NZ is the abbreviation for New Zealand. New Zealand is the legal name of the country, but Aotearoa is the name given to the country by the Indigenous Māori people before European colonisation in the 19 th

Term / Abbreviation	Description
	century. It is common to refer to New Zealand as Aotearoa New Zealand in recognition of Māori as tangata whenua (first people of the land).
NZMA New Zealand Medical Association	Founded in the 19 th century as an overseas branch of the British Medical Association (BMA), NZMA was an organisation made up of medical doctors that sought to represent the interests of these doctors. It was disestablished in 2022.
NZMG New Zealand Medical Graduates	NZMGs received their primary medical qualifications from one of Aotearoa New Zealand's two medical schools – in Auckland or Otago.
NZREX New Zealand Registration Examination	The NZREX is a clinical skills assessment that overseas-trained doctors not eligible for registration via any of the other licensing pathways are required to take as part of the process of seeking medical registration in Aotearoa New Zealand. Early iterations of the NZREX in the 1990s also included English language and medical knowledge components, and the examination was taken in several parts. Now, the NZREX only consists of one clinical skills examination.
Observership	A short-term, unpaid hospital placement for doctors or medical students, typically two to four weeks in duration, which offers an insight to the working environment and health system of Aotearoa New Zealand.
ODA Overseas Doctors' Association	ODA consisted of a group of IMGs in Aotearoa New Zealand that unified in the late 1990s after several hundred IMGs were granted permanent residency but were unable to register as doctors. It no longer exists.
OIA Official Information Act	The Official Information Act 1982 allows the public to request information held by government bodies.
OSCE Objective Structured Clinical Examination	A type of examination in medical education or registration settings that involves demonstrating clinical skills in simulated medical scenarios, often with actors playing the role of patients.
Othering	<i>Othering</i> is the process of ascribing a group, individual or an object the label of <i>The Other</i> as a means of establishing one's identity in opposition to this. This can result in the exaggeration of stereotypes and generalisations and replication of unequal power relations, as emphasis on difference tends to overwhelm any objective similarities.
Pākehā	A te reo Māori term for New Zealanders of European descent
Pathway to Registration	See <i>Licensing Pathway</i> .
PGY1 / PGY2 Postgraduate Year 1 / 2	First and second year supervised positions for recent medical graduates, known also as an <i>internship</i> , or a <i>House Officer</i> or <i>House Surgeon</i> role. The role consists of four three-month placements in different areas of medicine in public hospitals in Aotearoa New Zealand.
Physician's Assistant	See <i>Medical Assistant</i> .
PLAB 1 / 2 Professional and Linguistic Assessments Board Part 1 / 2	Medical licensing examinations for some overseas-trained medical doctors looking to work in the U.K. PLAB 1 is one of four international medical knowledge examinations accepted for IMGs seeking registration in Aotearoa New Zealand on the NZREX pathway.
PRENZ Probationary Registration Examination in New Zealand	Offered between 1984 and 1989, the PRENZ was required by IMGs who did not train in Australia, Canada, Ireland, South Africa, or the U.K. It encompassed an English language competence assessment, a written medical knowledge examination, and a clinical skills examination. It was replaced by the NZREX examination from 1989.

Term / Abbreviation	Description
<i>Primary Medical Qualification</i>	This is the first medical qualification a doctor receives, often known as a Bachelor of Medicine and Bachelor of Surgery (MBChB) or an overseas equivalent, such as a Bachelor of Medicine and Bachelor of Surgery (MBBS) or Doctor of Medicine (MD), among other titles.
<i>Probationary Registration</i>	See <i>Provisional Registration</i> .
<i>Provisional Registration</i>	Provisional registration is the only registration option available to IMGs upon arrival in Aotearoa New Zealand (except for Australian medical graduates). Provisional registration typically lasts for around 12 months, and doctors work under supervision before applying for <i>full registration</i> . In earlier policies, <i>provisional registration</i> was referred to as <i>conditional registration</i> , <i>probationary registration</i> , or <i>temporary registration</i> .
<i>Recognition</i>	Emphasising recognition involves seeking to achieve justice through the recognition of the human dignity of all individuals (Honneth, 2004). Lack of recognition and respect, manifesting as insults, degradation, and devaluation of individuals and groups, generates injustice not only by harming and constraining people and negatively impacting the formation of a positive sense of self (Fraser, 1995).
<i>Registration (Pathway)</i>	See <i>Licensing Pathway</i> .
<i>Scope of Practice</i>	This refers to the nature of the medicine that a medical doctor is licensed to practise in Aotearoa New Zealand. A <i>general scope of practice</i> refers to medical doctors who are not recognised as specialist, while the <i>vocational scope of practice</i> applies to specialists with recognised postgraduate qualifications.
<i>Specialists</i>	A medical doctor who has a postgraduate specialist qualification in a particular field over and above their primary medical qualification, such as Paediatrics, General Practice, Gynaecology, Psychiatry, Surgery, and so on. Specialists in Aotearoa New Zealand register within what is called the <i>vocational scope of practice</i> .
<i>Specialist Colleges</i>	These Colleges are responsible for regulating and registering specialist doctors. As most specialist Colleges that operate in Aotearoa New Zealand are Australasian, specialist Colleges usually advise both AHPRA and MCNZ on whether they consider an individual to be eligible for registration as a specialist. A doctor cannot register long-term as a specialist in Aotearoa New Zealand without becoming a member of a specialist College.
<i>Temporary Registration</i>	Temporary registration originally referred to the type of registration available to doctors seeking to work in Aotearoa New Zealand on a short-term basis. Originally, temporary registration was granted while an individual waited for probationary registration, but then it was available only to doctors waiting to take the PRENZ or NZREX. From the late 1980s, IMGs also had to take an initial screening examination to be eligible for temporary registration. In the 1990s, the meaning of temporary registration changed, as this status was granted to IMGs who trained in Australia, Canada, Ireland, South Africa, or the U.K. to allow them to be exempt for up to three years from the Medical Practitioners Act 1995, which required all IMGs to take the NZREX examination. See more in <i>Provisional Registration</i> .

Term / Abbreviation	Description
<i>U.K.</i> United Kingdom	Refers to the United Kingdom of Great Britain and Northern Ireland. In this thesis the U.K. is often grouped with Ireland, as doctors from these countries have the same pathway to licensing (see <i>CA</i>).
<i>U.S.A.</i> United States of America	Sometimes also referred to as the U.S. (United States).
<i>USMLE</i> United States Medical Licensing Examinations	USMLE examinations are medical taken by all overseas-trained and locally trained medical doctors (those with MD degrees), in order to work in the U.S.A. USMLE Step 1 and 2 are one of four international medical knowledge examination options accepted for IMGs seeking registration in Aotearoa New Zealand on the NZREX pathway.
<i>VOC1 / VOC2 / VOC3</i> Vocational 1 / 2 / 3 licensing pathway	The VOC licensing pathways are available for specialists to register as medical doctors in Aotearoa New Zealand. VOC1 and VOC2 are available for specialists with Australasian training or recognition, while VOC3 is available for specialists applying on the basis of a specialist qualification outside of Aotearoa or New Zealand. VOC3 is available on a case-by-case basis.
<i>WBA</i> Workplace-Based Assessment	This refers to an examination required for medical registration or acceptance by a specialist College, usually after a period of work under supervision. Some IMGs applying for registration via VOC3 are required to complete a WBA in order to obtain full registration.
<i>WHO</i> World Health Organization	The WHO is an agency of the United Nations agency that focuses on promoting and monitoring health worldwide.

1 INTRODUCTION: “BROKEN” PATHWAYS

Born and raised in Aotearoa New Zealand, I found myself unexpectedly navigating a complex and challenging journey during the heart of the COVID-19 pandemic in 2020. Locked down in Peru with my Peruvian-born husband and his family, we were contemplating a future together in Aotearoa New Zealand, where he aspired to practise medicine. However, the discovery that he would need to undertake the New Zealand Registration Examination (NZREX), in order to convert his medical degree and become registered as a doctor, opened our eyes to an intricate web of challenges within Aotearoa New Zealand’s medical licensing and registration processes.

The NZREX, a clinical examination designed for international medical graduates (IMGs), requires candidates to showcase their clinical skills in the Aotearoa New Zealand context through simulated scenarios, with actors playing the role of patients (MCNZ, 2024n). Delving deeper into the examination process, we uncovered something surprising: more than half of the IMGs who had successfully passed the NZREX within the previous two years, according to data from Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand (MCNZ, 2020b), were unable to secure employment as doctors.

Concerned about what this could mean for our plans to establish Aotearoa New Zealand as our home, I sought clarification from MCNZ in May 2020. I received the following response:

Your analysis of the data is correct. While successful NZREX candidates don’t find employment in the first few years, the majority do find employment within 5 years. However, there are only a limited number of internship positions available for NZREX candidates, so it’s really important that you gather as much information as possible on your employment prospects before you apply to sit NZREX. The best thing to do is contact the District Health Board (DHB) where you might want to work to see what’s available. [...] As to waiting times, Council [MCNZ] is currently not accepting applications for NZREX due to the impact of Covid-19. Previously, the waiting times are between 9 – 12 months. (MCNZ, personal communication, May 14, 2020; May 21, 2020)

This correspondence from MCNZ underscored the gravity of the situation. Qualified overseas-trained doctors, despite having met MCNZ’s stringent standards through the NZREX examination, were waiting for up to five years for employment. Moreover, the pre-pandemic waiting time for the NZREX examination itself was up to 12 months, with cancellations during COVID-19 exacerbating an already substantial backlog. Against the backdrop of significant

national health workforce shortages, as highlighted in research preceding the pandemic (e.g., Elkin, 2015; Gorman & Brooks, 2009; Nieuwoudt, 2017; Taylor, 2016c), this email came as a shock. Not only did MCNZ confirm the existence of a bottleneck in the licensing system for overseas-trained medical doctors, but they also appeared to urge caution on whether a prospective IMG should attempt the NZREX process at all.

On exploring this situation further, what struck me most was how these barriers to licensing do not apply to all doctors who trained overseas. Instead, IMGs navigate different pathways to achieve medical licensing in Aotearoa New Zealand, depending on the country where they received their training or recent work experience. Doctors who completed their medical degrees in Australia, the United Kingdom (U.K.) or Ireland, tend to be automatically eligible for registration. Similarly, those who have worked in a country MCNZ classifies as a “Comparable Health System” (MCNZ, 2024a), which includes Australia, the U.K., Ireland, and 21 other “high-income” (United Nations, 2019, p. 4) countries, can apply for medical licensing without further examination¹, and access immigration support as highly-skilled migrants.

Other IMGs, primarily doctors who trained in the Global South, usually undertake the NZREX licensing pathway. This pathway is costlier and more time-consuming for practitioners and is not typically associated with immigration benefits for highly-skilled migrants. Moreover, as noted in the personal communication from MCNZ above, many of these IMGs find themselves caught in a bottleneck that has been documented in the media, experiencing significant delays in securing employment after successfully passing the NZREX examination (Armah, 2022; Bhamidipati, 2022a; Bhatia, 2022a, 2022b; Crampton, 2022; Fenton & Chillag, 2022; RNZ, 2023; Russell, 2021b; Thomas-Maude, 2022; Thomas-Maude & McLennan, 2022).

From this context, my PhD project emerged, initially driven by the question of why individuals from some Global North countries are actively encouraged to immigrate to Aotearoa New Zealand and work as doctors, while doctors from Global South countries find themselves waiting for years to contribute to the under-resourced, overburdened health sector even after meeting MCNZ’s standards. One IMG, who participated in this research, passed the NZREX examination and had been waiting for employment for more than two years when I spoke to him in August 2022. He summarised his experiences with seeking registration to practise in Aotearoa New Zealand on the NZREX pathway:

¹ As will be discussed in [Chapters 2 and 7](#), doctors who trained in countries where English is not spoken as a first language, such as Germany or France, are required to take an approved English-language assessment. However, they do not need to take an examination of their medical knowledge or clinical skills (in contrast to doctors required to take the NZREX examination).

This pathway is a broken pathway – because if it’s a ‘pathway’, then everyone who goes through does the same steps...and if you follow it, you’ll get to the destination. But it’s a broken path, a broken line. To reach your destination you have to jump and go through loopholes, and you might not get there...it’s all about luck – it’s a totally random process. (IMG 9, NZREX)

This “broken pathway” not only affects these individual doctors and their families, but also has broader repercussions for the population of Aotearoa New Zealand. During the course of this research (2021 – 2024), the global COVID-19 pandemic has exacerbated the existing national health workforce crisis, leading to increasing reports of patients and ambulances being turned away from hospitals and General Practice (GP) clinics across the country (Armah, 2022; Broughton, 2021; Ellingham, 2022; RNZCGP, 2020; Russell, 2021a, 2022; Shahtahmasebi, 2021; Spence, 2024; Tebbutt, 2021; Trigger, 2022). Despite this, as demonstrated throughout this thesis, the medical licensing policies for doctors who trained overseas remain arduous, complex, and, for at least a hundred doctors on the NZREX pathway (RNZ, 2023), “broken”.

1.1 TOWARDS A CAPABILITIES APPROACH TO MOBILITY JUSTICE

Understanding the experiences of IMGs in Aotearoa New Zealand required a conceptual framework that could reveal and uncover IMGs’ professional experiences. Medical migration involves individual migratory choices, global development, and health outcomes, as well as the ability of doctors to maximise the use of their skillsets. In light of these complexities, I have drawn on both mobility justice and the capabilities approach in conceptualising this phenomenon.

This thesis discusses the potential contributions of a capabilities approach to mobility justice to existing understandings of the international migration of medical doctors. On the one hand, *mobility justice* theorisations suggest that prevailing theories of justice are inadequate, as they tend to prioritise historical and social factors over geographical and/or mobile concerns. Thus, mobility justice can be viewed as “an overarching concept for thinking about how power and inequality inform the governance and control of movement” (Sheller, 2018a, p. 14). On the other hand, the *capabilities approach* focuses on what people are “actually able to do and to be” and the “real opportunities available to them” (Nussbaum, 2011, p. x). Capabilities represent opportunities to choose and act (Sen, 1984, 2015), providing freedom of choice and contributing to the protection of freedoms central to maintaining human dignity (Nussbaum, 2006, 2011).

The capabilities approach to mobility justice developed and refined during this research builds on existing elements of the capabilities approach's contribution to theories of mobility justice, bringing capabilities to the forefront. The thesis considers how patterns of unequal (im)mobility interact with capabilities and opportunities at different scales to produce (in)justices. The overarching goal of this capabilities approach to mobility justice is to maximise both human and more-than-human mobilities and associated capabilities without trampling, endangering, or depriving others of such capabilities and mobilities. With this in mind, the thesis explores IMG experiences through four components that have evolved throughout this research, which I have termed the *4Ps*: mobilities and capabilities in *practice*, *professional* mobilities and capabilities, *(inter)personal* mobilities and capabilities, and the *power regimes* shaping and influencing these mobilities and capabilities.

1.2 RESEARCH QUESTIONS AND APPROACH

This research aims to understand the experiences of practising and non-practising international medical graduates (IMGs) in Aotearoa New Zealand, through a capabilities approach to mobility justice. The following questions guide the research:

- How do the different licensing pathways and processes for medical registration in Aotearoa New Zealand shape IMGs' experiences and professional outcomes?
- How can understanding these experiences and outcomes inform the development of a capabilities approach to mobility justice?

These questions are addressed through an exploratory sequential mixed methods approach, involving three key phases:

- 1) Phase 1: Qualitative interviews with IMGs in Aotearoa New Zealand ($n = 24$) and local experts ($n = 9$), followed by thematic analysis.
- 2) Phase 2: Development and dissemination of an online questionnaire targeting a wider pool of IMGs ($N = 80$), based on the thematic findings of Phase 1.
- 3) Phase 3: Integration and analysis of datasets from both Phase 1 and Phase 2, and complementary document analysis of relevant policies, grey literature, and media coverage ($N = 370$).

While this research is sequential in both name and design, the research outputs presented in this thesis were developed iteratively rather than consecutively. The theoretical framework, discussed in Chapter 4, expands on existing overlaps between mobility justice and the capabilities approach, which had not previously been explored in great depth. In that sense,

the theoretical framework serves as both an output of this research, and a foundation and guiding structure.

1.3 MIGRATION AND MEDICINE

Medical licensing policies for international medical graduates (IMGs) in Aotearoa New Zealand exist within the broader context of global migration patterns among medical professionals. Migration has been an integral part of medical culture for centuries; physicians historically travelled for additional experience and training, a tradition that continues in the contemporary world (Hsu, 2012; Johnson, 2005).

However, since the Second World War, there has been a notable trend of medical doctors moving from lower-income countries to higher-income countries (Gaillard & Gaillard, 1997). This migration pattern has raised concerns that “poorer countries have become a major supplier of health workers for the richer countries” (Driouchi, 2014, p. 295), potentially compromising their own healthcare systems. Migratory flows of medical professionals are also observed between Global South countries (e.g., Hsu, 2012; McLennan et al., 2020), Global North countries (e.g., Connell, 2009; Gauld & Horsburgh, 2015), with North to South movement of doctors occurring through initiatives such as Doctors without Borders (Fox, 2014). The net outflow of highly skilled professionals is described as a *brain drain* (e.g., Adovor et al., 2021; Choy & Glass, 2002; Gaillard & Gaillard, 1997; Negin, 2008; Perkins, 1966; Watanabe, 1969), while countries benefitting from a large migrant workforce are said to experience a *brain gain* (e.g., Beine et al., 2011; Brücker et al., 2012; Chacko, 2007; Colebatch, 2005; Meyer et al., 1997). In cases where medical professionals migrate but are unable or unwilling to work in their field, due to practical limitations or personal preferences, this is referred to as *brain waste* (e.g., Dovlo, 2005b; Pang et al., 2002).

Aotearoa New Zealand exemplifies all three phenomena. Up to 40% of doctors trained in Aotearoa New Zealand in the early 2000s now live abroad (MCNZ, 2022c), often migrating to other Global North countries for enhanced employment or training opportunities (ASMS, 2017). Despite improved retention of New Zealand medical graduates (NZMGs) in the past decade, the country still relies on a substantial influx of migrant doctors, with 43% (8,398) of the active medical workforce (19,442) in September 2023 having trained overseas (MCNZ, 2024h).

The landscape of international medical migration is complex, context-dependent, and positioned at the intersection of the individual rights of medical professionals to move and migrate, global dynamics systematically favouring Global North countries and former colonial

powers, and the rights of the public to access quality healthcare services and outcomes. Thus, in this thesis, my capabilities approach to mobility justice serves to situate the experiences of the IMGs within the broader academic, geopolitical, and historical context of migration, medicine, and (post)colonial Aotearoa New Zealand.

1.4 THESIS STRUCTURE

In addressing the research aim and questions, the first half of this thesis (Chapters 2-5) describes the development of the theoretical framework and the research design, positioning the project within the broader policy and research context. The second half (Chapters 6-10) explores the applicability of the theoretical framework, integrating and analysing data on IMG experiences, and both historical and contemporary geopolitical dynamics.

During the course of this research, political and public interest in this subject has increased, particularly in the lead up to Aotearoa New Zealand's national election held on 14th October 2023. The bulk of this thesis draws on research, media reports, and policy updates up to the time of the 2023 election only. It is only the final chapter, discussing potential future outcomes and changes for medical licensing and IMGs in Aotearoa New Zealand, which reflects on other updates current at the time of thesis submission (May 2024). However, research always presents a snapshot in time (Braun & Clarke, 2021), and the 2023 election served as a natural conclusion to data collection in terms of media updates and policy analysis during the course of this research.

The thesis unfolds as follows:

Chapter 2: Policy and Institutional Context of Medical Licensing in Aotearoa New Zealand situates this research within the broader policy and institutional context of medical registration in Aotearoa New Zealand. Key institutions involved in medical licensing are introduced. The chapter then outlines the different pathways to registration available to IMGs and how these are determined. Taking a historical view, similarities between colonial and contemporary policies are explored, raising questions about the influence of colonial legacies on medical licensing for IMGs in Aotearoa New Zealand.

Chapter 3: Coming and Going: Medical Migration Patterns and Othering in Aotearoa New Zealand contextualises key concepts from the literature by examining how dynamics of brain drain, gain, waste, and Othering, play out in Aotearoa New Zealand. Drawing on research and grey literature relating to both medical licensing and the broader medical workforce, the chapter underscores the important role that IMGs play in the local health system. A gap is

identified in the literature regarding the comparative experiences of IMGs from different licensing pathways and backgrounds, which this research addresses.

Chapter 4: The 4Ps: Towards a Capabilities Approach to Mobility Justice discusses the theoretical framework of a capabilities approach to mobility justice, with a focus on the development of the 4Ps. The chapter introduces literature on justice, situates mobility justice and the capabilities approach within this, and brings together these two approaches in a way that has emerged alongside data collection and analysis throughout this research. The 4Ps components, which have been developed alongside data collection and analysis in this research, form the foundation and guiding structure for the second half of this thesis.

Chapter 5: Researching Medical Migration in Context: A Mixed Methods Approach details the methodological approach used in this exploratory sequential mixed methods study. The chapter provides an overview of the epistemological approaches to the research, before describing the rationale, research design, and methods employed. Additionally, the chapter discusses how the research design reflects and contributes to the theoretical framework, and addresses ethical considerations.

Chapter 6: Ticking Boxes: Professional Mobilities and Capabilities explores the professional aspects of IMGs' experiences, the first of the 4Ps, examining how their qualifications, training, and experience align with their desired outcomes in Aotearoa New Zealand. A disconnect is observed between some IMGs' personal mobilities and capabilities, particularly for those on the NZREX pathway, which can result in brain waste. Registration processes that arbitrarily exclude individuals on the NZREX pathway are seen to contribute to mobility and capabilities injustices, disproportionately affecting those without training or experience in select Global North countries.

Chapter 7: Identity, (Mis)recognition, and Culture: (Inter)personal Mobilities and Capabilities looks at the second of the 4Ps, asking how the (inter)personal aspects of IMGs' lives influence their medical registration and work experiences in Aotearoa New Zealand. Key themes include identity, (mis)recognition, communication, and culture. The discussion underscores how mobilities and capabilities power regimes lead to arbitrary exclusions based on personal characteristics such as nationality, ethnicity, gender, and culture, thereby perpetuating injustices.

Chapter 8: Working (in) the System: Mobilities and Capabilities in Practice examines the translation of relevant policies from paper into practice for IMGs in Aotearoa New Zealand, the third of the 4Ps. The chapter explores IMGs' experiences with transparency, availability of information, and the workarounds some sought to attempt to subvert a system they found to

be prohibitive. Research participants' recommendations for ideal medical licensing approaches are then explored, highlighting a shared sentiment for more equitable, inclusive, transparent, and supportive processes.

Chapter 9: Comparability, Ambiguity, and Colonialism: Mobilities and Capabilities Power Regimes discusses the fourth of the 4Ps, the power regimes that shape mobilities and capabilities in this context. The focus shifts from *how* IMGs experience migration, medical licensing, and professional outcomes in Aotearoa New Zealand, to *why* these experiences and outcomes occur. The chapter explores themes of ambiguity in accountability, cyclical policy changes, and mismatched expectations. The recurring nature of medical licensing policies points to the power of colonial vestiges in (re)producing mobilities and capabilities power regimes and, consequently, injustices.

Chapter 10: Conclusions reflects on the project as a whole, discussing the use of the 4P framework and what this research can add to a capabilities approach to mobility justice. The chapter comments on the strengths and limitations of the research and explores potential opportunities for further investigation into the complex dynamics of medical migration and licensing for IMGs in Aotearoa New Zealand.

2 POLICY AND INSTITUTIONAL CONTEXT OF MEDICAL LICENSING IN AOTEAROA NEW ZEALAND

2.1 INTRODUCTION

International medical graduates (IMGs) constitute over 40% of Aotearoa New Zealand's medical workforce and play a crucial role in national healthcare provision. Aotearoa New Zealand's universities do not train adequate numbers of doctors for the population (Elkin, 2015; Gorman & Brooks, 2009; Lawrenson, 2023), leaving the country reliant on overseas-trained doctors to make up this deficit in order to meet local healthcare needs. Within this context, policies relating to medical registration differentiate between IMGs depending on their country of training, creating a complex landscape with uneven professional outcomes. This chapter foregrounds this research into the experiences of overseas-trained medical doctors in Aotearoa New Zealand by providing a comprehensive overview of the policy and institutional landscape surrounding medical licensing, spanning historical and contemporary time periods.

To begin, the chapter offers an institutional overview. It introduces key stakeholders in the medical registration of IMGs in Aotearoa New Zealand, highlighting the intricate power dynamics involved in decision-making within this domain. The current processes for medical registration are then delineated. This delineation brings attention to the differentiation in licensing pathways for IMGs based on the health system indicators of their countries of training, which is creating barriers to registration for some IMGs. This discussion of medical registration processes leads into an examination of the use of national health system indicators to determine the licensing pathway for IMGs, raising questions about the effectiveness of such measures in assessing the competence of medical practitioners.

Finally, the chapter explores the historical context of medical registration in Aotearoa New Zealand, revealing a connection between the countries of training privileged in the licensing process and former colonial preferences for migrants of specific backgrounds. This historical overview underlines the persistence of colonial legacies in contemporary policies. Overall, the chapter establishes a foundational context for understanding the experiences of IMGs in Aotearoa New Zealand, by underscoring the significance of policies, processes, and institutions in shaping the professional trajectories of overseas-trained doctors.

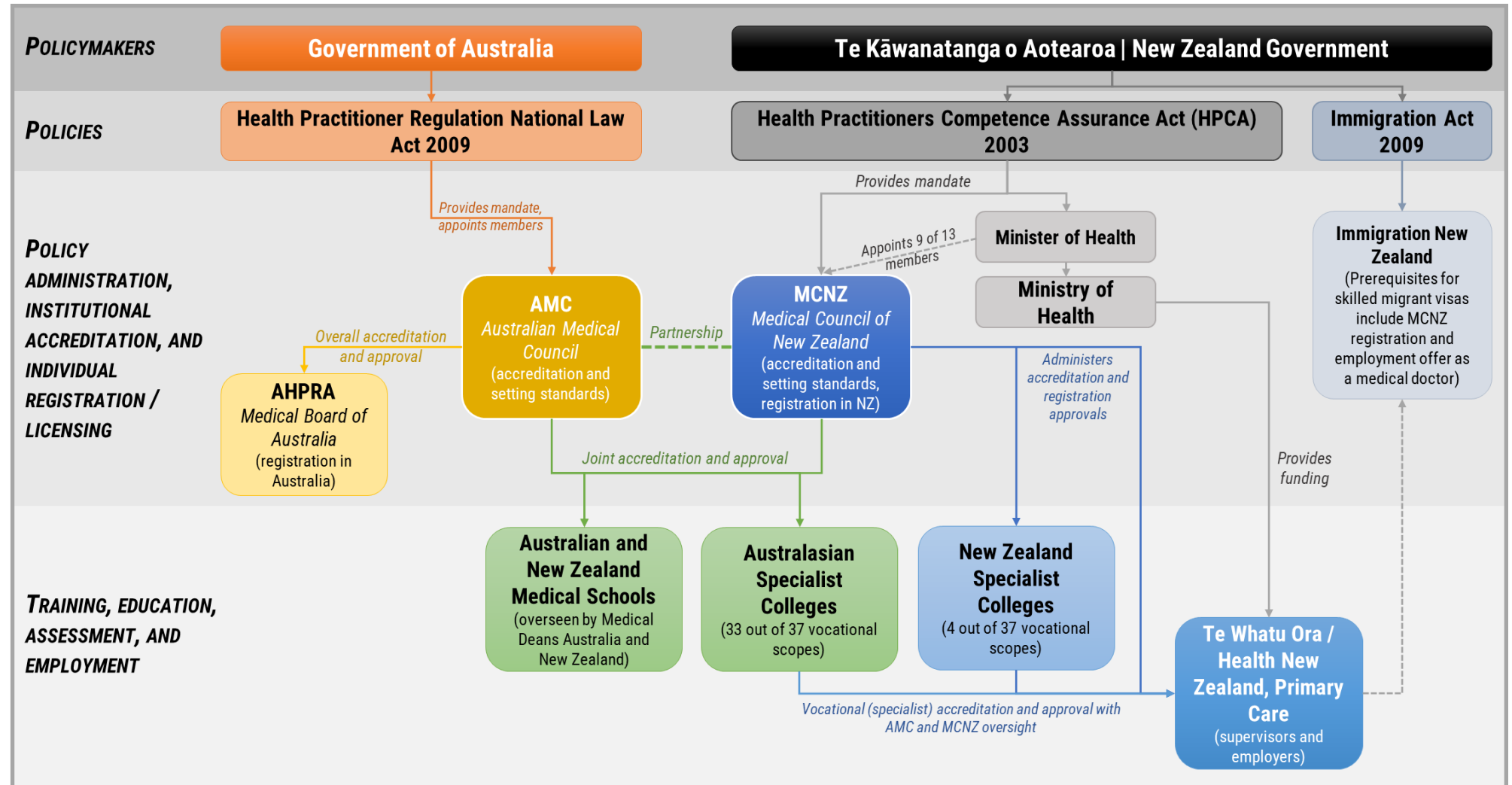
2.2 INSTITUTIONAL MAPPING

The policy and institutional landscape surrounding medical licensing in Aotearoa New Zealand is intertwined with a range of national and international entities. The primary authority

overseeing medical registration standards is Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand (MCNZ). MCNZ is a government-mandated organisation that provides autonomous self-regulation of the medical profession, by medical professionals (MCNZ, 2024r). While MCNZ acts independently from government, their role is interconnected with various stakeholders, such as the Ministry of Health, medical schools, specialist Colleges, Immigration New Zealand, the Australian Medical Council (AMC), and the governments of both Australia and Aotearoa New Zealand. Figure 1 provides a visual representation of the contemporary institutional relationships and policy administration that impact IMGs seeking to practise as medical doctors in Aotearoa New Zealand.

Figure 1

Overview of Institutional Relationships and Policies Shaping Medical Licensing for IMGs in Aotearoa New Zealand (Source: Created by Author)



2.2.1 *National Actors*

The main actor in medical licensing and regulation in Aotearoa New Zealand is MCNZ, who works in collaboration with several other actors and institutions. MCNZ consists of around 80 staff members who are overseen by a Council of 12 medical doctors and laypeople, plus a Chairperson (MCNZ, 2024m). The overarching purpose of MCNZ is to “protect the health and safety of the public by ensuring that doctors are competent and fit to practise...by setting standards of clinical and cultural competence and ethical conduct for doctors” (MCNZ, 2024c, para. 1). As such, MCNZ is responsible for setting standards and administering professional registration of all New Zealand medical graduates (NZMGs) and international medical graduates (IMGs), overseeing medical education in Aotearoa New Zealand, and monitoring the performance of registered medical doctors (MCNZ, 2024r). The Council of 12, and the Chairperson, are the key decision-makers in this regulatory space.

MCNZ is also intertwined with other national institutions, however. Of their 13 core members, nine are appointed by the Minister of Health. Historically, all MCNZ members were appointed by various institutions, including the Ministry of Health, the New Zealand Medical Association (NZMA), the two medical schools in Aotearoa New Zealand, and the Governor General (“Medical Practitioners Act,” 1968). The introduction of the Medical Practitioners Act 1995 granted MCNZ more autonomy, and since 1996, regular elections have allowed doctors on the Medical Register to directly elect four colleagues to MCNZ per cycle (MCNZ, 1997). However, the Minister of Health still needs to approve these appointments, and the remaining nine members are directly appointed by the Minister without election (MCNZ, 2024r).

While the Ministry of Health contributes to the composition of MCNZ members, they lack direct influence over institutional accreditation or individual registration activities. The historical impact of this power distribution was evident as early as 1921, when the Prime Minister attended an MCNZ meeting to advocate – unsuccessfully – for a doctor who had faced imprisonment for operating without registration under extenuating circumstances (Sainsbury, 2015). Despite being Government-mandated, MCNZ was already operating with a high degree of autonomy and self-regulation from this time, which has been reinforced by policies over the ensuing century (see [Appendix A](#)).

Other significant actors, as shown in Figure 1, include Immigration New Zealand and Te Whatu Ora | Health New Zealand. Immigration New Zealand has policies in place to grant skilled migrant visas or residency to medical doctors in specific fields, contingent upon MCNZ licensing approval (Immigration New Zealand, 2024). While many IMGs rely on work-related visas to enter the country, it is also possible for IMGs to enter Aotearoa New Zealand without

having received prior medical licensing. For example, some IMGs are Aotearoa New Zealand citizens who grew up in the country and then moved overseas to complete their medical education, returning later. The majority of IMGs tend to originate from overseas, however, and may be granted visas to work in Aotearoa New Zealand as the spouses or family members of other people who have received skilled migrant work visas or residency or are already citizens of Aotearoa New Zealand. However, visas cannot be granted solely on the basis of one's medical qualifications without first having obtained medical licensing. This marks an institutional shift from the early 1990s when several hundred IMGs, arriving on skilled migrant visas, faced registration barriers from MCNZ upon arrival that left them unable to work (Hawken, 2005a; Selvarajah, 2004).

Furthermore, medical registration and associated visas are linked to employment offers. Before 2022, District Health Boards (DHBs) managed public health services across 20 regions in Aotearoa New Zealand. However, these were dissolved and replaced by Te Whatu Ora | Health New Zealand in July 2022. Te Whatu Ora | Health New Zealand and its subsidiary providers serve as the primary employers for both New Zealand medical graduates (NZMGs) and IMGs in hospital and General Practice (GP) settings. As data collection for this research took place in 2022 and 2023, the term *DHB* is often used by research participants and in the literature, and therefore in this thesis.

2.2.2 *The Australian Influence*

In this research, I discuss two key categories of licensing available to IMGs seeking to practise medicine in Aotearoa New Zealand – *specialist* and *general* registration. IMGs who have a recognised postgraduate specialist qualification in a particular field, over and above their primary medical qualification, such as Paediatrics, General Practice, Gynaecology, Psychiatry, or Surgery, are *specialists*. Practitioners who have not completed postgraduate specialisation, or whose specialist qualifications are not recognised in Aotearoa New Zealand, are considered *generalists*.

While MCNZ primarily manages general registration, specialist registration processes involve a network of institutions in both Aotearoa New Zealand and Australia. Specialist Colleges provide oversight in specific medical fields – for example, the Australasian College for Emergency Medicine (ACEM) or the Royal Australasian College of Physicians (RACP). As illustrated in Figure 1, specialist Colleges that operate exclusively in Aotearoa New Zealand are responsible for just four areas of specialisation (*vocational scopes*)². In contrast, 33 vocational

² General Practice and Rural Health Medicine (Royal New Zealand College of General Practitioners); Public Health (New Zealand College of Public Health Medicine); and Urgent Care (Royal New Zealand College of Urgent Care).

scopes³ are managed by Australasian Colleges who provide joint accreditation across Australia and Aotearoa New Zealand (MCNZ, 2024j, 2024k). As of 30th September 2023, 60% of the specialist workforce were overseen by Australasian specialist Colleges (MCNZ, 2024h, 2024j, 2024k). Australian medical institutions thus influence the registration of 35% of the total medical workforce in Aotearoa New Zealand through these Australasian Colleges⁴.

Furthermore, the Australian Medical Council (AMC) significantly contributes to undergraduate medical education and regulation in Aotearoa New Zealand for NZMGs. The inception of trans-Tasman accreditation dates back to a partnership between AMC and MCNZ in 1992, with the aim of facilitating the seamless transfer of medical degrees between the two countries (MCNZ, 1992). Joint accreditation began in the 1990s for the University of Otago (MCNZ, 1995), followed by the University of Auckland (MCNZ, 1996a), the two medical schools in Aotearoa New Zealand. While accreditation of medical schools in both countries is presently led by AMC, there is always at least one assessor from Aotearoa New Zealand on the accreditation team, appointed by MCNZ (BSI Group New Zealand Limited, 2021).

However, questions can be raised about whether mechanisms established by or in conjunction with Australian institutions, are appropriate for Aotearoa New Zealand. For example, MCNZ policy is to decline specialist registration if the relevant College does not approve of that individual's qualifications (Walker, 2023). In a recent contentious case, the Royal Australasian College of Surgeons (RACS) resolved that the specialist qualifications of a Hungarian- and U.K.-trained neurosurgeon, whose primary medical qualification was from Poland, were not satisfactory (Broughton, 2022). Based on this advice, MCNZ declined his application, and the doctor returned to the U.K. to work (Houlahan, 2022). However, an appeal was made to the District Court about MCNZ's decision-making process, which found that MCNZ "had not seemed to appreciate that it was able to make a decision of its own rather than just following the advice from RACS" (*Rakasz v Medical Council of New Zealand [2022] NZDC 17460*, 2022, para. 1). This example suggests there is a tendency to defer to the recommendations of these Australasian specialist Colleges, even in cases where this may not be the most appropriate decision.

³ Anaesthesia, Cardiothoracic Surgery, Clinical Genetics, Dermatology, Diagnostic and Interventional Radiology, Emergency Medicine, Family Planning and Reproductive Health, General Surgery, Intensive Care Medicine, Internal Medicine, Medical Administration, Musculoskeletal Medicine, Neurosurgery, Obstetrics and Gynaecology, Occupational Medicine, Ophthalmology, Oral and Maxillofacial Surgery, Orthopaedic Surgery, Otolaryngology Head and Neck Surgery, Paediatric Surgery, Paediatrics, Pain Medicine, Palliative Medicine, Pathology, Plastic and Reconstructive Surgery, Psychiatry, Radiation Oncology, Rehabilitation Medicine, Sexual Health Medicine, Sport and Exercise Medicine, Sports Medicine, Urology, and Vascular Surgery.

⁴ As of 30th September 2023, 11,357 doctors were registered under the vocational scope of practise with current Annual Practising Certificates (APCs). Of these, 4,559 were working in General Practice, Rural Hospital Medicine, Urgent Care or Public Health, and were thus overseen by a New Zealand specialist College. The remaining 6,788 specialists (59.8% of specialists) made up 34.9% of the total registered medical workforce (19,442 doctors).

Overall, the key actors shaping medical licensing and the experiences of IMGs in Aotearoa New Zealand include MCNZ, the specialist Colleges, Immigration New Zealand, Te Whatu Ora | Health New Zealand, and other local employers and healthcare providers. As seen in Figure 1, the relationships between these institutions are complex, whereby no single entity shoulders complete responsibility for all aspects of medical registration and employment in Aotearoa New Zealand. Nevertheless, MCNZ is the primary regulatory authority entrusted with defining and implementing medical licensing policies under the Health Practitioners Competence Assurance Act (HPCA) 2003, despite operating within this complex landscape.

2.3 PATHWAYS TO MEDICAL REGISTRATION

In striving to “protect the health and safety of the public by ensuring that doctors are competent and fit to practise” (MCNZ, 2024c, para. 1), MCNZ have laid out a number of pathways for IMGs to achieve medical registration in Aotearoa New Zealand. These medical registration pathways create a distinction among medical doctors based on where they trained. This section examines the existing pathways to registration for doctors who trained overseas, considering how MCNZ categorises and distinguishes between groups of IMGs in Aotearoa New Zealand.

MCNZ provide two primary *specialist registration pathways* for IMGs with a recognised postgraduate specialist qualification beyond their primary medical qualification, as summarised in Table 2.

Table 2

Specialist Pathways to Medical Registration

Pathway	Who is Eligible?	Institutions Involved	Eligible for Skilled Migrant Visa?
1. Vocational (VOC3) Pathway	Specialists whose overseas qualifications are recognised in Aotearoa New Zealand, decided on a case-by-case basis	MCNZ and Australasian or Aotearoa New Zealand Colleges that oversee each particular specialty	Usually eligible for a skilled migrant work visa and/or residency, upon receiving a job offer
2. Special Purpose Locum Tenens (LOC) Pathway	Specialists who wish to migrate for up to 12 months, with one of the accepted qualifications stated by MCNZ (2015b)	MCNZ	Eligible for temporary work visa of up to 12 months only, with job offer

In addition, MCNZ offer five *general registration pathways*, as summarised in Table 3.

Table 3*General Pathways to Medical Registration*

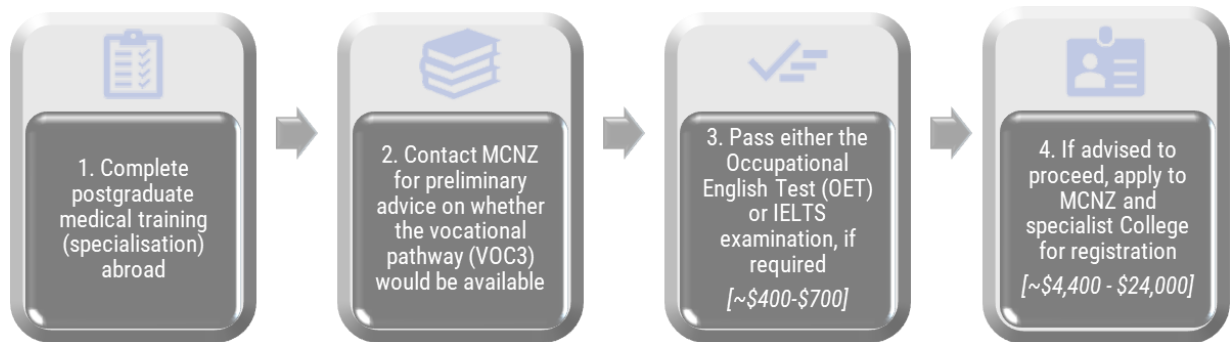
Pathway	Who is Eligible?	Institutions Involved	Eligible for Skilled Migrant Visa?
3. Australian Medical Graduates (AUS) Pathway	Individuals who have graduated from an accredited Australian medical school	MCNZ and AMC, who jointly accredit medical schools in Australia and Aotearoa New Zealand	Usually eligible for a skilled migrant work visa and/or residency, upon receiving a job offer, if they have completed a minimum of one year as an intern
4. Competent Authority (CA) Pathway	Individuals who have graduated from an accredited medical school in the U.K. or Ireland and have completed a minimum of one-year full-time clinical work experience (usually as an intern)	MCNZ	Usually eligible for a skilled migrant work visa and/or residency, upon receiving a job offer
5. Comparable Health System (CHS) Pathway	Individuals who have worked for at least 20 hours per week, for 33 out of the last 48 months in a country designated as a “Comparable Health System” by MCNZ (2024a), in a similar field of medicine as they intend to work in Aotearoa New Zealand	MCNZ	Usually eligible for a skilled migrant work visa and/or residency, upon receiving a job offer
6. Australian or U.K. General Registrants (GR) Pathway	Individuals who have achieved full registration in either Australia or the U.K. by completing at least one-year full-time work (usually as an intern)	MCNZ	Usually eligible for a skilled migrant visa and/or residency, upon receiving a job offer, but this will depend on the role they intend to work in
7. New Zealand Registration Examination (NZREX) Pathway	All IMGs who do not meet the criteria for any other pathway	MCNZ	No

The order of these pathways is arranged in accordance with MCNZ's (2024o) self-assessment tool. Medical professionals eligible for specialist licensing are generally encouraged to pursue specialist registration, and Pathways 1 and 2 are thus prioritised. For IMGs for whom general registration is the only option, the pathway to registration (Pathways 3-7) is determined through a process of elimination. IMGs are initially assessed for eligibility in pathways higher on the list, with NZREX (Pathway 7) considered the final recourse. Further details on each of the pathways are provided in the following subsections.

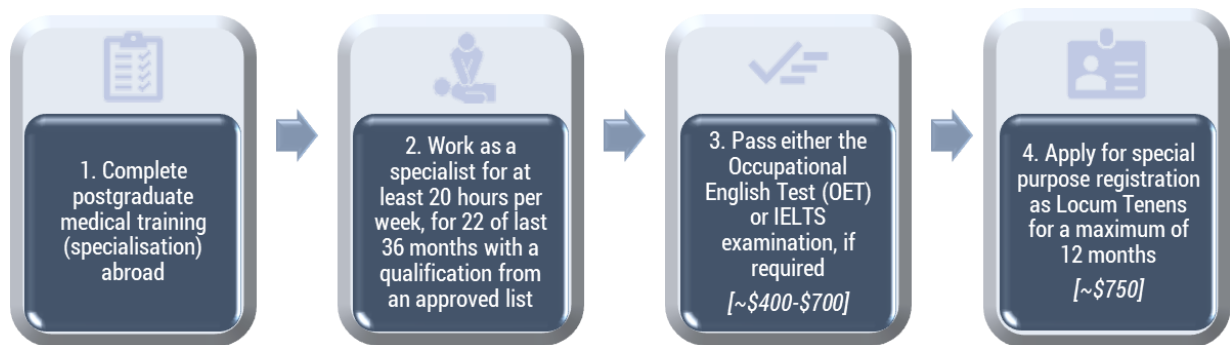
2.3.1 Specialist Registration

Pathway 1: VOC3

Under Pathway 1, there are three vocational licensing options for long-term registration as a specialist in Aotearoa New Zealand (MCNZ, 2024p). VOC1 and VOC2 registration are applicable to medical doctors with postgraduate qualifications from a specialist College in Australia or Aotearoa New Zealand. Although these specialists may have completed their undergraduate qualifications overseas, those trained in Australia are generally considered equivalent to those trained in Aotearoa New Zealand, owing to the joint accreditation between MCNZ and the Australian Medical Council (AMC), as discussed above (Subsection 2.2.2). As such, the pathway most relevant to this research is VOC3 (MCNZ, 2024q), designed for specialist IMGs without prior accreditation in Australia or Aotearoa New Zealand. VOC3 has no definitive registration requirements, as MCNZ makes licensing decisions on a case-by-case basis, in collaboration with the respective specialist College. However, as in the case of the Hungarian IMG with U.K. specialist training (Broughton, 2022) described in Subsection 2.2.2, it is unlikely that IMGs whose foundational, non-specialised medical qualifications are ineligible for the AUS, CA, CHS or GR general pathways (Pathways 3-6) would have specialist qualifications from the same country recognised in Aotearoa New Zealand. Figure 2 summarises the VOC3 licensing pathway.

Figure 2*Pathway 1: Vocational 3 (VOC3) (Source: Created by Author)⁵***Pathway 2: LOC**

Under Pathway 2 (see Figure 3), Locum Tenens (LOC) registration of up to 12 months is available for specialists in a narrower list of fields. This option is limited to those licensed with specific medical Boards and Colleges from Australia, Aotearoa New Zealand, the U.K., Ireland, Canada, U.S.A., and South Africa (MCNZ, 2015b), provided they have worked for at least 20 hours per week for at least 22 of the last 36 months (MCNZ, 2013b). Doctors on the LOC pathway cannot continue working in Aotearoa New Zealand after 12 months without being directed to a vocational licensing pathway for assessment on a case-by-case basis.

Figure 3*Pathway 2: Locum Tenens (LOC) (Source: Created by Author)***2.3.2 General Registration Without Examination**

Unlike the VOC3 pathway, the five generalist pathways to licensing for non-specialist medical doctors are distinctly outlined by MCNZ. Pathways 3-6 all provide options for registration that do not require further examination in Aotearoa New Zealand.

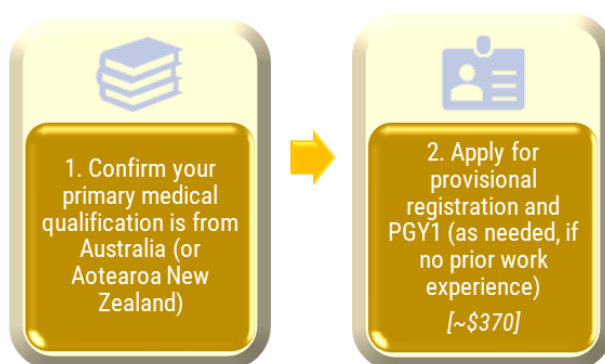
⁵ It should be assumed that "\$" refers to New Zealand Dollars (NZD) in this thesis, unless stated otherwise.

Pathway 3: AUS

As shown in Figure 4, Australian medical graduates on Pathway 3 (AUS) typically undergo a licensing process similar to New Zealand medical graduates (NZMGs). They work under supervision in either Australia or Aotearoa New Zealand for two years after graduation to achieve full registration (MCNZ, 2024e), facilitated by joint MCNZ and AMC accreditation processes. The two supervised internship years are known as Postgraduate Year One (PGY1) and Postgraduate Year Two (PGY2).

Figure 4

Pathway 3: Australian (and New Zealand) Medical Graduates (AUS) (Source: Created by Author)

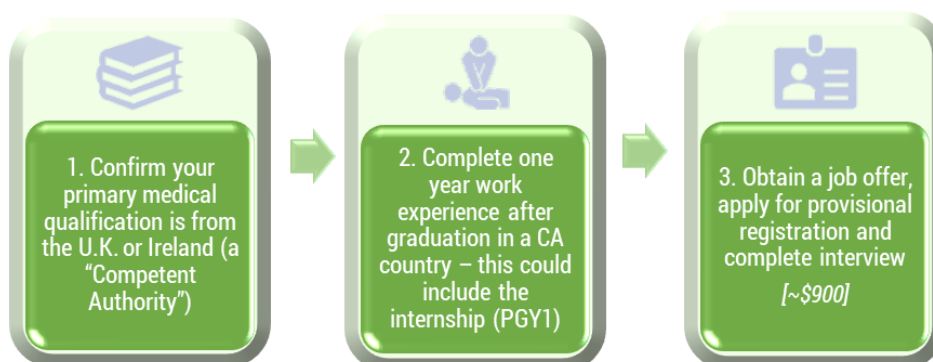


Pathway 4: CA

Pathway 4 (CA) operates in a similar way to the AUS pathway, as shown in Figure 5, but is designated for individuals who trained in the U.K. or Ireland and worked there for at least one year (MCNZ, 2024b). The key requirement of Pathways 3 and 4 is the origin of an IMG's primary medical qualification, with different available options depending on the years of experience the individual brings.

Figure 5

Pathway 4: Competent Authority (CA) (Source: Created by Author)

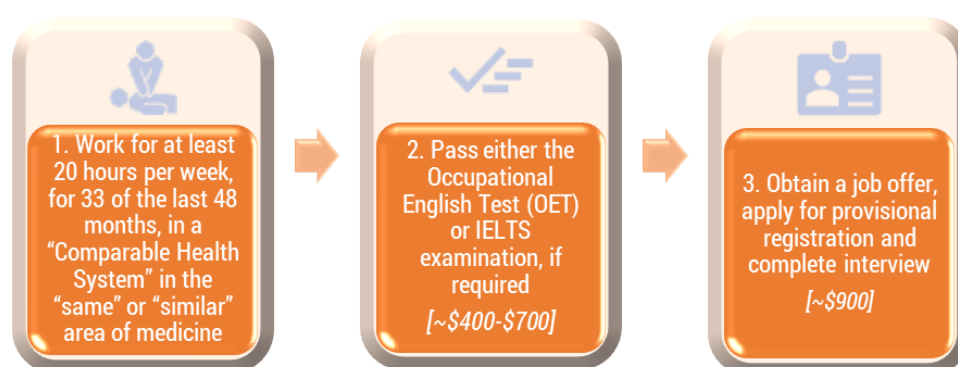


Pathway 5: CHS

In contrast to Pathways 3 and 4, Pathways 5 and 6 relate to the country of clinical experience, rather than country of primary qualification. The fifth pathway (CHS) is designed for IMGs with more extensive experience from a wider range of countries (refer to Figure 6). This pathway requires doctors to demonstrate recent clinical experience in a country deemed to have a “Comparable Health System”, regardless of the country of primary qualification (MCNZ, 2024a). MCNZ determines whether a country is considered as a Comparable Health System based on public health indicators such as life expectancy, mortality rates, the doctor-to-population ratio, the similarity of the registration system, and public health expenditure per capita. The determination of CHS countries is thus largely based on indicators linked to human and economic development and, notably, the 2023 list of accepted CHS countries are all classified as “high-income” by the United Nations (2019, p. 4)⁶. Consequently, doctors trained in low- or middle-income countries in the Global South often follow the final licensing pathway, NZREX.

Figure 6

Pathway 5: Comparable Health System (CHS) (Source: Created by Author)



Pathway 6: GR

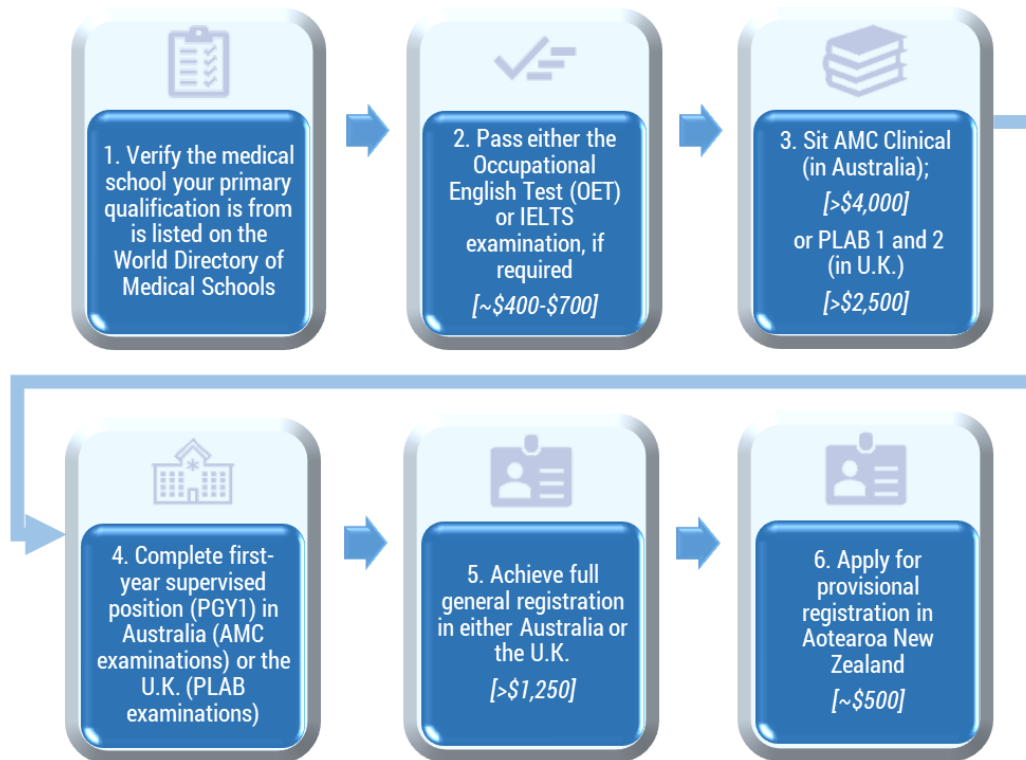
The GR pathway is the newest option and is designed for IMGs who did not initially train in Australia or the U.K. but have since obtained registration and worked for at least one year in either of these countries (refer to Figure 7). Since 2017, IMGs who successfully passed the Australian medical licensing examinations, worked there for at least one year, and obtained full general registration with the Australian Medical Council (AMC) can register under the GR – AUS pathway as junior doctors in their second year of postgraduate training (PGY2) (MCNZ, 2017b). This is the least commonly used pathway, and only 25 IMGs registered in Aotearoa

⁶ As of October 2023, the CHS countries include Australia, Austria, Belgium, Canada, Czech Republic, Denmark, Finland, France, Germany, Greece, Hong Kong, Iceland, Ireland, Israel, Italy, the Netherlands, Norway, Portugal, Singapore, Spain, Sweden, Switzerland, the U.K., and the U.S.A. (MCNZ, 2023a).

New Zealand via this pathway between 2017 and 2023 (MCNZ, 2024g). The GR – U.K. pathway, effective from June 2023, will allow IMGs who complete the U.K.'s Professional and Linguistic Assessments Board (PLAB) Part 2, along with a one-year supervised internship (PGY1) in the U.K., to register and apply for PGY2 in Aotearoa New Zealand (MCNZ, 2023c).

Figure 7

Pathway 6: General Registrants (GR) via Australia (from 2017) or the U.K. (from 2023) (Source: Created by Author)



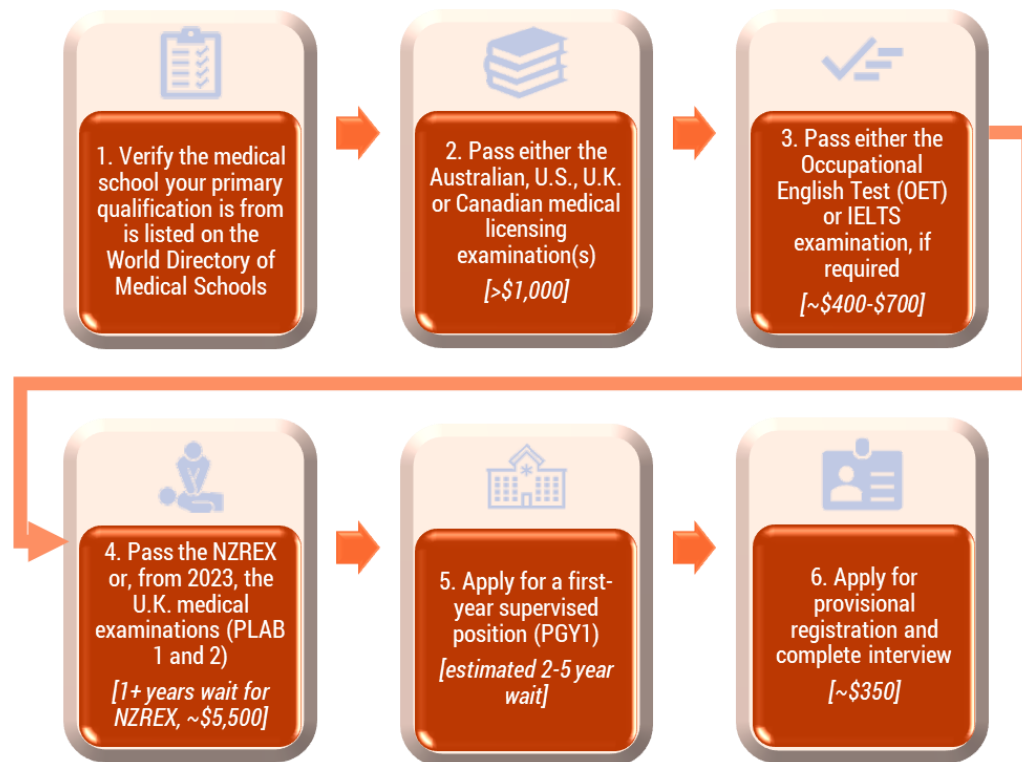
2.3.3 General Registration With Examination

Pathway 7: NZREX

IMGs who are not eligible for Pathways 1-6 follow the NZREX pathway, where they are required to complete additional international medical knowledge examinations, and have their clinical skills assessed in the New Zealand Registration Examination (NZREX). They must then complete two years of supervised work alongside NZMGs to obtain their full licensure (see Figure 8). This is more costly and time-consuming for practitioners compared to the AUS, CA, CHS, and GR general registration pathways (MCNZ, 2024n).

Figure 8

Pathway 7: New Zealand Registration Examination (NZREX) (Source: Created by Author)



The PGY1 Employment Bottleneck

NZREX candidates often encounter challenges in securing first-year supervised House Officer positions (PGY1). PGY1 consists of four three-month long clinical rotations in public hospitals under supervision in Aotearoa New Zealand (Haivas, 2005; Lillis et al., 2012). In contrast to second-year PGY2 positions, which have considerable vacancies, first-year supervised House Officer positions are rarely offered to NZREX candidates because the limited number of PGY1 places roughly corresponds with the medical students graduating from local universities, and NZMGs are given priority⁷.

MCNZ provides publicly available updates on the status of NZREX candidates, which have been used to understand the current state (MCNZ, 2020b, 2022d, 2023d, 2024l). I have compiled these since April 2020⁸ to produce Figure 9, which indicates the number of candidates waiting

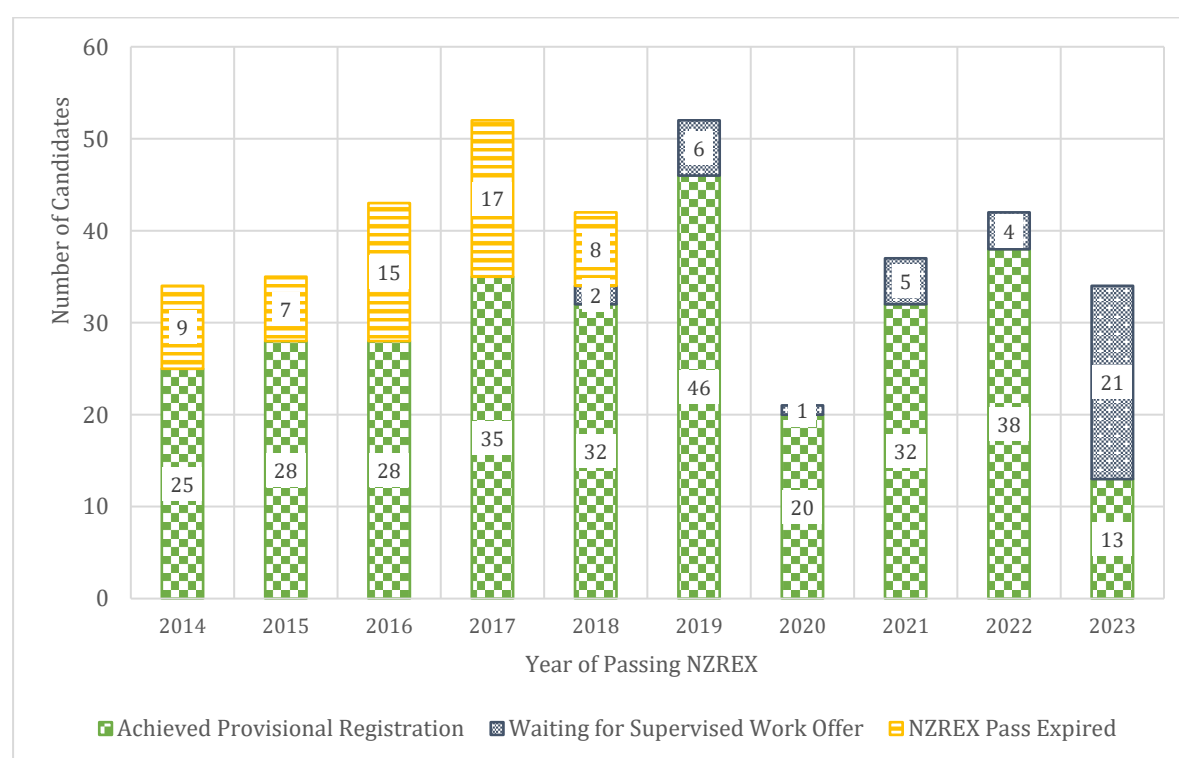
⁷ Official information requests, from all of the hospitals in Aotearoa New Zealand where PGY1 positions are available, revealed that 554 PGY1 hires were made in total in 2021 (data provided by Anjaria, 2022; Ash, 2022; Brown, 2022; Dougan, 2022; Fleming, 2022; Green, 2022; Low, 2022; McCarthy, 2022; McKinnon, 2022; O'Shea, 2022; La Salle, 2022; Saville-Wood, 2022; Schiebli, 2022; Sheffield, 2022; Shepherd, 2022; Sherborne, 2022; Smitheram, 2022; Watson, 2022). By comparison, 561 doctors graduated from New Zealand medical schools in 2020 (Medical Deans Australia and New Zealand, 2021) and were given priority for these positions.

⁸ As MCNZ publishes data online for the past five years only, information on NZREX passes and subsequent registration prior to 2018 are no longer available online. However, these data were saved during the course of this research and incorporated here.

for provisional registration, or with expired passes, from each year. Between March 2014 and September 2023, 392 individuals (of 684 attempts) successfully passed the NZREX examination (57% pass rate). As of October 2023, 297 (76%) of these candidates had obtained provisional registration. This means they were offered a full or partial PGY1 position at one of the public hospitals around Aotearoa New Zealand. NZREX doctors were most likely to find PGY1 positions in the central North Island, Bay of Plenty, and the broader Auckland region (see [Appendix B](#)).

Figure 9

Status of Candidates Who Passed NZREX Between March 2014 and September 2023 (as of October 2023)



As shown in Figure 9, 29% of the cohort who successfully passed the NZREX between March 2014 and June 2018 ($n = 56$) never managed to achieve provisional registration before their NZREX pass expired after five years. Meanwhile, 39 candidates with valid NZREX passes from 2018-2023 were waiting for a PGY1 placement, creating a bottleneck in the process. The average waiting time for those who passed between 2017 and 2021, to obtain a PGY1 placement, was 1 year and 4 months as of October 2023 (MCNZ, 2020b, 2022d, 2023d, 2024l)⁹.

Unlike doctors who become registered on the vocational, AUS, CA, and CHS pathways, with a direct pathway to New Zealand residency (Immigration New Zealand, 2024), NZREX

⁹ Note that MCNZ data on wait times only refer to individuals who have received provisional registration, without reporting on IMGs who are still waiting for a PGY1 position.

candidates do not usually experience any immigration benefits and are unlikely to successfully register without already having the right to work and reside in Aotearoa New Zealand. As a result, many IMGs who already reside in the country and have met (or are striving to meet) MCNZ standards, are unable to work as doctors (Bhamidipati, 2022b; Fenton & Chillag, 2022; RNZ, 2023; Russell, 2021b; Thomas-Maude, 2022, 2023; Thomas-Maude & McLennan, 2022). There is thus a critical bottleneck in the NZREX pathway that does not exist for the AUS, VOC, LOC, CA, CHS and GR licensing pathways.

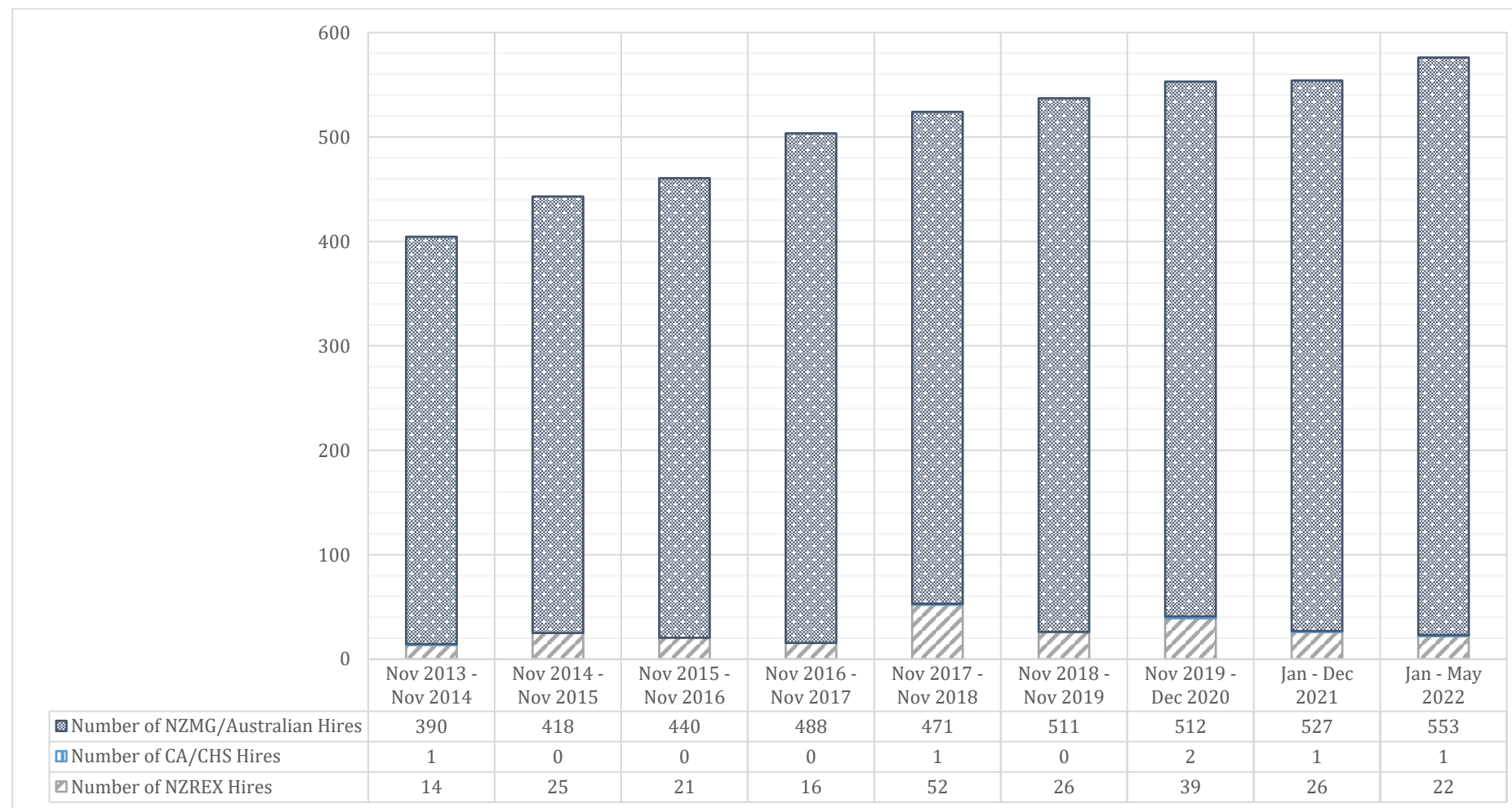
Impact of COVID-19

COVID-19 restrictions exacerbated the difficulties NZREX candidates face in Aotearoa New Zealand. First, COVID-19 presented a serious disadvantage to individuals with a valid NZREX pass, with additional delays in obtaining PGY1 positions during lockdowns putting them at further risk of their pass expiring before they achieved provisional registration. Second, the NZREX examination was previously offered three times annually. However, four examinations were cancelled during COVID-19 (March and June 2020, November 2021, and March 2022), only two took place in 2023, and only two are scheduled for 2024 (MCNZ, 2024n). There is no publicly available information regarding the reduction in examination offerings post-COVID-19, but the effects of these reductions are evident in Figure 9, with lower numbers of successful candidates than previous years. Furthermore, MCNZ no longer keeps a waiting list of applicants. Instead, they open examination offerings for applicants on a specified date, filling the spaces on a first-come, first-served basis. For example, applications for the September 2024 offering of NZREX opened in September 2023 (MCNZ, 2024n).

As there was a waiting list of up to 12 months to take the NZREX examination prior to the pandemic (as discussed in the [Introduction](#)), fewer examination offerings are also likely to have resulted in even longer waiting times. In other words, some of the bottleneck from the limited PGY1 positions has now shifted back to those waiting to take the NZREX examination, for which there is no publicly available data. This may, therefore, constitute what Ching (2018) refers to as a “deliberate bottleneck”, which “is designed to deliberately limit the flow through a system” (p. 51). While a higher proportion of NZREX passes since 2019 have successfully become registered, fewer candidates have been able to take the examination, and more positions have not been made available for NZREX graduates overall. As highlighted in Figure 10, NZREX hires spiked to 52 in 2018 compared to previous years, which saw 16 NZREX hires in 2017, 21 in 2016, 25 in 2015 and 14 in 2014. While this figure fluctuated in subsequent years, with 26 hired in 2019 and 39 in 2020, PGY1 hires fell again in 2021 to 26. Although the total PGY1 position offerings have increased from 404 in 2014, to close to 575 in 2022, this 42% increase in total positions has not been reflected in NZREX hires.

Figure 10

Total PGY1 Annual Hires Across Aotearoa New Zealand Between November 2013 and May 2022



Therefore, in addition to the visible bottleneck of 39 IMGs who passed the NZREX and were waiting for PGY1 positions (as of October 2023), there is also an invisible bottleneck for IMGs waiting to take the examination. With no publicly available information on numbers of NZREX enquiries, and without waiting lists in place, this blockage is not measurable, yet very real for dozens, if not hundreds, of IMGs residing or hoping to reside in Aotearoa New Zealand.

Responding to this issue, MCNZ and other actors, such as Te Whatu Ora | Health New Zealand, have explored some ways to make the NZREX pathway more viable. As illustrated in Figure 8, the PLAB Part 2 clinical examination is now accepted as an alternative to NZREX from June 2023 (MCNZ, 2023c); although it can only be taken in the U.K. (General Medical Council, 2023b), requiring IMGs to travel there. Furthermore, a pilot programme to allow 10 NZREX graduates to complete a significant portion of their PGY1 training in a primary care setting was underway in the Waikato at the time of this research (MCNZ, 2022h, 2023c; Te Whatu Ora | Health New Zealand, 2023). Additionally, a new bridging programme has been completed for a handful of NZREX graduates in Auckland to familiarise themselves with the New Zealand health system prior to applying for PGY1 positions (1 News, 2023; MCNZ, 2022h; Te Whatu Ora | Health New Zealand, 2023). While demonstrating a desire to address the PGY1 bottleneck, these programmes unfortunately “provide only a handful of places to the backlog of overseas doctors” on the NZREX pathway (Cassie, 2022d, para. 2); 61 applications were received for only 10 places in the GP pilot programme (Cassie, 2023a). The impact of these changes on IMGs on the NZREX pathway thus remains uncertain.

In illustrating the process, number of steps, and costs associated with these seven licensing pathways, Figure 2, Figure 3, Figure 4, Figure 5, Figure 6, Figure 7, and Figure 8 also reveal the increased financial and time burden on those unable to register via the AUS or CA pathways. While the CHS pathway consists of multiple steps, most IMGs licensed this way can practise upon arrival in Aotearoa New Zealand. The VOC3 pathway is the most expensive on paper, primarily due to the vocational practice assessment, which costs over NZD\$19,000. However, this assessment is only required on a case-by-case basis after working fulltime for 12 to 18 months in Aotearoa New Zealand and earning a specialist doctor salary (MCNZ, 2024q). Conversely, cost barriers on the NZREX pathway occur before commencing work, totalling around NZD\$10,000 when considering all examination and registration fees. This is notably higher compared to the NZD\$1,000 – \$1,500 for those on other generalist pathways (MCNZ, 2024d), despite doctors on the NZREX pathway often coming from lower-income countries.

Mpofu and Hocking (2013) explain that differential processes, policies, and sociocultural factors contribute to an “occupational apartheid” (p. 132) that negatively impacts doctors from non-English speaking backgrounds in Aotearoa New Zealand. Rather than directly connecting

to the linguistic background of IMGs, this section highlights how medical registration pathways create a more prominent divide between IMGs who trained in the Global North, compared to those who trained in the Global South. Doctors with training and/or a minimum threshold of experience in Global North countries, including Australia, the U.K., Ireland, and 21 other high-income countries listed as Comparable Health Systems – including non-English-speaking countries – are able to register in Aotearoa New Zealand without taking further licensing examinations. They can register, apply for work, and, if necessary, obtain working permits and New Zealand residency before physically entering the country.

In contrast, it is virtually impossible for an NZREX candidate to achieve medical registration without first having the right to work in Aotearoa New Zealand, as Resident Medical Officer visas are only available for PGY2 positions onwards (Immigration New Zealand, 2024; Te Whatu Ora | Health New Zealand, 2024). As noted above (Subsection 2.2.1), some IMGs are able to reside and work in Aotearoa New Zealand due to existing residency or citizenship rights afforded to them by growing up in the country and/or accompanying a family member with a skilled migrant or other kind of residency visa. These are the IMGs who most often find themselves applying for the NZREX pathway after moving to Aotearoa New Zealand. Consequently, medical recruitment agencies often indicate their inability to support NZREX doctors in finding work or obtaining visas (e.g., Jon and Jon Medical Recruitment Consulting, 2024; Medrecruit, 2024; Odyssey Recruitment, 2024; Triple0 Medical Recruitment, 2021). Furthermore, NZREX doctors struggle to obtain PGY1 positions even if they have the required work permits and have met MCNZ's standards by passing the requisite examinations. What looks possible on paper is not viable in practice for many NZREX candidates, and MCNZ and other organisations discussed in Section 2.2 are still seeking ways to improve professional outcomes for these individuals. Therefore, this thesis considers how medical licensing policies translate into the experiences and outcomes of IMGs from Global North and Global South backgrounds, providing insights into both sides of this occupational divide.

2.4 COMPETENT AND COMPARABLE: ANALYSIS OF THE CA AND CHS PATHWAYS

In order to understand the occupational divide occurring between doctors from 24 Global North countries and those who typically trained in the Global South, it is essential to examine how MCNZ determines which countries are accepted on the CA and CHS pathways. This thesis recognises the importance of medical licensing policies in protecting the public with rigorous medical practice standards (MCNZ, 2024c). However, this section explores the specified criteria for the CA and CHS pathways, prompting questions about why certain qualifications

and experiences are considered to support this aim of protecting the public, while others are not.

2.4.1 The Competent Authority (CA) Pathway

MCNZ outlines several criteria to identify a Competent Authority. These include ensuring doctors are fit to practise, confirming that local and international medical graduates meet required standards, regularly reviewing ongoing practice standards, accrediting postgraduate training and qualifications, monitoring first-year medical graduates, and maintaining a publicly available register of all licensed medical doctors (MCNZ, 2024b). Similar broad criteria are common to many regulatory medical councils and boards globally. For instance, India requires compulsory internships to monitor IMGs and recent local graduates (Teri, 2023), and all licensed medical doctors in Peru are listed on a publicly available register (Colegio Médico del Perú, 2024). Systems are in place in the U.S.A. to ensure doctors of all backgrounds are fit to practise (Federation of State Medical Boards, 2024) and ongoing medical practice standards are regularly reviewed and debated in Norway (e.g., Bringedal et al., 2022; Harbitz et al., 2021; Vandvik, 2018).

Nevertheless, only the U.K. and Ireland are recognised as having met these criteria, allowing British and Irish medical school graduates to register to work in Aotearoa New Zealand on the CA pathway (MCNZ, 2024b). In contrast, Australia also has a “Competent Authority” licensing pathway, which recognises individuals who have trained, or registered and practised, in the U.K., Ireland, Canada, the U.S.A., or Aotearoa New Zealand (Medical Board of Australia, 2024). Despite the close relationship between AMC and MCNZ in medical accreditation and regulation (see Subsection 2.2.2), only the U.K. and Ireland are designated as Competent Authorities in Aotearoa New Zealand. Although there may be additional factors influencing this licensing pathway behind the scenes, it is unclear from publicly available information why the U.K. and Ireland are the only recognised Competent Authorities in Aotearoa New Zealand.

2.4.2 The Comparable Health System (CHS) Pathway

The methodology for compiling MCNZ’s (2024a) list of countries with “Comparable Health Systems” also lacks some clarity. The CHS pathway aims to recruit IMGs from countries where the health system and standard of medicine are considered to be “equivalent” (BSI Group New Zealand Limited, 2021, p. 6) and/or “similar” (MCNZ, 2000, p. 10; 2004a, p. 9) to Aotearoa New Zealand. To assess comparability, a combination of public health, practice environment, and medical registration indicators are used.

Many of these indicators directly relate to a country’s level of human and economic development rather than its health system or the competency of its doctors. This implies that

suboptimal health indicators and lower healthcare budgets correlate with poorer medical training and competency. However, it is now widely accepted that health outcomes are heavily influenced by social determinants of health, rather than simply the competency of medical professionals (Adler, 2018; Braveman & Gottlieb, 2014; Hood et al., 2016; WHO, 2024). Moreover, relying on country-level health system indicators overlooks intranational variation in health systems, health outcomes, or medical education. For example, differences in many public health indicators between the states of Kerala and Uttar Pradesh in India are as significant as those between Aotearoa New Zealand and Sub-Saharan Africa (E. Roy, 2021; WHO, 2023). Therefore, it remains unclear how such indicators provide relevant information on the ability of a medical doctor from a particular country to practise competently in Aotearoa New Zealand.

2.4.3 *Analysing Comparability*

Although a comprehensive list of the specific indicators MCNZ employs to determine comparability is not publicly available, I conducted a comparative analysis based on the key indicators mentioned on their website for 23 Comparable Health Systems (CHS) and Aotearoa New Zealand, utilising data from the World Health Organization (WHO) and World Bank (WHO, 2023; World Bank, 2023)¹⁰. MCNZ (2024a) specifies that CHS countries are determined by “public health indicators” such as “life expectancy, mortality and other indicators from the World Health Organization”, along with “practice environment and registration indicators” including “the similarity of the registration system, the percentage of registered medical practitioners per head of population, and per capita total expenditure on health”.

For this analysis, I selected four indicators closely related to those publicly specified by MCNZ (2024a). The WHO has two key measures for “life expectancy” – life expectancy at birth, and life expectancy at age 60. Life expectancy at birth was selected for this analysis, as the more commonly cited measure (e.g., OECD, 2024). WHO (2023) also has a number of measures for adult and child “mortality”, such as the probability of dying between ages 15 and 60, or rates of homicide. Infant mortality rate (deaths per 1,000 live births) was selected due to the availability of more recent data (2021) than many of the other measures. The “percentage of medical practitioners per head of the population” was measured using the equivalent WHO indicator for doctors per 10,000 of the population, while “per capita total expenditure on health” (MCNZ, 2024a) was available in that format from World Bank (2023).

¹⁰ There were no publicly available data for Hong Kong from either the WHO or the World Bank, so Hong Kong could not be included in this analysis. The most current data were used for each indicator, as of October 2023. For doctors per 10,000 this ranged from 2019 to 2021, for life expectancy at birth this was from 2019, and infant mortality rates were from 2021 (WHO, 2023). Health expenditure per capita was from 2020 (World Bank, 2023).

Table 4 summarises the relationship between the health indicators for Aotearoa New Zealand and the 23 CHS countries with data available at the time of writing. For each indicator, I compared the value from that country to the values from Aotearoa New Zealand (WHO, 2023; World Bank, 2023), calculating the percentage difference. Table 4 organises the CHS countries according to the average percentage of absolute difference between the indicators for each country and Aotearoa New Zealand. It is assumed that *higher* values for doctors per 10,000 of the population, life expectancy at birth, and health expenditure per capita would be considered as higher performance in these indicators, while a *lower* infant mortality rate would indicate more favourable performance. According to this assumption, Aotearoa New Zealand tends to perform more poorly overall than other CHS countries in the health indicators specified by MCNZ as determining how Comparable or “similar” (MCNZ, 2000, p. 10; 2004a, p. 9) a health system is. Shading in yellow indicates that a country performs more poorly than Aotearoa New Zealand in a particular indicator, while green indicates higher performance.

The four percentage (“%”) columns refer to the percentage difference between the country’s value and the value for Aotearoa New Zealand, with negative percentages indicating that the country had a lower value than Aotearoa. These are also indicated by light green shading for higher performance and yellow shading for poorer performance. The final column (“Comparative Performance: Average”) refers to the mean of the absolute percentage difference between the indicators for Aotearoa New Zealand and the CHS country. In other words, it is not a reflection of being higher or lower, but rather how similar or comparable the values are in absolute terms. Green shading in the final column is used for those countries with up to 20.0% average absolute difference, while yellow indicates between 20.1% and 40.0% difference, and red indicates an average absolute difference of 40.1% or higher.

Table 4

Comparable Health System Countries According to Key Health Indicators, Compared With Aotearoa New Zealand

Country	Doctors Per 10,000 (2019-2021)			Life Expectancy at Birth (2019)			Infant Mortality Rate (Per 1,000 Live Births, 2021)			Per Capita Total Health Expenditure in USD (2020)			Comparative Performance
	Value	Difference	%	Value	Difference	%	Value	Difference	%	Value	Difference	%	Average
Aotearoa New Zealand	35.16	0.00	0.0%	81.96	0.00	0.0%	3.94	0.00	0.0%	\$4,201.63	\$0.00	0.0%	0.0%
France	33.24	-1.92	-5.5%	82.48	0.52	0.6%	3.45	-0.49	-12.4%	\$4,768.73	\$567.10	13.5%	8.0%
U.K.	31.71	-3.45	-9.8%	81.40	-0.56	-0.7%	3.65	-0.29	-7.4%	\$4,926.63	\$725.00	17.3%	8.8%
Israel	36.54	1.38	3.9%	82.62	0.66	0.8%	2.69	-1.25	-31.7%	\$3,867.40	-\$334.23	-8.0%	11.1%
Netherlands	38.36	3.20	9.1%	81.79	-0.17	-0.2%	3.50	-0.44	-11.2%	\$5,846.15	\$1,644.52	39.1%	14.9%
Canada	24.64	-10.52	-29.9%	82.24	0.28	0.3%	4.43	0.49	12.4%	\$5,619.42	\$1,417.79	33.7%	19.1%
Australia	41.02	5.86	16.7%	83.04	1.08	1.3%	3.16	-0.78	-19.8%	\$5,901.11	\$1,699.48	40.4%	19.6%
Ireland	37.72	2.56	7.3%	81.84	-0.12	-0.1%	2.74	-1.2	-30.5%	\$6,092.18	\$1,890.55	45.0%	20.7%
Italy	41.26	6.10	17.3%	82.97	1.01	1.2%	2.23	-1.71	-43.4%	\$3,057.04	-\$1,144.59	-27.2%	22.3%
Finland	43.25	8.09	23.0%	81.61	-0.35	-0.4%	1.78	-2.16	-54.8%	\$4,726.14	\$524.51	12.5%	22.7%
Iceland	38.91	3.75	10.7%	82.33	0.37	0.5%	2.10	-1.84	-46.7%	\$5,636.94	\$1,435.31	34.2%	22.8%
Germany	45.18	10.02	28.5%	81.72	-0.24	-0.3%	3.03	-0.91	-23.1%	\$5,930.33	\$1,728.70	41.1%	23.3%
Denmark	42.64	7.48	21.3%	81.32	-0.64	-0.8%	3.11	-0.83	-21.1%	\$6,438.39	\$2,236.76	53.2%	24.1%
Spain	45.77	10.61	30.2%	83.22	1.26	1.5%	2.56	-1.38	-35.0%	\$2,900.65	-\$1,300.98	-31.0%	24.4%
Singapore	24.34	-10.82	-30.8%	83.22	1.26	1.5%	1.73	-2.21	-56.1%	\$3,537.00	-\$664.63	-15.8%	26.1%
Belgium	62.57	27.41	78.0%	81.42	-0.54	-0.7%	3.38	-0.56	-14.2%	\$5,009.46	\$807.83	19.2%	28.0%
Austria	54.59	19.43	55.3%	81.65	-0.31	-0.4%	2.99	-0.95	-24.1%	\$5,585.09	\$1,383.46	32.9%	28.2%
Portugal	56.15	20.99	59.7%	81.57	-0.39	-0.5%	2.54	-1.40	-35.5%	\$2,341.64	-\$1,859.99	-44.3%	35.0%
Czech Republic	54.69	19.53	55.5%	79.13	-2.83	-3.5%	2.20	-1.74	-44.2%	\$2,119.85	-\$2,081.78	-49.5%	38.2%
Greece	63.06	27.90	79.4%	81.10	-0.86	-1.0%	3.27	-0.67	-17.0%	\$1,675.12	-\$2,526.51	-60.1%	39.4%
Norway	51.68	16.52	47.0%	82.62	0.66	0.8%	1.77	-2.17	-55.1%	\$7,704.44	\$3,502.81	83.4%	46.6%
Switzerland	44.43	9.27	26.4%	83.45	1.49	1.8%	3.38	-0.56	-14.2%	\$10,309.76	\$6,108.13	145.4%	46.9%
Sweden	70.62	35.46	100.9%	82.40	0.44	0.5%	2.01	-1.93	-49.0%	\$6,027.97	\$1,826.34	43.5%	48.5%
U.S.A.	35.55	0.39	1.1%	78.5	-3.46	-4.2%	5.36	1.42	36.0%	\$11,702.41	\$7,500.78	178.5%	55.0%

The analysis in Table 4 highlights that while life expectancy at birth is very similar across all countries analysed, clear trends indicate that Aotearoa New Zealand underperforms in the other indicators compared to many CHS countries. For instance, Aotearoa New Zealand has fewer doctors per 10,000 of the population than all CHS countries except for Canada, France, Singapore, and the U.K., and a higher infant mortality rate than all countries besides Canada and the U.S.A. Furthermore, Aotearoa New Zealand has a lower health expenditure per capita than 16 of the CHS countries. Sweden, for example, has twice as many doctors per 10,000, half the infant mortality rate, and higher health expenditure per capita, performing more favourably in all four indicators. Similarly, Australia, Iceland, Norway, and Switzerland also surpass Aotearoa New Zealand in all indicators. On the other hand, the U.S.A. performs more poorly in life expectancy at birth and infant mortality rates, despite having more than three times the public health expenditure per capita as Aotearoa New Zealand. Consequently, the U.S.A. is the least similar, with an average of 55% absolute difference. These findings highlight how health systems classified as Comparable actually exhibit significant differences in specified indicators compared to Aotearoa New Zealand. This raises questions about what being Comparable, “equivalent” (BSI Group New Zealand Limited, 2021, p. 6; MCNZ, 1985, p. 10) or “similar” (MCNZ, 2000, p. 10; 2004a, p. 9) means to MCNZ, and what other factors may influence the determination of CHS countries.

To gain further insight into how these indicators may be utilised to determine MCNZ’s list of Comparable Health Systems, I conducted a comparative analysis between Aotearoa New Zealand and 18 non-CHS countries. These countries have been selected because they were referred to in the literature or data collection during this research, and/or because they are on the United Nations (2019) list of “high-income countries” (p. 4) but not on MCNZ’s CHS country list. Table 5 summarises the percentage difference between the indicator value from Aotearoa New Zealand and the specified country, using the same methodology and data sources as in Table 4 (WHO, 2023; World Bank, 2023).

Table 5

Summary of Percentage Difference of 18 Non-CHS Countries to Aotearoa New Zealand's Health Indicators (Using Data From 2019-2021)

Country	Doctors Per 10,000	Life Expectancy at birth	Infant Mortality Rate (Per 1,000 Live Births)	Health Expenditure Per Capita	Average (Absolute Value)
Croatia	-1.4%	-4.1%	-0.5%	-74.0%	20.0%
Chile	-15%	-1%	1.0%	-70%	22.0%
Japan	-25.7%	2.8%	-55.8%	4.4%	22.2%
Korea (Republic of)	-28.7%	1.6%	-37.3%	-37.1%	26.2%
Poland	6.0%	-5.0%	-5.0%	-76.0%	22.8%
Hungary	-6.4%	-6.7%	-16.2%	-72.3%	25.4%
Russian Federation	9.0%	-11.0%	3.0%	-82.0%	26.1%
Slovakia	31.7%	-4.6%	17.5%	-66.8%	30.2%
Saudi Arabia	-20.7%	-9.3%	44.7%	-69.3%	36.0%
China	-32.1%	-5.5%	28.2%	-86.1%	38.0%
Argentina	10.8%	-6.6%	56.1%	-79.4%	38.3%
Uruguay	76.3%	-5.9%	26.9%	-66.0%	43.8%
Cuba	140%	-5.0%	43.0%	-72.0%	64.8%
Brazil	-39.1%	-7.4%	226.9%	-83.3%	89.2%
Egypt	-79.8%	-12.4%	311.9%	-96.4%	125.1%
Fiji	-76.8%	-17.0%	490.4%	-95.6%	170.0%
India	-79.3%	-13.6%	547.0%	-98.7%	184.7%
South Africa	-77.0%	-20.4%	570.8%	-88.3%	189.1%

Table 5 highlights how some countries that are not considered Comparable are, in fact, more similar to Aotearoa New Zealand in terms of absolute percentage difference. For instance, Chile performs lower in each of the indicators, but the overall absolute average difference from the Aotearoa New Zealand health indicators is still 22%, making it more Comparable, in terms of being “equivalent” (BSI Group New Zealand Limited, 2021, p. 6; MCNZ, 1985, p. 10) or “similar” (MCNZ, 2000, p. 10; 2004a, p. 9), than 16 countries on the CHS list. Croatia is the most Comparable on this list, despite having significantly lower public health expenditure per capita.

On the other hand, Japan performs more favourably than Aotearoa New Zealand in every indicator except for doctors per 10,000, although it still performs more highly on this indicator than Canada and Singapore, which are recognised as CHS countries. All the listed CHS countries perform better in at least two of the four areas, which is also the case for Japan, the Republic of Korea, and Poland, although these are not recognised as CHS countries. While Cuba has a lower life expectancy and health expenditure per capita, as well as a higher infant mortality rate, the number of doctors per 10,000 is almost three times as many as Aotearoa New Zealand,

contributing to the significant difference in absolute percentage. MCNZ (2023a) specifies that Argentina, Brazil, Cuba, and South Africa were all recently assessed as “not comparable” (p. 33), but there is no indication as to whether the other countries in Table 5 have been given recent consideration.

2.4.4 What is Being Measured?

The objective of this analysis is not necessarily to assert that some of these countries should be classified as Comparable Health Systems, although this is a point worth considering, especially for those which outperform Aotearoa New Zealand in some areas. Instead, the aim is to illustrate how countries not deemed as Comparable may in fact exhibit greater similarity or equivalence to Aotearoa New Zealand than many current CHS countries in the publicly specified indicators. If the onus for determining comparability is whether a country performs equally or *more* favourably than Aotearoa New Zealand, countries such as Japan would still meet that criterion, surpassing the overall performance of countries such as Canada or the Czech Republic. Therefore, it remains uncertain, from the publicly available data on the CHS licensing pathway structure, how such indicators result in the list of Comparable Health Systems and why some countries have been excluded.

MCNZ (2024a) does mention that the “similarity of the registration system” is part of their criteria for a Comparable Health System, but there are no specified indicators for this or a detailed description of what this would involve in practice. It is thus unclear how the similarity of a registration system such as that of the U.S.A. which, in contrast to Aotearoa New Zealand, requires *all* local medical graduates (MDs) and IMGs to take the same medical licensing examinations before practising (Federation of State Medical Boards, 2024), could mitigate the significant differences between the U.S.A. and Aotearoa New Zealand in the other health system indicators. While an argument could be made for the use of English language in the U.S.A., this is not specified by MCNZ as part of their consideration of CHS countries. Furthermore, this would not explain why only six of the 24 CHS countries speak English as an official language, and why Indian or Pakistani medical graduates, for example, who typically complete all their training in English, would be excluded. Moreover, broader questions emerge from this discussion as to why “similarity of the registration system” (MCNZ, 2024a) would be used to determine the equivalence of an IMG, rather than, for example, similarity of the medical training provided in that country. Lastly, it is unclear how the equivalence of a national health system, with regard to any of the indicators discussed in this section, reflects the equivalence of an IMG’s capability to practise medicine in Aotearoa New Zealand.

In Table 5, I included South Africa as an example of a non-CHS country. Notably, until 2004, doctors from South Africa, along with those the U.K., Ireland, Canada, Australia, and the U.S.A.,

were not required to undergo retraining or additional examinations to secure general medical licensing in Aotearoa New Zealand. Even at the time of writing this thesis, specific South African specialists remain eligible for licensing under the Locum Tenens (LOC) pathway for up to 12 months without examination (MCNZ, 2015b). Despite the acceptance of some South African qualifications, South Africa's health indicators are less comparable than other excluded middle-income countries such as Fiji, India, and Egypt, as well as high-income countries such as Croatia, Japan, the Republic of Korea, and Chile (United Nations, 2019).

What South Africa does have in common with Aotearoa New Zealand, and thus a point of comparability, is the historical classification both nations shared as part of what Barnett (1991a) terms the "Old White Commonwealth" (p. 460). This suggests a link between the evolution of medical licensing and patterns of exclusion and inclusion rooted in colonial times, which policymakers may or may not be aware of. For example, concerns about "enemy" practitioners during World War II led to the exclusion of doctors from countries such as Italy and Japan (Sainsbury, 2015). It is notable, therefore, that Japan remains excluded from the list of Comparable Health Systems at the time of writing, despite outperforming many CHS countries in the health system indicators discussed in this section. Acknowledging this historical relationship, the following section delves into the history of medical licensing policies in Aotearoa New Zealand since 1849, when the country was a colony of the British Empire.

2.5 MEDICAL LICENSING AS A COLONIAL LEGACY

Aotearoa New Zealand, an island nation with a population of over 5.1 million, has a unique historical context shaped by its colonial past. Its establishment dates back to the signing of the Treaty of Waitangi in 1840, a significant agreement between the British Crown and Indigenous Māori leaders (Groot & Van Ommen, 2017). However, it is crucial to recognise the distinction emphasised by Emery-Whittington (2021) between the English version, known as the "Treaty of Waitangi", and the Māori version, referred to as "Te Tiriti o Waitangi" (p. 155). Discrepancies in these translations have had documented impacts on the Indigenous population, including historical failures to uphold the agreement (e.g., Came et al., 2018; Groot & Van Ommen, 2017; Mikaere, 2011; Mutu, 2019; Spoonley & Bedford, 2012; Waitangi Tribunal, 2023). The colonial history of Aotearoa New Zealand is thus marked by recurrent breaches of the Treaty / Te Tiriti by the British Crown and later the New Zealand Government, with far-reaching consequences across the social, political, and migratory spheres (Spoonley & Bedford, 2012).

Migration has been a defining force in shaping the demographic landscape of Aotearoa New Zealand, with distinct "waves" throughout history (Callister et al., 2011, p. 205). The first wave

involved settlers from the broader Pacific region around 1,000 years ago, who became the ancestors of the Indigenous Māori population. Subsequent waves, especially in the colonial context of the mid-19th century, saw European migration becoming dominant by the mid-1880s. Despite some exceptions, migration policies until the early 1970s were inclined towards British and other European migrants (Kumar, 2021), with limitations on migration from Asia (Facchini & Lodigiani, 2014).

In the 1960s and early 1970s, new policies encouraging migration from the Pacific islands led to a surge in Pacific migrants, while Asian migration saw a significant increase in the 1980s and 1990s with the liberalisation of immigration policies and a focus on skilled migrants (Bedford et al., 2001; Kumar, 2021; Selvarajah, 2004). The introduction of a points-based immigration system in the early 1990s, still in effect at the time of writing, evaluates migrants based on skills without necessarily requiring an offer of employment (Kumar, 2021). This system assigns different points for skills and qualifications until a prospective migrant reaches the threshold for a highly-skilled migrant visa (Facchini & Lodigiani, 2014). Finally, the most recent “wave” of migration involves refugees and migrants from the Middle East and Africa (Callister et al., 2011, p. 205). Spoonley and Bedford (2012) characterise these contemporary waves of migration as the “final abandonment of the ‘white’ New Zealand immigration policy” (p. 11). Over a quarter of the 2023 population (27%) was born overseas (EHINZ, 2023), making Aotearoa New Zealand a “multicultural” (Kumar, 2021), “superdiverse” society (Cameron & Poot, 2019; Spoonley & Bedford, 2012).

However, not all migrants have a comparable experience. Hahn (2017) and Hazou (2017) describe the heightened sense of precariousness among former refugees or asylum-seekers who have settled in Aotearoa New Zealand but continue to encounter barriers to socioeconomic and cultural inclusion. Hahn’s (2017) research, drawing on an interview with a former refugee from South Sudan, underscores how labels such as “refugee” can inadvertently perpetuate distancing from other groups and limit the opportunity for these individuals to define themselves not by the unfortunate circumstances that brought them to Aotearoa New Zealand, but as “just another person” (p. 232). Similarly, Slade’s (2019) research with former refugees in Aotearoa New Zealand describes how many individuals given this label reject the term because of inaccurate assumptions around being “helpless victims, potentially unskilled and uneducated” (p. 193). Simon-Kumar (2015) also stresses the significance of classifying migrants as “desirable” or “undesirable” (p. 1174), within the context of a neoliberal agenda that favours individuals with specific skillsets and experiences deemed “highly-skilled” and beneficial to the country in a primarily economic sense (Carey, 2019).

Throughout Aotearoa New Zealand's historical "waves" of migration (Callister et al., 2011, p. 205), policies have consistently labelled and classified different groups based on prevailing ideologies of the time. This includes direct or indirect prioritisation of those of European descent and a preference for migrants who can contribute most to a neoliberal labour market, often overlooking other forms of skilled work with a less consumerist focus (Simon-Kumar, 2015). As discussed in the following subsection, the colonial tendency to favour certain migrants, particularly those with a European or "Western" (Barnett, 1991a) background, can be seen throughout Aotearoa New Zealand's medical licensing history, and continues to persist.

2.5.1 A Timeline of Medical Licensing History

Contemporary medical licensing pathways have clear links to the nation's colonial history. As the first medical school in Aotearoa New Zealand was not established until the late 19th century, all licensed medical doctors in Aotearoa New Zealand were technically IMGs for at least half a century. However, these individuals were not considered to be foreign practitioners, due to the relationship between Great Britain and the colony of New Zealand during that period. The first Medical Practitioners Act of 1849¹¹ defined a "medical practitioner" as someone recognised by a College of Physicians or Surgeons in Great Britain or Ireland, or those who had served as medical officers in the British armed forces ("Medical Practitioners Act," 1849). Other early medical licensing policies also privileged British and Irish medical practitioners over other IMGs ("Medical Board Ordinance," 1854; "Medical Practitioners' Act," 1867; "Medical Practitioners' Registration Act," 1869; "Medical Practitioners Act," 1849), reflecting colonial ties with Great Britain (Wright-St Clair, 1985). The Competent Authority (CA) licensing pathway, which is exclusively available to British and Irish medical school graduates, may thus be influenced by colonial legacies. The historical evolution of medical registration in Aotearoa New Zealand forms the foundation for the intricate relationship between current medical licensing policies distinguishing between IMGs based on country of origin, and the institutional actors involved.

Figure 11 offers an overview of medical licensing policies since Aotearoa New Zealand became a British colony in 1840, organised to reflect their correspondence with current processes. The delineation between primary medical qualifications and postgraduate specialist qualifications was not clearly established until 1971. For instance, members of a recognised British College of Surgeons in the 19th and early 20th century might now be viewed as specialists, even though

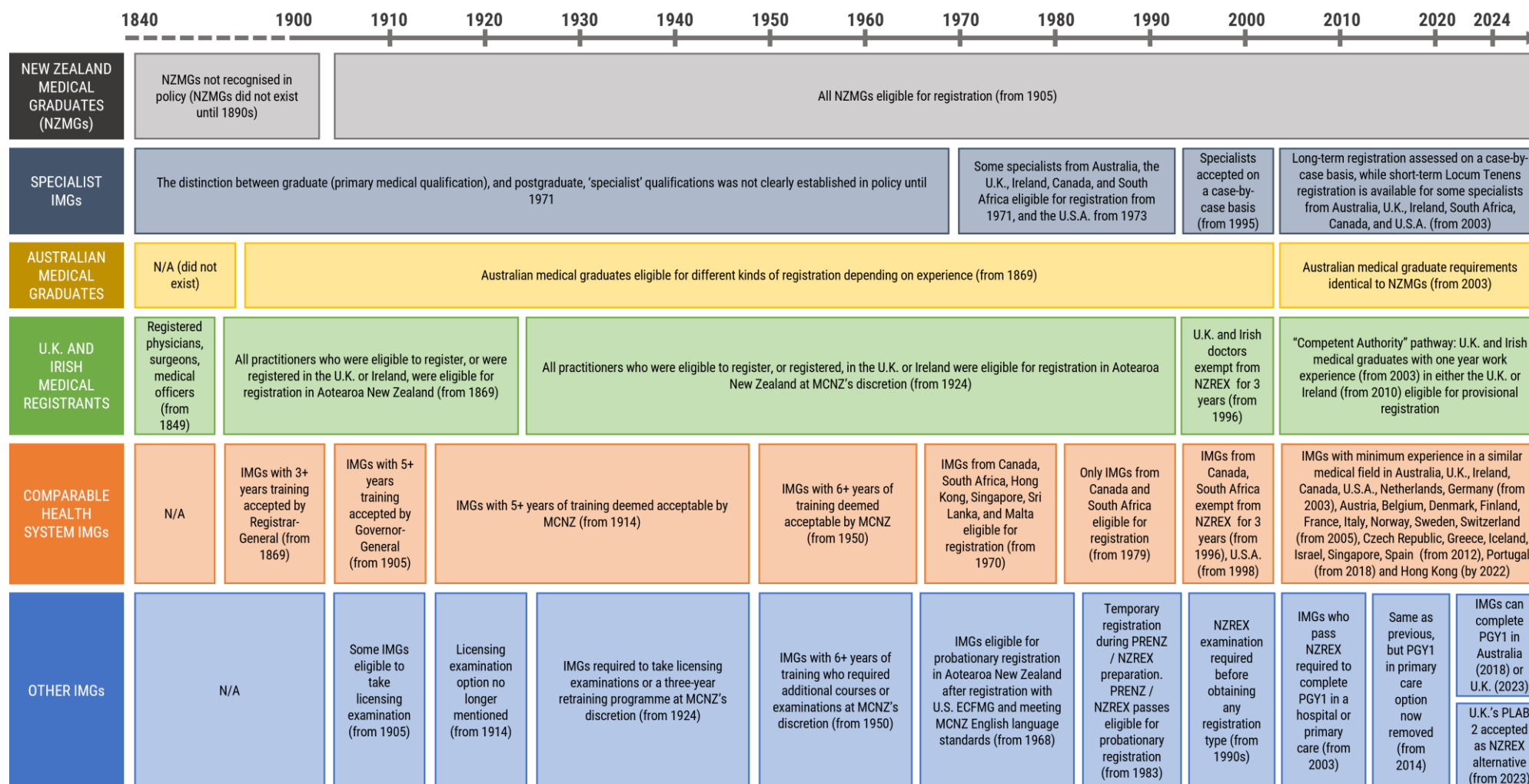
¹¹ After the signing of the Treaty of Waitangi in 1840, the national parliament was established in 1854 (Wright-St Clair, 1985). Between 1840 and 1854, some areas of New Zealand were cogoverned with what are now states of Australia, as the nation of New Zealand did not yet exist in an administrative sense. For example, the Province of New Munster, where this first Act was passed in 1849, was made up of parts of the South and North Islands as well as much of what is now known as New South Wales in Australia.

no such distinction was outlined in policy at that time. Those who would now be classified as specialists registered through the available pathways applicable to them during their respective time periods.

The historical trajectory of medical licensing policies, outlined in Figure 11 and the accompanying timeline (see [Appendix A](#)), reveals a consistent pattern of privileging certain groups over others. The earliest policies in the mid-19th century explicitly favoured physicians and surgeons recognised by British institutions, setting the stage for ongoing distinctions.

Figure 11

Historical Overview of Key Policies Indicating who was Eligible For Medical Licensing in Aotearoa New Zealand Since 1849 (Source: Created by Author)



2.5.2 *The Colonial Era*

In 1867, the consolidation of prior Acts and Ordinances occurred with the enactment of the first overarching national policy on medical registration (“Medical Practitioners’ Act,” 1867). This Act mandated the creation of Aotearoa New Zealand’s first Medical Board and the publication of a public register of accepted practitioners in the *Gazette* newspaper. Legally qualified practitioners from the U.K. and Ireland were entitled to automatic registration, while all other applicants were required to demonstrate completion of a medical qualification with at least three years of training for assessment by the Medical Board. However, in 1869, the 1867 Act was repealed and replaced with a new Act following Parliament’s relocation from Auckland to Wellington (Sainsbury, 2015). The most notable change was the appointment of the Registrar-General (from Births, Deaths, and Marriages) to be responsible for registering all licensed medical practitioners, removing the need for a Medical Board (“Medical Practitioners’ Registration Act,” 1869).

The late 19th and early 20th centuries witnessed ongoing tension regarding the concept of a Medical Board or Medical Council, with several unsuccessful attempts to create such a governing body. Before the 1867 Act, the first formal, national Bill was presented to the New Zealand Government in 1860 to regulate the recognition of medical practitioners under the oversight of a national “Medical Board”, though it did not receive parliamentary approval (Sainsbury, 2015). After the 1867 Act was repealed, a subsequent unsuccessful Bill was proposed in 1889 (“Medical Practitioners Bill,” 1889) that advocated for the formation of a “General Council of Medical Education and Registration of New Zealand” (p. 3) to oversee the registration of medical practitioners. One objection to the Bill concerned fears that the proposed Council would only serve the interests of an elite class of registered doctors, “for the purpose of giving them greater monopoly” (Ayres, 1889, p. 2). Later, another Bill in 1910 proposed the establishment of a Medical Board to shift regulatory power away from colonial authorities, yet it too was not passed in Parliament (“Medical Practitioners Bill,” 1910). It was only with the onset of World War I that an Act was finally enacted to establish a new medical Board, later known as the Medical Council of New Zealand (“Medical Practitioners Amendment,” 1924). MCNZ’s¹² inaugural meeting occurred in March 1915 (Sainsbury, 2015).

In 1905, graduates from the University of Otago Medical School, which had its first graduate in 1887 (Sainsbury, 2015), were listed as automatically eligible for registration (“Medical Practitioners Registration Act,” 1905). As outlined in Table 6, the Medical Practitioners Act 1905 shares significant parallels with contemporary medical licensing pathways, with

¹² Although MCNZ was called the “Medical Board” until 1924, it is referred to as MCNZ in this thesis for simplicity.

automatic recognition of NZMGs, and U.K. and Irish graduates and registrants. This also extended to Australian medical graduates who, under colonial rule, were eligible for British medical licensing. The policy further included a prepared list of overseas qualifications and experience deemed “equal in status to that of New Zealand” (p. 198) by the Governor General, bearing clear similarities to the present-day notion of Comparable Health Systems and the CHS licensing pathway. For IMGs not meeting these criteria, the option was available to take an examination at the University of Otago medical school, representing the earliest iteration of the concept of the NZREX medical licensing examination.

Table 6

Comparison of General Registration Pathways in 1905 and 2023

Pathway	1905 (“Medical Practitioners Registration Act,” 1905)	2023 (MCNZ, 2023g)
NZMGs	✓ NZMGs automatically eligible for registration	✓ NZMGs automatically eligible for registration
AUS / GR	✓ Australian medical graduates automatically eligible for registration (because they were eligible for British registration)	✓ Australian medical graduates automatically eligible for registration ✓ IMGs with general registration in Australia eligible for the AUS GR pathway
CA / GR	✓ All practitioners registered or eligible to register in the U.K. or Ireland were entitled to registration	✓ Doctors with a primary medical degree from the U.K. or Ireland, and one year of general medical experience in that country, are eligible for registration under the CA pathway ✓ IMGs with general registration in the U.K. are eligible for the U.K. GR pathway
CHS	✓ Governor in Council (now known as the Governor General) prepared a list of foreign qualifications he considered to be “equal in status to that of New Zealand” (p. 198), and such IMGs were eligible for registration	✓ IMGs are eligible for registration if they have worked 20 hours per week (for a minimum of 33 months within the past 48 months) in country MCNZ designates as a Comparable Health System
NZREX	✓ IMGs whose qualifications were not deemed “equal in status” could apply for registration after completing the final examination at the University of Otago medical school	✓ To be eligible for registration via PGY1, IMGs must pass an approved medical knowledge examination and complete the New Zealand Registration Examination (NZREX) or the U.K.’s PLAB 2 clinical skills examination

With the formation of the MCNZ from 1914, the option for IMGs without approved qualifications to take a medical examination was not explicitly mentioned in policy. In 1915, a Canadian doctor was denied registration due to the absence of “reciprocity with New Zealand without further examination”, suggesting that the option to take “further examination” was not

available at this time (Sainsbury, 2015, p. 27). Nonetheless, this was reinstated in 1924, along with a three-year retraining programme. In the 1930s, the introduction of Annual Practising Certificates (APCs), which required doctors to pay a fee to MCNZ, faced resistance from the medical community at the time (Sainsbury, 2015) but remains a current requirement.

Alongside the establishment of stringent medical licensing processes for IMGs who did not train in countries considered “equal in status” (“Medical Practitioners Registration Act,” 1905), the early 20th century saw the introduction of policies that sought to outlaw traditional Māori healing practices, or Rongoā Māori. Traditional practices were seen as “unsafe and an impediment to Māori progress by the medical fraternity” (“Demystifying Rongoā Māori: Traditional Māori healing,” 2008, p. 33). The Tohunga Suppression Act 1907 forbid these practices in favour of the Western biomedical model (Norris & Beresford, 2024), and was further enforced by the Quackery Prevention Act 1908 that sought to suppress other alternative healing practices that were common at the time. These policies are believed to have had devastating effects on Māori, associated with the colonial suppression and domination of culture and language, and ongoing health inequities for Māori (Kapa, 2022).

2.5.3 An Influx of IMGs

The next significant development in medical registration occurred with the enactment of the Medical Practitioners Act 1950, which introduced the concept of “conditional registration” (now known as *provisional registration*). As a prerequisite to obtaining full registration, conditionally registered doctors were required to work at an approved hospital or institution for a duration specified by the Minister for Health (Sainsbury, 2015). This essentially constituted a compulsory internship, akin to an early iteration of PGY1.

Apart from this change, licensing pathways remained nearly identical to earlier policies. Doctors eligible for registration in the U.K. or Ireland, including Australian medical graduates, were considered eligible to practise in Aotearoa New Zealand, although they could be refused at MCNZ’s discretion. Graduates with diplomas from other foreign universities approved by MCNZ required a minimum of six years’ study and, at MCNZ’s discretion, were required to take further courses or examinations in Aotearoa New Zealand, or may have simply been refused (“Medical Practitioners Act,” 1950).

Medical services in Aotearoa New Zealand were said to be in a “state of crisis” by the beginning of the 1970s (“Medical services in “state of crisis,” 1970), prompting changes that allowed more than 200 IMGs per year to enter the country and work (“Medical Practitioners Act,” 1968; New Zealand Medical Journal, 1970a). As a result, IMGs became instrumental in the local medical landscape, with a notable surge in the 1960s and 1970s, particularly from the U.K.,

Ireland, Canada, Sri Lanka, and South Africa (Barnett, 1991a). The impact of this influx was predominantly redistributive, with IMGs tending to work in geographical areas avoided by local medical graduates (Barnett, 1988).

By 1980, IMGs constituted 33% of the medical workforce, triggering concerns about an oversupply of doctors (“Call to restrict influx of doctors,” 1979). The contentious decision was made to reduce medical school admissions in Aotearoa New Zealand by a quarter (“Cuts in medical student intakes recommended,” 1979; “Medical training cuts ‘crazy’,” 1979) and, alongside this, immigration applications from doctors required approval from the Department of Health before a visa was granted (The Management Services and Research Unit, 1982). This shift reflected a move from actively encouraging medical migration to address local workforce shortages, to restricting the inflow of IMGs, echoing policy changes in Canada, the U.K., and the U.S.A. in the 1970s (Barnett, 1991a).

Despite these fears of a surplus, however, workforce shortages were prevalent in rural and under-privileged areas (Barnett, 1987, 1991b; “Call to restrict influx of doctors,” 1979). In 1976, Aotearoa New Zealand had a lower ratio of medical practitioners (130 per 100,000) than Canada, Denmark, Finland, France, Germany, Netherlands, Norway, Sweden, Switzerland, the U.K., the U.S.A., and Australia (The Management Services and Research Unit, 1982). As discussed above (Subsection 2.4.3), Aotearoa New Zealand continues to have fewer doctors per capita than most of these countries – which are all classified as Comparable Health Systems – at the time of writing.

2.5.4 *The Origins of NZREX*

Despite the low ratio of doctors to population, apprehensions about an oversupply of IMGs prompted the introduction of new policies in the 1980s, marking a more explicit distinction between IMGs based on their country of origin. Graduates from the “Old White Commonwealth” (Barnett, 1991a, p. 460) – the U.K., Ireland, Australia, Canada, and South Africa – were automatically eligible for general medical registration. In contrast, IMGs from other countries received a two-year temporary registration and had three opportunities to pass a registration examination to continue practising in Aotearoa New Zealand. The first of these examinations was the Probationary Registration Examination in New Zealand (PRENZ), encompassing an English language competence assessment, a written medical knowledge examination, and a clinical skills examination (MCNZ, 1983). Between 1984 and 1988, the most frequently represented countries of primary medical qualification for IMGs taking the PRENZ were India, (West) Germany, and Fiji (MCNZ, 1988). It is interesting to note how many unsuccessful candidates in the 1980s were from countries now deemed to have Comparable

Health Systems (Germany, France, Singapore, and Switzerland; 27 unsuccessful attempts in total)¹³.

PRENZ was phased out by 1989 and replaced by the New Zealand Registration Examination (NZREX). This required IMGs who trained outside of the Old White Commonwealth¹⁴ to take a screening examination of medical knowledge and English language abilities before being granted a two-year temporary registration. The key difference was that temporary registration was only granted *after* passing the first two components, marking a shift towards more stringent policies. Additionally, a clinical examination similar to the current NZREX was required to progress from “temporary” to “probationary” registration (MCNZ, 1989). The NZREX thus originally consisted of several parts.

By 1997, however, the initial NZREX screening examinations were phased out and replaced by the United States Medical Licensing Examinations (USMLE). From the late 1990s, only the NZREX clinical skills examination was administered in Aotearoa New Zealand (MCNZ, 1996a, 1997), as is still the case with NZREX at the time of writing this thesis. From 2006, the Australian Medical Council (AMC) MCQ medical knowledge examination was also included as an alternative to USMLE (MCNZ, 2006a), with recognition of the U.K. PLAB Part 1 examination added from 2009 (MCNZ, 2009a), and the Canadian medical knowledge examination (MCCEE Part I) from 2018 (MCNZ, 2018a).

Challenges were identified early on with both PRENZ and NZREX. Candidates faced difficulties accessing the necessary exposure to the local medical system, resulting in low pass rates (MCNZ, 1984). The purpose of these examinations, both then and at the time of writing, is to verify that candidates are “equivalent” to NZMGs (MCNZ, 1994, p. 23; Selvarajah, 2004, p. 60). Nevertheless, Selvarajah (2004) points out that IMGs on the early NZREX pathway had to take 13 examination papers, compared to six for final-year New Zealand medical students. They were also denied clinical experience in Aotearoa New Zealand and lacked access to medical library resources (particularly crucial before the age of the internet), student loans, or government-subsidised fees. MCNZ thus explored opportunities for “refugees and other immigrants to obtain some experience in New Zealand medicine” (MCNZ, 1986, p. 6),

¹³ Of the 128 total attempts at the PRENZ between 1984 and 1988, 47 were from India (of which 10 candidates passed), 21 were from (West) Germany (of which 5 passed) and 11 were from Fiji (of which 2 passed). Both of the 2 candidates from The Netherlands passed, while 1 candidate each from Egypt (of 3), Pakistan (of 3), Philippines (of 3), Romania (of 2), Sri Lanka (of 8), Taiwan (of 1), and Vietnam (of 1) passed respectively. None of the attempts were successful for candidates from Albania (of 2), Cambodia (of 1), China (of 1), France (of 2), Iran (of 1), Japan (of 1), Nigeria (of 1), Papua New Guinea (of 6), Peru (of 4), Poland (of 1), Singapore (of 2), Switzerland (of 2) or Zambia (of 3).

¹⁴ Some specialist IMGs from the U.S.A. were also accepted to practise – the registration examinations only applied for general registrants or those whose specialist qualifications were not recognised.

encouraging hospitals to offer clinical attachments and observerships. Despite these efforts, only 52% of candidates (2045 of 3907) passed the clinical component of PRENZ and the NZREX between 1984 and 2023. The average annual pass rate was 58% (see [Appendix C](#)).

A noticeable increase in total attempts and successful passes occurred when NZREX became briefly compulsory for all IMGs seeking general registration, except for Australian medical graduates, including those from the Old White Commonwealth, in July 1996. This came in spite of proposals in the late 1980s to exempt IMGs of “Western origin” from taking these examinations, which Barnett (1991a) felt had a “political rather than a theoretical basis” (p. 462). Nevertheless, when NZREX became compulsory for all non-Australian IMGs, hospitals became concerned that this would result in staffing shortages, particularly in rural areas. MCNZ initially responded to these apprehensions in 1996, stating that “the requirement to sit NZREX reflects international trends of providing a level playing field for all doctors and medical graduates and gives no preference to overseas doctors from any country” (Aggett, 1997, para. 10). However, MCNZ then announced a new exemption for doctors from the same five Commonwealth countries, making them eligible for temporary registration of up to three years (MCNZ, 1996a), with the U.S.A. included in this group from 1998 (MCNZ, 1998b).

During this time, registration data shows that most IMGs from the U.K., Canada, Ireland, South Africa, and the U.S.A. took advantage of this exemption from NZREX. For example, in 1999, there were 254 temporary registrants from the U.K., compared to just six taking the NZREX examination (MCNZ, 2000). Despite these changes, the number of IMG registrations still decreased in the late-1990s (MCNZ, 1999), suggesting that the examination added an obstacle to permanent registration and acted as a deterrent for doctors from countries now considered Comparable. From 2004, however, this exemption from NZREX was formalised for IMGs from Competent Authorities and Comparable Health Systems, with the introduction of the CA and CHS pathways (MCNZ, 2004c).

The NZREX pass rate was also lower on average prior to September 2005, when “standard setting was by expert opinion with no psychometric data to inform the process” (Lillis et al., 2012, p. 75), and there was limited coordination between the different disciplines of medicine that were being examined in the NZREX. The reconfigured NZREX Clinical examination, which has maintained the same format, consists of a 16-station Objective Structured Clinical Examination (OSCE). Each specified domain of medicine (cardiovascular, respiratory, neurological, gastroenterology, genitourinary, musculoskeletal, pregnancy, endocrine/metabolic, haematological, oncological, behavioural and senses) is tested in at least one of the 16 stations, while several core competencies are assessed – history taking, clinical examination, clinical investigation, management, and clinical reasoning. Three or four of the

stations are considered “static” and are paper-based, while the others are all “dynamic” and involve a simulated patient encounter. The majority of these simulations are with paid actors, although sometimes “real”, stable patients are involved too (Lillis et al., 2012). The examination was held four to five times per year until 2012, for up to 28 candidates at a time. After this time, offerings were reduced to three per year, and reduced even further since 2020 and the COVID-19 pandemic. As the time of writing, NZREX examinations are only being held twice annually (MCNZ, 2023e, 2024n).

The historical evolution of MCNZ’s licensing policies reflects a responsiveness to the shifting workforce demands in Aotearoa New Zealand, while maintaining certain characterisations and distinctions of IMGs from different backgrounds. Stringency increased in the 1970s and 1980s amid concerns about an excessive influx of IMGs, with exceptions made for doctors who trained in the “Old White Commonwealth” (Barnett, 1991a, p. 460). Subsequently, in response to predicted workforce shortages, exceptions to government requirements for all IMGs to take the NZREX in the late 1990s (“The Medical Practitioners Act,” 1995) privileged IMGs from the same five Commonwealth countries (MCNZ, 1996a).

This historical overview of medical licensing policies thus reveals distinctions between IMGs based on country of training that echo colonial ideologies, with clear similarities in the ways IMGs were grouped and classified on licensing pathways historically and at the time of writing. Such an ostensible link to colonial policies is problematic because the assumptions and ideologies that shaped imperial policymakers significantly differ from those accepted in the 21st century. Colonial administration favoured “desirable” European migrants while discouraging migration from backgrounds deemed “undesirable” (Simon-Kumar, 2015, p. 1174). Despite officially inclusive policies, “social antipathy towards the in-migration of non-European populations” (Simon-Kumar, 2015, p. 1173) remains prevalent (Groot & Van Ommen, 2017; Spoonley, 2017; Spoonley & Bedford, 2012). Policies that distinguish between IMGs based on the development status of their country of training create an “occupational apartheid” (Mpofu & Hocking, 2013, p. 132) between doctors from the Global North and Global South. This divide mirrors the dynamics observed in broader migration literature and hints at persistent colonial legacies at the systemic level.

2.6 CONCLUSION

In contextualising the medical registration experiences of IMGs in Aotearoa New Zealand, this chapter has navigated the complex web of historical and current licensing policies, institutions, and pathways. By delineating the differential registration procedures and criteria for IMGs, which depend on whether they trained in the Global North or the Global South, the chapter

brings attention to the ways that medical licensing policies distinguish between doctors from a subset of high-income countries, and the rest of the world.

Moreover, this discussion of medical licensing in Aotearoa New Zealand prompts reflection on the underlying rationale behind policies that impede some individuals from practising medicine in Aotearoa New Zealand. These barriers are based on the socioeconomic development indicators of the country in which they received their training, rather than a comprehensive evaluation of the quality of their medical education, or individual merit. Consequently, the chapter underscores the potential connection of these exclusions to colonial legacies in migration and medical licensing policies, reinforcing disparities between migrants from different backgrounds.

The contemporary experiences of IMGs are inseparable from this policy and institutional context. It has thus been imperative to explore how these historical trends continue to shape the landscape of medical licensing in Aotearoa New Zealand. These insights illuminate the broader implications for the current and future healthcare workforce, as discussed in [Chapter 3](#). Furthermore, this analysis underscores the need for a theoretical framework that considers how migrant encounters with barriers and enablers to professional success are interlinked with broader historical and contemporary structures of power, as developed in [Chapter 4](#).

3 COMING AND GOING: MEDICAL MIGRATION PATTERNS AND OTHERING IN AOTEAROA NEW ZEALAND

3.1 INTRODUCTION

In order to make sense of IMG experiences in Aotearoa New Zealand, this chapter discusses existing literature relating to international medical migration. First, I examine the key phenomena of *brain drain*, *gain*, and *waste*, highlighting the intricate dynamics of the global movement of medical professionals. Second, the chapter considers how these concepts apply to the historical and contemporary medical workforce of Aotearoa New Zealand. Finally, the chapter explores current understandings of the experiences of IMGs in the context of Othering processes, and factors relating to identity, communication, and culture. While the primary focus is on local literature, international examples enrich the discussion, underlining the relevance of this research to broader global discourse on migrating doctors.

Overall, the chapter identifies a literature gap in comprehensively exploring the experiences and outcomes of IMGs from diverse backgrounds in Aotearoa New Zealand within the geopolitical, historical, and sociocultural dynamics outlined in the preceding chapter. While broader discourse on medical migration has delved into workforce dynamics and concepts of brain drain, gain, waste, and circulation, a gap exists in understanding the unique experiences of IMGs in their pursuit of professional registration and integration (e.g., Bourgeault & Neiterman, 2013; Wong & Lohfeld, 2008). In later chapters, this thesis endeavours to address the identified gap by presenting a nuanced examination of IMG experiences in Aotearoa New Zealand. These experiences offer a snapshot into a broader global picture, emphasising the interconnectedness of medical professionals and healthcare systems worldwide.

3.2 MIGRATION AND MEDICINE: “MODERN MEDICINE IS GLOBAL”¹⁵

The experiences of IMGs in Aotearoa New Zealand are situated within the broader context of global medical migration, reflecting a historical pattern where medical doctors have crossed borders in search of additional training and experiences (Hsu, 2012; Johnson, 2005; McKimm & Wilkinson, 2015). Historical practices saw renowned physicians in Renaissance Europe hired by the elite classes and travelling extensively to attend to their needs (Park, 2014). In some parts of Africa, precolonial healers were believed to possess enhanced efficacy if they had

¹⁵ (McKimm & Wilkinson, 2015, p. 837)

travelled from distant locations, reflecting the truism that “mobility is power”, in relation to healing (Dilger et al., 2012, p. 1).

The interplay between medical practitioners, knowledge, and mobility has been integral to medicine across various cultures and traditions, evolving amidst shifting borders, conquests, and migratory patterns throughout history (Beladi et al., 2015; Connelly & Künzel, 2018; Helble, 2011). The twofold mobilities of those offering healthcare services, and those seeking healthcare, represent a key dynamic of the nature of medicine and healing across a range of cultures and medical traditions. Tucker (2003) contends that “all medical traditions have grown out of particular cultures and have been altered by the medical traditions of other cultures” (p. 376), with the mobility of doctors, knowledge, and patients forming a cornerstone of medicine.

The mobility of doctors in contemporary times predominantly occurs from less developed to more developed countries. This trend, while reflecting the globalisation of healthcare, raises ethical concerns regarding the accessibility and provision of global healthcare (Ahmad, 2005; Driouchi, 2014; Ferracioli & De Lora, 2015; Gaillard & Gaillard, 1997; Gaillard et al., 2015; Serour, 2009; Yeates & Pillinger, 2018). Scholars argue that this migration pattern, where “poorer countries have become a major supplier of health workers for the richer countries” (Driouchi, 2014, p. 295), contributes to the depletion of healthcare resources in source countries, leading to workforce shortages. For instance, Australia and Aotearoa New Zealand have witnessed an influx of health professionals from Pacific Island countries, exacerbating shortages in the Pacific region (Connell, 2014; Craig et al., 2022; Negin, 2008; Oman et al., 2006).

This phenomenon is often referred to as *brain drain*, a term used to describe migratory patterns where there is a net outflow of highly skilled professionals. As brain drain was highly stigmatised in the 20th century (e.g., Gaillard & Gaillard, 1997; Perkins, 1966; Watanabe, 1969), this prompted a WHO investigation into the migration of medical doctors and nurses from less prosperous to wealthier nations (Mej'ia et al., 1979). While there was a literature gap during the 1980s and early 1990s (Astor et al., 2005), renewed interest emerged in the late 1990s due to shifts in migratory patterns and evolving global policies associated with technological advancements and geopolitical changes (Gaillard & Gaillard, 1997). This renewed interest has fostered a more inclusive discussion of medical migration, acknowledging positive changes in international policies surrounding medical recruitment that can promote the global exchange of medical knowledge and perspectives (Shakil, 2016).

3.2.1 Addressing Medical Brain Drain

The discourse surrounding medical brain drain is contested, with much debate regarding the extent to which medical emigration adversely affects healthcare systems. On one side, scholars argue that brain drain exacerbates staffing shortages, leading to a cascade effect of unmet healthcare needs for local populations (Ahmad, 2005; Aluwihare, 2005; Chauvet et al., 2013; Chikanda, 2007; Connell, 2014; Dovlo, 2005a; Driouchi, 2014; Mackey & Liang, 2012; Serour, 2009; Short et al., 2016; Stilwell et al., 2003; Yeates & Pillinger, 2018). Conversely, others question the direct causality of medical emigration on local healthcare outcomes, emphasising the absence of counterfactuals and suggesting that any potentially negative effects could also be attributed to other factors such as limited resources (Alkire & Chen, 2006; Clemens, 2007, 2011; Hidalgo, 2013; Yeates & Pillinger, 2018). Moreover, some scholars argue that brain drain may have positive consequences for Global South countries, such as increased remittances (Beine et al., 2011), adding further complexity to the issue.

Despite these complexities, discussions on addressing medical brain drain have been extensive. One perspective places responsibility on the governments of countries from which many medical doctors emigrate (*source countries*), urging them to provide conditions and salaries attractive enough to retain physicians (Benatar, 2007). *Protective strategies* (Alkire & Chen, 2006) for source countries adopt a “train, retain, and sustain” approach (Chen & Boufford, 2005, p. 1851), aiming to enhance public healthcare systems and working conditions (Astor et al., 2005; Boncea, 2013; Dovlo, 2005b; Kollar & Buyx, 2013; OECD, 2010; Serour, 2009; Zarocostas, 2006), or tailoring medical education to local contexts (Eyal & Hurst, 2008; Levy, 2003; Rashid et al., 2023; Serour, 2009). Other protective strategies involve enforcing a perceived *duty to stay* for qualified physicians, by placing restrictions on their ability to emigrate, at least temporarily (Benatar, 2007; Brock, 2015; Donoso & Mancilla, 2017; Gaillard & Gaillard, 1997; Snyder, 2017; Yuksekdog, 2018).

The enforcement of a perceived duty to stay aligns with a perspective that individual doctors who emigrate are considered to have a duty to their home countries (Brock, 2017; Ferracioli & De Lora, 2015). Some scholars therefore argue that the state has a right to limit the ability of their talented professionals to leave the country, or impose taxation on emigrants, due to their moral obligation to serve their home nation (Brock, 2017; Snyder, 2017). Blake (2017), however, contends that it is never morally permissible to restrict the right to exit and movement enshrined in the Universal Declaration of Human Rights, as it is not the responsibility of people from lower-income countries to contribute to the development of these countries simply because they were born there.

Opportunistic strategies, in contrast, focus on incentivising, rather than coercing, doctors to stay or return to their home countries (Alkire & Chen, 2006; Benatar, 2007; Chacko, 2007), employing measures such as scholarships (Connell, 2014). Such strategies rely on *plant* factors that encourage doctors to remain planted in the country they originally resided in (Al-Haddad et al., 2022). Nonetheless, researchers acknowledge that improving local conditions might not be sufficient to counter the *pull* factors drawing doctors overseas, such as increased remuneration, improved working conditions, or access to professional development opportunities (Gaillard et al., 2015). The ongoing challenge in retaining medical doctors lies in striking a balance between protective and opportunistic measures that addresses the multifaceted nature of medical brain drain.

3.2.2 *Understanding Brain Gain*

Shifting the focus from source countries, some scholars assert that *recipient countries*, who have a net inflow of overseas-trained medical professionals, should shoulder responsibility for brain drain from source countries (Eyal & Hurst, 2008). As the primary beneficiaries of *brain gain* (Brücker et al., 2012; Chacko, 2007; Colebatch, 2005; Meyer et al., 1997), it is suggested that these countries should consider policy changes, including placing restrictions on hiring healthcare professionals from the Global South (Benatar, 2005; Hooper, 2008; Martineau et al., 2004). Additionally, measures such as facilitating the return of healthcare professionals to their countries of origin (Patel, 2003), or providing compensation to these countries (Aluwihare, 2005; Driouchi, 2014; Serour, 2009; Stilwell et al., 2003; Yeates & Pillinger, 2018), have been proposed. Other recommendations for recipient countries include strengthening local medical schools and training capacity (Benatar, 2007; Bundred & Levitt, 2000; Chojnicki & Moullan, 2018; The Lancet, 2005), and making long-term migration more challenging for prospective doctors (Adovor et al., 2021; Alkire & Chen, 2006; Driouchi, 2014; Hooper, 2013).

Brain gain in Global North countries can lead to a situation where “foreign aid might simply be a misnomer for domestic assistance with overseas implications” (Perkins, 1966, p. 618). This is because high-income countries often do not have to invest in additional medical training to expand their workforce with workers from Global South countries who may, ironically, be recipients of foreign aid from the Global North (Johnson, 2005). This pattern, reminiscent of colonial resource extraction, has been critiqued for potentially further disadvantaging countries that have historical ties to (post)colonial structures and regimes (Benatar, 2007; Brock & Blake, 2015). Despite inconclusive data regarding the impact of brain drain on population health outcomes in Global South countries, critiques of the broader global system persist (Ahmad, 2005; Alkire & Chen, 2006; Mpofu et al., 2016), highlighting a tendency to “systematically enrich the wealthy while further impoverishing the poor” (Benatar, 2007, p. 4).

Local health systems and individual IMGs thus constitute part of global migratory patterns that are seen to disproportionately benefit Global North countries.

Moreover, despite the emphasis on brain drain from Global South countries, medical migration is not confined to movements from the Global South to the Global North. Extensive North-North migration exists (Yakovlev & Steinkopf, 2014), as exemplified by the movement of medical professionals between Australia, the U.K., the U.S.A., Canada, and Aotearoa New Zealand (Connell, 2009). In addition to the movement of doctors from the Global North to the Global South through initiatives such as “Doctors without Borders” (e.g., Fox, 2014), South-South mobility is significant. This is seen, for example, in the global migration of Cuban-trained doctors to countries such as South Africa, Timor-Leste, Tuvalu, or the Solomon Islands (Hammett, 2014; McLennan et al., 2020). Some Chinese doctors also temporarily migrate to Kenya (Hsu, 2012), while significant movement of Sub-Saharan African doctors to South Africa is reported by the WHO Health Workforce (2017).

Recognising these global trends, some scholars advocate for reframing brain drain as *brain circulation* (Driouchi, 2014; Gaillard et al., 2015). This approach moves away from concerns around the migration of medical doctors from Global South countries, by acknowledging and promoting the contributions of global medical migration to the growth of scientific and technical human capital (Driouchi, 2014). Such a reframing is argued to be a potential way to contribute to the overall improvement of medicine (Shakil, 2016; Stein et al., 2002), aligning with the historically mobile nature of medicine and healing across the world (Dilger et al., 2012; Hsu, 2012).

3.2.3 Brain Waste of IMGs

In contrast to the notion of brain circulation are ideas of *brain loss* (Connell, 2004), *brain waste* (Pang et al., 2002) or *brain wastage* (Dovlo, 2005b). While brain drain implies a shortage of healthcare workforce due to emigration, brain waste focuses on factors that hinder healthcare systems from fully utilising available resources. These barriers include administrative challenges, unemployment, inefficient resource allocation, or professionals transitioning to different sectors.

Migrant doctors, particularly those who trained in the Global South, face barriers to licensure globally. These challenges, such as convoluted, slow, expensive, and bureaucratic registration processes, may divert IMGs from pursuing medical careers, leading to employment in alternative fields (Fenton & Chillag, 2022; Motala & Van Wyk, 2019; Peterson et al., 2014; Purewal, Encalada Grez, et al., 2023; Russell, 2021b). Licensure regulations, designed to certify competence and protect the public (e.g., MCNZ, 2024c), may inadvertently become formidable

barriers for skilled migrants (Peterson et al., 2014). In Canada, for example, despite a shortage of medical doctors, many IMGs struggle to register and work in their profession, often taking up other work such as driving taxis or delivering meals (Bourgeault & Neiterman, 2013; Covell et al., 2016; Dauphinee, 2005). Challenges with registration include a lack of clear information about licensing processes before migration, resulting in mismatched expectations and difficulties in recertification (Purewal, Encalada Grez, et al., 2023), particularly for those from “non-Western” backgrounds (Purewal, Ardiles Gamboa, et al., 2023). Additional barriers to registration include costly and time-consuming processes to verify prior qualifications, language and communication challenges, and cultural competence (Covell et al., 2016).

Australia also grapples with brain waste, as IMGs often encounter barriers to licensing despite securing job offers (Yeomans et al., 2022). Research highlights difficulties in accessing information about licensing steps, examination content, and resources, coupled with financial hardships during the process (McGrath et al., 2012). The absence of a centralised source of information, insufficient orientation, and limited feedback and guidance compound these challenges (McGrath, 2004). Research into brain waste thus underscores the need for streamlined processes, clearer information dissemination, and enhanced support mechanisms for internationally trained medical graduates.

Overall, the discourse on medical migration and the migratory flows that manifest in brain drain, brain gain, and brain waste, illuminates the complexities embedded in the global movement of healthcare professionals. Medical migration is a dynamic process with varying impacts, and it is important to reframe traditional notions of brain drain as inherently negative and brain gain as unequivocally positive, to allow for a more nuanced understanding. Existing gaps in empirical data necessitate further research that understands and contextualises these global dynamics by directly engaging with the perspectives of IMGs, particularly those who face challenges with professional integration.

3.3 BRAIN DRAIN, GAIN, AND WASTE: A WORKFORCE IN CRISIS

The complex interplay of historical policies and contemporary realities discussed in [Chapter 2](#) underscore the need for a critical examination of current practices, challenging potential biases and assumptions that influence medical licensing. Shifts in medical licensing policy have taken place in conjunction with a changing medical workforce. This section discusses how the concepts of brain gain, brain drain, and brain waste are useful in understanding the role of IMGs in the medical workforce of Aotearoa New Zealand.

3.3.1 IMGs and Brain Gain

As illustrated in Figure 12¹⁶, the proportion of IMGs in the “active”¹⁷ medical workforce has fluctuated over the decades, with an overall increase from approximately 30% in the 1980s (MCNZ, 1986, 1989; The Management Services and Research Unit, 1982) to 43% in 2023 (MCNZ, 2024f). This represents a significant *brain gain* of doctors who trained overseas. From 1956 to 1976, snapshots provide total numbers of practising medical doctors without specific data on their country of primary qualification (The Management Services and Research Unit, 1982), to illustrate the overall growth of the medical workforce over the past 70 years.

¹⁶ Because of the processes involved with keeping the medical register up to date throughout the decades, especially before digitisation, there were often doctors recorded on the register who were no longer practising in Aotearoa New Zealand. As a result, MCNZ would periodically review and remove a significant number of records (e.g., MCNZ, 1983; MCNZ, 2000). For this reason, the Council's indication of “active” practitioners prior to the introduction of technology for a digital database, is considered a more accurate representation of the workforce than the total number of IMGs on the register. From 1980 to 2009, data correspond to the respondents to the annual medical workforce survey, completed each year by the 31st of March (Hannah, 1996; Hannah et al., 1991; MCNZ, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996a, 1997, 1998a, 1999b, 2005b, 2006b, 2008b, 2009b; The Management Services and Research Unit, 1982). From 2010, data are current as of 30th September that year (MCNZ, 2010c, 2024f).

¹⁷ The definition of what constitutes the “active” workforce varies from year to year, initially referring to those who responded to MCNZ's annual workforce survey, and later referring to those with current Annual Practising Certificates (APCs). Nevertheless, estimates have been compiled based on data available, illustrating the increasing contribution of IMGs to the medical workforce overall. As the response rate to this survey was high, but not 100%, there is an increase in the total number of “active” medical doctors in 2010 due to the changing definition of “active” to include all those with current Annual Practising Certificates (APCs).

Figure 12

“Active” Medical Workforce in Aotearoa New Zealand Between 1956 and 2023

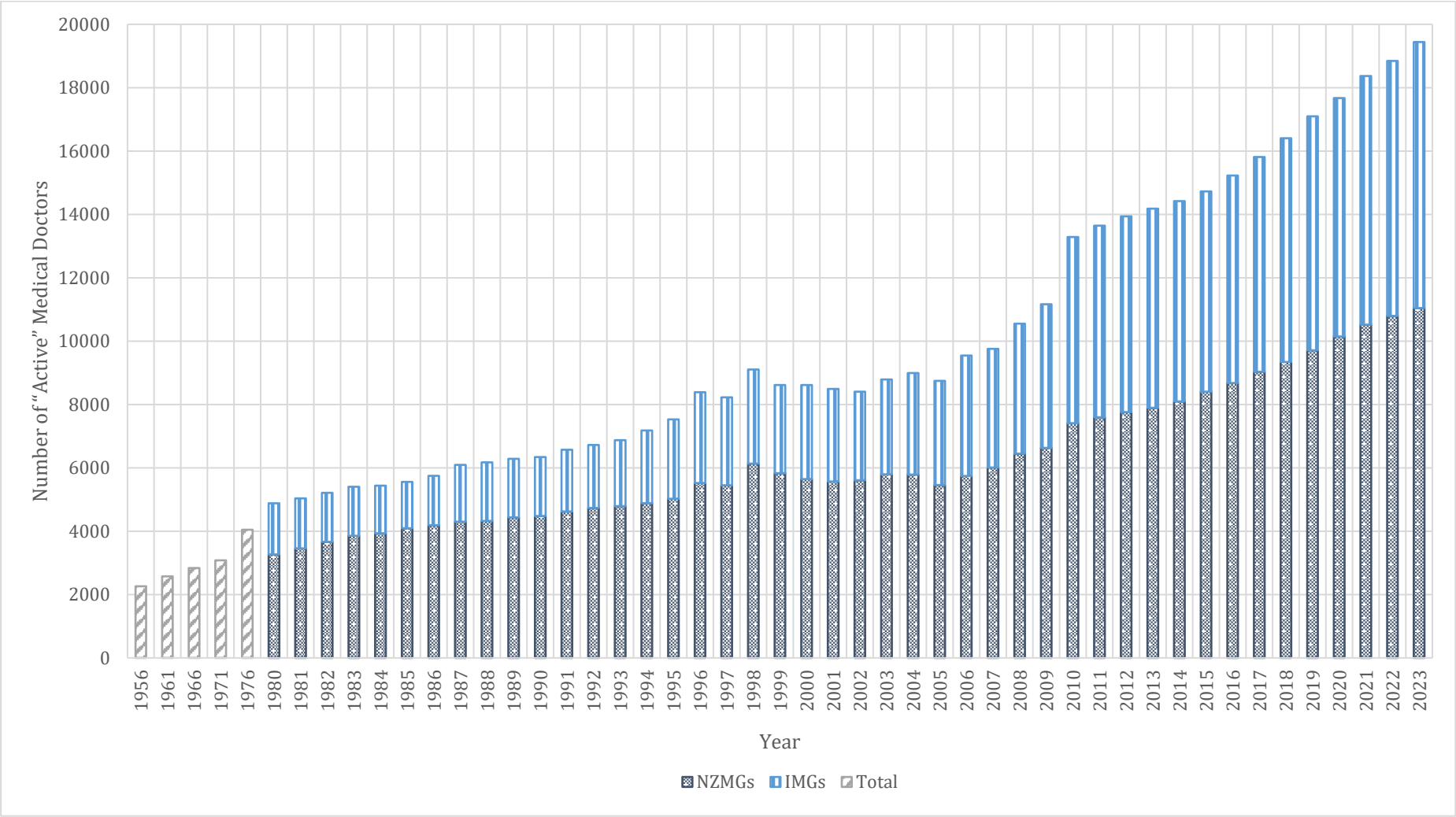
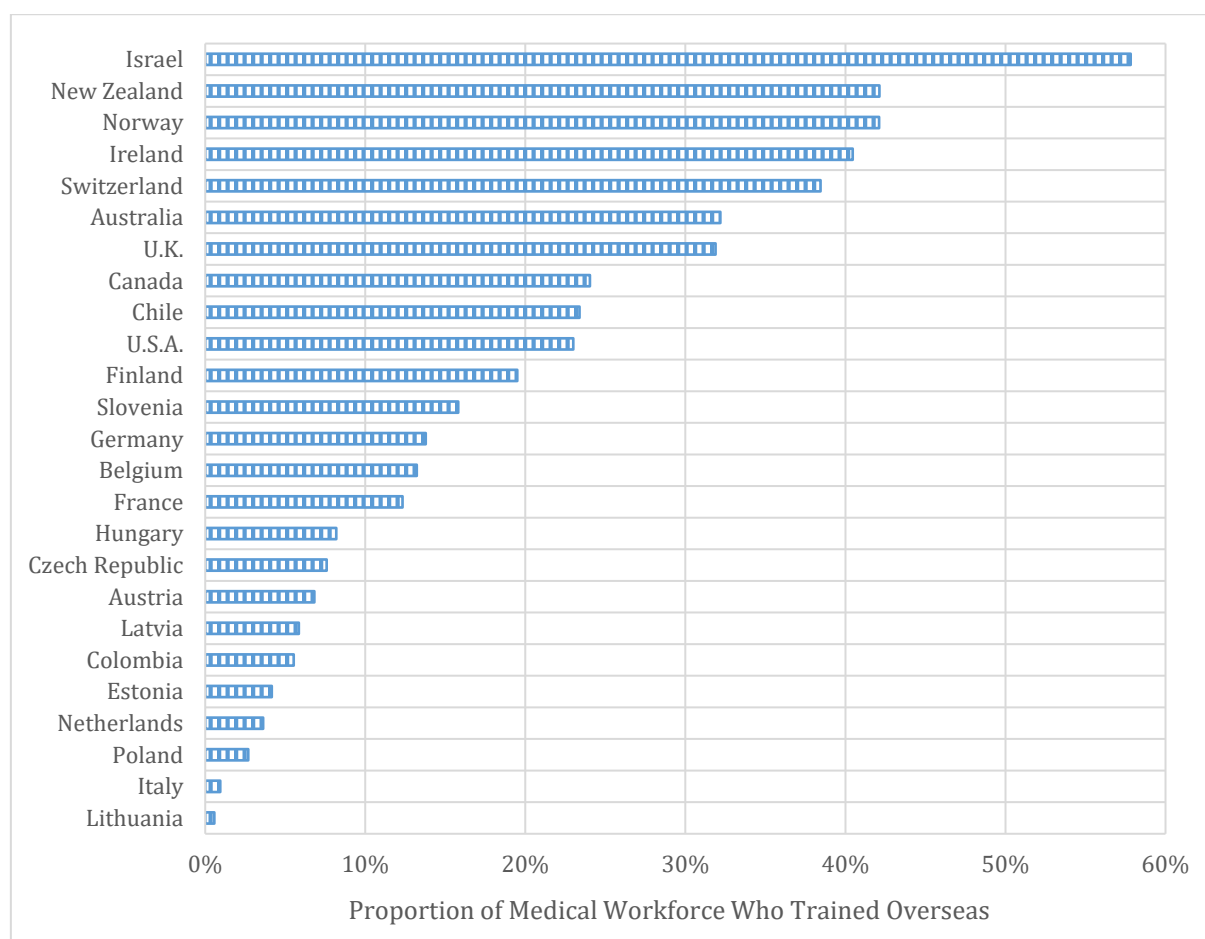


Figure 12 underscores the notable increase in the proportion of IMGs within the medical workforce of Aotearoa New Zealand. In 2023, the active medical workforce included over three times as many NZMGs compared to 1980, marking a 338% increase. In contrast, the number of IMGs in the workforce in 2023 was more than five times the figure in 1980, representing a 520% increase. This increasing dependence on IMGs sets Aotearoa New Zealand apart from other OECD countries, with a higher proportion of IMGs compared to all other CHS countries in the OECD database, except for Israel and Norway, as depicted in Figure 13. Notably, France, with health system indicators most similar to Aotearoa New Zealand (see Table 4 in [Chapter 2](#), Subsection 2.4.3) has less than a third of the proportion of IMGs in their medical workforce compared to Aotearoa New Zealand (12% in total).

Figure 13

Percentage of Medical Workforce Who Trained Overseas in 2021, in Countries With Data Available on the OECD Database (OECD, 2023)



Aotearoa New Zealand's low proportion of local graduates relates to the way that the country "trains fewer healthcare workers than many comparable countries" (Fenton & Chillag, 2022, p. 1). Lawrenson (2023) emphasises the need for almost 900 doctors annually for a modest 3% workforce increase. However, with only two medical schools producing approximately 550

doctors per year, Aotearoa New Zealand continues to “rely on importing doctors from other countries” (para. 7).

This dependence has sparked historical and contemporary discussions around Aotearoa New Zealand’s “morally reprehensible” (“M.A.N.Z. explains stand over doctors’ salaries,” 1970, p. 13), “indefensible and immoral” (Wilson, 1972, p. 159) contribution to the brain drain of doctors from less developed countries, particularly from the Pacific (Campbell, 2007; Connell, 2014; Craig et al., 2022; Negin, 2008; Oman et al., 2006). Overseas-trained doctors play a crucial role in the nation’s medical workforce, and the increasing reliance on IMGs raises questions about the sustainability of healthcare service provision and the role of Aotearoa New Zealand in relation to broader dynamics of global medical migration.

3.3.2 Brain Drain and Workforce Shortages

The significant presence of IMGs in the workforce is linked to both insufficient local training opportunities (Gauld & Horsburgh, 2015; Grimmond et al., 2021), and challenges in retaining NZMGs (“Action on medical “exodus” sought,” 1971; ASMS, 2017; “Loss of doctors will equal graduates,” 1968; Lynch, 2008; “Too many doctors coming to N.Z.,” 1966). Historical data reveals an ongoing brain drain, with up to 40% of NZMGs trained in the early 2000s now living abroad (MCNZ, 2022c). Consequently, Aotearoa New Zealand still had fewer doctors per capita between 2019 and 2021 than many non-CHS countries such as Argentina, Poland, the Russian Federation, Cuba, and Kazakhstan (WHO, 2023). The resulting negative effects of current staffing shortages on the population of Aotearoa New Zealand are well-documented (e.g., Armah, 2022; Broughton, 2021; Ellingham, 2022; RNZCGP, 2020; Russell, 2021a, 2022; Shahtahmasebi, 2021; Spence, 2024; Tebbutt, 2021; Trigger, 2022).

Concerns over doctor shortages date back to World War II (“Alien doctors and public needs,” 1942; “Alien doctors in N.Z.,” 1943). Despite this historical precedent, contemporary research indicates mixed public acknowledgment of staffing shortages. Government statements denying a crisis are often contradicted by healthcare practitioners (McGinn, 2022). For McGinn (2022), this reflects a “lack of listening” and a “disconnect between decision makers and those working within the system” (p. 1). A survey of 1,100 doctors indicated that 89% of respondents agree there is a workforce crisis in Aotearoa New Zealand, with 95% stating that working conditions have deteriorated due to COVID-19 (Cassie, 2022a).

Exacerbated staffing concerns during COVID-19 (Cassie, 2022c; Fenton & Chillag, 2022; McGinn, 2022; RNZCGP, 2020; Shahtahmasebi, 2021) have also led to immigration and employment challenges for IMGs. Aotearoa New Zealand implemented some of the strictest pandemic lockdown and border policies globally (Gunia, 2021; McClure, 2021) and many IMGs

left due to immigration and employment challenges (Bonnett, 2021a, 2021b; Cassie, 2021a; Fonseka, 2021; O'Brien, 2021). Despite global trends excluding healthcare workers from restrictions on movement during the pandemic (Constantin & Sternstein, 2023), many IMGs struggled to overcome COVID-19 related restrictions in Aotearoa New Zealand. Skilled migrants, including IMGs, found themselves “kept in limbo” (1 News, 2021, para. 4), with some feeling like they were “left to sink or swim” (Bonnett, 2021b, para. 13).

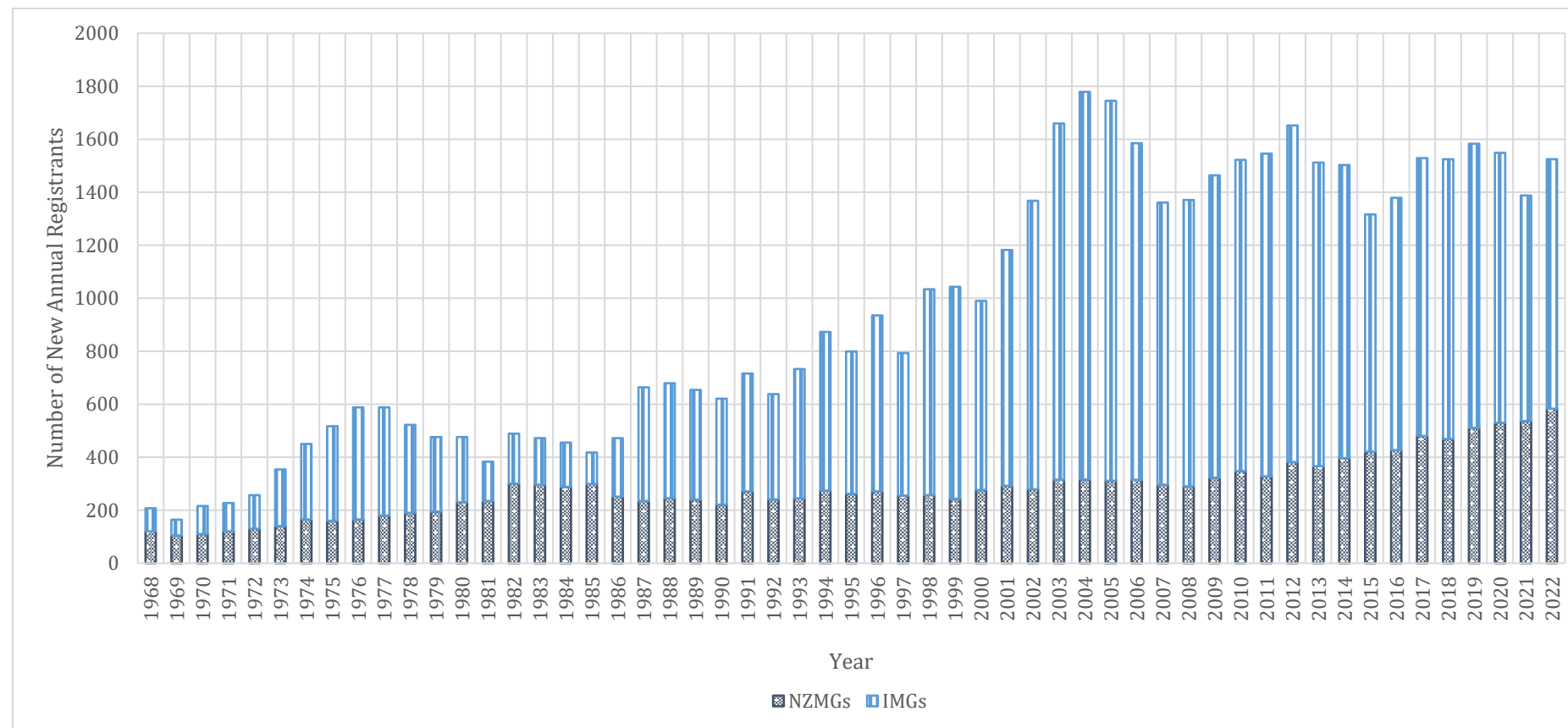
Furthermore, immigration challenges were compounded by policies restricting acceptable COVID-19 vaccinations for entry to Aotearoa New Zealand. Notably, certain vaccines, even those approved by the WHO, were not accepted, creating additional hurdles for medical professionals, especially those coming from the Global South (Strang, 2022). While Aotearoa New Zealand managed to retain more doctors during COVID-19, fewer IMGs could start working due to immigration-related concerns, delays in processing licensing applications, and challenges in participating in the necessary assessments, particularly specialists (Cassie, 2021b). The reopening of borders in 2022 also led to an “exodus” of skilled professionals (Burfitt, 2023), including doctors and nurses (Cassie, 2022b, 2023b), and it is too early to understand the impacts of pandemic-related migratory flows.

A third medical school has periodically been discussed as a way of addressing medical workforce shortages in the longer term. Initially proposed in the 1970s, the idea was not implemented due to ultimately unfounded concerns about a potential surplus of doctors (“Doctor surplus suggested,” 1975). After a proposed graduate-entry medical programme (Lawrenson et al., 2017) was set aside by the Labour Government (Stephenson, 2018), this became a topic of debate leading up to the 2023 election (e.g., Lawrenson, 2023), and the outcome will depend on the National Government, recently elected at the time of writing. One concern with increasing the intake of NZMGs is there may not be enough graduate training positions (PGY1) to allow an increased number of NZMGs to gain provisional registration after graduation (Bremner, 2022), thereby further intensifying the current bottleneck experienced by NZREX candidates and impacting future NZMGs as well.

Workforce data show improved retention of NZMGs, with 84% of graduates from 2010 and 2014 still working in Aotearoa New Zealand (MCNZ, 2022c). However, IMGs continue to be overrepresented in new annual registrations with MCNZ. While NZMGs have tended to constitute 60-70% of the medical register since the 1980s, NZMG registrations have made up less than 40%, and at times less than 20%, of new registrants since 1987. This suggests that IMGs are regularly becoming licensed on a short-term basis. Figure 14 captures these trends, highlighting the significant numbers of new annual IMG registrants.

Figure 14

Annual Estimated Number of New Registrants With MCNZ, From 1968-2022, According to Status as Locally (NZMG) or Overseas-Trained (IMG) Doctors¹⁸



¹⁸ Data have been compiled on the relationship between new IMG registrations and the registrations of NZMGs from 1968 until 2022 (MCNZ, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996a, 1997, 1998a, 1999, 2000, 2001a, 2002a, 2003, 2004a, 2005, 2006a, 2007, 2008, 2009, 2010a, 2011, 2012a, 2013a, 2014a, 2015a, 2016, 2017a, 2018a, 2019, 2020, 2021, 2022a). Data fluctuate between different reports (for example, workforce survey reports or MCNZ annual reports), due to the time of year when reports were published, and also depending on which types of registration are included in the data.

The issue of low IMG retention rates is not a recent phenomenon. In 1966, only around 100 of the 280 IMGs recruited in the previous five years were still in the country (“Too many doctors coming to N.Z.,” 1966). During the 1970s, approximately 60% of IMGs left within three years (“Call to restrict influx of doctors,” 1979), using registration as a steppingstone to countries such as Australia (“26,000 leave ‘Godzone’ in year,” 1978). IMGs tend to work in underserved areas (Garces-Ozanne et al., 2011; Yow et al., 2015), aligning with international trends (Carlbaum, 2021; Dywili et al., 2012; Han & Humphreys, 2005; Holloway et al., 2020; Simard, 2009; Spiliopoulos et al., 2021). However, their high turnover, especially in low-population areas, raises concerns about continuity of care (Barnett, 1991a; “Difficulties over doctors,” 1977; Gorman, 2011) and may leave the medical workforce in a more vulnerable position than statistics reflecting the number of registered doctors can convey (Garces-Ozanne et al., 2011; Gorman, 2011; Kai Tiaki Nursing New Zealand, 2014).

Pull factors attracting IMGs to Aotearoa New Zealand include a sense of community (Kearns et al., 2006), travel opportunities (McCluskey & Spilg, 2012), an appealing lifestyle (Gauld & Horsburgh, 2015; MCNZ, 2011b), a perception of safety and security (Jackson et al., 2005), improved working conditions (ASMS, 2017; Gauld & Horsburgh, 2015; Sharma et al., 2012), and a desire for a “new life” (MCNZ, 2011b). However, significant *push* factors discourage long-term commitment (Al-Haddad et al., 2022). Push factors in the Aotearoa New Zealand context include limited educational opportunities (“Action on medical “exodus” sought,” 1971; ASMS, 2017; Gorman, 2011; Gorman & Brooks, 2009; Kearns et al., 2006; Morton et al., 2008), challenges with remuneration (ASMS, 2017; “Dept. blamed over hospital staffing,” 1966; MCNZ, 2012a; Morton et al., 2008; Yow et al., 2015), medical indemnity (Gorman & Brooks, 2009), and working conditions (“Action on medical “exodus” sought,” 1971; ASMS, 2017; Lynch, 2008; MCNZ, 2012a; Yow et al., 2015).

Similar push factors are also seen in research relating to IMG experiences in Australia (e.g., Han & Humphreys, 2005), Canada (e.g., Purewal, Encalada Grez, et al., 2023; Simard, 2009), the U.K. (e.g., Spiliopoulos et al., 2021), and other CHS countries (e.g., Huijskens et al., 2010; Jirovsky et al., 2015), highlighting the difficulties with retaining both locally and overseas-trained medical professionals. Despite this, limited research has explored the reasons behind both NZMGs and IMGs leaving Aotearoa New Zealand (ASMS, 2017; Powell, 2013).

There is, however, a link between IMG brain drain and restrictive medical licensing policies. The early 21st century saw hundreds of IMGs unable to work in Aotearoa New Zealand despite obtaining residency permits (Hawken, 2005a; King, 2002; Selvarajah, 2004). These IMGs used their time out of the medical workforce to gain citizenship and enhance their English language skills, before moving to Australia, where there are more flexible licensing processes (Elkin,

2015). As Powell (2008) explains, “the Australian threat to New Zealand is two-fold – recruiting doctors from New Zealand across the Tasman and competing against New Zealand for international medical graduates from other parts of the world” (para. 6). Many IMGs, who face challenges in navigating medical licensing and finding work in Aotearoa New Zealand, explore opportunities elsewhere.

IMG retention data highlights a relationship between licensing pathways, country of origin, and the likelihood of staying long-term. Doctors from the U.K., Canada, and Australia often view their time in New Zealand as part of an “overseas experience” (MCNZ, 1994), while those from other countries are more likely to settle. This trend persists, with doctors from the U.K. and North America more likely to seek medical licensing for a “working holiday” (MCNZ, 2022c). Figure 15¹⁹ groups new provisional²⁰ IMG registrants by licensing pathway since 1997.

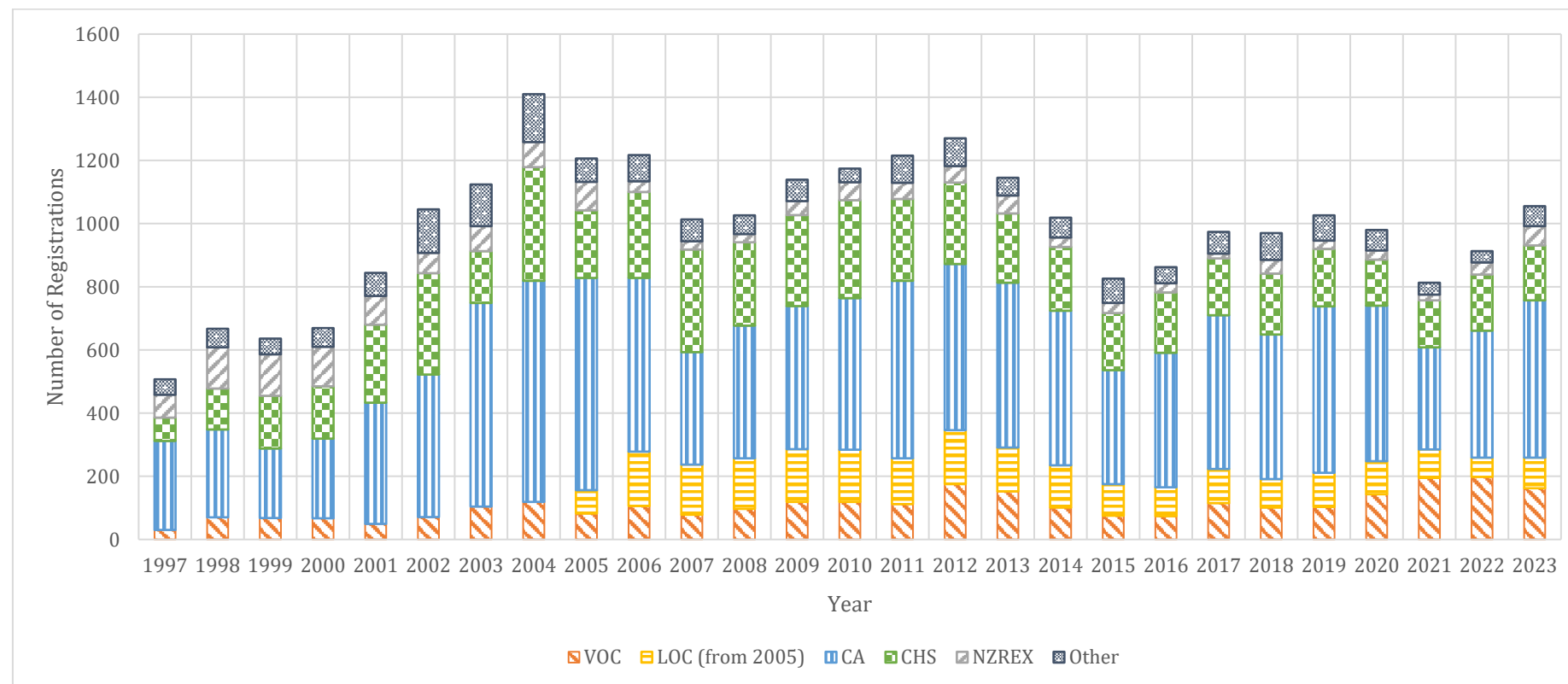
¹⁹ From 1997 to 2013, data have been sourced from MCNZ annual reports, while data for 2014 to 2023 are available online on the MCNZ database (MCNZ, 2024f). MCNZ reporting is from 1st April to 31st March of the year indicated, until 2004 when the reporting year shifts from 1st July to 30th June of the year indicated.

Prior to the introduction of the CA and CHS pathways, doctors with medical degrees or certain types of registration in the U.K., Ireland, Australia, South Africa, Canada, and the U.S.A. could apply for “temporary” registration without examination for up to 3 years. For simplicity, U.K. and Irish registrants with temporary registration are classified as “CA” prior to 2005, while all other doctors with temporary registration are classified as “CHS”. Between 2004 and 2008, “transitional” registrants have also been added into CHS, as this referred to doctors who were eligible for “temporary” registration under the previous Medical Practitioners Act 1995, until it was completely phased out by 2008.

²⁰ In 2005, during the transition to the new licensing pathways, “probationary” and “provisional” registrants are grouped together, as “provisional” registration replaced the term “probationary” and served the same function of requiring doctors to work under some kind of supervision for a period of time before being able to apply for full registration.

Figure 15

Provisional (or Equivalent) Registrations Granted to IMGs Between 1997 and 2023 According to Licensing Pathway²¹



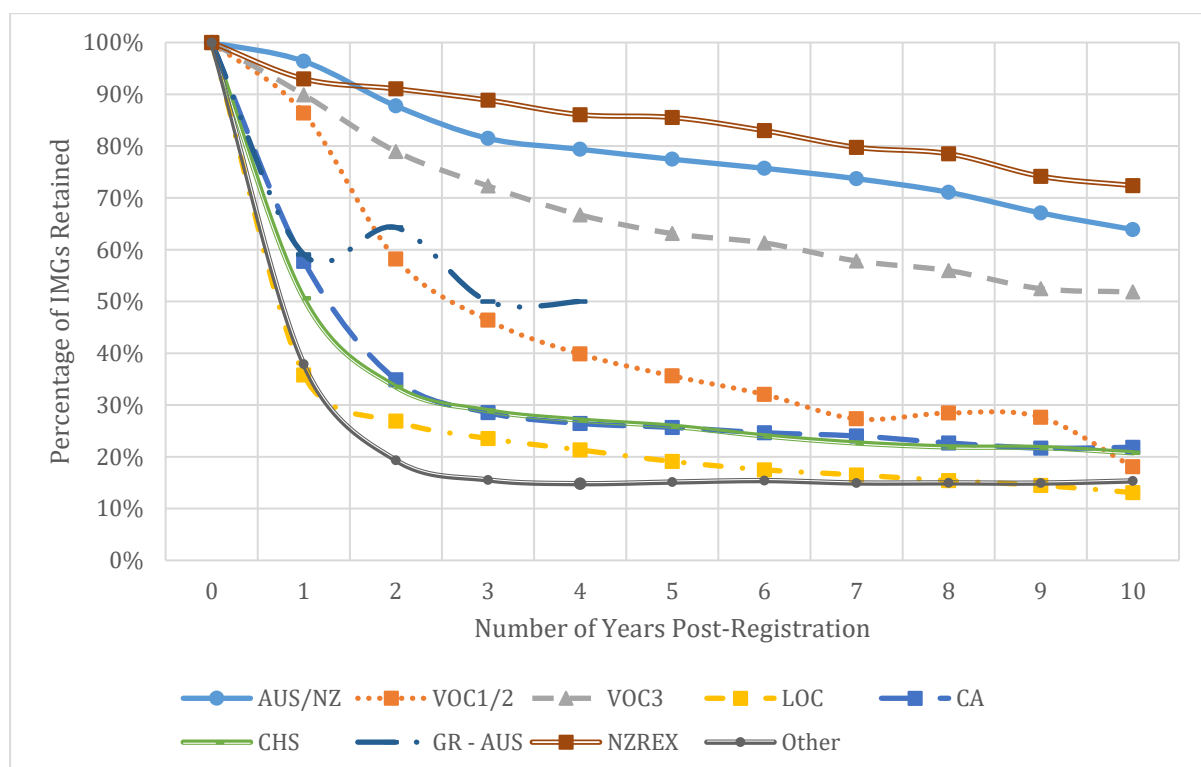
²¹ VOC refers to all provisional vocational registrations of those with a primary medical qualification from overseas, regardless of whether their postgraduate qualification was completed in Aotearoa New Zealand; this therefore includes registrants on the VOC3 (overseas postgraduate qualifications) pathway, as well as the VOC1 and VOC2 (Australasian postgraduate qualifications) whose undergraduate degree was completed overseas (and the equivalent pathways prior to 2005). Due to the integration of the licensing pathways for New Zealand and Australian medical graduates, it was not possible to consistently distinguish Australian medical graduates from NZMGs and so the AUS pathway has been excluded here. The Australian General Registrant pathway (GR – AUS) has only been active since 2018 and a total of just 25 doctors have registered on this pathway during these years, so these have been included under “Other”. Categories classified as “Other” refer to, for example, teaching or research positions, vocational training positions, and other options for which only a very small number of IMGs were eligible but did not require an examination such as NZREX or a vocational workplace-based assessment (WBA).

Figure 15 illustrates the continued dominance of CA doctors (those with medical degrees from the U.K. or Ireland) as the largest group among new provisional registrants. The introduction of the LOC pathway in 2005 has also led to a noticeable trend of increased registration granted to specialist IMGs. However, the number of NZREX candidates receiving provisional registration has declined, reaching a low of 18 in 2021, during the COVID-19 pandemic.

Despite limited registration opportunities, due to the PGY1 bottleneck and reduced examination offerings, Figure 16 demonstrates how NZREX doctors exhibit significantly higher retention rates compared to those on other registration pathways. This trend aligns with earlier studies and data indicating that doctors from Africa, the Middle East, and Asia (typically NZREX candidates) are more likely to stay in Aotearoa New Zealand long-term (MCNZ, 2024i; Morton et al., 2008).

Figure 16

Retention Rates for Doctors in Aotearoa New Zealand According to Registration Pathway, 2013-2023 (as of October 2023)²²



The data presented in Figure 16 illustrate how IMGs with smoother pathways to licensing, such as those on the CA, CHS and LOC pathways, and those with Australasian specialist qualifications (VOC1/2), tend to have lower retention rates in Aotearoa New Zealand. Additionally, registered doctors from Canada, the U.S.A., the U.K., Ireland, and other European countries are

²² Compiled by the author with data from MCNZ (2024h).

least likely to hold a current Annual Practising Certificate (APC), indicating lower long-term retention (see [Appendix D](#)). In contrast, NZREX doctors, despite facing significant barriers, including PGY1 position bottlenecks, exhibit higher retention rates. Their 70% retention after 10 years surpasses that of all other licensing pathways, including Australian and New Zealand medical graduates. Nevertheless, NZREX doctors constituted less than 6% of new IMG registrants in 2023 (MCNZ, 2024g).

Addressing concerns about underutilisation of IMGs already in Aotearoa New Zealand who are not practising, MCNZ's CEO, Joan Simeon, highlighted that "for the vast number of IMGs, there is no longer any need to sit an examination to gain registration in New Zealand", with 96% of IMGs gaining registration without further examination (RNZ, 2023, para. 31). The data in Figure 15 support this claim, showing that doctors eligible for other registration pathways are more likely to obtain medical licensing than NZREX candidates. However, the low average percentage (4%) of NZREX registrations does not diminish the impact of bottlenecks and barriers on this pathway. Rather, Figure 15 emphasises how few IMGs successfully navigate these obstacles. As NZREX doctors are more likely to contribute to long-term workforce stability, there appears to be a misalignment between workforce needs, retention trends, and policies for IMGs who did not train or work in Comparable Health Systems.

3.3.3 Brain Waste and Bottlenecks

IMGs in Aotearoa New Zealand face varied outcomes in medical registration based on their country of origin, contributing to brain waste. As discussed in [Chapter 2](#) (Subsection 2.3.3), NZREX doctors, who typically trained in Global South contexts, experience barriers to licensing that often result in significant delays, or an inability to practise medicine in Aotearoa New Zealand (Bhamidipati, 2022b; Fenton & Chillag, 2022; Forbes, 2022; RNZ, 2023; Russell, 2021b; Thomas-Maude, 2022, 2023; Thomas-Maude & McLennan, 2022). Limited NZREX examination offerings and challenges in securing PGY1 employment lead to "downward occupational mobility" (Salami & Nelson, 2014, p. 153), pushing these individuals into non-professional roles. While this may be viewed as a strategy to mitigate global brain drain dynamics, by discouraging medical migration from the Global South, such "brain waste can be costly for health systems that are heavily reliant on immigrant health workers" (Fenton & Chillag, 2022, p. 3), thus exacerbating Aotearoa New Zealand's medical workforce shortages.

The challenges faced by NZREX doctors in gaining employment date back to the 1990s, when over 900 resident IMGs were unable to practise (Hawken, 2005a), despite having their

qualifications assessed as equivalent by the New Zealand Qualifications Authority (NZQA²³). For Selvarajah (2004), the plight of the individuals who migrated prior to 1995 represents a form of structural discrimination on the part of MCNZ. The Overseas Doctors' Association (ODA) formed in the late 1990s to advocate for these IMGs' registration rights. Selvarajah surveyed members of this group to better understand their experiences, finding that their most significant challenges related to overcoming government bureaucracy and navigating medical licensing pathways without support and clear information.

Concerns around lack of clear information were also seen in other research relating to NZREX graduates (Lillis et al., 2012; Mpofu & Hocking, 2013; Pande, 2015). In lieu of clear, publicly available guidelines regarding the NZREX Clinical examination, many participants stressed the importance of peer support networks such as the ODA and group study sessions with other candidates who had successfully been through the NZREX process (Lillis et al., 2006). Although an external review of the NZREX clinical examination included recommendations relating to improved transparency and standard-setting for the NZREX (CHRE, 2010; Lillis et al., 2012), it is unclear to what extent these recommendations have been implemented. The ongoing issues with brain waste of IMGs on the NZREX pathway highlight the continued relevance of research in this sphere.

Challenges with NZREX candidates struggling to find work (e.g., MCNZ, 1998a) led to the implementation of a government-backed bridging programme in 2000 (King, 2002). This initiative aimed to prepare NZREX graduates for practice in Aotearoa New Zealand, focusing on clinical competency, language proficiency, and behavioural attributes (Hawken, 2005b). Initially successful, the first bridging programme was replaced by another programme ("Ready for Work"), with the addition of a specific examination preparation course ("NZREX Preparation Programme") from 2010. Taylor (2016b) interviewed several IMGs who completed bridging programmes in the early 2000s, describing their experience as crucial in overcoming the sense of isolation that the solitary study for NZREX created as a new migrant, and for understanding more about the local health system.

However, a number of initiatives in place to support NZREX doctors were removed between 2012 and 2014. First, the decision was made in 2012 to exclude NZREX graduates from the Advanced Choice of Employment (ACE) matching programme for PGY1 positions, which allows eligible candidates to register for an online database visible to all prospective PGY1 employers (Thomas, 2018). This decision came about, in part, because NZREX hires do not bring the same

²³ NZQA was established as an accrediting body for foreign qualifications for assessing the suitability of prospective skilled and qualified migrants (Selvarajah, 2004) after the 1991 introduction of the General Skills Category of Residency Policy, a points-based system for assessing skilled migrant visa applications (Hawken, 2005).

government funding that accompanies PGY1 hires of NZMGs and Australian graduates, making it more costly for employers to hire them (Thomas, 2018). NZREX doctors, therefore, cannot even apply to be considered for these positions through the same online database as local graduates, and can only find PGY1 positions if a hospital chooses to advertise a vacancy, or recruit without advertisement, outside of the ACE platform.

Second, the bridging programme and NZREX preparation courses were terminated in 2013 because of the lack of PGY1 positions for NZREX doctors (Taylor, 2016a, p. 13). Shortly thereafter, in 2014, the option for experienced GPs on the NZREX pathway to complete their PGY1 year in a GP rather than hospital setting was also removed (MCNZ, 2014b). These changes compounded the restrictions NZREX doctors experienced, resulting in NZREX doctors feeling “kind of stuck...in limbo” as they competed for limited PGY1 positions (Taylor, 2016b, p. 12). Dr Stephen Child, Chair of the New Zealand Medical Association (NZMA) in 2016, commented on these changes, emphasising the need to prioritise taxpayer money for NZMGs. As he explained:

If you no longer have a shortage and have problems placing your graduates, it’s a paradox. If the country has a New Zealand graduate, and if they are competing for a job with someone who has come over to the country with a qualification – where should the taxpayer money be put? (Taylor, 2016b, p. 13)

However, as noted in Subsection 3.3.2, at the time of writing the “shortage” of medical professionals has not ended in Aotearoa New Zealand. The surplus of PGY1 applicants may mask significant staffing deficits in other roles.

Employers are open about the way that New Zealand and Australian medical graduates are prioritised for PGY1 hires, over NZREX candidates with Aotearoa New Zealand citizenship or residency, who are considered as the last option (e.g., McCarthy, 2022; Shepherd, 2022). NZREX candidates without citizenship or residency in Aotearoa New Zealand are not mentioned and are unlikely to be considered at all (e.g., McCarthy, 2022; Shepherd, 2022). In contrast, the Australian Capital Territory’s (ACT) prioritisation of equivalent PGY1 positions, based on university of primary medical qualification, was ruled as discriminatory by the ACT Civil and Administrative Tribunal in 2016, because it offered “no real possibility” of any IMG securing an internship (Medical Observer, 2016). The Tribunal overruled the assumption that Australian graduates were able to perform better due to their local training, finding the claim “offensive to other domestic and overseas universities and even more so to well-qualified experienced overseas doctors” (Medical Observer, 2016, para. 15). Despite this ruling in a country Aotearoa New Zealand’s shares medical standards accreditation processes with (as

discussed in [Chapter 2](#), Subsection 2.2.2), IMGs on the NZREX pathway continue to be disadvantaged when applying for PGY1 positions Aotearoa New Zealand.

Barriers to IMG registration, a recurring theme in global contexts with workforce shortages, are often attributed to concerns about compromising competence and safety standards (Mpofu & Hocking, 2013). Reflecting this trend, every annual report released by MCNZ since 2001 opens with a statement to the effect of “we protect the public, and promote good practice” (e.g., MCNZ, 2021a, p. 2). In fact, MCNZ (2021a) repeats this sentiment at least seven times in just a few pages, perhaps in response to the criticism the Council has faced with regards to licensing policies that excluded some IMGs who were residing in the country during the COVID-19 (Armah, 2022; Bhamidipati, 2022a; Bhatia, 2022a; Crampton, 2022; Forbes, 2022; Russell, 2021b).

Mahat et al. (2023) reflect on the ways that health practitioner regulations were modified worldwide during COVID-19, recommending a critical re-examination of medical regulation to ensure registration processes are supporting rather than impeding progress towards broader national health goals. In Aotearoa New Zealand, historical expressions of concern about the workload associated with processing IMG applications (e.g., MCNZ, 1985, 1987, 1988, 1995) appear to have culminated in MCNZ’s (2023f) advertisement for proposals to outsource the NZREX examination. It is thus unclear to what extent the reduction in NZREX examinations at the time of writing is a result of MCNZ’s stated goal to “protect the public” (MCNZ, 2021a, p. 2), or resource constraints relating to medical licensing in the post-pandemic era.

In September 2023, Member of Parliament (MP) Dr Shane Reti (Minister for Health at time of writing) estimated there were at least 100 individuals in this registration bottleneck in Aotearoa New Zealand (RNZ, 2023), representing a significant resource that could address New Zealand’s medical workforce needs. These bottlenecks thus represent a brain waste and loss of potential – a loss of realised capabilities (see [Chapter 4](#)) – and underscore the need for systemic changes. Calls for more bridging programmes and steps towards resolving this bottleneck (Cassie, 2023a; RNZ, 2023) will depend on any policy changes resulting from the 2023 election.

3.4 MEDICINE, MIGRATION, AND OTHERING IN AOTEAROA NEW ZEALAND

As a growing body of literature from the second decade of the 21st century, international research on IMG experiences reflects the need to explore this sphere more comprehensively (e.g., Bourgeault & Neiterman, 2013; Jirovsky et al., 2015; Klingler & Marckmann, 2016; Purewal, Encalada Grez, et al., 2023; Skjeggstad, Gerwing, et al., 2017; Skjeggstad, Norvoll, et

al., 2017; Spiliopoulos et al., 2021; Stureson et al., 2019). In Aotearoa New Zealand, a growing body of literature attempts to unravel facets of IMG experiences. Research considers IMG contributions to the health sector (Barnett, 1988, 1991a; Fenton & Chillag, 2022), integration into the workforce (Hawken, 2005b; Wearne et al., 2019), migratory patterns (Callister et al., 2009; Connell, 2010; Garces-Ozanne et al., 2011; Gorman, 2011; Kumar, 2021; McDermott et al., 2014; Yow et al., 2015), perceptions of IMGs (Elkin, 2013, 2015; Narasimhan et al., 2006; Narayanan, Vayro, et al., 2022; Sheehan et al., 2006; St George, 2003), and success in licensing examinations (Hatcher et al., 2007; Lillis & Roblin, 2014; Lillis et al., 2012; Lillis & Van Dyk, 2014). Direct explorations of IMG perspectives have tended to focus on their experiences with entering, integrating and leaving the medical workforce (Gauld & Horsburgh, 2015, 2016; Haivas, 2005; Hawken, 2005a; Kearns et al., 2006; Lillis et al., 2006; Mannes et al., 2023a; McCluskey & Spilg, 2012; Morton et al., 2008; Mpofu & Hocking, 2013; Narayanan, Greco, et al., 2022; Pande, 2015; Selvarajah, 2004; Sharma et al., 2012; Vamos & Watson, 2009). However, an overarching gap exists in the comparative exploration of IMG experiences from diverse backgrounds.

This research gap is connected to broader notions of the migrant experience in Aotearoa New Zealand. Groot and Van Ommen (2017) highlight the “Othering” often experienced by non-European migrants in Aotearoa New Zealand, which is rooted in colonial legislation that aimed to exclude specific immigrant groups (Spoonley, 2017). “Othering” is the process of ascribing a group, individual or an object the label of “The Other” as a means of establishing one’s identity in opposition to this (Johnson et al., 2004). This process often results in stereotyping, generalisations, and unequal power dynamics, emphasising differences over similarities. Migrants from non-European backgrounds, particularly Asia and the Pacific, often encounter challenges in income and labour markets due to barriers such as limited local networks, lack of union support, and obstacles to recognising their qualifications. Spoonley (2017) connects these challenges to employer attitudes favouring immigrants of certain backgrounds, perpetuating barriers for those who are “visibly and culturally different” (p. 191). The preference for European migrants, especially from the U.K. and Ireland, is historically tied to Te Tiriti o Waitangi, with the Treaty acting as “the country’s first immigration policy in so far as it privileged British immigrants and colonial connections” (Spoonley & Bedford, 2012, p. 10). Colonial legacies contribute to contemporary disparities in employment outcomes for immigrants from non-European backgrounds.

These migration and employment policies reinforce “Othering” processes that exclude and discriminate against migrants and citizens based on their backgrounds (Groot & Van Ommen, 2017; Selvarajah, 2004). Labelling practices and group definitions play a crucial role in

perpetuating power imbalances and disparities among migrants and between different migrant groups (Cranston, 2017). Shahtahmasebi (2019), an immigration lawyer, explains how in his view Immigration New Zealand continues to introduce policies that solidify “a longstanding bias and cultural problem within New Zealand’s framework that has prejudiced many potential Kiwis²⁴” (para. 9) towards notions of how a “good” migrant should look and behave. Building on Koutonin’s (2015) question of why “white people” are generally referred to as “expats” and others are “migrants”, Cranston (2017) notes that the term “expatriate” often distinguishes migrants as “qualitatively different” (p. 2058) depending on their countries of origin, with a racialised “expatriate” identity corresponding with the notion of a “good” migrant.

This racialised identity influences how migrants are perceived and treated. In examining the experiences of IMGs, who are typically not from Aotearoa New Zealand originally, it is thus essential to consider how migrant identities are constructed and experienced, and how Othering processes may mean some individuals’ or groups’ contributions have been systematically or institutionally overlooked.

3.4.1 “Alien” Medical Practitioners

The historical context of immigration policies discussed in [Chapter 2](#) (Section 2.5) suggests that obstacles with labour mobility for non-European migrants are rooted in colonial systems and (post)colonial attitudes. While no available prior research focuses on how colonial legacies may translate into medical licensing policies, research on complaints against doctors in Aotearoa New Zealand and Australia indicates that IMGs from specific national or ethnic backgrounds are more likely to face criticism (Elkin, 2013, 2015). Similarly, St. George’s (2003) analysis of data collected by MCNZ between 1996 and 2002 demonstrated that IMGs were more likely to be referred for competence reviews than NZMGs. This raises questions about whether complainants exhibited xenophobia, or whether IMGs were simply more likely to have demonstrated incompetence (Elkin, 2013, 2015; St George, 2003). With no publicly available data regarding complaints and performance reviews of IMGs, it is unclear whether these trends have continued.

Barnett (1991a) noted that IMGs in Aotearoa New Zealand held a “second-class status” within the medical profession (p. 459). This status has historical roots, with descriptions and categorisations of IMGs throughout history providing additional insight into the Othering processes these individuals have experienced. During MCNZ’s first meeting in 1915, during

²⁴ People from Aotearoa New Zealand are often referred to colloquially as “Kiwis”. This term relates to the country’s national bird (the kiwi).

World War I, they assigned new English names to several registered practitioners with German surnames. The Council also responded to a number of complaints from the public about registered doctors of German origin or descent (Sainsbury, 2015, p. 31), who expressed concerns about leniency in registering “hostile alien medical men” (“Notices,” 1919, p. 2). Indeed, IMGs were often referred to as “aliens”²⁵ during public debates about whether they should be welcomed into Aotearoa New Zealand, particularly during World War I and II (“Alien doctors,” 1943; “Alien doctors,” 1945; “Alien doctors and public needs,” 1942; “Alien doctors in N.Z.,” 1943; “Budget debate: Alien doctors defended,” 1943; “Control of aliens,” 1941; “Letters to the editor: Alien doctors,” 1944; “Licensing of alien doctors,” 1943; “Medical students,” 1943; “N.Z. degrees for alien doctors,” 1948; “Notices,” 1919; “Protest against alien doctors,” 1945). The term “alien” reflected resistance and caution towards overseas-trained doctors, influenced by geopolitical circumstances and preconceived notions of the Other.

In 1924, MCNZ was given the right to refuse to register a doctor eligible for registration in the U.K. (“Medical Practitioners Amendment,” 1924), rather than their being automatically entitled to practise in Aotearoa New Zealand. This reciprocity between the U.K. and Aotearoa New Zealand further “disintegrated” in the subsequent decades (Cole, 1988, p. 375). On the one hand, Sainsbury (2015) argues this symbolised a shift away from imperialism and colonial rule. On the other hand, this policy change allowed for more restrictions on which overseas medical qualifications would be accepted, which were met with some concern. In 1928, for example, a practising doctor criticised licensing barriers, stating that “the difficulties in the way of medical registration in New Zealand should be known to all practitioners before coming to the country, in order to avoid, or be prepared for, irritation and disappointment” (“A doctor’s complaint,” 1928, p. 7). Furthermore, this 1924 amendment was later used as a tool to respond to changing geopolitical relationships, with the exclusions of practitioners from Italy and Japan during World War II, despite these doctors being recognised in the U.K. (Sainsbury, 2015).

By the time of World War II, public sentiment also tended to be less favourable towards “alien” practitioners. The acceptance of “refugee” IMGs at the University of Otago medical school, who were fleeing Hitler’s regime, led to public concern that these individuals might be taking the place of local students (“Foreign doctors,” 1938; “Refugee medical students,” 1939). The Hawkes Bay Hospital Board went a step further when they stated that “gaol is the best hospital” for IMGs to work in (“Control of aliens,” 1941, p. 5). Moreover, protests were held at the end of the war “against alien doctors being permitted to have a free hand in touring this country”

²⁵ Doctors from the U.K. and Ireland were not considered “aliens” (“Alien doctors,” 1943). It was only with the introduction of the new Act in 1968 (“Medical Practitioners Act,” 1968) that Aotearoa New Zealand’s shift from being a Dominion of the British Empire to an independent nation was made clear, and British and Irish doctors were distinguished as overseas graduates.

(“Protest against alien doctors,” 1945, p. 4). MCNZ responded to ongoing complaints about the admission of “alien doctors” during the war by removing the opportunity for refugees and other migrant doctors to retrain in their profession. This in turn was met by accusations of Aotearoa New Zealand becoming “the most exclusive country in the world” (Sainsbury, 2015, pp. 53-54) for IMG licensing.

During this public debate in the early to mid-20th century, commentators noted the trend of IMGs to work in underserved areas (“Budget debate: Alien doctors defended,” 1943), addressing staffing gaps that continue to be filled by IMGs at the time of writing (Fenton & Chillag, 2022). An MP from Auckland, for instance, was strongly in favour of “alien doctors”, stating that two IMGs in his electorate were employed in a “working class district” and thus not competing with NZMGs or British doctors (“Alien doctors in N.Z.,” 1943, p. 2). Meanwhile, one public commentator pointed out that:

It strikes some of us very forcibly that in discussions about the admission of alien doctors and their position when our own doctors return to practice, the last party to be considered is the public...where are the doctors? [...] If the responsible authorities had been more liberal in their treatment of aliens we should have more doctors today. [...] Another point is the addition that aliens can make to our store of medical skill...why not make the fullest use of that skill? (“Alien doctors and public needs,” 1942, p. 4)

These historical examples underscore the Othering processes in attitudes toward IMGs from different backgrounds, while pointing to the competing interests of the public, politicians, and health organisations. Medical licensing policies became so restrictive for doctors who did not train in accepted British Commonwealth countries that until the end of the 1960s, graduates from renowned institutions in the U.S.A., such as Harvard or Yale University, “could not get registration in New Zealand without further assessment, and this, of course, meant that many did not bother” (Sainsbury, 2015, p. 143). Geopolitical concerns, public perceptions, and attitudes towards IMGs were already pivotal in defining and reforming licensing processes more than a century ago and, policy changes have tended to move in a cyclical pattern (see timeline in [Appendix A](#)), rather than offering fundamentally new approaches.

3.4.2 Medical Licensing and the Other

This cyclical pattern of policy development continued into the 1970s. During this period, overwhelmed health services (“Medical services in “state of crisis”,” 1970) led to a relaxation of post-World War II policies on medical registration, giving rise to the “probationary”

registration scheme (“Medical Practitioners Amendment Act,” 1970; New Zealand Medical Journal, 1970a). This pathway ushered in an influx of IMGs described in the media as:

...medical graduates from overseas whose basic medical degree is not at present recognised by the Medical Council [MCNZ] and whose facility in the English language may not be adequate to enable them to communicate properly with colleagues and with patients. (“Wider scope for overseas doctors,” 1970, p. 24)

Terms relating to *recognition* and *adequacy* thus became central to the perception of these migrant medical professionals. Similarly, the New Zealand Medical Journal (1970b) described IMGs from outside of the Old White Commonwealth as “less adapted” (p. 164) to the needs of the Aotearoa New Zealand context, while Wilson (1972) reported that some practising doctors felt these individuals were trained to “lower standards” (p. 159). In the 1980s, some IMGs’ qualifications were described as “not acceptable in this country” (“Prerequisites for medical registration to be tightened,” 1982, p. 4), raising concerns about Aotearoa New Zealand being an “easy” place for “sub-standard doctors” from “Third World countries” to practise medicine (“N.Z. an easy place for ‘sub-standard doctors’,” 1988, p. 7). The language of Othering is evident in the way terms such as *sub-standard* are directly linked to doctors who trained in what is described as the *Third World*.

In the late 1980s, a representative from MCNZ commented on increasing hospital reports about unsatisfactory performance of IMGs, noting that “New Zealand is currently probably the easiest Western country in which to obtain temporary registration” (Cole, 1988, p. 376). On the other hand, the Chair of MCNZ indicated no specific examples had been drawn to his attention of malpractice by “Third World” doctors (“N.Z. an easy place for ‘sub-standard doctors’,” 1988). Despite these inconsistencies, more stringent registration requirements were introduced in the late 1980s. Policies began to more strongly favour doctors from “equivalent” (MCNZ, 1985, p. 10) or “comparable” (Cole, 1988, p. 377; New Zealand Medical Journal, 1970b, p. 164) backgrounds, while excluding the “sub-standard”, “Third World” Other. Cole (1988) reiterated, however, that MCNZ “has no role in controlling doctor numbers for political or ethnic purposes” (p. 376).

This Othering phenomenon is not unique to Aotearoa New Zealand. Canada saw a similar evolution in IMG demographics with the inclusion of migrant doctors from a wider range of backgrounds in the 1970s. This, in turn, prompted concerns about the “equivalency” of different qualifications (Bourgeault & Neiterman, 2013) and led to policy changes resulting in brain waste of IMGs from the Global South (Purewal, Ardiles Gamboa, et al., 2023). In a review

of more than 50 studies relating to IMG experiences in the U.K., Al-Haddad et al. (2022) note that both IMGs and locally-trained medical practitioners from ethnic minority backgrounds were more likely to receive patient complaints or perform less well in postgraduate examinations. These differential outcomes prompted the U.K.'s General Medical Council (GMC) to set a target to "eliminate disproportionate complaints from employers about ethnic minority doctors and eradicate disadvantage and discrimination in medical education and training" (General Medical Council, 2021, para. 1). Similarly, Franklyn (2023) discusses how a professional hierarchy that privileges U.S.-trained doctors over IMGs in the U.S.A. is continually reproduced through systems of recruitment for postgraduate medical training. These international examples highlight the Othering processes that occur among medical doctors from diverse backgrounds in countries classified as Comparable Health Systems to Aotearoa New Zealand.

As noted in the above quote from the GMC (2021), a distinction is also made in some literature between *discrimination* and *disadvantage*. This was explored in depth by Musoke (2012), who argues that while IMGs from non-European countries are not explicitly "discriminated against", they are "disadvantaged" (p. 26) by a "convoluted and inefficient process" (p. 30) involving additional courses and examinations not required for European doctors. Musoke (2012) draws on postcolonial theory to explain the lack of recognition for non-European IMGs, arguing that "by undermining the competence of "the Other", or claiming that "the Other" could only handle simple tasks, it became justifiable to exclude "the Other" from certain positions" (p. 32). Similar themes were also present in another Swedish study, with IMGs reporting experiences with discrimination and the sense of having their prior qualifications and experience undervalued (Stureson et al., 2019).

In Aotearoa New Zealand, research by Mpofu and Hocking (2013) aligns with these international studies. The researchers found that IMGs trained in non-English speaking countries felt their clinical experience was underutilised, despite the potential of this training to enhance their resilience, resourcefulness, and knowledge of diverse medical conditions. Participants also viewed their transcultural strengths as untapped resources for the country's "superdiverse" population. Similarly, Lillis et al.'s (2006) study of NZREX doctors noted frustration with the underutilisation of their skills and "tacit assumptions about their acceptability to a medical community of practice in a different country" (p. 52). These findings underscore the need for broader research into the experiences of IMGs from various backgrounds, shedding light on the consequences of Othering in medical licensing processes.

Participants in Mpofu and Hocking's (2013) study also expressed concerns about protectionist attitudes in obtaining medical registration. The emotional consequences of these barriers are

substantial, leading to feelings of frustration, isolation, disappointment, and a loss of identity. Similar emotional tolls were noted in other research (Lillis et al., 2006; Selvarajah, 2004; Vamos & Watson, 2009), emphasising the need for a cultural shift in attitudes towards IMGs by employers, regulatory bodies, and the public in Aotearoa New Zealand (Mpofu & Hocking, 2013). In Vamos and Watson's (2009) study of IMGs registering as Psychiatrists, participants also discussed the perceived "discriminatory" and "humiliating" nature of the need for retraining (p. 40). While other local literature tends to avoid explicit use of the term discrimination, international literature, such as Purewal, Encalada Grez, et al.'s (2023) work on "non-Western" IMGs in Canada, emphasises "systemic barriers" that "unfairly discriminate against certain individuals and limit their ability to participate" (p. 5). Discrimination allegations are also seen in literature relating to IMGs from ethnic minority backgrounds in the U.K. (Al-Haddad et al., 2022; General Medical Council, 2021; Moberly, 2014).

Furthermore, qualitative interviews with IMGs in the Netherlands highlight challenges with obtaining information, accessing continuing education, financial constraints, discrimination, and language barriers (Huijskens et al., 2010). IMGs in German hospitals also report challenges with legal and medical regulatory processes, context-specific knowledge, skills, and discrimination (Klingler & Marckmann, 2016). Similarly, IMGs from Sub-Saharan Africa in Austria have mixed experiences, with registration and employment processes being challenging and sometimes discriminatory (Jirovsky et al., 2015). While limited research in Aotearoa New Zealand directly explores the experiences of IMGs who face significant obstacles to medical licensing (Hawken, 2005a; Lillis et al., 2006; Lillis et al., 2012; Mpofu & Hocking, 2013; Pande, 2015), international literature provides broader insights into the challenges with registration and Othering experienced by IMGs in CHS countries.

Despite documented concerns around interpersonal skills and communication, language barriers, Othering, and potential discrimination towards some IMGs, a gap exists in understanding these experiences within broader geopolitical and historical dynamics such as colonialism. While existing literature often analyses global phenomena such as brain drain, gain, and waste, and the relationship between immigration, medical licensing policies, and international development, this research aims to explore IMG experiences in Aotearoa New Zealand through a conceptual lens that considers the individual, national and international scale (see [Chapter 4](#)).

3.4.3 Medicine and Identity

This research focuses on the medical licensing processes, outcomes, and experiences of IMGs in Aotearoa New Zealand, as they seek registration within a healthcare system firmly entrenched in the allopathic, biomedical model, commonly known as *Western medicine*. This

healthcare paradigm may pose an inherent paradox, however. On the one hand, evidence-based medicine and knowledge is treated as standardised to the extent that, for example, NZREX candidates can demonstrate this general understanding of medicine by taking an examination from either the U.K., Australia, Canada, or the U.S.A., all of which are considered to measure an equivalent set of knowledge. On the other hand, the more relational and context-dependent aspects of medical practice, such as communication and interpersonal skills, may conflict with the historically privileged scientific model of Western medicine.

Exploring this paradox between the clinical and humanistic elements of medical practice, Johansen et al. (2012) interviewed GPs caring for cancer patients in Norway. They found that “doctors’ personal, continual and contextual knowing of patients still is undervalued”, with specialists focused on “curing cancer” holding a higher status in the medical hierarchy than GPs “caring for the dying” (p. 578). A similar privileging of scientific medicine over “humanistic” approaches is evident in Apker and Eggly’s (2004) exploration of the construction of medical identities during medical training in clinical settings, where medical students were asked to direct their focus back to pathophysiology, despite their consideration of broader aspects of patients’ lives.

Furthermore, biomedical knowledge acquisition and development outside of clinical interactions play a crucial role in shaping a medical doctor’s professional identity. Dickinson et al. (2020) note how one medical student they interviewed in the U.S.A. felt that “it is this very knowledge that makes us doctors” (p. 9), connecting this knowledge not only to clinical practice but relationship building among peers, enhanced credibility, and competence as a physician. In the context of Aotearoa New Zealand, Thompson (2014) reflects on the perceived lower status of medical doctors specialising in public health, highlighting tensions in navigating professional identities shaped by preconceived notions of medical hierarchies and the definition of a “proper doctor” (p. 97).

The evolving perceptions of medical doctors in the modern world further contribute to the construction of professional identities. Childress (2021), for example, reflects on the life of Fady Joudah, who occupies the positionality of a physician, a poet, and a second-generation migrant in the U.S.A., noting how these roles, particularly that of a physician and a poet, are often assumed to be incompatible with one another. Furthermore, Nussbaum (2021) discusses the shift from medical narratives focused on “battling against disease” to concerns about “burnout” (p. 131), while Lipworth et al. (2013) distinguish between “status” and respect” in relation to a perceived reduction in status afforded to those working in the medical profession. Issues related to status include tasks considered demeaning, while concerns about respect centre on behaviours towards medical doctors by patients or peers.

Doctors are seen to construct their identities in relation to evolving understandings of medicine that, while context-specific, have a complex relationship with the scientific model of Western medicine. A medical practitioner's background and, if applicable, experiences with Othering processes, are thus also linked to their sense of identity. An extensive exploration of literature exploring more pluralistic understandings of medical models and practices in non-Western cultures (e.g., Maynard, 2007; Na, 2021; Oseni & Shannon, 2020; Rao & Sundararaman, 2014), and the growing emphasis on "holistic" approaches to allopathic medicine (Thomas et al., 2018) is beyond the scope of this research. However, it has been crucial to position this research within a broader understanding of the relationship between the biomedical model that guides Western medicine, perceptions of medical doctors from diverse backgrounds, and professional identity.

3.4.4 *Communication and Language*

Perceptions of IMGs and associated Othering processes are also connected to language proficiency. While scholars agree that language competency is critical to the provision of competent medical practice, Mpofu and Hocking (2013) noted the challenges IMGs faced with English language requirements in Aotearoa New Zealand exceeding those in other Global North countries. This observation led the authors to question the appropriateness of requisite examinations (the International English Language Testing System (IELTS) or the Occupational English Test (OET)). Similarly, Sheehan et al. (2006) argue that formal English training does not adequately prepare overseas-trained doctors for idiomatic expressions used in Aotearoa New Zealand, or the "repertoire of communication strategies" (p. 64) expected by the public in accessing health services.

Furthermore, Narasimhan et al. (2006) found that some IMGs' poor communication abilities, as assessed by their New Zealand-trained peers, was not related to lower English competency, but other challenges with interpersonal skills. Narayanan, Vayro, et al. (2022) had comparable findings, noting that patient perceptions of IMGs' interpersonal communication and interpersonal skills, such as empathy, depended on their background and training. The literature thus suggests that examinations solely focused on academic English abilities may not be the most appropriate measure of an IMG's ability to engage with patients in the Aotearoa New Zealand healthcare setting.

3.4.5 *Culture and Integration*

Concerns about the interpersonal and communication skills of IMGs are linked to an emphasis on cultural adaptation. Lillis et al. (2006) interviewed several IMGs on the NZREX pathway in 2004 and 2005, who felt they were not given adequate orientation when starting work. As a

result, they struggled to adapt to new processes and information technology systems and did not feel comfortable asking their colleagues for support with this period of adjustment. In contrast, Hawken (2005a) sent out a questionnaire to graduates of the first three intakes of the bridging programme for NZREX doctors between 2000 and 2003. Those who responded to the questionnaire thought the course was valuable in improving their communication skills, including interacting safely with Māori, and they felt better prepared to work in Aotearoa New Zealand. Based on these findings, Hawken (2005b) emphasised the importance of such retraining courses, and recommended further development of modules focused on Māori and Pacific cultural safety and health needs, and a specific focus on the ethical and legal components of healthcare provision in Aotearoa New Zealand.

However, a national survey highlights the challenges IMGs from all backgrounds experience with cultural adaptation to Aotearoa New Zealand, and an associated lack of support and training (Mannes et al., 2023a). Other researchers have also investigated the challenges of “cross-cultural adaptation”, highlighting the need for additional support to aid IMGs in integrating into their new role and society (Pande, 2015; Terry et al., 2021). In an international review of literature relating to interventions designed to support the transition of IMGs into their new countries, Kehoe et al. (2016) argue that establishing ongoing support and cultural awareness for IMGs is crucial for enhancing IMG self-efficacy, reducing stress levels, and improving their ability to contribute to the local workforce. While initiatives such as a pilot series of workshops for IMGs (“Welcome to practice in Aotearoa New Zealand”) have been designed to meet this need in Aotearoa New Zealand (MCNZ, 2022a, 2022b), it is unclear when such offerings could be extended throughout the country.

Despite this growing emphasis on cross-cultural adaptation and orientation, there is a gap in both local and international literature regarding the cultural safety practices of IMGs in a new healthcare setting (Chan, 2015; Covell et al., 2016; Kehoe et al., 2016; Ragg et al., 2015; Spiliopoulos et al., 2021; Stureson et al., 2019). A cultural safety approach shifts the focus from an IMG’s sense of integration, to ensuring they foster safety and inclusion when engaging with patients. In Aotearoa New Zealand, a historical focus on *cultural sensitivity* training in the 1970s evolved into *cultural competency* in the early 21st century, and has culminated in a contemporary focus on *cultural safety* (Fountain, 2022). While cultural sensitivity related to “being aware of ways of greeting, seating, eating, and treating the other person” (Fountain, 2022, para. 27), cultural competency emphasised “the attitudes and skills health professionals need if they are to function effectively when providing care to somebody of a different culture” (Fountain, 2022, para. 28).

However, Curtis et al. (2019) argue that cultural competency approaches can be seen as “Other-focused”, and “promote oversimplified understandings of other cultures based on cultural stereotypes” (p. 13). Rather than seeking to learn the “cultural customs of different ethnic groups”, a cultural safety approach “seeks to achieve better care through being aware of difference, decolonising, considering power relationships, implementing reflective practice and by allowing the patient to determine whether a clinical encounter is safe” (Curtis et al., 2019, p. 13). Cultural safety is thus seen as a more effective strategy for addressing health inequities, especially among the Indigenous Māori population, by acknowledging determinants of health related to institutionalised discrimination. Furthermore, it is a strategy recommended for all medical practitioners, regardless of whether they trained in Aotearoa New Zealand or overseas (Fountain, 2022). Professor Tipene-Leach, a notable proponent of the cultural safety approach, explains that the key is for professionals “to take your biases, your assumptions, your stereotypes and your prejudices and look and see what they do to you and, in doing something to you, what they do to the patient” (Fountain, 2022, para. 32).

Nevertheless, biases, assumptions, stereotypes, and prejudices continue to be evident in literature and media analyses relating to overseas-trained doctors. Mannes et al. (2023a), for example, explain that “doctors from incomparable systems may need to unlearn existing medical skills and learn professional and communication skills appropriate to their new environment” (p. 44). Despite recommending the cultural safety approach to identifying passive racism and subconscious biases, the authors do not question the assumption of who is classified by MCNZ as “incomparable” and the lack of publicly available data relating to the performance of IMGs from comparable and “incomparable” backgrounds. Furthermore, the pilot NZREX bridging programme was reported in the media as being necessary to “naturalise” overseas-trained doctors (1 News, 2023), although this programme only applies to doctors on the NZREX pathway who are more likely to have trained in the Global South. The choice of the word “naturalise” underscores the perceived differences, or *Otherness*, of IMGs who are not from the Global North.

In addition, cultural education and orientation requirements are dependent both on an IMG’s place of work and their licensing pathway. Although doctors who trained in Global North countries usually undergo varying degrees of post-registration cultural training and orientation, this is neither regulated nor a requisite for medical licensing. For NZREX doctors, on the other hand, a degree of cultural understanding and integration is expected for them to perform well in the NZREX examination *prior* to medical registration (Hawken, 2005a; Lillis et al., 2006). This could suggest an a priori assumption that IMGs from CA or CHS countries are automatically equipped to integrate and provide culturally safe care in a new environment with

a unique Indigenous population, while doctors from the Global South require prior evaluation of these skills.

Dywili et al. (2012) note that IMGs in Australia, Canada, the U.K., the U.S.A., and Aotearoa New Zealand are expected to fill employment gaps, have adequate clinical and interpersonal skills, and to understand and adapt to the new culture, “no matter what” (p. 176). This sentiment was reiterated by Mannes et al. (2023b), who found that IMGs were expected to “code-switch” from their “default cultural code of interaction” (p. 2). This was particularly challenging for IMGs from backgrounds with greater perceived cultural and professional differences, a theme also seen in Al-Haddad et al.’s (2022) meta-ethnography of more than 50 articles on IMG experiences in the U.K.

By the same token, IMGs also have expectations that their qualifications, experience and cultural background would be recognised and valued, as well as a desire for a consistent, comprehensive orientation process on arrival which, as noted, is often not the case. Hatcher et al. (2007) reflect on the challenges of incorporating “culture” into their clinical examinations for Psychiatry fellowship in Aotearoa New Zealand, noting that “we need to ensure that the examiners are competent to examine candidates from different cultures, so that difference in exam performance is not necessarily seen as deficit” (p. 495). These examples highlight the overlap between what are considered to be desired interpersonal or communication skills, and the cultural background of an individual. McKimm and Wilkinson (2015) thus urge employers and regulatory authorities to:

...reconsider any assumptions that the reason for problematic performance from doctors from a different culture is due simply to cultural “difference”. Making cultural transitions is a complex, multi-layered process...Not only do individuals have to manage these transitions, but when they arrive in a new culture, they may find themselves being treated as an “outsider” by members within the profession, thus causing more difficulty and distress whilst acclimatizing. (p. 842)

There is a gap, therefore, in literature in Aotearoa New Zealand not only reflecting on the cultural safety practices *of* IMGs, but cultural safety *for* IMGs. IMGs who experience barriers to registration and Othering processes related to their country of training or origin are at risk of being further ostracised as an “outsider”, thereby exacerbating their challenges with entering medical practice in Aotearoa New Zealand. As one Samoan-born NZMG explains, “the public perceives IMGs as foreign doctors and foreign is perceived as non-white, whether they were

trained in New Zealand or not”, citing experiences with racist remarks from co-workers and patients (Ratcliffe, 2007, para. 23).

While IMGs may at times require more time to adapt and understand their new environment (Mannes et al., 2023a, 2023b; Wearne et al., 2019), this should not undermine the potential diversity in clinical knowledge and experience, as well as cultural skills, that many IMGs from Global South backgrounds have to offer, as pointed out by an anonymous member of the public more than 70 years ago (“Alien doctors and public needs,” 1942, p. 4). Having a high proportion of junior doctors who trained overseas can be beneficial in stimulating “intellectual discussion” and “cultural interchange” that can enhance the “future standards of New Zealand medicine” (Holmes, 1981, p. 395). Nevertheless, many IMGs report that there is little interest from their co-workers and employers in learning from their overseas experience (Dywili et al., 2012; Gauld & Horsburgh, 2016; Mannes et al., 2023a; Vamos & Watson, 2009), thereby limiting the opportunity for a brain “circulation” (Driouchi, 2014; Gaillard et al., 2015) of not only clinical but cultural skills and knowledge.

3.5 CONCLUSION

International medical graduates (IMGs) do not represent one homogeneous group of individuals (Chan, 2015) and Aotearoa New Zealand is a clear example of how this is true in practice. While some local empirical studies directly engage with IMGs to comprehensively understand their experiences, it is clear that IMGs have differential experiences depending on the licensing pathway they are eligible for. This is seen both in literature relating to the motivations of IMGs working in or leaving Aotearoa New Zealand, and studies that have directly tackled the challenges faced by IMGs on the NZREX pathway.

There are, however, some gaps in research to date. First, research has tended to focus on only one group of IMGs, or has tended to group IMGs together in comparison to NZMGs. Second, the literature points to a number of assumptions about IMGs from certain backgrounds that can also be seen in historical and contemporary media reports, underscoring the importance of analysing IMG experiences in relation to the broader policy, historical, and sociocultural context of Aotearoa New Zealand. Third, there is a tendency to focus on how IMGs may struggle with adapting to the professional context of Aotearoa New Zealand, and the need for them to learn culturally safe practices, with limited exploration of how IMGs may also feel culturally unsafe, disadvantaged, or even discriminated against.

Therefore, this research addresses a gap in the academic literature relating to IMG perspectives, translating anecdotal media stories and workforce statistics into an

understanding of the lived experiences of doctors in Aotearoa New Zealand who trained overseas (see Chapters 6, 7 and 8). Furthermore, the research considers how these experiences and outcomes interact with policy, politics and postcolonialism (see Chapter 9). To this end, a theoretical framework that draws on concepts of mobility justice and capabilities has guided the design and analysis of this research, as discussed in the following chapter.

4 THE 4PS: TOWARDS A CAPABILITIES APPROACH TO MOBILITY JUSTICE

4.1 INTRODUCTION

Questions of justice arose early when conceptualising this research. I began to ask what is fair or reasonable in relation to both medical licensing for IMGs in Aotearoa New Zealand, and the broader global discourse of medical migration. This led me to seek an analytical framework that could allow an exploration of what could be considered just in this complex landscape.

Conceptualisations of justice have evolved and transformed throughout history, with a growing contemporary focus on justice in relation to geographical aspects such as spaces and mobilities (e.g., Cook & Butz, 2018; Sheller, 2018a; Soja, 2010), as well as capabilities as forms of freedom and opportunities (e.g., Nussbaum, 2011; Robeyns, 2017; Sen, 2009). Although the capabilities approach is referenced in mobility justice literature (e.g., Pereira et al., 2017; Sheller, 2018a), the relationship between mobility justice and the capabilities approach has not been fully explored. As IMG licensing sits at the intersection of medical migration and the capacity of IMGs to maximise use of their skillsets, both of these approaches have provided a valuable foundation for framing the research. During the research process, I found it imperative to further incorporate the capabilities approach within the framework of mobility justice, in order to conceptualise a research context tied not only to the movement of individuals across borders, but also their abilities, knowledge, and training.

This thesis addresses two primary outputs aligned with my research questions. First, it bridges a research gap by examining IMG experiences in Aotearoa New Zealand and the sociohistorical factors shaping medical licensing. Second, as laid out in this chapter, the research pioneers a capabilities approach to mobility justice that builds on existing literature, tailored to the migration of medical professionals in this context.

This capabilities approach to mobility justice has evolved through an “inductive interpretative approach” (Creswell & Plano Clark, 2018, p. 43), wherein theoretical insights were iteratively refined as data were collected and analysed. While the methodological considerations crucial to this approach are detailed in [Chapter 5](#), the inductive interpretation process enabled the research to contribute to and be shaped by the evolving theoretical framework. Therefore, this chapter describes a framework that builds on existing bodies of literature and has been continuously refined through the process of collecting, analysing, and discussing data.

The first section introduces key characteristics and concepts from justice literature, which I later use to describe my capabilities approach to mobility justice, before providing an overview of mobilities and capabilities approaches to justice. The final section discusses the capabilities approach to mobility justice I have developed through this research process. This framework, referred to as the 4Ps, encapsulates *professional* mobilities and capabilities, *(inter)personal* mobilities and capabilities, mobilities and capabilities in *practice*, and mobilities and capabilities *power* regimes, providing a structured lens for exploring the experiences of overseas-trained medical doctors in Aotearoa New Zealand.

4.2 KEY CHARACTERISTICS AND CONCEPTS OF JUSTICE

Justice, in Western philosophy, is linked to the treatment of individuals, often has an enforceable nature, implies impartiality and consistency in application, and typically requires an agent to modify relevant circumstances according to their will (Miller, 2017). However, the diversity of historical perspectives on justice, spanning thousands of years (Solomon & Murphy, 2000), underscores the need to acknowledge not only the ideological preferences of key thinkers but also the contextual nature of their discussions (Miller, 2017). Theories of justice are inherently entwined with the contexts in which they are conceived and debated, highlighting the importance of a theoretical framework that acknowledges and emphasises contextuality.

Miller (2017) outlines four key distinctions that often characterise theories of justice. First, there is a distinction between conserving existing norms and practices as a form of justice (*conservative justice*) and advocating for changes to the status quo, current laws, and practices to achieve justice (*ideal justice*). Second, justice is conceptualised both in terms of the just distribution of goods and resources (*distributive justice*) and as a remedial principle to rectify a perceived “wrong” committed against another (*corrective justice*). Third, a dichotomy exists between viewing justice as a process and justice in terms of outcomes – essentially, a distinction between examining the means (*procedural justice*) and the ends or results (*substantive justice*). Finally, *comparative* and *non-comparative* approaches to justice distinguish whether it is necessary to consider others when making a claim about justice. For instance, a theory of justice may involve assessing what others possess to relationally determine the fairness of one person having access to certain goods or opportunities.

4.2.1 Recognition and Respect

Beyond these four outlined distinctions, several other concepts within the justice literature have proven particularly relevant for this research. Solomon and Murphy (2000) note that justice has appeared to fall in and out of favour in philosophical conversation throughout the

centuries. However, the topic has gained increased attention in the last fifty years, with philosopher John Rawls playing a central role in discussions around the just distribution of goods, resources, and opportunities. In response to the overwhelming prevalence of distribution in conceptualising justice (Schlosberg, 2007), other distinctions have surfaced, bringing the concepts of *recognition* and *respect* to the forefront of justice discourse. Emphasising recognition and respect shifts the focus from striving for social equality or freedom through redistributing goods or opportunities, to achieving justice through the recognition of the human dignity of all individuals (Honneth, 2004).

Young (1990) and Fraser (1995) were among the first scholars to challenge the emphasis on distribution in theories of justice. Instead of attributing injustices solely to inequitable distribution, these scholars underscore the importance of questioning why inequitable distribution patterns exist in the first place. Young (1990) argues that understanding and challenging existing domination and oppression are crucial to any pragmatic theory of justice, stating that:

...instead of focusing on distribution, a conception of justice should begin with the concepts of domination and oppression...where social group differences exist and some groups are privileged while others are oppressed, social justice requires explicitly acknowledging and attending to those group differences in order to undermine oppression (Young, 1990, p. 3)

In other words, the primary question in thinking about distributive justice through this approach should be “how does the current maldistribution get produced?” rather than “what is the best model for distribution?” (Schlosberg, 2007, p. 15). Goods and resources are not static objects but are produced by social, cultural, economic, and political contexts and relations.

Therefore, these contexts and processes must be included in discussions and theorisations of justice. A comprehensive examination of the sociohistorical context shaping medical licensing in Aotearoa New Zealand, as seen in [Chapters 2](#) and [3](#), has been crucial to developing and applying the theoretical framework adopted in this research. An emphasis on identifying institutional processes and policies that may create a maldistribution of resources and opportunities for IMGs in Aotearoa New Zealand begins with understanding how these are experienced and why they may be produced, rather than directly seeking an ideal scenario.

Fraser (1998) also argues that it is crucial to examine the social norms, language, and customs that distinguish between those who are better or worse-off in the sociocultural sphere, in order to understand recognitional injustice. Lack of recognition and respect, manifesting as insults,

degradation, and devaluation of individuals and groups, generates injustice not only by harming and constraining people, thus inhibiting equitable distribution, but also because these behaviours negatively impact the formation of a positive sense of self. In this way, an individual's self-worth, dignity, and integrity are reliant, either directly or subliminally, on the approval or recognition of others (Schlosberg, 2007).

Potential injustices lie not only in inflicting physical and/or psychological pain but also in the victim's perception of misrecognition. Fraser's (1998) interpretation of injustice by misrecognition is inseparable from social relations and status, characterising misrecognition as a "status injury" (p. 25). Associated processes of misrecognition include cultural domination, being rendered invisible by nonrecognition, and disrespect in the form of stereotypical public and cultural representations. These interpretations do not rely on the psychological interpretation of the victim's feelings, and Schlosberg (2007) argues that this is connected to a wish to move away from a victim-centred understanding of recognition. This idea aligns with a shift towards a focus on an individual's capabilities, rather than shortfalls, as explored further in Subsection 4.3.3.

4.2.2 Context and Pluralism

The emphasis on contextual contributors to injustice also relates to another key distinction noted in justice literature: the contrast between *universalism* and *contextualism* (Miller, 2013). Universalist theories of justice strive to discover principles applicable across all circumstances, guiding judgment and behaviour. While these principles may be applied differently depending on the situation, the underlying universality remains constant (Miller, 2013). Conversely, contextualist views of justice are context-specific, commencing with an understanding of "who is distributing what to whom and in what circumstances" (Miller, 2013, p. 43), rather than by identifying universal and generic principles to apply. Any identified principles would only exist in relation to that specific context, as may be applicable, for instance, in Young's (1990) approach.

Despite allowing for multiple scales and contextual factors, Miller (2013) notes that the distinction between contextual and universal theories of justice is not synonymous with *monism* and *pluralism*. While contextualist theories are likely to be pluralist (accepting multiple, overlapping approaches), not all universalist theories are necessarily monist (with a preference for one overarching approach). Hence, a middle ground exists between these approaches, where, for example, a theory that appears to be universalist in nature (beginning with principles of justice), may only be applicable in specific contexts. Miller (2013) suggests that a theory of justice occupying this middle ground is likely to be the most defensible, arguing that contextual approaches have been "short-changed" in philosophy, which has tended to

favour universalist conceptualisations. Consequently, the theoretical framework for this research places a strong emphasis on context – in fact, it could not have been developed without consideration of the research context of this project (see Section 4.5).

4.2.3 Scales of Justice

Finally, the notion of context in justice intertwines with theories of scale. Walzer (1983) observes that principles of justice may only be pertinent within certain spheres of social life. As such, he proposes the existence of various life spheres, each with distinct criteria of justice, contending that applying the principles of justice from one sphere to another can lead to negative outcomes such as tyranny and inequality. Young (1990), for example, discusses “scaling of bodies”, examining how modern conceptions and theories have established some bodies as more or less desirable, and the interplay of this with race and the “Other”. Meanwhile, Soja’s theory of spatial justice (2010) draws analogies across different scales, highlighting how local examples can be microcosms for global issues. For instance, he characterises the “Third World” as akin to a “global ghetto”, located on the periphery and resembling “a redlined zone in a city, an area of purposeful disinvestment and superexploitation” (p. 58). Case studies of local examples can thus provide insights into justice issues on a broader scale.

The notion of scales of justice is particularly pertinent to this research, which explores the intricate relationship between IMGs’ experiences, their connections to both the country where they studied and where they currently reside, and the concerns raised in medical migration literature regarding global migratory patterns of doctors from the Global South to the Global North. A conceptual framework grounded in discussions and debates relating to recognition, context, and scale has therefore been pivotal to the development of this research.

This section has laid the initial groundwork for the theoretical framework of this research, by introducing crucial concepts and distinctions from the justice literature. These concepts form the bedrock upon which the capabilities approach to mobility justice, employed in this research, has been developed. A summary of key terms, derived from the sources discussed in this section, is presented in Table 7. This table serves as a reference point for the terms used to describe the theoretical framework that will unfold in the subsequent sections.

Table 7*Key Concepts and Distinctions Made Between Justice Theories*

Concepts	Definition(s)
Distributive, recognition, or corrective?	Focusing on how goods, opportunities and/or liberties are or should be distributed (<i>distributive</i> justice) compared an emphasis on the injustice presented by lack of recognition or misrecognition in particular situations (justice as <i>recognition</i>), and/or thinking about how to address this (<i>corrective</i> justice).
Universalist or contextualist?	Creating principles of justice that can be adapted to any situation (<i>universalist</i>), compared to developing principles that only apply to particular contexts (<i>contextualist</i>).
Comparative or non-comparative?	Depends on whether it is necessary to look at others in order to make a claim about justice (<i>comparative</i>) or whether the theory can be applied without comparison between individuals or groups (<i>non-comparative</i>).
Monist or pluralist?	Preference for one theory or ideology of justice (<i>monist</i>), compared to multiple, overlapping and equally acceptable approaches (<i>pluralist</i>).
Conservative or ideal?	Tension between conserving existing norms and practices as a form of justice (<i>conservative</i>), and demanding changes to the status quo to achieve justice (<i>ideal</i>).
Procedural or substantive?	Consideration of justice as process compared to justice in terms of outcomes; in other words, the difference between looking at just means (<i>procedural</i>) compared to the just ends or results (<i>substantive</i>).
Objective or relativist?	Whether the theory holds that independent moral truths exist independent of context (<i>objectivism</i>) or whether such truths can only exist in relation to a specific culture or society (<i>relativism</i>).

4.3 MOBILITIES AND CAPABILITIES

As highlighted above, conceptualisations of justice have evolved and transformed throughout history, with growing emphasis on grounding these theories within specific contexts. This trend is closely related to an increasing focus on justice in relation to geographical aspects such as spaces and mobilities. This section provides a theoretical overview of *mobility justice* and the *capabilities approach*, which form the foundational pillars of the theoretical framework for this research.

4.3.1 The New Mobilities Paradigm

Mobility justice is situated within a broader discourse known as the *new mobilities paradigm*, which integrates “social”, “spatial”, and “cultural” concerns to argue that the systematic movements of people, resources, and ideas have been largely minimised in the social sciences (Sheller, 2021, p. 12). Nevertheless, social worlds, including places, people and objects, do not exist in a sedentary state (Krämer & Schindler, 2016; Sheller, 2018a, 2021; Sheller & Urry, 2006, 2016). As Sheller and Urry (2006) explain, “sedentarism treats as normal stability, meaning, and place, and treats as abnormal distance, change, and placelessness” (p. 208). In this way, bounded places and spaces are prioritised as the “fundamental basis of human identity and experience and as the basic units of social research” (pp. 208-9). Mobilities

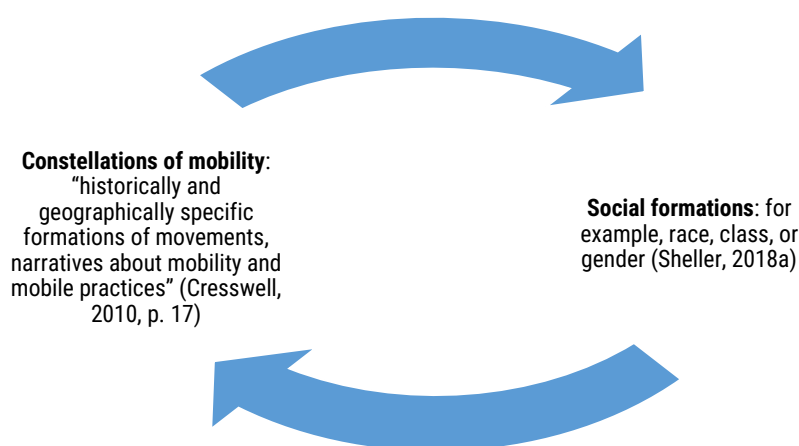
scholars challenge this way of thinking by conceptualising mobility on multiple, interactive scales as an integral, “normal” aspect of human life and society (Urry, 2007).

Going beyond a consideration of spaces as “containers”, where people, things, and ideas go to and come from (Soja, 2010), mobilities perspectives assert that the flows of people and goods to, from and within spaces are what *creates* these spaces, rather than being one characteristic of such spaces (Sheller, 2018a; Sheller & Urry, 2006). Spatial justice theorists such as Soja (2010) argue that forms of mobility and immobility constitute one aspect of the spatial, while scholars of the new mobilities paradigm, such as Sheller (2021), view the spatial as one component of mobility. In essence, mobilities have “always been the precondition for the emergence of different kinds of subjects, spaces, and scales” (Sheller, 2018a, p. 9).

As such, mobilities research underscores that movement, circulation, and uneven access to (im)mobilities should not be seen as a new phenomenon. Instead, historical and contemporary “constellations of mobility” (Cresswell, 2010, p. 17), which refer to interwoven patterns, representations and ways of practising movement, are shaped by social formations such as race, class, or gender which, in turn, contribute to such hierarchical systems. Mobilities and social formations are mutually constitutive, as illustrated in Figure 17. The intricate relationship between mobility and societal structures is particularly pertinent to understanding the complexities of medical migration, aligning with the objectives of this research.

Figure 17

Constellations of Mobility and Social Formations (Source: Created by Author)



The new mobilities paradigm is not confined to examining individual movements but extends to the development, transformation, and governance of systems of movement (Sheller, 2021). Instead of focusing only on the physical aspects of mobility, such as transportation, the

paradigm encompasses mobility within and between various scales, representing an intersection of approaches and topics across multiple disciplines. As Sheller (2018a) explains:

One social implication of mobilities research is that we need to address entire mobility systems, logistical practices, energy cultures, and the ways in which everyday mobility practices are embedded in these large socio-technical systems that are complex, interdependent, and more-than-human. These are fundamentally political and social questions that require attention to the social injustices built into present ways of “doing” everyday life, going places, moving things, and processing mobile information. (p. xv)

As highlighted in this quote, the new mobilities paradigm goes beyond considering human movement alone; the paradigm encompasses more-than-human components such as resources, animals, or knowledge. This broader perspective also allows exploration of the “power of discourses, practices and infrastructures of mobility in creating the effects of both movement and stasis” (Sheller, 2011, p. 2). In this thesis, the term *mobility* therefore encompasses various types of movement, including physical movement such as human migration, as well as intangible processes such as the movements of ideas, skills, and experience across and within people and places.

The COVID-19 pandemic has underscored the importance of mobility issues with its impact on daily movements, temporalities, routines, and communication, while exacerbating existing inequalities. Uneven mobilities within and across national borders became apparent, with public health justifications leading to border closures, restrictions, and deportations that disproportionately impacted vulnerable populations, including refugees (Sheller, 2021). Keil (2014) draws parallels between the characterisation of a virus as a threatening foreign body and the perception of racialised “foreign bodies” (p. 390) of migrants as socioeconomic, cultural, and biosecurity threats. The pandemic thus offers an opportunity for a fundamental reconstruction of structures of power toward more equitable systems (Sheller, 2021) and underscores the importance of mobilities-based research at this time.

4.3.2 *Mobility Justice*

The conceptualisation of mobility justice emerges within the framework of the new mobilities paradigm. Central to mobility justice is the assertion that prevailing theories of justice are insufficient because they often prioritise historical and social factors over mobility concerns. Sheller (2018a) argues that mobility injustices do not simply occur after people or objects enter a “space”, such as a car manufactured in one country and exported to another for sale and use, or a medical doctor who trained in one country and migrated to another for work. Rather,

injustices transpire via the processes in which these “unequal spatial conditions and differential subjects are made” (Sheller, 2018a, p. 21). Sheller (2018b) further argues that this requires consideration of “longer histories of colonial, racial, imperial, and military mobility” (p. 29). These contextual factors and processes determine whose freedom of movement is “a manifestation of liberty, and should therefore be maximized, and those whose freedom is a problem, and should therefore be tightly regulated” (Kotef, 2015, p. 100). In other words, mobility (in)justices can be formed when structures of power or “mobility regimes” (Sheller, 2018a, 2021) dictate who does and does not have the right to “move”.

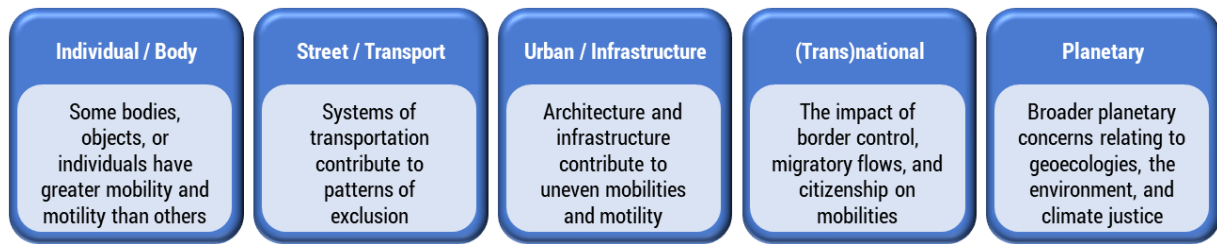
Constitutive of the concept of mobility, therefore, is the ability or *potential* for movement. This involves the uneven distribution (Adey et al., 2014) of “network capital” (Elliott & Urry, 2010, p. 11), or mobility capacity and capability, across multiple scales, such as the individual, urban, international, and planetary (Sheller, 2018a, 2018b). More privileged groups tend to have greater access to, and the potential for, mobility, known as “motility” (Kaufmann et al., 2004, p. 745), a highly “coveted” form of capital in contemporary times (Bauman, 1998, p. 2). Hence, as outlined in the Introduction, it is possible to view mobility justice as:

...an overarching concept for thinking about how power and inequality inform the governance and control of movement, shaping the patterns of unequal mobility and immobility in the circulation of people, resources, and information...occurring at different scales (Sheller, 2018a, p. 14)

Connecting to the notion of scales and spheres of justice introduced in Subsection 4.2.3, Sheller (2018a, 2018b) theorises mobility justice using a multi-scalar approach that considers five key scales of justice (refer to Figure 18). First, the scale of the individual or “body” considers how some bodies, based on factors such as ability, race, or gender, can move more easily than others in different situations. Second, the “street” scale loosely relates to forms of transportation in cities, while the “extended urban” scale relates to broader concerns of infrastructure and (un)even access to forms and methods of movement. The fourth, (trans)national scale examines the regulation of mobilities across borders, encompassing, for example, migration and tourism. Finally, mobilities at the planetary scale has a broader focus on climate and environmental justice. This multi-scalar perspective provides a comprehensive framework for analysing and addressing mobility injustices across various contexts and dimensions.

Figure 18

Scales of Mobility Justice, Based on Sheller (2018a, 2018b), Diagram Created by Author



While mobility justice theory underscores the importance of context, Sheller (2018a) puts forth 27 principles of mobility that should be protected in support of mobility justice. These principles begin with a core tenet that Sheller (2018a) characterises as the “rule of mutuality”, whereby one’s freedom of mobility should not infringe on the others’ capability for mobility. Returning to the key concepts and distinctions outlined above, this key principle speaks to the comparative nature of this theory of justice, emphasising the importance of avoiding harm to others in the pursuit of one’s own mobility or movement.

The remaining 26 principles span the five scales of mobility justice and include avoiding unjust restrictions based on immutable personal characteristics, achieving minimum thresholds of physical mobility, ensuring freedom of movement across borders without “arbitrary exclusion” (p. 174), and holding entities accountable for pollution and climate change. While these principles imply a theoretical orientation toward an ideal state, there is also strong emphasis on the conservation of the planet and environment at the planetary scale of mobility justice; the theory is both idealist and conservative in that respect. Furthermore, mobility justice encompasses the processes and the outputs of movement and mobility regimes, suggesting both a procedural and substantive focus.

In summary, Sheller’s (2018a, 2018b) mobility justice theory accentuates the just distribution of mobility and motility across all scales, while also highlighting the importance of recognition to prevent arbitrary exclusion of certain individuals and groups from forms of mobility and motility. While acknowledging the importance of understanding historical, sociocultural, and geographical contexts, universalist principles of justice are also proposed, rendering the approach both universalist and contextualist. The implied fluidity in mobility justice theory also mirrors the nature of mobilities, suggesting a degree of pluralism with overlapping disciplines, ideologies, and contexts.

4.3.3 The Capabilities Approach

The mobility justice framework, designed to be expansive and multi-scalar (Sheller, 2018a), has been further enriched by incorporating and emphasising capabilities approaches in

framing this research. The *capabilities approach*²⁶ to human development and wellbeing, which challenges an observed tendency to focus on the economic aspects of life, was developed from the 1980s onwards (Claassen, 2014). The approach contends that true human flourishing encompasses a variety of factors that influence what people are “actually able to do and to be” and the “real opportunities available to them” (Nussbaum, 2011, p. x). Capabilities, known also as “substantial freedoms” (Sen, 2009), represent the potential opportunities for individuals to choose and act in pursuit of things they have reason to value. Put simply, therefore, a capability is a means, not an end and, as a result, represents a potential opportunity rather than the active realisation, or “functioning” (Nussbaum, 2011), of a capability.

“Combined” capabilities denote the interaction between an individual’s abilities and the opportunities afforded to them by their environment (Nussbaum, 2011, p. 21), while “conversion factors” refer to the ability to translate capabilities into “functionings” or outcomes (Robeyns, 2017, p. 45). These conversion factors involve “personal” elements such as intelligence or physical condition, “social” factors including policies and norms, and “environmental” factors such as location and available infrastructure (Robeyns, 2017, p. 46). Whether someone can utilise a set of means or resources, in a way that they manifest as a capability or functioning, depends on personal, sociopolitical, and environment conditions (Robeyns & Byskov, 2020). The capabilities approach thus shifts the focus from the distribution of resources to an individual’s ability to utilise resources, skills, opportunities, and freedoms.

4.3.4 Capabilities and Justice

Robeyns (2017), a prominent scholar in the capabilities sphere, reflects on the discourse around capabilities and how the concept has evolved and been applied since its development. She distinguishes between the “capability approach”, referring to an open-ended, pluralistic framework with multiple applications, and more precise capabilities “theories”. For Robeyns, there is just one capability approach, characterised by the general features outlined above, but there are multiple capabilities theories. This perspective is echoed by Pereira et al. (2017), who explain that the capabilities approach is not intended as a full theory of justice, nor as one single theory, but rather aims to put human capabilities “at the heart of justice concerns” (p. 175).

Two noteworthy theorists who have contributed to the development of a capabilities approach to justice include Nussbaum (2006, 2011) and Sen (1984, 1985, 2009, 2015). Sen, who pioneered and developed the capabilities approach since the 1980s, supports elements of

²⁶ This is also referred to as the “capability approach” (e.g. Robeyns, 2017).

Rawls's distributive justice theory (e.g., Rawls, 1999, 2003). However, he also proposes that the focus of the Difference Principle²⁷ should not be on distributing primary goods, but rather the just distribution of human capabilities. According to Sen (2009), reducing inequalities in capabilities is crucial for promoting equality of opportunities, and any list of basic capabilities and minimum thresholds must be culture- and context-dependent. These contextual thresholds are tied to agency and choice regarding whether to act to convert capabilities into functionings. This theory is thus contextualist, rather than universalist in nature.

In contrast, Nussbaum (2006, 2011) supports the idea of a universal baseline of central capabilities that any state should guarantee for its citizens, even if the specifics are context-dependent. These baseline capabilities include entitlements to life, health, bodily integrity, freedom of movement, and political and material control over one's environment. Capabilities provide freedom of choice, and a capabilities approach to justice involves protecting freedoms central to maintaining human dignity. Human dignity, in this theory, is understood as a fluid and "intuitive" (Nussbaum, 2011, p. 29) concept related to "respect" and "nonhumiliation" (Nussbaum, 2006, p. 292), "agency" (Nussbaum, 2011, p. 30) and "equality" (Nussbaum, 2006, p. 303; 2011, p. 31). In this sense, "people are entitled not only to mere life, but to a life compatible with human dignity, and this entitlement means that the relevant goods must be available at a sufficiently high level" (Nussbaum, 2006, p. 292). This thesis uses Nussbaum's understanding of human dignity.

These capabilities theories, while differing in their orientation, underscore the importance of enhancing opportunities and freedoms, emphasising context, and acknowledging the intricate relationship between personal, sociopolitical, and environmental conditions.

4.4 A CAPABILITIES APPROACH TO MOBILITY JUSTICE

In this thesis, I follow Robeyns's (2017) distinction between the capabilities approach and capabilities theories and do not attempt to create a new capabilities theory of justice. Instead, I seek to explore how the pluralistic capabilities approach can contribute to expanding mobility justice theorisations, particularly in the context of the skilled migration of medical professionals. This approach aims to closely examine the nuances of the movement of individuals and their associated capabilities across borders, bringing capabilities more explicitly into mobility justice theorisations.

²⁷ Rawls proposes an alternative form of egalitarianism (a theory of justice favouring notions of equality), based on the "Difference Principle". This principle argues that some inequalities in wealth can ultimately lead to benefits for all, by, for example, covering the costs of training and education and providing incentives for people to aspire to certain jobs or futures (Rawls, 2003).

4.4.1 Existing Overlaps Between the Capabilities Approach and Mobility Justice

The distinction Robeyns (2017) draws between the capabilities approach and capabilities justice theories is akin to the relationship between the new mobilities paradigm and mobility justice. The capabilities approach and the new mobilities paradigm both highlight specific areas that proponents believe have been overlooked in earlier theory and discourse. On the one hand, the capabilities approach is concerned with shifting away from the emphasis on economic factors as measures of development or wellbeing, focusing instead on what people are truly able to “be” and “do” (Nussbaum, 2011, p. x). On the other hand, mobilities approaches challenge the way that bounded places and spaces are prioritised as the “fundamental basis of human identity and experience and as the basic units of social research” (Sheller & Urry, 2006, pp. 208-209), conceptualising mobility on multiple, interactive scales as an integral, “normal” aspect of human life and society.

Both approaches thus advocate for a general shift away from perceived theoretical norms, encouraging scholars to consider more encompassing ways of viewing people, spaces, and places. The integration of the capabilities approach into mobility justice theorisations allows for a nuanced understanding of individuals’ abilities and opportunities within the context of skilled migration, enriching the analysis with a focus on wellbeing, agency, and the freedom to pursue valued functionings. This combined framework provides a more comprehensive lens for exploring justice concerns in the mobility of medical professionals.

While there is some existing connection between the capabilities approach and mobility justice, this overlap remains limited in scope. Nussbaum (2011), for instance, discusses the relationship between an enhanced capability for mobility and political participation in democracy. Sheller (2018a) also integrates elements of the capabilities approach in her conceptualisation of mobility justice, emphasising freedom of movement as a capability. However, her discussion of capabilities primarily centres around the physical aspects of mobility such as transportation (pp. 25-26), rather than the movement of capabilities associated with ideas, knowledge, or skills. Pereira et al. (2017) also explore how mobility can be viewed as a capability, conceptualising it as “accessibility”, a combined capability referring to both the ability to move freely and the ability to convert mobility into access to other resources. These approaches conceptualise both the idea of movement, and the potential for movement, or “motility” (Kaufmann et al., 2004, p. 745). While not explicitly mentioned in existing literature, I would thus suggest that motility also be considered as a capability.

In this way, mobility can be conceptualised as a capability (a means to achieve a functioning), a functioning (an end in and of itself), and as a key factor in the production, maintenance, and distribution of other capabilities and primary goods. In other words, mobility is both an end

and a means to (in)justice, where it is both a capability and a functioning, as well as both distributed and distributive. Such a conceptualisation allows for a more intersectional approach to understanding mobility, which considers the international mobility, transferability, and recognition of capabilities associated with education, training, and skills, within the wider global dynamics of medicine and health. This broader conception of mobility intersects with the capabilities approach's emphasis on the non-tangible elements of life, highlighting the importance of enabling individuals to achieve goals that are crucial to leading a satisfactory life (Nussbaum, 2011; Sen, 2009).

4.4.2 Mobility Justice, Capabilities, and Notions of Scales

The intersection of mobility justice and the capabilities approach could be argued to extend to notions of scales. The new mobilities paradigm (Sheller & Urry, 2006), Sheller's (2018a) mobility justice theorisations, and the capabilities approach, are multi-scalar. In Nussbaum's (2011) capabilities approach to justice, the international responsibility to address the unequal global distribution of capabilities is emphasised. Similarly, as outlined in Subsection 4.3.2, Sheller's (2018a) mobility justice theory considers justice within and between scales ranging from the individual to the planetary.

This consideration of scales is instrumental in addressing the dichotomy seen in some medical migration literature between the right of the individual doctor to migrate and of populations to have access to adequately staffed health systems (refer to [Chapter 3](#), Section 3.2). While the prioritisation of individual agency over the greater good in the capabilities approach has been critiqued (Gasper, 2002; Stewart, 2005, 2013), Robeyns (2017) emphasises how the capabilities approach acknowledges the environmental and social factors associated with translating capabilities into realised functionings. Both mobility justice and the capabilities approach underscore the interconnectedness of individuals within broader societal structures, encouraging scholars to consider a more nuanced range of scales that resist the tendency to place the individual and the collective in opposition to each other.

The nuanced nature of capabilities and mobility justice approaches is further enriched by the consideration of "capabilities", "motility", and "mobility" as value neutral concepts (Robeyns, 2017; Sheller, 2021). While mobility justice and mobilities approaches often view the freedom to move as a fundamental good that should be available to more of the population, the capabilities approach also recognises the positive aspects of the freedom to move without restriction. However, the approach also acknowledges that not all capabilities, such as the capability to inflict harm on others, should be automatically considered valuable. Similarly, greater mobility and "network capital" (Elliott & Urry, 2010, p. 11) in daily life does not always equate to increased privilege and opportunities. Rather, as Sheller (2018a) notes, an unlimited

capability for mobility (motility) through travel and transportation would result in disastrous consequences for the environment and negative daily impacts through increased congestion. Therefore, a greater capability for mobility at one scale, such as the individual, does not necessarily translate into enhanced mobility justice at other scales, such as the planetary level. This nuanced perspective encourages a comprehensive evaluation of mobilities and capabilities at various scales.

Although a key aspect of capabilities is the opportunities they afford, I would thus suggest a distinction may be drawn between the *quantity* and *quality* of these opportunities. Scholars such as Oberman (2016) argue that true equality of opportunity comes from entitlement to a full range of options, emphasising the importance of quantity. Blake (2020), on the other hand, suggests that the size of these sets of options is less important than why they are the size they are. This line of thinking might be expanded further to introduce a consideration of the quality of these opportunities. A large quantity of capabilities and/or conversion factors do not automatically translate into quality opportunities. In adopting a capabilities approach to mobility justice in this thesis, the focus is on understanding which capabilities and opportunities hold value or possess greater quality for research participants in this context, and why.

In addition, the intersectional focus of mobility justice allows for further incorporation of the more-than-human when bringing the capabilities approach to the forefront. Sheller (2018a) observes that knowledge from the Global South is often perceived as less valuable than that from the Global North. This, I suggest, can result in a misalignment between an individual and their associated capabilities when crossing borders. As discussed in [Chapter 3](#) (Subsection 3.3.3), for example, many individuals on the NZREX licensing pathway are able to move to Aotearoa New Zealand but are not able to convert their professional capabilities associated with their medical training and experience into functionings that allow them to practise medicine. In this sense, “uneven mobilities” (Sheller, 2021, p. 11) are created not only between individuals and various scales of justice, but *within* the individual themselves. Their physical capability for movement across borders does not always align with their professional capabilities. The theoretical framework in this thesis explores not only the capability *for* knowledge and training but also the capabilities *of* knowledge and training in the context of transnational movement. When crossing borders, knowledge, skills, and experience can have agency depending on power structures and mobility regimes.

Moreover, both mobility justice and the capabilities approach include an element of advocacy. Nussbaum’s (2006, 2011) capabilities theory of justice is not just theoretical, but also a call to action that should inform governments and public policy in improving the quality of life for all

people and addressing entrenched injustices. Similarly, Sheller's (2018a) theory of mobility justice aims to provide a means of identifying, understanding, and addressing mobility injustices. Therefore, a capabilities approach to mobility justice not only seeks to identify and understand forms of (in)justice but also considers ways of making practices more just. In this way, the approach is also a call to action. During this research, opportunities to share initial findings with the wider public to raise awareness of the experiences of IMGs in Aotearoa New Zealand have been taken up (e.g., Thomas-Maude, 2022; Thomas-Maude & McLennan, 2022).

4.4.3 Towards a Capabilities Approach to Mobility Justice

In developing an analytical lens to frame this research, I have sought to synthesise ideas from the existing literature to further the conceptualisation of a capabilities approach to mobility justice. The capabilities approach to mobility justice developed in this research explores patterns of unequal mobility and motility, considering both human and more-than-human elements, such as resources, information, and accreditation. The aim is to understand how these patterns interact with opportunities and freedoms at different scales, leading to injustices that may hinder individuals from leading the lives they wish to live, with dignity. The framework places human capabilities not "at the heart of justice concerns" (Pereira et al., 2017, p. 175), but at the heart of *mobility* justice concerns, with a specific focus on medical migration and licensing in Aotearoa New Zealand. In this way, the approach seeks to protect and advance human dignity.

Two principles from Sheller's (2018a) mobility justice framework have also been instrumental in shaping this theoretical approach. First, the "rule of mutuality" emphasises the importance of achieving freedom of movement without detriment to others. Building on this principle, this capabilities approach to mobility justice seeks to maximise human and more-than-human mobilities and capabilities without inhibiting the mobilities and capabilities of others.

Second, Sheller (2018a) advocates for "fairness and equity in determining the freedom of movement across borders without arbitrary exclusion of entire categories of persons on the basis of race, religion, ethnicity, nationality, sexuality, health status, or socioeconomic status" (p. 174). In incorporating this principle, my theoretical lens also strives to identify and consider ways to overcome arbitrary exclusions – or inclusions – of individuals or groups based on such immutable characteristics.

Embracing pluralism, this approach further acknowledges that justice considerations may be context-dependent, with multiple, potentially conflicting, perspectives. For instance, in the context of Aotearoa New Zealand's medical licensing pathways for IMGs, advantages available to doctors from the Global North might be interpreted as discouraging brain drain from the

Global South. In this way, the limitations on professional mobilities and capabilities experienced by doctors who trained in the Global South may be justified by the reconfigured rule of mutuality, in that these constraints could be viewed as necessary to protect the provision of healthcare in Global South countries. However, at the same time, barriers preventing the registration of IMGs from the Global South could be perceived as an injustice, as individuals and their capabilities and mobilities are arbitrarily excluded based on the country of training rather than personal merits, skills, or knowledge.

This capabilities approach to mobility justice is thus inherently pluralistic. The approach enables researchers to navigate conflicting forms of (in)justice, recognising that the same regulatory framework can be experienced and interpreted differently by various groups or individuals. However, this pluralistic nature also means the approach does not provide definitive answers to all questions emerging from the literature, such as establishing baseline capabilities for IMGs in Aotearoa New Zealand or determining how mobilities and capabilities should be justly distributed. Instead, this approach allows for a range of perspectives, emphasising the complex and multifaceted nature of medical licensing through a contemporary and sociohistorical lens that considers both individual experiences and the power regimes shaping mobilities and capabilities. In this way, the approach places a strong emphasis on contextuality over universal principles and contends that determining justice in a particular situation cannot rely solely on predefined, hypothetical principles but must be considered within the specific context. This perspective has been instrumental in shaping a framework guided by initial precepts from capabilities and mobility justice literature and then further refined by the contextual findings of IMG experiences.

Furthermore, this capabilities approach to mobility justice also emphasises the role of recognition and respect in contributing to forms of (in)justice. As noted in Subsection 4.2.1, Young (1990, 2003) and Fraser (1995, 1998, 2009) are among a group of scholars who have highlighted how a lack of recognition contributes to the production of injustices. Given the themes of Othering and discrimination observed during the literature review and policy analysis (see [Chapter 3](#), Section 3.4), this approach brings questions related to recognition and respect to the forefront in the research design and implementation. By incorporating these threads of justice, this capabilities approach to mobility justice becomes more than the sum of its parts. The approach allows for a clearer integration of other relevant aspects, such as recognition, in understanding the experiences of highly-skilled medical professionals moving across borders.

Table 8 summarises the key aspects of my capabilities approach to mobility justice in relation to the distinctions and concepts discussed in this chapter, synthesising key ideas and serving as a reference point for the overarching framework applied in this research.

Table 8

Key Characteristics of a Capabilities Approach to Mobility Justice

Characteristic	Description
Guiding principle(s)	The approach seeks to protect and advance human dignity, by maximising human and more-than-human mobilities and capabilities without inhibiting the mobilities and capabilities of others, while identifying and considering ways to overcome arbitrary exclusions of individuals and/or capabilities based on immutable characteristics such as nationality, gender, or ethnicity.
Distributive, recognition, or corrective?	Emphasis is on the (un)even distribution of (im)mobilities and capabilities (<i>distribution</i>), while also bringing <i>recognition</i> to the forefront in considering the protection of human dignity.
Universalist or contextualist?	The interaction between mobilities and capabilities is unique to the context, and justice considerations cannot be made outside of this context (<i>contextualist</i>).
Comparative or non-comparative?	The reconfigured rule of mutuality means that justice issues surrounding mobilities and capabilities are considered in relation to others (<i>comparative</i>), rather than emphasising the prescription of a minimum threshold of capabilities and/or mobilities.
Monist or pluralist?	Multiple perspectives and theorisations can exist in relation to a capabilities approach to mobility justice, although there are some key shared characteristics, making the approach <i>pluralist</i> .
Conservative or ideal?	Although a universal ideal state is not advanced, the approach aims to identify and explore the production of (in)justices and how these may be addressed, leading more towards an <i>idealist</i> stance.
Procedural or substantive?	Mobilities and capabilities are both distributed and distributive; they can represent both the means (<i>procedural</i>) and ends (<i>substantive</i>) of (in)justice.

4.5 DEVELOPMENT OF THE 4Ps

The purpose of a theoretical framework is to guide the researcher in selecting methods, in considering which questions to ask during data collection, and providing the lens through which data analysis and discussion is carried out. While Section 4.4.3 describes how existing literature on justice, recognition, capabilities, and mobility justice has been explored and synthesised to provide a foundation for this capabilities approach to mobility justice, this section lays out the components that have evolved in conjunction with data collection and

analysis. In other words, the section discusses how this framework has been useful in conceptualising this research.

First, the development of this theoretical framework, and the research process, have been mutually constitutive. On the one hand, existing literature provided a basis for key questions and themes to consider in collecting and analysing qualitative data in the first phase of this research (refer to [Chapter 5](#) for further discussion of research design). On the other hand, the themes that emerged from the data collated during this project were crucial in shaping the way this framework was developed and applied in this context. For example, it became clear early on that IMGs in Aotearoa New Zealand distinguished between their professional qualifications and experiences, and the personal and social factors they saw as influencing their professional outcomes. Participants often also cited a disconnect between their physical ability to migrate as individuals, and the ability to migrate while being recognised for their professional capabilities. It was thus important to explore the nuances of how policies and norms shaping the mobilities and capabilities for migrant doctors in this context were applied and experienced in practice. Furthermore, there was a sense that many research participants were struggling to understand why some professional capabilities were recognised, while others were not, leading to broader questions around the mobilities regimes and structures of power influencing IMG experiences in Aotearoa New Zealand.

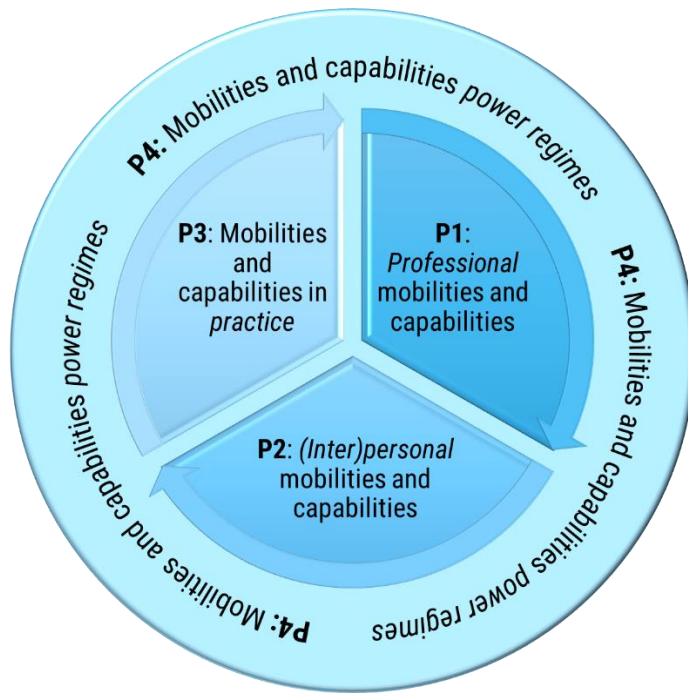
Second, I initially sought to consider how the notion of five scales of mobility justice put forward by Sheller (2018a, 2018b) may be useful in conceptualising these distinctions. However, the thematic distinctions identified by research participants in characterising their experiences did not align neatly with these scales. The bodily scale considers how individual characteristics impacted on mobilities, capabilities, and recognition. Furthermore, the (trans)national scale focuses on the way systems and regulations control movement across borders, which is particularly applicable to the international migration of medical professionals. Nevertheless, the professional and (inter)personal elements, as well as those relating to power and the transition of policy from paper into practice, could be seen across these scales. Therefore, I drew on concepts from the mobility justice and capabilities literature, and themes from the data collected during this research, to create what I have termed the *4Ps*.

The four components of the *4Ps* comprise *professional* mobilities and capabilities (P1), *(inter)personal* mobilities and capabilities (P2), mobilities and capabilities in *practice* (P3), and mobilities and capabilities *power regimes* (P4). While all four components are interrelated and may often overlap, P4 encompasses and is also woven into the other three key components of this framework. Collectively, the *4Ps* offer a comprehensive lens for examining skilled

migration, professional capabilities, and mobility justice. Figure 19 offers a visual overview of the interrelationship between the 4Ps components.

Figure 19

Visual Representation of the 4Ps Framework (Source: Created by Author)



The 4Ps components provide a nuanced and adaptable approach for exploring the complexities of skilled migration, guiding the research in understanding the (un)just aspects of a given context and suggesting potential avenues for addressing perceived injustices. To this end, in accordance with the contextualist and pluralistic nature of the framework, several key questions were drawn out of the literature and the research findings, rather than universalist principles. These were refined and expanded on during data collection and analysis, and associated with each of the 4Ps, as laid out below.

While the 4Ps emerged from this research context, these components may also be adapted to other research related to skilled migration. Rather than referring specifically to medical licensing in Aotearoa New Zealand, therefore, with the exception of illustrative examples, the following subsections focus on how these questions might relate in a more general sense to research into the experiences of migrant professionals.

4.5.1 P1: Professional Mobilities and Capabilities

In this capabilities approach to mobility justice, knowledge, skills, and experience are seen not only as capabilities, but as having their own mobilities and capabilities connected to translating these into functionings in a new context. Professional mobilities and capabilities concern the

qualifications, training, and experiences of individuals as they move across borders, and involve examining the extent to which their capabilities can be translated into functionings that enable meaningful work in their chosen profession. In essence, P1 explores the realisation of an individual's professional potential in a new environment.

This component speaks to professional aspirations, labour mobility, and the pursuit of professional recognition in a new context. P1 underscores more-than-human mobilities and capabilities, emphasising the recognition and conversion of capabilities linked to qualifications and training in a new setting. For instance, in this research, P1 has involved investigation of the acceptability of qualifications and clinical experiences of IMGs from diverse backgrounds in Aotearoa New Zealand.

Consideration of P1 involves posing the following types of questions during the research design and analysis process:

- How do individuals and their professional skillsets interact with a new environment to facilitate or inhibit the conversion of capabilities into desired functionings?
- Which knowledge, skills, and experience can or cannot be translated into functionings when crossing borders?
- How can uneven mobilities or arbitrary exclusions be identified and addressed in relation to the recognition of skillsets and experiences of migrant professionals from diverse backgrounds?
- To what extent are a migrant professional's capabilities recognised and valued in the destination country?
- Does the (mis)recognition of the skills and capabilities of migrant professionals generate mobility and capabilities (in)justices and/or impact the protection of human dignity? If so, how?
- How might professional mobilities and capabilities injustices be addressed in this context?

Through these kinds of inquiries, P1 enables a comprehensive exploration of the dynamics and challenges associated with the professional mobility and capabilities of individuals, highlighting the factors influencing the recognition and translation of their skills into a new environment.

4.5.2 P2: (Inter)Personal Mobilities and Capabilities

P2 directs attention from qualifications and training to the personal, social, and cultural dimensions that intersect and shape the mobilities and capabilities of migrant professionals. This component considers various (inter)personal dimensions, including “personal conversion

factors”, such as personality, age, or health and “social conversion factors” such as ethnicity and gender, which may limit or enhance the translation of professional capabilities into functionings (Robeyns, 2017, p. 46). These factors are closely tied to cultural aspects associated with navigating a different environment when crossing borders, influencing a migrant’s sense of integration and acceptance.

P2 facilitates an exploration of the identity and interactions of individuals and groups upon entering new environments. It is intertwined with themes of (mis)recognition, Othering, language, and communication. In this research, for instance, P2 has been investigated by prompting internationally trained medical professionals to reflect on the personal, social, and cultural factors influencing their medical licensing experiences in Aotearoa New Zealand. The interpretation of data has also explored relationships between independent variables such as gender or country of primary qualification, and professional experiences and outcomes.

Key questions guiding the research design and analysis in relation to P2 include:

- What kinds of personal and interpersonal (social) conversion factors may limit or enhance the combined capabilities of migrant professionals in a new environment?
- How do social formations, such as race, class, and gender, intertwine with “constellations of mobility” (Cresswell, 2010, p. 17) to shape the migrant professional experience and their combined capabilities?
- Who can or cannot exercise professional mobility and achieve their desired professional functionings with dignity?
- How do forms of (mis)recognition or Othering contribute to (un)even mobilities and capabilities, and differential experiences and outcomes?
- What other personal, social, or cultural factors may impact the way the capabilities of migrant professionals interact with their new environments?
- How might (inter)personal mobilities and capabilities injustices be addressed in this context?

P2, therefore, provides a lens through which to examine the intricate interplay of personal and social dimensions that influence the mobilities and capabilities of migrant professionals in a new environment.

4.5.3 P3: Mobilities and Capabilities in Practice

The third component considers the practical aspects of achieving professional combined capabilities and functionings in a new context. In general, this component focuses on examining how policies and regulations associated with the migrant professional experience are translated from theory into practice. P3 considers the ease of navigating processes and

institutions upon entering a new environment, the availability of information and guidance, and the presence of support systems. Moreover, when bureaucratic or systemic barriers impede the mobilities and capabilities of migrant professionals, P3 explores how individuals or groups attempt to subvert the system or find alternative solutions. This expands on Sheller's (2018a) notion of "subversive mobilities" (p. 19), to encompass both the mobilities and capabilities employed as a form of resistance against dominant mobilities and capabilities power regimes.

In the context of this research, P3 has been applied to consider how medical licensing policies and processes, as outlined in Chapters 2 and 3, are experienced in practice. This includes an examination of the extent to which these policies create differential experiences or arbitrary exclusions for individuals from certain backgrounds, and how lived experiences match what is expected on paper.

Questions that have guided the research design and analysis in relation to P3 include:

- How do policies, regulations, and standards defined on paper translate into practice, either maximising or inhibiting certain mobilities and capabilities?
- How do policies and processes directly or indirectly generate (un)even mobilities and capabilities, patterns of (mis)recognition, or arbitrary exclusions?
- How do policies, mobilities, and capabilities constitute spaces and places in this context?
- How do processes of transparency, (in)consistency, and clarity support or inhibit the inclusion or exclusion of some individuals and their capabilities and forms of mobility?
- What modes of counter-power and/or subversive mobilities might allow resistance, confrontation, or escape from the mobilities and capabilities power regimes that shape these dynamics?
- How might mobilities and capabilities injustices be evident in policy, as well as the translation of policy into practice, be addressed in this context?

P3, therefore, provides a lens through which to investigate the practical implementation of policies and regulations and their impact on the mobilities and capabilities of migrant professionals.

4.5.4 P4: Mobilities and Capabilities Power Regimes

The fourth component introduces the concept of mobilities and capabilities power regimes, an extension of Sheller's (2018a) notion of "mobility regimes", with a greater emphasis on capabilities. This component aims to identify and understand the power structures that influence the experiences of migrant professionals, including who or what makes decisions,

how accountability is assigned, and how these regimes are encountered. In essence, P4 shifts the focus from exploring how mobilities and capabilities are manifested and experienced in a specific context (as seen in the first three Ps) to why these are experienced in such a way.

P4 involves a broader examination of the sociohistorical and cultural context that has shaped the emergence of systems and governance regimes regulating various mobilities and capabilities. In this research, this component is also connected to internationally impactful concepts such as brain drain, gain, and waste, and their interactions with workforce shortages, the COVID-19 pandemic, and development dynamics between the Global North and Global South.

Questions associated with research design and analysis guided by P4 include:

- Who governs or controls mobilities and capabilities systems and regimes, and who stands to gain from these systems and regimes?
- How have sociohistorical and cultural ideologies shaped the formation of contemporary mobilities and power regimes, and how do these ideologies contribute to (mis)recognition or arbitrary exclusions?
- How do power regimes generate (un)even mobilities and capabilities concerning the professional, (inter)personal, and practical components of the migrant professional experience?
- How might outcomes related to unjust mobilities and capabilities power regimes be addressed in this context?
- How might mobilities and capabilities power regimes be reimaged in this context to promote mobilities and capabilities justice and protect human dignity?

By investigating these questions, P4 aims to uncover the underlying power structures and systemic influences that shape the experiences of migrant professionals in terms of mobilities and capabilities, paving the way for a deeper understanding of justice considerations in this context.

4.6 CONCLUSION

Medical migration involves not only the potential physical (in)ability of doctors to move internationally (especially in the context of COVID-19), but also the transferability of knowledge, skills, and abilities across borders. In seeking a framework to unpack these complexities, this chapter describes a mobility justice approach that further incorporates and emphasises capabilities, and has been developed over the course of this research into IMG medical licensing in Aotearoa New Zealand. By drawing insights from existing literature on

capabilities and mobility justice, complemented by the research context, a conceptual framework has emerged. This framework has not only shaped the trajectory of research design, data collection, and analysis in this project but also offers broader implications for understanding barriers and enablers to capabilities and mobility justice.

This capabilities approach to mobility justice has culminated in the development of the 4Ps, which comprises four interrelated components, each contributing a unique perspective to the intricate tapestry of the migrant professional experience. P1, focusing on professional mobilities and capabilities, explores the translation of qualifications and skills into meaningful work. P2, centring on (inter)personal mobilities and capabilities, explores the personal, social, and cultural dimensions shaping the experiences of migrant professionals. P3 considers mobilities and capabilities in practice, examining the practical aspects of navigating policies and processes. Finally, P4 examines mobilities and capabilities power regimes, seeking to unravel the sociohistorical and cultural contexts influencing governance structures and decision-making. Together, these components provide a comprehensive lens for examining how capabilities and mobilities intersect, addressing the diverse facets of the migrant professional experience and uncovering the underlying power dynamics that shape their mobilities and capabilities.

While initially developed in the context of medical migration, the versatility of the 4Ps could extend to a broader spectrum of contexts, especially in relation to the recognition and conversion of migrants' professional capabilities into functionings in new environments. The ensuing sections of this thesis explore the nuanced application of the 4Ps components, describing the research design before unravelling the complexities of IMG experiences with medical licensing in Aotearoa New Zealand.

5 RESEARCHING MEDICAL MIGRATION IN CONTEXT: A MIXED METHODS APPROACH

5.1 INTRODUCTION

In this chapter I discuss my mixed methods approach to conducting this research, explaining how this relates to the capabilities approach to mobility justice framing outlined in the preceding chapter. The development of a methodology during the research process is not a straightforward, linear progression but a cyclical and iterative one (Cheng, 2018) and this has been the case with this research, where the objectives and methodology have undergone continuous refinement before, during, and after data collection and analysis.

As discussed below, an advantage of an exploratory sequential mixed methods approach lies in the inherent flexibility of the research design. The initial phase, comprised of qualitative, semi-structured interviews, was important in laying the groundwork for the second phase, which involved a quantitative, online questionnaire. Consequently, the content of the second phase could not be fully predicted or pre-planned until the first stage was complete. This deliberate feature facilitated a comprehensive understanding of the research problem, ensuring that the most appropriate questions were posed and addressed.

In this chapter, I begin with an exploration of the research paradigms within which this study is situated, social constructionism and postpositivism. I then explain how these paradigms can be reconciled within a sequential mixed methods approach. The rationale for the research design is then laid out, followed by the data collection and analysis strategies for each of the sequential phases of this research. The chapter concludes with a reflection on the ethical considerations that are particularly salient to this project. Overall, I demonstrate how a mixed methods approach has proven effective in addressing the under-researched nature of IMG licensing experiences in Aotearoa New Zealand, and in facilitating the iterative development of the theoretical framework.

5.2 RESEARCH QUESTIONS AND PARADIGMS

As outlined in the [Introduction](#), this research has aimed to understand the experiences of practising and non-practising international medical graduates (IMGs) in Aotearoa New Zealand, through a capabilities approach to mobility justice, considering the following research questions:

- How do the different licensing pathways and processes for medical registration in Aotearoa New Zealand shape IMGs' experiences and professional outcomes?
- How can understanding these experiences and outcomes inform the development of a capabilities approach to mobility justice?

5.2.1 *Mixed Methods*

I have drawn on a mixed methods approach to answering these research questions. *Mixed methods* refers to a methodological approach that involves integrating qualitative and quantitative approaches to data collection and analysis at some or all stages of the study (Bryman, 2006; Creswell & Plano Clark, 2018; Johnson et al., 2007; Plano Clark & Ivankova, 2016; Teddlie & Tashakkori, 2009). While mixed methods often go beyond just method integration, encompassing the blending paradigms and data analysis techniques (Creswell, 2015; Creswell & Plano Clark, 2018), the term mixed methods has become well-established in the literature (Creswell, 2010, 2015).

Mixed methods are believed to offer a deeper understanding of the research problem than qualitative or quantitative approaches alone (Creswell, 2015; Doyle et al., 2019), akin to the “research equivalent of $1 + 1 = 3$ ” (Creswell & Plano Clark, 2018, p. 13). This approach is particularly useful for research with both “exploratory” and “confirmatory” questions and for discovering unknown aspects of a topic (Plano Clark & Badiee, 2010). As IMGs in Aotearoa New Zealand are an under-researched group, this research employed in-depth interviews to gain a comprehensive understanding of their experiences before attempting to quantify related themes.

Mixing methods can *offset* the potential limitations associated with each method (Creswell, 2015). While quantitative data may lack personalisation and an understanding of participants' contexts, the qualitative component explores these aspects (Creswell, 2015). Additionally, quantitative methods help avoid “elite bias” (talking only to high-status individuals), which is more likely to occur in qualitative approaches, contributing to a more comprehensive understanding of themes uncovered in the qualitative component of my design (Johnson et al., 2007). Indeed, the benefits of this mixed methods approach became evident during participant recruitment, when some individuals initially interested in interviews withdrew due to concerns about vulnerability and confidentiality. The anonymous, quantitative component of the research helped address these challenges and enriched the overall study design.

5.2.2 *Research Paradigms*

In addressing these research questions, this project is also grounded in two research paradigms: social constructionism and postpositivism. A paradigm is a framework of beliefs

and practices that guides researchers in selecting questions and research methods (Morgan, 2007). This subsection first explores social constructionism before moving on to postpositivism.

Social constructionism, despite many variations, generally posits that “all knowledge claims and their evaluation take place within a conceptual framework through which the world is described and explained” (Schwandt, 2007, p. 38). Essentially, social constructionism contends that our perception of reality is not an objective or fixed truth but is actively shaped by social processes, language, and cultural contexts. Social constructionism also highlights the subjective nature of experiences, the influence of power dynamics on defining norms, and the fluid, evolving nature of social constructs over time (Schwandt, 2007).

In this research, applying a social constructionist paradigm has involved examining how participants experience and make sense of their realities. The diverse pathways to medical licensing in Aotearoa New Zealand are themselves also social constructs. This paradigm aligns with the conceptual framing of a capabilities approach to mobility justice, which emphasises pluralistic and contextualised understandings of power structures related to movement and capabilities – themselves social constructs – and how these are brought into being or are experienced (see [Chapter 4](#)). The research has thus explored how the social constructs of medical licensing policies and pathways are experienced, and how these shape the realities of IMGs in Aotearoa New Zealand.

Qualitative methods are usually favoured for investigating research questions aligned with a social constructionist epistemology, while quantitative methods have historically been associated with hypothesis testing and generalisation, reflecting a positivist epistemology (Ghiara, 2020; Lichtman, 2014). However, these distinctions have become less rigid in the 21st century, particularly with the growing popularity of mixed methods approaches. Positivist approaches generally assume an objective reality can be measured, observed, and analysed using scientific methods (Ryan, 2018). In contrast, postpositivism has emerged in response to some limitations of earlier positivist notions by recognising the role of subjectivity, context, and interpretation in the research process (Lichtman, 2014), while still emphasising the existence of a singular reality (Creswell & Plano Clark, 2018).

Extensive debate on the compatibility of social constructionist and (post)positivist approaches to research in the late 20th century led to what has been described as the “paradigm wars” (Bryman, 2008; Creswell & Plano Clark, 2018; Johnson et al., 2007; Maxwell & Mittapalli, 2010). Some scholars argued that qualitative and quantitative research methods are fundamentally incompatible (e.g., Smith & Heshusius, 1985), suggesting that social constructionism and

(post)positivism are irreconcilable due to the contrasting assumptions they make about knowledge. However, these stances have become less prominent since the 1990s, as mixed methods increased in popularity (Bryman, 2008; Creswell & Plano Clark, 2018). Scholars have since considered using two or more paradigms together, or adopting an alternative paradigm that embraces a plurality of assumptions and methods (Greene, 2006), whereby mixed methods rely on mixed paradigms. Consequently, mixed methods approaches, which incorporate both qualitative and quantitative methods, represent an attempt to reconcile paradigmatic differences (Bryman, 2008) in search of a balance between subjectivity and objectivity (Shannon-Baker, 2016).

Mixed methods researchers often adopt a pragmatist approach that prioritises the appropriateness of methods for comprehensively answering the research questions over close engagement in paradigmatic debate (Bryman, 2008; Lichtman, 2014; Plano Clark & Ivankova, 2016). This research follows a pragmatist approach, focusing on the pragmatic advantages of this methodology in addressing research questions that are both qualitative and quantitative in nature.

5.3 OVERARCHING RESEARCH DESIGN

An exploratory sequential core design serves as the foundation for this research, allowing for preliminary exploration with individuals (qualitative research) to ensure the appropriateness of instruments and measures (quantitative research) (Creswell, 2015). This design, also known as “integrated mixed design” (Greene, 2007), “sequential mixed design” (Teddlie & Tashakkori, 2009), “qualitatively driven sequential design” (Morse & Niehaus, 2009), or “quantitative follow-up design” (Morgan, 2014), is particularly suited for in-depth exploration with some individuals while aiming to extend findings to a larger population. The chronological sequence also means the research can be easier for one researcher to carry out, instead of attempting to implement multiple, simultaneous methods (Teddlie & Tashakkori, 2009). Further details on the rationale for adopting this mixed methods approach can be found in [Appendix E](#).

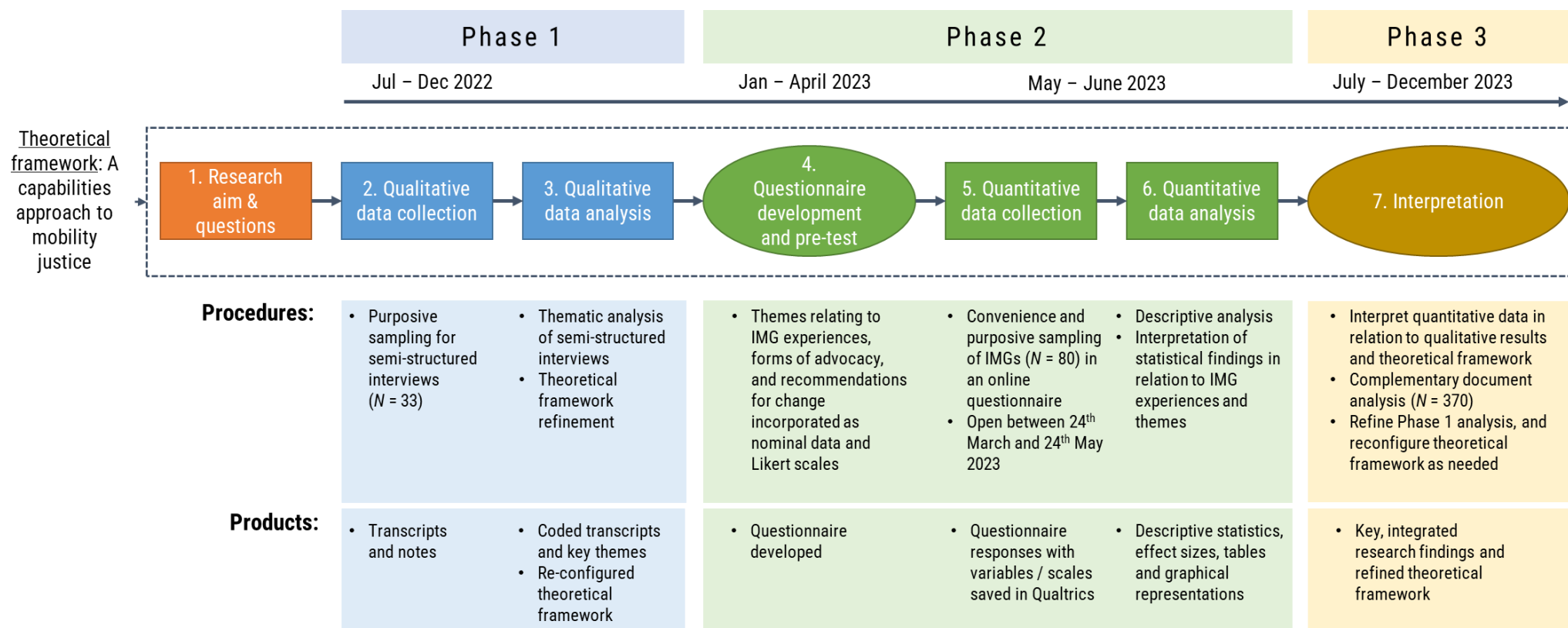
Mixed methods research designs are characterised by three key components: *timing*, *priority*, and *mixing*. Timing refers to the sequencing of research procedures, priority involves determining whether qualitative or quantitative components hold greater emphasis, and mixing involves the integration of qualitative and quantitative methods, data collection, and/or analysis (Creswell, 2010; Plano Clark & Ivankova, 2016). The timing of this research design is sequential, with mixing occurring at connecting phases of the study and priority given to the first, qualitative component (Plano Clark & Ivankova, 2016).

The development of the theoretical framework is also intertwined with the research design, following an “inductive interpretative approach” (Creswell & Plano Clark, 2018, p. 43), wherein new theoretical insights are iteratively modified as data are analysed. By both incorporating and contributing to the development of a theoretical framework, this research builds on the core exploratory sequential mixed methods design, shifting the methodology from what is known as a “basic” design, to an “advanced” design (Creswell, 2015; Doyle et al., 2019; Plano Clark & Ivankova, 2016; Tashakkori & Teddlie, 2010).

Figure 20 provides a visual summary of the key steps and methods employed in this advanced exploratory sequential mixed methods design, adhering to the recommended procedural diagram layout outlined by contemporary mixed methods scholars (Creswell, 2015; Creswell & Plano Clark, 2018; Plano Clark & Ivankova, 2016).

Figure 20

Procedural Diagram for Research Design (Final Iteration, March 2024)



The mixed methods literature often uses specific codes to indicate the relative priority and timing of the qualitative and quantitative methods used (Creswell, 2010; Creswell & Plano Clark, 2018; Morse, 1991; Morse & Niehaus, 2009; Plano Clark & Ivankova, 2016; Teddlie & Tashakkori, 2009). For this research, this would read: QUAL → Quan, indicating that priority is given to the first, qualitative portion of this sequential study.

5.4 PHASE 1: SEMI-STRUCTURED INTERVIEWS

5.4.1 *Research Participants and Selection Strategies*

Phase 1 involved the collection and thematic analysis of qualitative data through semi-structured interviews. As this is a phenomenon and context with limited prior research, I followed Creswell's (2015) recommendation of recruiting around 20 to 30 participants. I interviewed 24 IMGs who reside or have resided in Aotearoa New Zealand. Additionally, nine relevant experts, including medical educators, representatives of medical associations, employers, local representatives, and political commentators with an interest in the topic, were interviewed.

The selection strategy during Phase 1 was purposeful, utilising maximal variation sampling to select participants with diverse perspectives (Creswell, 2015), and snowball sampling (Morgan, 2008). Snowball sampling began with Facebook groups for IMGs in Aotearoa New Zealand (with administrator permission, see advertisement in [Appendix F](#)). To align with the initial theoretical concepts of a capabilities approach to mobility justice, participants from various backgrounds were selected, representing doctors who trained in both the Global South and Global North. Selection criteria were geared towards ensuring representation from various licensing pathways, different stages along the licensing pathways, a balance of genders, ages, years of professional experience, participants from different regions of the world, and those who had spent varying lengths of time in Aotearoa New Zealand.

A trend was observed that doctors undertaking the NZREX pathway were easier to recruit, likely due to their prevalence in the social media forums I used for recruitment. These participants often expressed a sense of not feeling seen or heard in their professional lives, and appreciated the opportunity to share their stories in the interview. In contrast, individuals on other licensing pathways were more challenging to recruit. This was related to the time commitment these individuals had while all working full-time as medical doctors, compared to the NZREX participants, of whom only six of the 19 were fully registered as doctors at the time of interview. In contrast to NZREX doctors, who often expressed that I was doing them a favour by interviewing them, non-NZREX doctors tended to express the sentiment that they were happy to do me a favour by participating in the research. Table 9 provides an overview of the IMGs who participated in the first phase of this research, including their licensing status at the time of the interview. In subsequent chapters, to maintain confidentiality, participants are referred to by number (indicated in the first column of Table 9) and then by licensing pathway; for example, IMG 1 (NZREX).

Table 9*Phase 1 IMG Research Participants and Their Registration Status at Time of Interview*

IMG #	Training Region ²⁸	Gender	Pathway	Licensing Stage	First Graduation	Specialist?	Prior Experience	NZ Arrival	NZREX	Registered?	Interview
1	Southern Asia	Female	NZREX	Not attempted	1996	No	2 years	1996	Not attempted	No	5/8/2022
2	Southern Europe	Female	CHS	Provisionally registered	2007	Yes (2013)	10+ years	2022	N/A	Yes (2022)	7/8/2022
3	Southern Europe	Male	CHS	Preparing for English-language assessment	2008	Yes (2013)	10+ years	2022	N/A	No	7/8/2022
4	Southern Asia	Male	NZREX	Fully registered	2010	No	< 1 year	2012	2012	Yes (2014)	11/8/2022
5	North America	Female	LOC	Provisionally registered	2012	Yes (2014)	5-10 years	2022	N/A	Yes (2022)	13/8/2022
6	Eastern Asia	Male	NZREX	Waiting for PGY1	2012	Yes (2015)	5-10 years	2021	2022 (pass)	No	15/8/2022
7	Southern Asia	Female	NZREX	No longer attempting	2009	No	< 1 year	2009	Not attempted	No	15/8/2022
8	Southern Asia	Male	NZREX	Waiting to take NZREX	2008	Yes (2012)	5-10 years	2014	2020, 2021 (fail)	No	16/8/2022
9	Eastern Asia	Male	NZREX	Waiting for PGY1	2010	No	4 years	2014	2019 (fail), 2020 (pass)	No	17/8/2022
10	Oceania	Male	NZREX	Provisionally registered	2014	No	4 years	2017	2018 (pass)	Yes (2021)	17/8/2022
11	Eastern Europe	Male	NZREX	Waiting to take NZREX	1990s	Yes (1990s)	20+ years	2018	2022 (fail)	No	18/8/2022
12	South America	Female	NZREX	Waiting for PGY1	2017	Yes (2020)	3 years	2021	2022 (pass)	No	21/8/2022

²⁸ In this thesis, all participants are referred to by their region, rather than country, of training, to protect confidentiality. Global subregions were defined by United Nations (2019), with several exceptions as applicable to this research. The U.K. and Ireland were separated from the Northern Europe geographic region, due to the particular emphasis on these countries in the CA licensing pathway structure. Similarly, Aotearoa New Zealand is also excluded as the questionnaire was only for respondents who trained overseas. This means Australia is presented as a single country, rather than as a region, as United Nations (2019) distinguishes between “Australia/New Zealand” and the rest of “Oceania” (Melanesia, Micronesia, and Polynesia).

IMG #	Training Region ²⁸	Gender	Pathway	Licensing Stage	First Graduation	Specialist?	Prior Experience	NZ Arrival	NZREX	Registered?	Interview
13	Southern Asia	Female	NZREX	Preparing for medical knowledge examinations	2014	Yes (2018)	5-10 years	2022	Not attempted	No	23/8/2022
14	U.K. / Ireland	Female	VOC	Fully registered	1997	Yes (2006)	10+ years	2009	N/A	Yes (2009)	29/8/2022
15	Southern Asia	Female	NZREX	Fully registered	2009	No	3 years	2012	2013 (pass)	Yes (2014)	1/9/2022
16	Eastern Europe	Female	NZREX	Fully registered	2007	No	< 1 year	2011	2011 (fail), 2012 (pass)	Yes (2012)	2/9/2022
17	Western Asia	Male	NZREX	Fully registered	2001	No	6 years	2007	2009 (pass)	Yes (2011)	5/9/2022
18	North Africa	Male	NZREX	Fully registered	2003	No	4 years	2007	2013 (pass)	Yes (2013)	11/9/2022
19	Western Asia	Female	NZREX	Waiting for PGY1	2007	Yes (2014)	5-10 years	2017	2021 (fail), 2022 (pass)	No	12/9/2022
20	Southern Asia	Female	NZREX	Waiting for PGY1	2016	No	1 year	2017	2022 (awaiting result)	No	22/9/2022
21	South America	Male	NZREX	Waiting for PGY1	2009	Yes (2013)	5-10 years	2018	2022 (pass)	No	22/9/2022
22	U.K. / Ireland	Female	CA	Fully registered	1993	Yes (1990s)	10+ years	2007	N/A	2007	24/10/2022
23	Southern Asia	Female	NZREX	Registered and working in CA country	2016	No	< 1 year	2016	2019 (pass)	No (working in U.K.)	31/3/2023
24	Southern Africa	Female	NZREX	Waiting to take NZREX	2012	Yes (2017)	5 years	2017	Not attempted	No	6/4/2023

The interviews with local experts, including employers, policymakers, commentators, or advocates for change, served the purpose of contextualising IMG experiences by gaining insights into the perceptions of others in the field. These interviews not only highlighted further areas for investigation but also played a crucial role in situating findings in the broader sociopolitical context, a key aspect of applying a capabilities approach to mobility justice. These expert perspectives contributed significantly to enriching the understanding of the challenges and opportunities surrounding IMG licensing in Aotearoa New Zealand.

The selection criteria for local expert interviews involved individuals having extensive experience with IMGs and a comprehensive understanding of the pathways these individuals undergo to practise medicine in Aotearoa New Zealand. These experts were identified through their work in this field and recruited via direct contact, initially through email or phone. Table 10 provides a summary of the local expert research participants and their respective roles.

In discussing research findings in this thesis, these participants are referred to by number and role; for example, Expert 1 (Employer).

Table 10

Phase 1 Local Expert Research Participants

Expert #	Gender	Role	Further Detail	Interview
1	Male	Employer	NZMG and employer at a public hospital	29/7/2022
2	Male	Political Commentator	Political expert and advocate for change in IMG licensing processes	3/8/2022
3	Male	Researcher	NZMG with research interests relating to vocational licensing pathways in Australia and Aotearoa New Zealand	9/8/2022
4	Male	Recruitment Agent	Senior employee at a medical staffing company	11/8/2022
5	Female	Local Government Representative	Advocate for change in IMG licensing processes that negatively impact ethnic minorities	16/8/2022
6	Male	Educator	NZMG involved in medical education, as well as some health workforce policy initiatives	28/9/2022
7	Male	Policy Advisor	Advisor on health-related policy in Aotearoa New Zealand	18/2/2023
8	Male	Employer	Registered IMG and hospital employer seeking to support increased employment opportunities for NZREX candidates	18/4/2023
9	Male	Policy Advisor	Advisor on health-related policy in Aotearoa New Zealand	1/5/2023

5.4.2 Data Collection

In light of COVID-19, the internet has become both a medium for and a site of research (Kabutaulaka, 2021). While my preference was for in-person interviews whenever possible, to allow the opportunity to decrease social distance between participants and develop a greater rapport (Roberts et al., 2021), Zoom or phone interviews were offered as alternatives based on participant preference. Most interviews were conducted in person (22 in-person and six virtually) between August and October 2022, with five supplementary online interviews carried out between March and July 2023.

In-person interviews were arranged at locations convenient for participants, typically local cafés. During the in-person data collection phase, I travelled to various cities in Aotearoa New Zealand, including Tāmaki Makaurau (Auckland), Kirikiriroa (Hamilton), Te Papa-i-Oea (Palmerston North), Te Whanganui-a-Tara (Wellington), the Wairarapa region, Te Awa Kairangi ki Tai (Hutt Valley), and Ōtautahi (Christchurch). The highest concentration of participants ($n = 10$) was in the Tāmaki Makaurau (Auckland) region, Aotearoa New Zealand's largest city.

Participants received a virtual information sheet (see [Appendices G and H](#)) and consent form (see [Appendices I and J](#)) before we met. With the exception of one interview with a married couple (IMGs 2 and 3), all participants were interviewed individually. In-person meetings typically involved a handshake, although two female doctors preferred a short hug in accordance with their cultural background. Before starting any interview, I verbally confirmed that participants met the relevant criteria and addressed any questions about the research's purpose, providing a physical copy of the information sheet for in-person interviews.

Common pre-interview questions related to the research's intended use and confidentiality. I clarified that while absolute confidentiality could not be guaranteed, every effort would be made to protect participants' identities in presenting research data, focusing on pseudonyms and general regions rather than specific details. In-person participants signed a physical consent form, while virtual participants sent a signed form via email prior to the interview. Verbal consent to record was always reconfirmed before beginning recording in both online and in-person interviews, with participants given three weeks to request a copy of their transcript for revision, though none chose to do so.

Interview durations varied greatly, with the shortest being 20 minutes on Zoom during a participant's lunch break and the longest exceeding two hours in person. In-person interviews tended to be longer, as people were usually less time-constrained, allowing for greater rapport

building and fewer time constraints. Participants were offered a voucher as a token of appreciation for their time and to cover associated costs.

5.4.3 Interview Structure

Interviews concentrated on the professional experiences of IMGs from a range of backgrounds. Open-ended questions were framed around themes and questions outlined in [Chapter 4](#), such as exploring who can or cannot exercise mobility, and the capabilities afforded to participants. The capabilities lens encouraged an inclusive approach to data collection, seeking to capture not just the challenges faced by IMGs but also their aspirations and potential.

The semi-structured nature of the interviews, guided by the evolving capabilities approach to mobility justice (see final interview schedules in [Appendix K](#)), allowed participants to discuss various interrelated components while avoiding confining answers to “preconceived conceptual boxes” (Fife, 2005, p. 8). This allowed participants to elaborate on their perspectives and share how they made sense of their experiences with medical licensing in Aotearoa New Zealand (O’Leary, 2004), crucial for addressing the first research question.

Despite having semi-structured interview schedules, many participants had stories they wished to share and did not wait to be asked a question when recording commenced. Consequently, many IMG interviews resembled life history interviews, a method where “researchers study and analyse how people talk about their lives, their experiences, events in life and the social context they inhabit” (Germeten, 2013, p. 612). According to Germeten (2013), this approach grants maximum autonomy to narrators and helps give voice to those who may not have been able or permitted to tell their life stories to society. As this was the experience expressed by many individuals, particularly those on the NZREX pathway, this approach was useful during the data collection process. Therefore, during interviews, I typically began by asking IMGs an open-ended question about their journey to practising medicine in Aotearoa New Zealand, allowing them to guide the conversation. I then supplemented this discussion with questions related to key themes outlined in the interview schedule, along with other follow-up questions that emerged organically. However, expert interviews retained a more semi-structured style, focusing on extracting key details about the health system and medical registration, rather than exploring individual personal experiences.

As most participants did not speak English as their first language, allowing them space to express themselves was crucial. In some cases, this meant I took a more active role in the interview, working to develop rapport and clarifying my understanding of what they had said. Language, however, did not pose a significant barrier, as all participants had demonstrated

high levels of English language competency during their medical training or the licensing process in Aotearoa New Zealand.

5.4.4 Thematic Analysis

For in-person interviews, recordings were made on my phone, while virtual interviews were conducted via Zoom and uploaded directly into the password-protected *Otter.ai* for transcription. I then reviewed the automatically generated text, made necessary corrections, and downloaded these transcripts to import into NVivo. In addition to verbatim transcripts, a small timeline for each IMG interview was created to capture key dates and steps in their medical licensing journey. Some written notes were also taken during interviews.

Both IMG and local expert transcripts underwent thematic analysis. Thematic analysis of qualitative data involves identifying patterns or shared meaning among different interview accounts (Braun & Clarke, 2022). I adopted a reflexive approach, identifying codes with similar key words or topics, developing initial themes, before refining and naming them (Braun & Clarke, 2020). Initially, more than 80 codes were identified in NVivo, which were then refined into broader themes related to the evolving theoretical framework of a capabilities approach to mobility justice.

Braun and Clarke (2022) note two broad approaches to thematic analysis. One approach focuses on themes reflecting key topics or domains of interest in the dataset; for example, the motivations of IMGs for moving to Aotearoa New Zealand. In contrast, the other approach aims to tell a story or offer insight into a shared core concept, such as (un)met expectations. Expert interviews were predominantly analysed in relation to key topics, such as the structure of the national health system, the impact of COVID-19, or the role of regulation in medical licensing. These interviews provided valuable direction for further exploration of policies or grey literature but did not directly speak to the lived experiences of IMGs. Thematic analysis of IMG interviews allowed for groupings of themes both united by a topic and themes that united shared core concepts, such as identity, accountability, or transparency. Coding and thematic analysis of both kinds of themes facilitated the concurrent refinement of the theoretical framework and the development of the Phase 2 questionnaire.

5.5 PHASE 2: ONLINE QUESTIONNAIRE

The second, quantitative phase of this research was the design, administration, and analysis of an online questionnaire. The questionnaire was developed based on the key themes explored in Phase 1, derived from the iterative analysis of interview data in conjunction with refinement of the theoretical framing.

5.5.1 *Research Participants and Selection Strategies*

Two key groups of IMGs constituted the population for this research:

1. IMGs licensed and currently working as medical doctors in Aotearoa New Zealand; and
2. IMGs not currently licensed or working as medical doctors in Aotearoa New Zealand, but residing or having resided in the country.

Sub-groups within these categories related to licensing pathways and current country of residence. It is possible to estimate the size of the first group based on publicly available medical workforce data. At the time of the questionnaire development in December 2022, there were 8,196 IMGs registered to practise in Aotearoa New Zealand (MCNZ, 2024h). However, identifying the total population size and participant selection strategies to reach a diverse range of IMGs was a challenge. The population size of IMGs residing in Aotearoa New Zealand but not currently registered to practise is unknown. This group includes individuals who choose not to practise medicine in Aotearoa New Zealand or those completing the NZREX pathway post-arrival. Though MCNZ data indicates around 40 IMGs passed the NZREX exam annually between March 2014 and September 2023 (MCNZ, 2020b, 2022d, 2022e, 2023d, 2023e, 2024l), the number of individuals caught in the pre-examination bottleneck described in [Chapter 2](#) (Subsection 2.3.3) is uncertain.

For this reason, I could not accurately estimate how many would constitute a representative sample, or how many responses to expect. A Facebook group of NZREX doctors indicates that while there are 4,000 members, only several hundred of these show signs of activity on this platform. Many members are also not IMGs, but other interested parties such as employers. As it is beyond the scope of my doctoral research to approach every household in Aotearoa New Zealand in order to understand exactly how many IMGs are living here and not able to work, probability sampling was not feasible for this research. Instead, I used purposive and convenience sampling (Fowler Jr., 2014) and acknowledge the limitations of this in relation to the generalisability of the findings. It is also possible that some doctors who participated in interviews may have completed the online questionnaire as well.

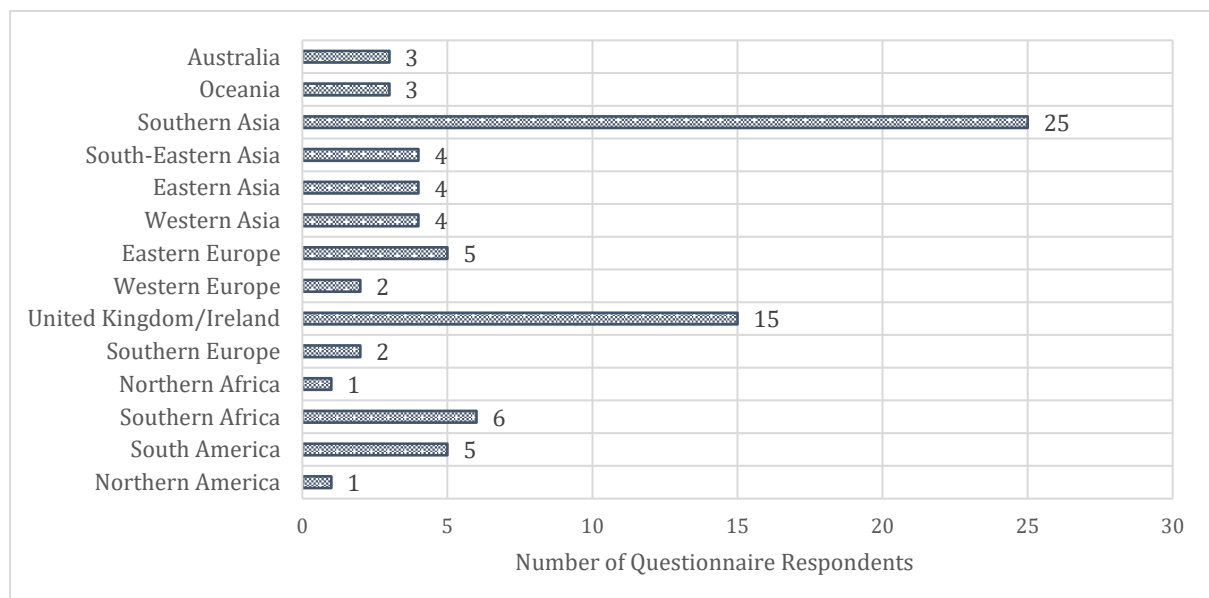
In the Phase 1 interviews, IMGs on the NZREX pathway described a number of forms of mobility injustice and were struggling to have their voices heard. In accordance with the theoretical framing of this research, the selection strategy for Phase 2 aimed to include these underrepresented individuals, avoiding recruitment via employers. Potential participants were identified through a post in the Facebook group used for Phase 1 recruitment (with administrator permission) and a public share on LinkedIn (see advertisement in [Appendix L](#)). The advertisement was also placed in the *NZ Doctor* newsletter, circulated among health

professionals in Aotearoa New Zealand, and in a national health network newsletter. As responses were anonymous, there was no feedback loop between me and any individuals who choose to disseminate the questionnaire further.

Two-thirds of respondents indicated they were eligible for the NZREX licensing pathway only, aligning with the goal of reaching unregistered individuals more likely to be experiencing forms of mobility and capabilities injustice. The questionnaire also drew responses from various geographical backgrounds, as illustrated in Figure 21, which details where respondents received their primary medical qualifications based on United Nations (2019) subregion classifications²⁹.

Figure 21

Questionnaire Respondents According to Global Subregion of Primary Medical Qualification (N = 80)



5.5.2 Questionnaire Structure

Initially, questions were grouped by key themes in relation to an early iteration of the 4Ps. These were then refined and simplified to enhance flow and prevent the questionnaire from becoming overly time-consuming (see questionnaire in [Appendix M](#)). Through this process, the questionnaire was structured into three main sections: background information, experiences with medical licensing, and possibilities for change.

²⁹ As there were no respondents from Northern European countries besides the U.K. and Ireland, this subregion does not appear on the chart. Several other subregions (Central Asia; Central America and the Caribbean; and Eastern, Middle and Western Africa) also do not appear as there were no respondents from these regions.

A deliberate choice was made to not directly inquire about the IMGs' eligibility for specific licensing pathways. Instead, proxy questions were employed to discern this information based on participant responses. After the information blurb (see [Appendix N](#)), the initial section of the questionnaire focused on gathering nominal, descriptive data aimed at developing independent variables, including licensing pathway, income level of the country of training, and gender.

The second and third sections of the questionnaire captured nominal and ordinal data used to derive dependent variables reflecting participants' experiences as medical professionals. In the second part, respondents ranked 16 aspects of their experiences as IMGs in Aotearoa New Zealand on a seven-point Likert scale, ranging from "strongly disagree" to "strongly agree" in a matrix format. The final section prompted participants to contemplate potential changes to medical licensing and any involvement they have had in advocacy for change. Seventeen options for potential changes were presented in a seven-point Likert scale with the same format as the second section, with options from "strongly disagree" to "strongly agree". This section played a pivotal role in applying a capabilities approach to mobility justice, capturing not only how IMGs experienced medical licensing but also how they envisaged ways to improve policies and advocate for change.

Likert scales are recommended as instruments for measuring opinions, beliefs and attitudes, particularly when strong statements are used (DeVellis, 2017). For instance, a strong statement from the questionnaire would be "as a medical professional, I feel welcome in New Zealand", while a milder statement might state that "medical professionals are important in New Zealand", which is likely to elicit agreement from most people. Using strong statements allowed for a nuanced range of responses grounded in personal experiences.

The inclusion of a central point, "neither agree nor disagree", in both Likert matrices provided participants with a means to express neutrality, accounting for those with mixed experiences or those who felt the question was not relevant (DeVellis, 2017). Participants were also given the option to skip questions they felt were irrelevant or preferred not to answer. Opting for seven stages of agreement, as opposed to five, allowed for more nuance in describing the complexity of professional and personal experiences revealed in the Phase 1 interviews. Moreover, participants could provide written comments in various sections. These comments were integrated with data from the Phase 1 interviews for thematic analysis, enriching the integrated dataset.

5.5.3 Descriptive Analysis

The online questionnaire was designed, disseminated, and analysed using Qualtrics software. While there were 90 responses in total, initial data cleaning, as recommended by Fowler Jr. (2014) involved filtering out 10 responses that did not meet inclusion criteria. These respondents either omitted their country of primary qualification, indicated they had no interest in registering as a medical doctor in Aotearoa New Zealand, or stated that they had never resided in Aotearoa New Zealand. Quality checks were also carried out in Qualtrics to highlight responses with questionable reCAPTCHA scores, a repeatable pattern in answering questions, and “straightlining”, where individuals provided identical answers in Likert matrices.

After data cleaning, 80 responses were available for analysis. Among these, 71 participants completed the questionnaire in its entirety, even if they chose to skip some questions. The mean number of responses in the Likert scale matrix concerning professional experiences was 67, while the Likert matrix on possibilities for change had an average of 61 responses.

As I did not directly ask participants which licensing pathway they had pursued, or were pursuing, in case they were unsure, questions were included that aligned with the licensing policies laid out by the MCNZ. Following the MCNZ self-assessment tool (MCNZ, 2024o), eligibility for some registration pathways was prioritised (see [Chapter 2](#), Section 2.3), establishing the following hierarchy: VOC³⁰ → AUS → CA → CHS³¹ → GR → NZREX. Participants were assigned the first pathway they were eligible for in this list.

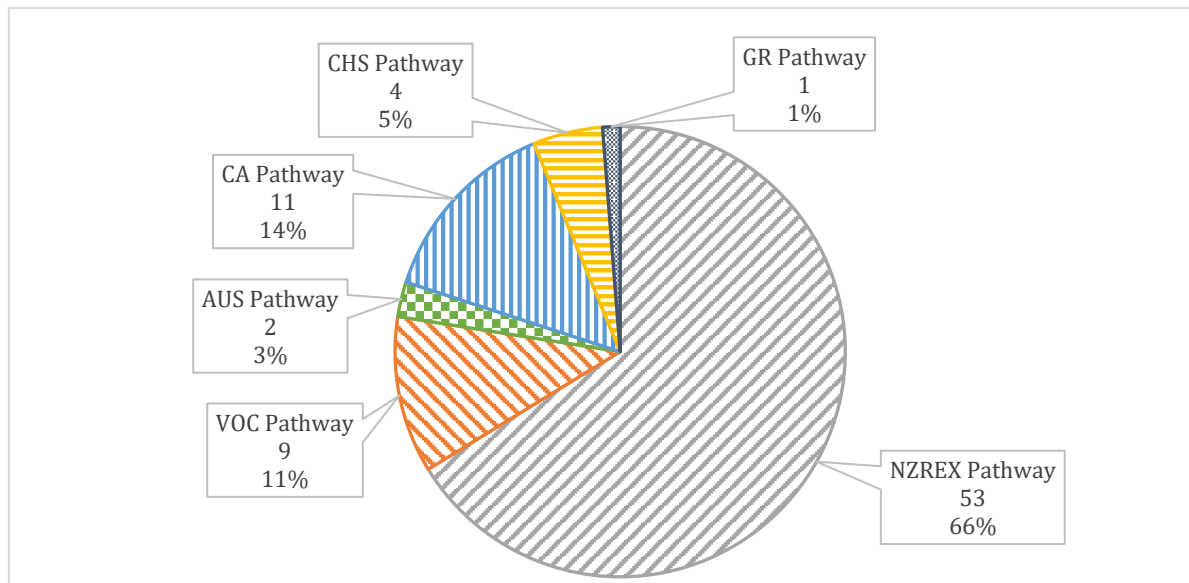
In cases where individuals indicated recognition of overseas specialist qualifications in Aotearoa New Zealand, they were presumed to have pursued a specialist licensing pathway. While there is a possibility that some might not have chosen to work as specialists, I made an assumption that they would likely apply through the specialist routes, given the professional and remunerative disadvantages associated with returning to an unspecialised role. Figure 22 categorises questionnaire respondents according to their assumed medical licensing pathway.

³⁰ A distinction was not made in data collection regarding whether a recognised specialist would have registered via the short-term Locum Tenens (LOC) pathway, or one of the long-term Vocational (VOC) licensing pathways. However, the LOC pathway is only available for up to 12 months, and all nine recognised specialist respondents indicated they obtained registration prior to 2020 and are currently still registered to practise. It is thus assumed that they registered via one of the VOC pathways, rather than for a short-term Locum Tenens position.

³¹ All participants eligible for the CHS pathway had completed their minimum of 33 months’ work experience in countries that were included in the CHS list from as early as 2005. It is acknowledged, however, that 36 months of work experience would have been required prior to 2012 (see [Appendix A](#)). It is assumed that these candidates met the earlier requirements for the CHS pathway that corresponded with their time of arrival in Aotearoa New Zealand.

Figure 22

Total Questionnaire Respondents According to Their Medical Licensing Pathway Eligibility (N = 80)



As seen in Figure 22, there were very few responses for the GR, AUS and CHS pathways, prompting the decision to collate some of the responses to ensure meaningful analysis. Respondents were consequently grouped into three main categories:

- **Specialist Pathways:** This group encompasses all IMGs who indicated their overseas specialist qualifications were recognised in Aotearoa New Zealand ($n = 9$).
- **Competent/Comparable Pathways:** This category includes IMGs eligible to register on the AUS, CA, CHS, and GR pathways. These pathways to general registration were grouped together because they do not require additional medical licensing examinations for registration, but all require experience and/or qualifications from specified Global North countries ($n = 18$).
- **NZREX Pathway:** IMGs who did not indicate their eligibility for any of the other pathways were classified as NZREX doctors ($n = 53$).

Next, I conducted descriptive analysis using the Stats iQ feature in Qualtrics to explore relationships and correlations between independent variables (such as licensing pathway, country of primary qualification/experience, gender, and specialisation) and dependent variables reflecting IMG experiences in Aotearoa New Zealand. This analysis was pivotal in applying the capabilities approach to mobility justice, highlighting the intersection between IMG backgrounds, licensing pathways, and their varied experiences. Calculations of central tendency and effect size of correlations were conducted using recommended measures of association (Cramér's V, Cohen's d, or Cohen's f). Inferential statistics were not used to make

claims about the broader generalisability of the findings, given the barriers to accessing the population size and sampling noted above.

Additionally, 35 respondents chose to write additional comments about their experiences as IMGs in Aotearoa New Zealand, particularly in relation to medical licensing. These responses were imported to NVivo for integrated thematic analysis alongside interview data in Phase 3.

5.6 PHASE 3: INTEGRATION AND ANALYSIS

Phase 3 involved the comprehensive analysis and integration of data collected in the previous phases. Integration in mixed methods research extends beyond the mere combination of qualitative and quantitative data; it involves a holistic synthesis of findings from both phases to construct a cohesive narrative (O’Cathain, 2010). In this advanced exploratory sequential design, integration first occurred at the connecting point between the first and second phases, enabling a nuanced understanding of the research questions. This allowed for what Creswell (2015) describes as *building*, when qualitative data are built on to develop a quantitative phase in a study (Creswell & Plano Clark, 2018).

Integration in an advanced exploratory sequential design also involves threading the theoretical framework throughout the study (Creswell, 2015). The 4Ps shaped the initial analysis and presentation of integrated data from Phases 1 and 2. While an early iteration of the 4Ps guided the key themes in the questionnaire design, this was refined and reconfigured in Phase 3, influenced by insights derived from both Phase 1 and Phase 2 datasets. A second point of integration thus occurred after the collection of both datasets, when these were interwoven and analysed through a capabilities approach to mobility justice lens.

Furthermore, complementary data collection occurred during Phase 3, prompted by comments from local experts and insights from IMG interviews. A robust policy and workforce data analysis was carried out, utilising publicly available statistics from MCNZ and other sources. I also made Official Information Act (OIA) requests to all 20 District Health Boards (DHBs) in May 2022 (before the DHBs became known as Te Whatu Ora | Health New Zealand), to understand more about their hiring practices of NZREX candidates for PGY1 positions. This real-world data, coupled with statistical insights from MCNZ regarding IMGs and NZREX candidates, was compiled and analysed in Excel, forming the basis for the descriptive charts in Chapters 2 and 3.

To complement this workforce data, I completed a document analysis of 370 historical and current IMG licensing policy documents and other grey literature. These documents included parliamentary acts and bills ($n = 30$), MCNZ annual reports ($n = 40$), medical workforce surveys

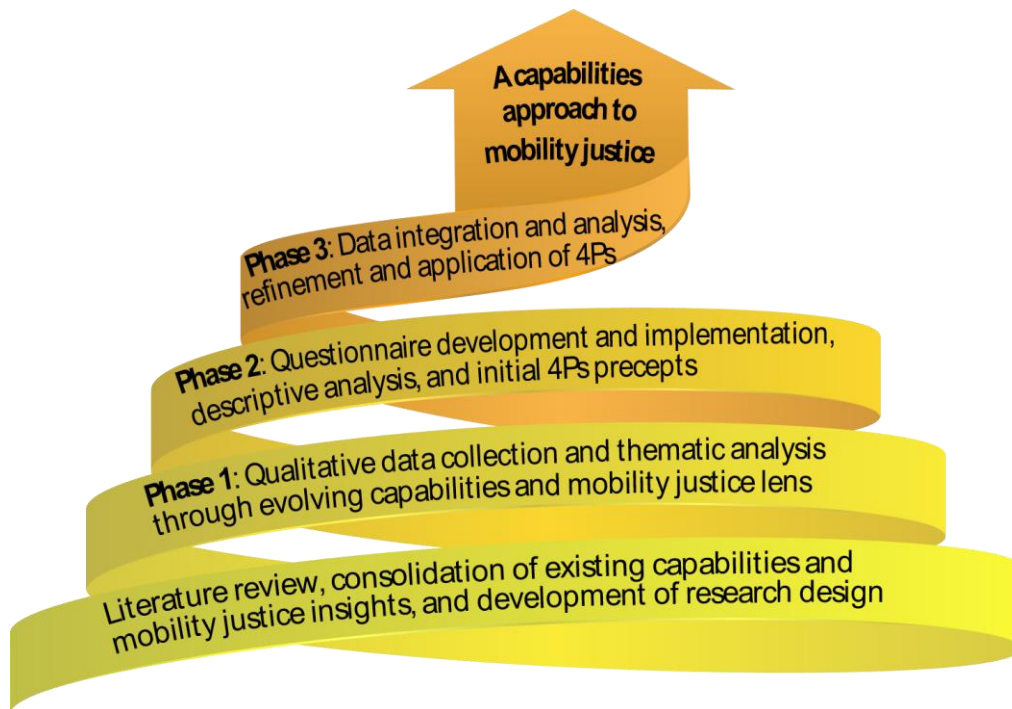
($n = 22$), MCNZ newsletters ($n = 18$), Gazette notices ($n = 23$), and other webpages ($n = 24$), and performance reviews of MCNZ ($n = 4$). In addition to the Official Information Requests made by me in 2022 ($n = 20$), and another member of the public in 2019 ($n = 16$), I also reviewed media reports spanning historical (1849-1979, $n = 61$) and contemporary (1980-2023, $n = 112$) periods.

Sheller (2018a) argues that mobilities research should transcend individual journeys to focus on entire mobility systems, requiring exploration of, for example, colonial, racial and imperial forms of mobility. The integrated research findings achieve this by not only providing insight into the experiences of IMGs, but also embedding these within the broader historical, institutional and (post)colonial context. In this way, the integrated findings do provide “a whole greater than the sum of its parts” (Doyle et al., 2019, p. 11). Guided by the capabilities approach to mobility justice, this research design provides a comprehensive understanding of the challenges and opportunities experienced by IMGs seeking medical licensing in Aotearoa New Zealand.

While the core research approach is characterised in mixed methods literature as an advanced exploratory sequential mixed methods design, in Phase 3 it became clear how, in practice, this design is not only sequential, but also iterative and cyclical. As the research outputs of this thesis include exploration of the phenomenon of IMG medical licensing in Aotearoa New Zealand, and the development of a theoretical framework, the processes of data collection and analysis have been both informative of, and informed by, a capabilities approach to mobility justice. In this sense, the methodology may be visualised not only as a sequential process, but as a way of spiralling up, where each iteration of the theoretical framework became more comprehensive as the project moved through the three phases outlined in this chapter, as shown in Figure 23.

Figure 23

Development of Theoretical Framework Alongside Data Collection, Integration, and Analysis
 (Source: Created by Author)



This thematic integration shapes the ensuing chapters, with Chapters 6-9 organised according to the 4Ps. In each chapter, descriptive analyses from Phase 2 are blended with the thematic insights from the Phase 1 interviews and Phase 3 document analysis. Phase 3 has thus allowed the research to meet two aims. First, the research offers a snapshot of IMG medical licensing experiences in Aotearoa New Zealand. Second, this approach has enhanced the significance of these experiences by situating them within the broader sociohistorical context, framed and interpreted by a capabilities approach to mobility justice.

5.7 ETHICAL CONSIDERATIONS

Ethical considerations are paramount in research involving human participants. While it is not necessarily possible to mitigate all ethical issues, I aimed to be aware of these and work reflexively throughout the research process, with ethics at the forefront of my thinking. I underwent two full ethics application reviews by the Massey University Human Ethics Committee before commencing data collection for both Phase 1 (SOA 22/19, approved on 7th July 2022) and Phase 2 (OM1 23/03, approved on 24th March 2023). The research adhered to prescribed ethical protocols, including informed consent, secure data storage, and

confidentiality. Further elaboration on ethical issues that were especially relevant to the design and implementation of this research are discussed below.

5.7.1 Privacy and Confidentiality

Ensuring privacy and confidentiality was critical, especially considering potential professional repercussions for participating IMGs. To address this, I have refrained from providing overly specific participant information. In Phase 2, the questionnaire was also designed to be fully anonymous, though participants were asked for demographic information related to medical licensing, such as the country they trained in. This kind of data is presented in cumulative ranges in this thesis; for example, by global subregion, rather than by country. Furthermore, very personal details from responses in the open-ended components of the questionnaire were omitted in discussing the findings. Participants could opt-in to leave their email address, to receive a project summary. To protect confidentiality, the questionnaire directed them to a new page to save their email addresses separately from their responses, so I cannot link these individuals to their questionnaire responses. All responses to the questionnaire were anonymised, and I do not know who accessed the questionnaire.

5.7.2 Potential Harm

As the study considered perspectives from a range of different associated actors, paying attention to the relationships and power dynamics between these actors and myself was especially important to ensure that participants understood these potential associated risks. In addressing potential career implications for participants, the measures to try to ensure confidentiality of the data were once again stressed. Phase 1 participants were able to take a break or end the interview whenever it suited them. The participants' wellbeing was prioritised.

While the Phase 2 questionnaire was expected to have a low risk of discomfort, for some participants, especially those not yet registered to practise medicine, reflecting on their professional experiences may have evoked some emotions of frustration. It was hoped that the short and anonymous nature of the questionnaire would allow participants to feel heard without the potential risks for their professional future some mentioned during Phase 1 recruitment. In the questionnaire, people could choose to answer differently than they would in a face-to-face interview if they were not comfortable disclosing some experiences. Participants also had the option to exit the questionnaire at any time. Of the 80 respondents, an average of 67 answered all of the questions, suggesting that others may have skipped questions or otherwise chosen not to complete the whole questionnaire.

Participants were also invited to leave comments relating to their experiences in the open-ended question boxes, and to contact me and/or my primary supervisor if they had any concerns. Links were provided to relevant employee and mental health support organisations. While two respondents did contact me after I advertised the questionnaire, this was to ask if I was willing to speak with them in an interview to hear more of their story. I accepted their offers and conducted interviews with IMG 23 and IMG 24 after posting the online questionnaire, to hear more of their insights. While the intention was to complete the interviews before the development of the questionnaire, per my sequential methodology, the process was more fluid in practice and my aim was to ensure participants' voices were heard.

5.7.3 *Researcher Positionality*

As noted in the [Introduction](#), I have a personal interest in this topic as my husband was considering pursuing medical licensing as an IMG in Aotearoa New Zealand at the commencement of this research. While this was an advantage, due to having some first-hand experience with the subject and facilitating rapport-building with some participants, a reflexive stance was crucial to the research design and process, as I have additional emotional investment in the project. It was important that I strove to ensure I did not overly generalise or make assumptions about IMG experiences and outcomes, and that I remained open to the potential that my personal experiences may not have been part of a broader trend. I also disclosed my personal connection to the project to participants interested in understanding how I came to learn about this topic, while making it clear that it is my project, and I am doing it for my own research interests and not on anyone's behalf.

My positionality as a female, Pākehā³² New Zealand researcher was also intertwined with interpretations of IMG experiences in relation to sociohistorical factors such as colonialism. Acknowledging the vulnerability of individuals who contacted me in Phase 1, but chose not to participate, and the way some participants referred to me as being their "voice" (e.g., IMG 13, NZREX; IMG 20, NZREX), Phase 2 offered a way for participants to respond anonymously and without any potential perceived power imbalance between themselves and the researcher. Bringing the two datasets together in Phase 3 also involved making considered choices around how participant stories and voices were represented in the writing of this thesis, which was navigated by focusing on the theoretical framework. A key focus of my capabilities approach to mobility justice is on why and how mobilities and capabilities power regimes shape IMG experiences.

³² *Pākehā* is a te reo Māori term for New Zealanders of European descent.

It was also important to consider my positionality in relation to ethical concerns around potential power imbalances based on factors such as nationality, ethnicity and/or language barriers. Although the project does not claim to change the policy landscape on migration and fairness for physicians from different countries, it could raise awareness of this, both within this group and among other stakeholders. It was important that I emphasised this, to avoid any misunderstandings with participants believing that I may be able to directly influence their circumstances. Nevertheless, there is a strong connection between mobility justice literature and forms of advocacy, which inspired me to write two articles in *The Conversation* (Thomas-Maude, 2022; Thomas-Maude & McLennan, 2022) to raise awareness of the challenges overseas-trained doctors face in Aotearoa New Zealand during the research process. Further publications are planned.

5.7.4 Cultural Concerns

As this research focuses on the experiences of migrants, and I sought diversity in my selection strategies, participants were from a wide range of cultural backgrounds. I thus needed to be aware of cultural aspects and protocols for my participants, as well as potential exclusions, such as those related to gender, migration status or region of origin, and work to mitigate these. Interview participants' preferences to interview in a public space, or a more private location, or online, may have related to what they considered as culturally appropriate. My approach to interviews was negotiated with each individual participant, and I was mindful of appropriate dress, use of language and location to ensure it was a safe space for participants.

While the focus of this research is not specifically on *tangata whenua* (the Indigenous people of Aotearoa New Zealand), some interviews with local experts included speaking to Māori or learning more about the particular concerns for Māori in the Aotearoa New Zealand healthcare context. Additionally, consultation was carried out with a Māori adviser from within Massey University prior to the commencement of the research. These consultations emphasised the importance of cultural sensitivity when working with Māori or discussing issues that address Māori. A similar awareness and sensitivity also applied to interactions with participants from the Pacific and/or those concerned with the health outcomes of Pacific people in Aotearoa, as they are another vulnerable population identified in many national health policies.

5.7.5 Research Location and COVID-19

This research took place in Aotearoa New Zealand, a research site that I am very familiar and comfortable with as I was born and grew up there. I designed this research to mitigate potential risks due to COVID-19 including border closures, and lack of access to participants, and abided by the university's policies on face-to-face research (with appropriate mask use

and social distancing in place). While there was a preference for the qualitative component of research to take place in-person, it was possible to have carried out the entire project virtually if this had been necessary. The questionnaire was also a way to mitigate potential challenges relating to COVID-19 and IMG time availability, as it was less time consuming than an interview, did not need to be scheduled, and took place online.

5.7.6 Knowledge and the Global North

A more substantive ethical concern raised by this research is the privileging of certain kinds of medical knowledge over others, which was strongly connected to my capabilities approach to mobility justice. In addition to medical knowledge and experience from Global North often being perceived as more legitimate (Escobar, 2018), there is a global tendency for Indigenous/traditional medicine to be excluded in favour of “Western” models of medicine, in both the Global North and the Global South (Rashid et al., 2023). This phenomenon was seen historically in Aotearoa New Zealand, with the Tohunga Suppression Act 1907 (discussed in [Chapter 2](#), Subsection 2.5.2). It is thus important to recognise that there are inevitable exclusions and biases in this project.

In this sense, the project indirectly privileges the Western bio-medical model above spiritual, religious and/or Indigenous knowledge and healing traditions by focusing on doctors trained in the Western (allopathic) medical tradition. By exploring how certain kinds of knowledge and knowers are considered valuable or acceptable in Aotearoa New Zealand, the project intersects with geopolitical inequality, (post)colonial legacies, the hegemony of the Global North and xenophobia/racism. This is a crucial ethical consideration as these themes did emerge throughout the research process and analysis. During the course of this research, I have been in constant reflection around whether this research promotes compassion and understanding towards medical professionals from diverse backgrounds, or the potential for increased Othering within the medical professional community.

5.8 CONCLUSION

In navigating the complex landscape of IMGs’ medical licensing experiences in Aotearoa New Zealand, this methodology chapter has outlined my mixed methods research design. The advanced exploratory sequential design, grounded in a capabilities approach to mobility justice, has involved a dynamic and iterative process. The design includes three distinct phases, which have been instrumental in unravelling the complexities inherent in IMGs’ interactions with medical licensing policies and refining the theoretical framework.

The initial phase, driven by insights from existing capabilities and mobility justice literature, laid the foundation for a qualitative exploration. Thematic analysis of interviews not only explored nuanced insights but also contributed the iterative refinement of the theoretical framework. In Phase 2, I adopted a quantitative approach, with the development and analysis of an online questionnaire that aimed to understand the prevalence of key themes from Phase 1 among a wider pool of IMGs.

The third and final phase involved integrating and analysing the Phase 1 and Phase 2 datasets, alongside conducting a policy and media document analysis to further contextualise and synthesise these findings and ensure all aspects of the research aim were addressed. During this phase, the 4Ps that form the cornerstone of my capabilities approach to mobility justice were refined, and these components have guided the analysis, discussion, and presentation of data in the following chapters. This sequential methodology has contributed to a spiralling up effect in the cyclical, iterative development of a theoretical framework that has both shaped data analysis and has been shaped by the data.

This mixed methods approach has been paramount in addressing research questions that seek to understand the way individuals experience their realities, and the extent to which external social constructs – in this case, medical licensing policies – impact their perceptions and experiences. Through a pragmatist approach of blending social constructionist and postpositivist ways of knowing, this research has harnessed the strengths of both qualitative and quantitative methods, fostering more comprehensive analysis and discussion in Phase 3.

Moreover, this methodology's contribution to the development of the theoretical framework adds another layer of social constructionism. The framework, itself a social construct, has evolved as a dynamic lens for making sense of the lived experiences of IMGs with medical licensing in the broader context of mobilities and capabilities power regimes. This cyclical and reciprocal relationship between data and theory has enriched the data collection, analysis, and discussion process, providing insight into the multifaceted nature of medical licensing in Aotearoa New Zealand.

6 TICKING BOXES: PROFESSIONAL MOBILITIES AND CAPABILITIES

6.1 INTRODUCTION

This chapter discusses the first of the 4Ps in my capabilities approach to mobility justice, the professional mobilities and capabilities of IMGs in Aotearoa New Zealand. In exploring P1, which focuses on the realisation of professional potential in this new environment, the chapter discusses the recognition of the qualifications and clinical experience among IMG participants undertaking different pathways to medical registration in Aotearoa New Zealand.

This chapter is divided into three sections. First, I focus on the uneven conversion and recognition of professional capabilities associated with IMGs' qualifications, training, and experience, exploring how these differ depending on licensing pathway. Second, the chapter considers the "conversion factors" (Robeyns, 2017, p. 46) that enable or hinder the translation of professional capabilities into functionings in this context, looking at the unequal burdens posed by delays, financial considerations, and COVID-19. Finally, I discuss how these conversion factors and uneven recognition of medical skillsets contribute to unequal consequences both for individual IMGs, and the broader population of Aotearoa New Zealand, through (un)realised potential and brain waste.

Overall, the chapter centres on the mobilities and capabilities of both the human and the more-than-human, with participants often facing a misalignment between their physical mobilities and capabilities, and those associated with their knowledge and experience. While many individuals exercise physical mobility and are able to move to Aotearoa New Zealand, the capabilities associated with their training and experience do not always move with them in an actionable way. This, I argue, generates mobility and capabilities injustices by excluding and/or disadvantaging some individuals, and their knowledge and experience, with implications for the notion of human dignity.

6.2 UNEVEN MOBILITIES AND RECOGNITION OF PROFESSIONAL CAPABILITIES

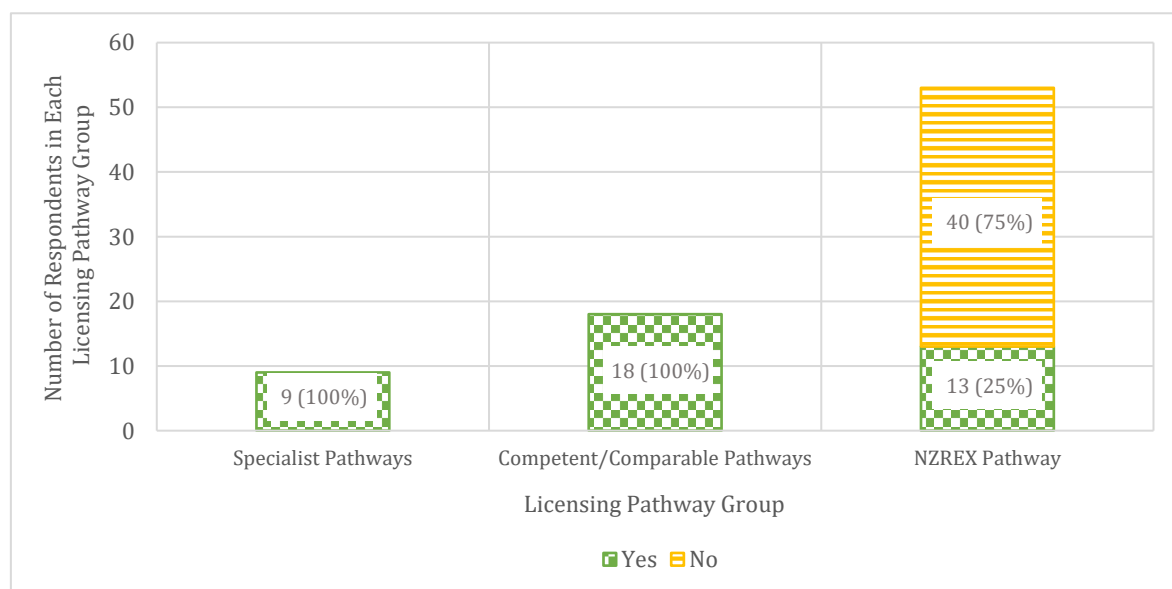
As Robeyns (2017) argues, each individual "has a unique profile of conversion factors" that enable them to translate their capabilities into "functionings" in different contexts (p. 113). Personal conversion factors are internal to an individual, such as their physical condition or skillsets, while social conversion factors relate to social norms, practices, and policies, and environmental conversion factors refer to the physical environment, such as climate or

infrastructure. The process of drawing on different conversion factors in turn generates “combined capabilities”, which refer to the interaction between one’s capabilities and the opportunities available in their environment (Nussbaum, 2011). The ability of IMGs in this research to convert their professional capabilities into functionings, by achieving their professional aspirations, was connected to their pathway to medical registration. This social conversion factor was seen to either enable or inhibit IMGs from working as medical doctors in Aotearoa New Zealand, generating uneven mobilities and capabilities among research participants.

Specifically, there was a relationship between an IMG’s licensing pathway and whether or not they had achieved provisional or full medical licensing to work as a doctor in Aotearoa New Zealand. Of the 19 NZREX IMGs interviewed in Phase 1, only six (32%) had obtained any form of licensing. In contrast, four out of five (80%) non-NZREX respondents were provisionally or fully registered at the time of interview. These trends were also seen in the questionnaire. As shown in Figure 24, only one quarter (25%) of NZREX questionnaire respondents had ever achieved provisional or full medical licensing, compared to 100% of respondents on the Specialist (VOC) and Competent/Comparable (AUS, CA, CHS, or GR) general pathways³³.

Figure 24

Questionnaire Responses to “Have You Ever Achieved Provisional or Full Registration to Work as a Medical Doctor in New Zealand?” by Respondent Licensing Pathway (N = 80)



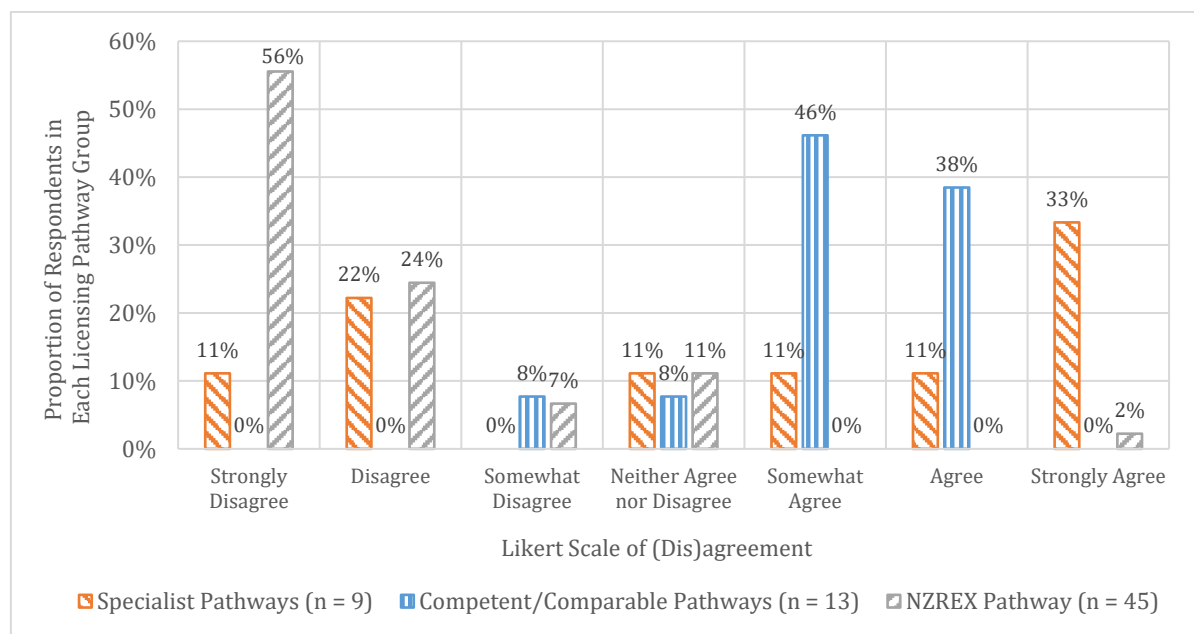
³³ Cramér’s V (Reid, 2014) is a measure of association that is helpful in identifying the effect size of the relationship between independent and dependent variables that produce nominal data (i.e., Yes or No). For three groups, a value larger than 0.35 is considered a large effect size – in this case, the Cramér’s V for the relationship between licensing pathway eligibility and whether the respondent had achieved medical licensing in Aotearoa was 0.71. In short, there was a strong statistical indication that NZREX doctors tended to answer “No”, compared to the other two pathway groups.

Licensing pathways have a clear correlation with the conversion of IMGs' professional capabilities into functionings, with NZREX doctors seen to have a lower chance of becoming registered as medical doctors in Aotearoa New Zealand. This aligns with earlier studies (e.g., Lillis & Roblin, 2014; Mpofu & Hocking, 2013), news articles (e.g., Bhamidipati, 2022b; Forbes, 2022; RNZ, 2023; Russell, 2021b), and workforce data (e.g., MCNZ, 2020b, 2022e, 2024l), suggesting that concerns around the bottlenecks and viability of the NZREX pathway remain current, impactful, and far from resolved.

The ability of IMGs to achieve medical registration in Aotearoa New Zealand was related to the extent to which their professional skills, qualifications, and experience were recognised and valued in this context. In the questionnaire, registered specialists and Competent/Comparable general registrants were far more likely than NZREX IMGs to feel that their skills, education, and experience were valued in Aotearoa New Zealand. In fact, as depicted in Figure 25, just 2% of NZREX doctors responding to the questionnaire either somewhat agreed, agreed, or strongly agreed that their overseas training and qualifications are valued in Aotearoa New Zealand, as opposed to a total of 56% of recognised specialists and 85% of Competent/Comparable general registrants. Furthermore, 56% of NZREX participants expressed strong disagreement with the statement, compared to just 11% of specialist respondents and none of the Competent/Comparable general registrants. These responses not only highlight the differential experiences of IMGs in the three licensing pathway groups, but also the strong nature with which their views tended to differ.

Figure 25

Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “My Overseas Training and Qualifications Are Valued in New Zealand” (N = 67)³⁴



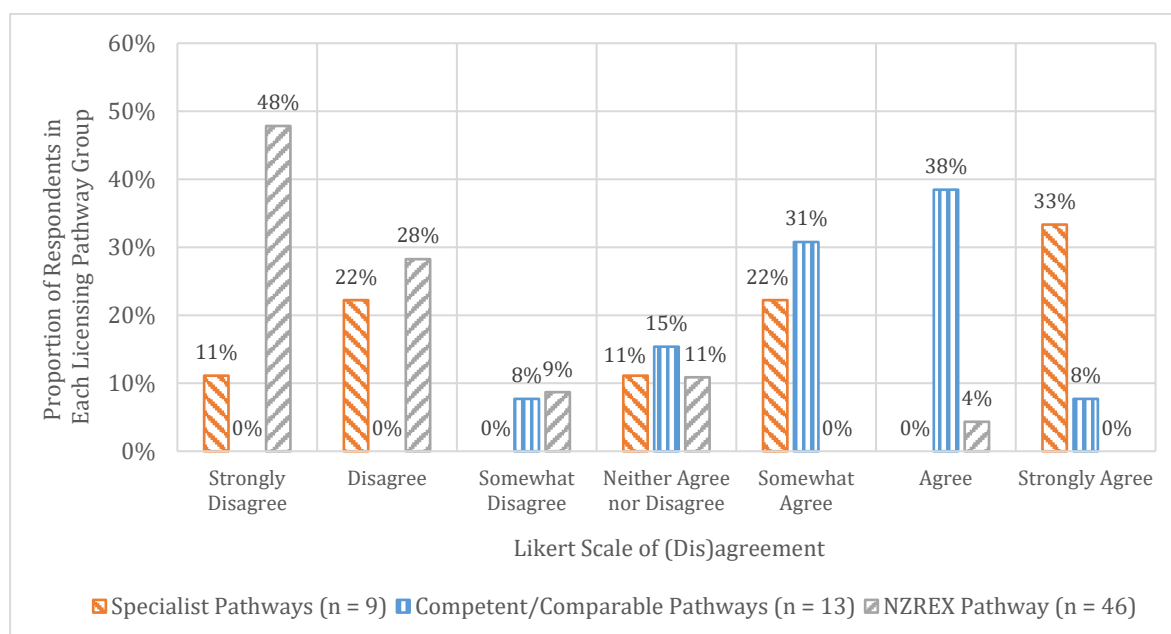
Similar trends were seen in responses to the statement regarding the perceived value of professional experience in this context, as highlighted in Figure 26.

³⁴ Charts relating to the Likert scale matrices in the questionnaire have been presented as percentages of the total subgroup, rather than whole numbers. This is because of the vast differences in the total size of the specialist ($n = 9$), Competent/Comparable ($n = 18$), and NZREX ($n = 53$) pathway subgroups. Three respondents among the specialists are equivalent to 33% of the total subgroup, as opposed to just 6% of NZREX. It was therefore considered more useful to capture these trends with percentages in the charts. For example, 11% of both specialists and NZREX participants neither agreed nor disagreed with the statement in Figure 25. This equates to one specialist and five NZREX candidates.

Note that there is also some variance in group size between each Likert scale question, as participants had the choice of which question(s) to respond to. Therefore, each chart specifies the total number of participants from each licensing pathway who answered that question in the legend. Further details of statistical analysis associated with IMG experiences and licensing pathways can be found in [Appendix O](#).

Figure 26

Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “My Overseas Clinical Experience Is Valued in New Zealand” (N = 68)



NZREX doctors were markedly more likely to feel professionally undervalued compared to IMGs on other pathways, with 85% either strongly disagreeing, disagreeing, or somewhat disagreeing that their prior clinical experience was valued in Aotearoa New Zealand. As evidenced by the limited number of NZREX participants who attained medical registration in Figure 24, this lack of recognition has direct implications for their “network capital” (Elliott & Urry, 2010, p. 11), in relation to the professional potential afforded to them after migrating, their combined capabilities, and the translation of these capabilities into desired functionings.

However, there was also variation in both Figure 25 and Figure 26 between registered specialists and Competent/Comparable generalists (refer to [Appendix Q](#) for detailed statistical analysis). While none of the Competent/Comparable pathway participants disagreed or strongly disagreed with either of the two statements, there was greater diversity in responses by recognised specialists. Specialist responses encompassed almost the full range of (dis)agreement on the Likert scale, with 11% strongly disagreeing, 22% disagreeing, and 33% strongly agreeing with both statements. Overall, specialists with recognised overseas qualifications were less inclined to agree that their training, qualifications, and experience were valued, compared to Competent/Comparable general registrants.

As noted in [Chapter 3](#), prior research on IMG experiences in Aotearoa New Zealand often homogenises this diverse group, limiting the possibility for comparative analysis between IMGs of different backgrounds. Nonetheless, policy documentation and workforce data suggest

the existence of an “occupational apartheid” (Mpofu & Hocking, 2013, p. 132) among IMGs from different backgrounds and on different licensing pathways (see [Chapter 2](#), Subsection 2.3.3), which often correlates with whether they trained in a Global North or Global South country. This research indicates the possibility of a third occupational divide between the experiences of general registrants and specialist IMGs. To this end, the following subsections discuss the experiences of participants with recognition of their overseas training, qualifications, and experience in relation to these three pathway groupings.

6.2.1 NZREX Pathway Participants

In both phases of the research, NZREX doctors, predominantly from middle-income countries, were more likely to feel their professional capabilities were undervalued and underutilised compared to IMGs with training or experience in Comparable Health Systems (CHS) in Global North countries. Despite being less likely to have achieved medical licensing, NZREX participants often felt that their overseas backgrounds, usually in Global South countries, provided them with skillsets that distinguished them from Global North practitioners in ways that should be considered advantageous. IMG 1 (NZREX) highlighted that “while New Zealand’s health system is more effective, the level of exposure, training, and resilience you learn in [Southern Asia] is higher”. Similarly, a questionnaire participant (NZREX) emphasised that:

Being labelled ‘non-comparable’ is also frustrating when this could be valuable to New Zealand; for example, doctors who have worked in [Southern Africa] have a significant amount of trauma experience, experience working under a constrained system, and in a multi-cultural setting.

IMG 21 (NZREX) also believed the skills he learned in South America prepared him more thoroughly than NZMGs, noting that in his experience medical students in Aotearoa New Zealand “are too protected”. He felt, for example, that too many examination exemptions and supports are available during medical school for illness or wellbeing in Aotearoa New Zealand, inhibiting the opportunity for medical students to develop the necessary hardiness to work as doctors. This belief echoes IMG 1’s point that IMGs from non-CHS countries may have higher levels of resilience, something that IMG 10 (NZREX) felt was especially applicable when completing the highly demanding PGY1 internship year. He shared how he “trained in a more rigid environment” in the Pacific and that “the way I’ve been burnt out before means my baseline is a little different compared to the baselines of other people who I work with”. Nevertheless, NZREX participants felt this experience was often undervalued and underutilised, compelling individuals to “start from scratch” (IMG 1, NZREX). IMG 15 (NZREX)

explained that NZREX candidates, regardless of their experience, must begin at the entry level, in stark contrast to their counterparts from CHS countries:

Suppose somebody were to come from the U.K. having done three years as a House Officer, like I did, they could automatically get work, and the salary required for PGY1, or more. But for us [NZREX candidates], irrespective of our case, irrespective of what our experience is, none of that counts. You start at the beginning. You could be a surgeon for 20 years or just graduated – you start at the beginning with the lowest salary.

As IMG 15 explained, clinical experience is not considered in the NZREX process. In fact, MCNZ (2024n) explicitly states that completing PGY1 “is your only pathway to registration in Aotearoa New Zealand...regardless of your previous experience”. However, IMG 23 (NZREX) noted inconsistencies surrounding recognition of prior experience when seeking work opportunities. She was informed upon applying for the new PGY1 pilot programme in the Waikato (see [Chapter 2](#), Subsection 2.3.3) that priority would be given to NZREX doctors with extensive experience in General Practice (GP) settings, even if this was not in a health system considered “Comparable” for medical registration purposes. Noting that this was the first time she had heard of any experience in a “non-comparable” country being required or recognised, she felt “very, very disheartened” because “that experience usually doesn’t count in New Zealand for registration”.

While IMG 23’s experience may indicate growing recognition of prior clinical experience from a greater range of backgrounds, this example also prompts concerns around consistent standards. For Expert 8 (Employer), any move to recognise clinical experience outside of CHS countries needs to be accompanied by clear guidelines and standards, due to the diversity of NZREX doctors:

NZREX doctors are a unique group in that they bring such a diversity of skills and competencies ranging from very, very adequately skilled and no different to the New Zealand graduate, to abysmally skilled, absolutely shockingly skilled, who haven’t worked for eight to ten years, and some have never worked actually, as a doctor in their country...so you can’t really consider all the NZREX doctors as a group – they are just so diverse.

While NZREX doctors tended to highlight the underutilisation of their professional capabilities more than other general registrants, this comment underscores how, like IMGs on all licensing pathways, NZREX candidates “are anything but homogeneous” (Chan, 2015, p. 850). Just as

there is an “occupational apartheid” (Mpofu & Hocking, 2013, p. 132) between IMGs on different licensing pathways, vast differences also exist among NZREX doctors themselves.

This diversity, seen among NZREX research participants ranging from recent graduates to specialists with over two decades of experience, challenges the classification of IMGs based solely on the country of primary qualification. Licensing processes bracket all of these individuals and their diverse skillsets into one group, limiting the motility and combined capabilities of every IMG under this classification, rather than only those who may indeed be, to use the words of Expert 8, “abysmally skilled”. This creates “uneven mobilities” (Sheller, 2021, p. 11) for NZREX doctors in relation to their professional skills and backgrounds, compared to Competent/Comparable general registrants.

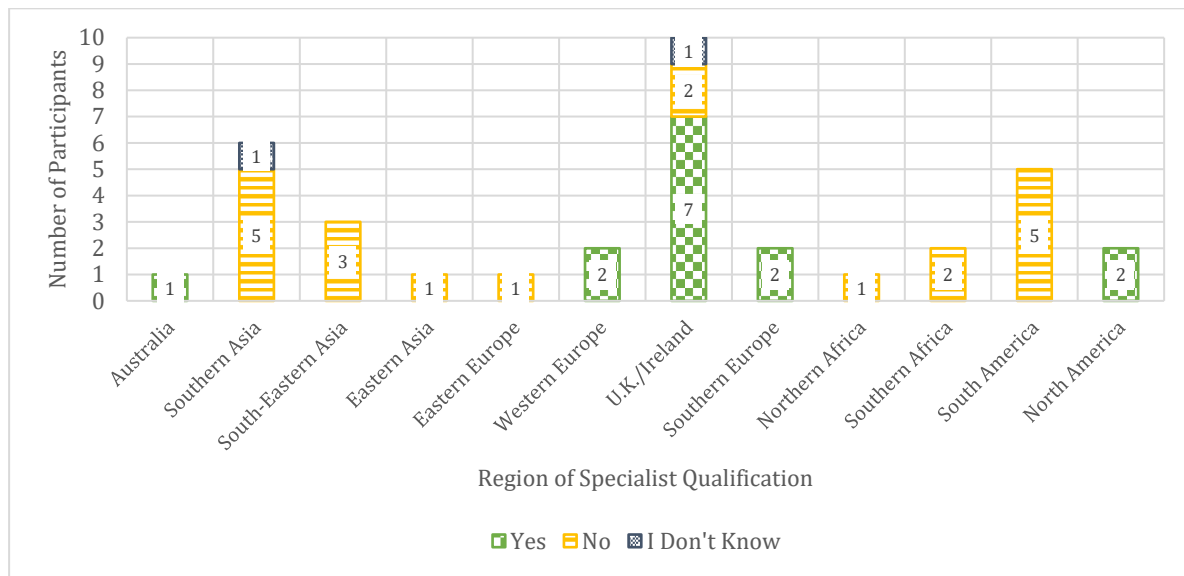
6.2.2 Specialist Participants

Specialist IMGs also experienced uneven mobilities and capabilities depending on their background. Of the 28 questionnaire respondents with overseas specialist qualifications, nine noted that these were recognised in Aotearoa New Zealand. In Phase 1, four of the 13 interview participants with overseas specialist training shared that these qualifications were recognised in Aotearoa New Zealand³⁵. Given that vocational (VOC) licensing is granted on a case-by-case basis (MCNZ, 2024q), these findings offer insights into which kinds of specialist qualifications, for which there is limited publicly available information, may be recognised on the VOC pathway. Accepted qualifications were from Australia, Europe, and North America, while qualifications from parts of Asia, Africa, or Latin America were not recognised. Figure 27 provides an overview of participants in both Phase 1 and Phase 2 with overseas specialist qualifications, indicating whether they were eligible for specialist registration in Aotearoa New Zealand.

³⁵ IMG 2 and IMG 3 noted that while their specialist qualifications in General Practice were recognised in Aotearoa New Zealand, they had chosen to pursue the CHS pathway instead of the VOC pathway because it was less expensive and resulted in the same job opportunities. This is because of the nature of General Practice in Aotearoa New Zealand and these circumstances would not apply to other specialist fields.

Figure 27

Responses From Phase 1 and Phase 2 Research Participants Regarding Whether Their Overseas Specialist Qualifications Are Recognised in Aotearoa New Zealand, by Region of Specialist Qualification (N = 36)



As Figure 27 illustrates, only three respondents who completed specialist training in CHS countries (in the U.K./Ireland) did not indicate their specialist qualifications were recognised in Aotearoa New Zealand. Conversely, many NZREX respondents had trained as specialists overseas but were only eligible for general registration, as these qualifications were not accepted. This lack of recognition disadvantaged some specialists compared to recent graduates, as explained by IMG 11 (NZREX):

I realised that to pass the exam [NZREX], I need to study medicine again. I studied medicine more than 20 years ago...even if they would give me the opportunity to pass this exam in my native language, I couldn't, because I need to start again – Psychiatry, Paediatrics, and all of General Medicine. I worked as a surgeon and that's still quite a broad field, but of course there's nothing in Surgery about Neurology, nothing about Psychiatry, or Obstetrics.

Rather than providing an advantage, extensive specialised experience posed additional challenges in completing the NZREX process, leaving specialists at a strong disadvantage due to the lack of opportunities to complete an equivalent examination or retraining process in their specialty.

IMG 8 (NZREX) made a similar observation, noting that he was at a disadvantage because of his extensive specialist training, as the NZREX examination “was more like a final-year medical student exam”. MCNZ (2024n) states that the NZREX examination provides a standard for

verifying that an IMG is considered “equivalent” to an NZMG, with documentation from the initial offerings of the NZREX stating that the examination was “equivalent in standard to our 5th and 6th year student examinations” (MCNZ, 1994, p. 23). It is thus not unexpected that the examination may share some similarities with a final-year medical school assessment. In fact, IMG 16 (NZREX) agreed that there were some advantages to her not having practised medicine at all prior to moving to Aotearoa New Zealand, because “I didn’t have to unlearn anything from another country”. Therefore, specialist qualifications and training afford IMGs specific capabilities which, when combined with the medical registration environment of Aotearoa New Zealand, are sometimes not merely underutilised, but can also inhibit their ability to work as medical practitioners. There may be a gap in providing a viable pathway to registration for IMGs who did not recently graduate, particularly those with postgraduate specialisation from non-CHS countries, to retrain or convert their qualifications in their specialty.

Furthermore, not all specialists whose qualifications were recognised in Aotearoa New Zealand reported positive experiences with registration. While specialists such as IMG 5 (LOC) and IMG 14 (VOC) did not report challenges obtaining medical licensing, IMG 5 acknowledged her fortunate experience compared to peers from a similar background in North America. She noted that MCNZ prioritises Family Medicine (General Practice) specialists when applying for both specialist and CHS registration, making it challenging for friends working in other fields, such as Internal Medicine or General Surgery, to secure registration. Similarly, one specialist questionnaire respondent, trained as a specialist in a non-English-speaking, Western European country, commented that “overseas qualifications, especially from first-world countries, are not appreciated or recognised”. Another Western European participant explained that her specialist qualifications were still not recognised after three years, which meant she had to register via the CHS pathway as a generalist. Such anecdotes provide context for why one-third of specialist respondents to the questionnaire disagreed to some extent that their training, qualifications, and experience were valued in Aotearoa New Zealand (see Figure 25 and Figure 26). This sentiment was also seen in the literature, when a group of psychiatrists registered with the Royal Australian and New Zealand College of Psychiatrists discussed the lack of recognition of advanced specialisation in areas such as addiction, and suggested this may act as a deterrent to recruiting qualified IMGs (Rao et al., 2023).

Finally, it is notable that Australian-trained specialists also reported challenges in recognition of their prior training and experience. In the questionnaire, an Australian-trained specialist attributed the underutilisation of his prior training to “extreme and archaic limitations on enhanced skill sets (sometimes called enhanced scopes of practice) that are simply not recognised” (Questionnaire Respondent, VOC). Similarly, Expert 3 (Researcher), who

underwent specialist training in Australia despite being originally an NZMG, also noted that returning to New Zealand would be “quite difficult”, despite joint Australian Medical Council (AMC) and MCNZ accreditation processes. The lack of transferability of some subspecialist qualifications from Australia was unexpected, considering the influential role of AMC in Aotearoa New Zealand’s medical licensing, especially concerning Australasian specialist colleges (see [Chapter 2](#), Subsection 2.2.2). Consequently, these examples point to bureaucratic limitations in processes and policies that may not align with the contemporary healthcare setting of Aotearoa New Zealand, particularly in specialist fields.

6.2.3 Competent/Comparable Pathway Participants

In contrast to the other two licensing groups, Competent/Comparable general registrants tended to indicate more consistently that their qualifications, training, and prior experience were recognised and valued in Aotearoa New Zealand. As seen in Figure 25 and Figure 26, only 11% of Competent/Comparable pathway participants somewhat disagreed that their training, qualifications, and experience were valued in Aotearoa New Zealand, with none disagreeing or strongly disagreeing. Moreover, 85% somewhat agreed or agreed that their training and qualifications were valued, while 77% somewhat agreed, agreed, or strongly agreed that their prior experience was valued in Aotearoa New Zealand.

Nevertheless, some participants expressed concerns relating to the recognition of prior experience on the CHS pathway. The main challenge is that the CHS pathway requires individuals to have worked in the “the same or a similar area of medicine” (MCNZ, 2022g, p. 1) in a CHS country. Other experience, such as that in the Emergency Department, would not be considered as “similar” to working in a General Practice (GP) setting, for example. IMG 2 (CHS) observed this dilemma first-hand, struggling to meet required hours to work as a GP due to recent Emergency Department experience, despite having postgraduate specialisation as a GP. She explained that it is common in many countries for General Practitioners to work in both GP clinics and Emergency or Urgent Care settings and was frustrated that this experience counted against her. Similarly, IMG 23 (NZREX) mentioned the difficulty this restriction poses for junior doctors, who typically spend their initial years rotating between departments, thus falling short of clinical experience requirements to work in any one field, even if they have worked for at least 33 months in a CHS country.

Expert 4 (Recruitment Agent) described how he sought clarification from MCNZ around why some IMGs and their prior experience were not considered “valuable”. MCNZ emphasised the importance of public protection, citing the lack of “continuity of care” and experience managing chronic conditions for doctors who have worked primarily in an emergency setting. This reflects Aotearoa New Zealand’s strong distinction between secondary (hospital) and primary

(General Practice) care (e.g., Te Whatu Ora - Health New Zealand, 2011) that may not be so prevalent in other countries. The challenges participants noted regarding recognition of experience on the CHS pathway may thus be related to international differences in health systems and approaches in healthcare. In other words, challenges CHS participants reported with regard to the recognition of some clinical experience may be related to areas where the health system of Aotearoa New Zealand is simply less comparable to some CHS countries in practice.

6.2.4 Professional Recognition and Human Dignity

The examples explored in these subsections illustrate how the differential value ascribed by licensing pathways to the medical training, qualifications, and experience of IMGs from diverse backgrounds can result in the uneven mobilities of professional capabilities. Medical licensing pathways therefore impact an IMG's ability to convert these capabilities into functionings, in the purest sense of being registered to practise medicine. In this way, these subsections emphasise the more-than-human combined capabilities associated with an IMG's training, qualifications, and experience, rather than the personal capabilities and conversion factors an individual IMG may have access to. Medical licensing pathways pose questions of whether these more-than-human aspects are recognised or valued, meaning that the mobilities afforded to the professional capabilities in this context often exist independently from the mobilities of an IMG in terms of their migration to Aotearoa New Zealand.

Alongside this emphasis on the differential mobilities of IMGs' skills and training, these subsections have discussed the value and recognition of these human and more-than-human capabilities. As introduced in [Chapter 4](#), (Subsection 4.2.1), recognitional injustice can occur when the devaluation of individuals and groups results in some people being harmed or constrained (Fraser, 1998). The way that medical licensing pathways in Aotearoa New Zealand primarily focus on the geographical origins of the qualifications, training, and experience of IMGs, rather than using the language of individual merit, may create distance between these policies and the human beings who are affected in unequal ways. Instead of categorising IMGs from a particular national background as non-comparable, their skills and qualifications undergo (de)valuation and/or (lack of) recognition in accordance with MCNZ classifications of Competent Authorities and Comparable Health Systems. One of the strengths of the mobility justice approach is the promotion of the exploration of both human and more-than-human mobilities (e.g., Sheller, 2018a), and this research highlights the importance of noting when such distinctions are made in practice. Policies that focus exclusively on the more-than-human capabilities of a skilled migrant's training and experience risk dehumanising the impacts these policies have on the individual.

This risk in turn has implications for the understanding of human dignity in this context. Rather than stating that, for example, “a Global South medical *doctor* is considered non-comparable”, medical licensing pathways have the effect of stating that “a Global South medical *degree* is considered non-comparable”. Drawing on Nussbaum’s (2006, 2011) understanding of human dignity as an intuitive concept relating to respect, nonhumiliation, agency, and equality, it is possible to interpret the framing of licensing pathways as aiming to uphold nonhumiliation by emphasising the lack of recognition relating to qualifications, rather than human beings. Nevertheless, the result is that, in contrast to IMGs from Competent/Comparable backgrounds, many individuals from non-CHS countries have limited options for demonstrating their ability to contribute to the understaffed health system of Aotearoa New Zealand. This could be seen to limit the human dignity ascribed to these individuals, by utilising the language of the more-than-human in defining the recognition of certain qualifications, training, and experience. While the capabilities approach has been critiqued for being individual-centred (Robeyns, 2017), this discussion highlights the value of bringing this human component to the forefront when discussing the uneven mobilities of more-than-human professional capabilities.

6.3 DIFFERENTIAL BURDENS: CONVERSION FACTORS CONTRIBUTING TO UNEVEN MOBILITIES AND COMBINED CAPABILITIES

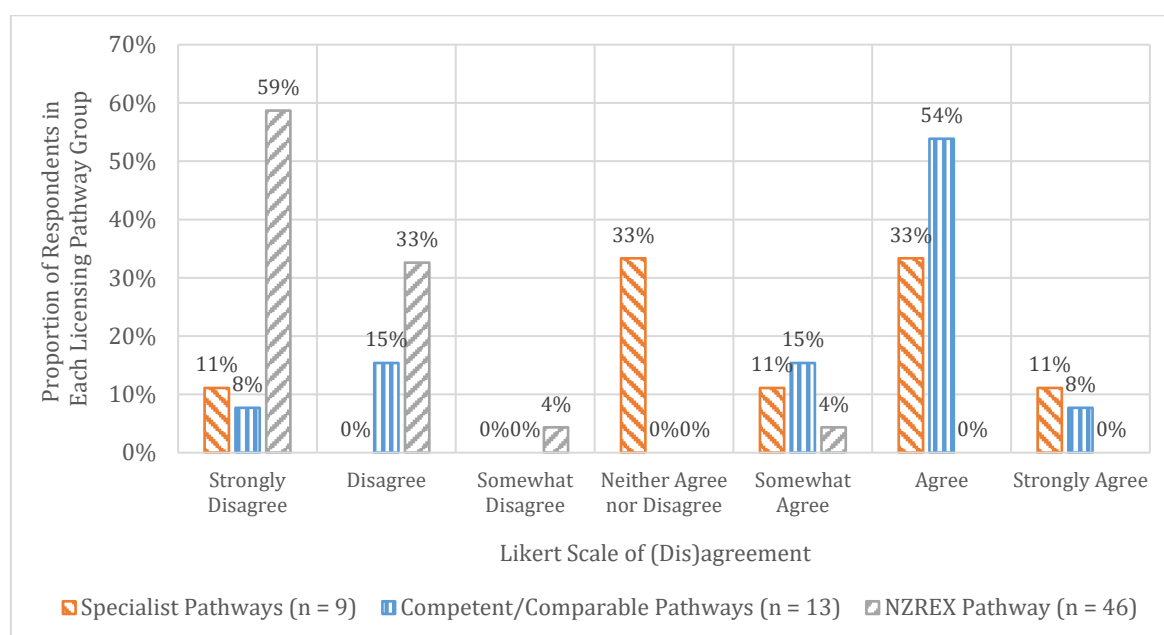
In addition to the uneven recognition of professional capabilities in this context, other social conversion factors contribute to the differential functionings of IMGs in the three licensing pathway groups with regard to registering to practise medicine. These factors include delays, timing, financial considerations, and the COVID-19 pandemic.

6.3.1 *Delays and (In)efficiencies*

The difficulties faced by IMGs in translating their capabilities into rewarding opportunities and functionings were deeply entwined with discussions on inefficiencies within medical licensing processes. Participants voiced concerns about the practical limitations experienced during registration, describing the process as inefficient, expensive, and inflexible. IMG 1 (NZREX), for example, explained that “everyone has dreams, everyone has ambitions, and these things slow down a little bit when you change place, but it should not take so much time”. Figure 28 illustrates the varying concerns across different licensing pathways, with NZREX doctors expressing more significant apprehensions about the duration of the process compared to other IMGs.

Figure 28

Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “The Time it Takes to Register as a Medical Doctor in New Zealand Is Reasonable” (N = 68)



Among NZREX doctors, 91% either strongly disagreed, or disagreed that the time required for medical licensing is reasonable, with only 4% of NZREX participants selecting “Somewhat Agree”, and none choosing “Agree” or “Strongly Agree”. In contrast, IMGs who pursued registration through specialist or Competent/Comparable general licensing pathways were more likely to find the time associated with medical licensing reasonable. Seventy-seven per cent of Competent/Comparable participants either somewhat agreed, agreed, or strongly agreed with this statement, compared to 56% of specialists. These responses suggest that IMGs from all backgrounds may experience inefficiencies and delays in the medical registration process.

Nevertheless, the average wait time for registration among questionnaire participants was much higher for NZREX doctors than for specialists and Competent/Comparable pathway registrants. From the 40 licensed questionnaire respondents, 39 indicated when they initially achieved medical registration in Aotearoa New Zealand, and 37 specified the year they began their registration process. The relationship between these dates allowed for an estimation of the average registration time as five months for Competent/Comparable general pathway participants, and seven months for recognised specialists³⁶. These data suggest that these

³⁶ Note that only the year was provided by respondents, not the month – so, for example, someone who started the licensing process in December 2019 and became registered in January 2020 would have indicated that they started the process in 2019 and achieved registration in 2020. This would count as one year for the purposes of this

IMGs' experiences may roughly correspond with MCNZ's (2022a) expressed goals of processing Competent/Comparable general registration and LOC pathway applications within 20 working days, and vocational applications within four to six months. Exceptions were evident though, as highlighted by IMG 2 and IMG 3, who experienced a notable three-year delay on the CHS pathway during COVID-19. IMG 3, from Southern Europe, described the circular registration processes that contributed to this:

You need three references from people who have worked with you within the past two years, and at least one has to be from someone who is more experienced than you. The problem is you have to upload them when you start your international portfolio, and then after seven or eight months when you finally get your medical degree accepted, the letters have expired, and you have to get three letters from three new people. It was very difficult for us to find three new people in the small, rural practice where we worked, who were comfortable writing in English and uploading it to the Medical Council [MCNZ] directly.

IMG 3's circumstances represent an exception from the average amount of time required to process applications for IMGs from CHS countries, which may have been related to COVID-19 (discussed further in Subsection 6.3.4). Nevertheless, IMG 5 (LOC) also described the LOC pathway as "complicated" and "not done efficiently", attributing her successful registration to a recruitment agency that she claimed deducted 40% of her pay. Similarly, IMG 2 (CHS) found the registration processes in Aotearoa New Zealand unnecessarily stringent compared to other CHS countries where she had been offered work, expressing frustration over the extensive requirements:

In Ireland or England, they don't ask you for 4,000 hours of experience. It's about your education, your training, and your level of English. They take into account your work experience for getting a job, but not for your registration. Those are two separate things...in our case, the problem is not with what education we had, because they [MCNZ] agree that it's Comparable. We have the work experience, we have the knowledge, but they have decided to make it harder than other countries to accept us.

Registration processes for specialist and Competent/Comparable pathway participants thus came with their own set of challenges. For NZREX questionnaire participants, on the other

analysis, and someone who started in January 2019 and registered in December 2019 (therefore entering "2019" and "2019") would count as zero years. This average wait time should be taken as an approximation only.

hand, the licensing process took an average of three and a half years for those who had successfully registered³⁷. Furthermore, an additional 29 respondents still working towards registration shared the year they started the NZREX process (from 2014 onwards). The average length of time between the year they began the process, and when they took the questionnaire in March/April 2023, was just over three years³⁸.

These wait times surpass MCNZ's (2024l) data, which indicate an average delay of one year and four months in obtaining a PGY1 position after passing NZREX between 2017 and 2021 (see [Chapter 3](#), Subsection 3.3.3). This is because the data in this research consider the licensing pathway as a whole, while MCNZ data only report on the delay between passing the NZREX examination and achieving a PGY1 position. Consequently, these data suggest that the process of preparing for and taking international medical knowledge and English-language examinations, the wait time of around a year to book an NZREX examination slot, and then the subsequent delays in finding supervised work after passing, result in a total wait time of at least three years. Uneven mobilities of professional capabilities can be seen between these licensing pathway groups not only in terms of their differential experiences with recognition and success in achieving licensing, but also in the time commitment required to complete the process.

6.3.2 Financial Considerations

Uneven experiences with delays in registration were compounded by the experiences IMGs reported with financial considerations. As noted in [Chapter 2](#) (Subsection 2.3), the cost of provisional registration is significantly higher for NZREX doctors than other licensing pathways³⁹, disproportionately burdening these doctors and their families financially (Lillis et al., 2006; Mpofu & Hocking, 2013; Pande, 2015). Figure 29 provides a snapshot of the uneven cost burdens experienced by IMGs in this research, with 48% of NZREX participants strongly disagreeing that the cost of medical licensing is reasonable in Aotearoa New Zealand, compared to none of the Competent/Comparable pathway or specialist respondents.

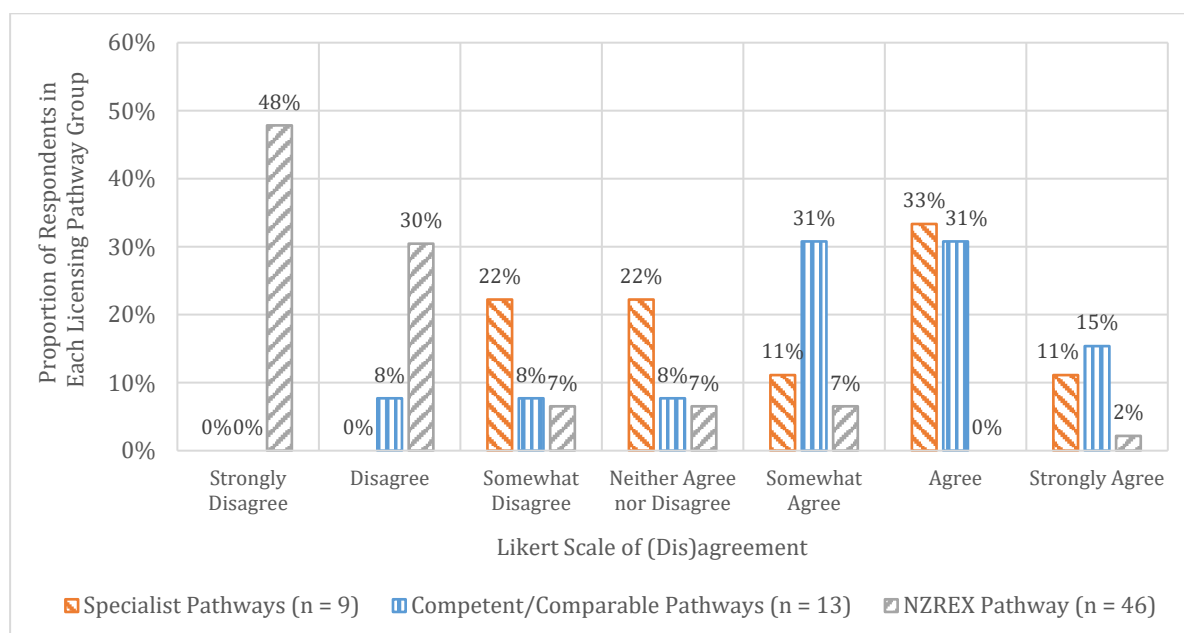
³⁷ Twelve of the 13 NZREX participants who had achieved medical registration included the start and end years of their process. The thirteenth NZREX participant who achieved medical registration indicated they gained registration in 2020 but did not include the year they began the licensing process – hence their wait time could not be included in this average.

³⁸ One participant who began the NZREX licensing process prior to 2000 and had not yet achieved registration was excluded as an outlier. This individual indicated that they had not attempted the process upon moving to Aotearoa New Zealand in the 1990s.

³⁹ The significant costs involved in some case-by-case vocational licensing assessments of more than NZD\$19,000 generally occur in the transition from provisional to full registration.

Figure 29

Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “The Cost of New Zealand Medical Licensing for Doctors who Trained Overseas Is Reasonable” (N = 68)



As shown in Figure 29, just 9% of NZREX doctors somewhat agreed, agreed, or strongly agreed that the cost of medical licensing in Aotearoa New Zealand was reasonable, compared to 56% of specialists and 77% of Competent/Comparable pathway respondents. By the same token, just 22% of specialists and 16% of Competent/Comparable pathway participants expressed some extent of disagreement with the given statement, as opposed to 85% of NZREX respondents. The upfront cost burden is not only higher for NZREX doctors on paper, but also tends to be perceived as unreasonable in practice. IMG 23 highlighted this financial strain, emphasising the lack of a guarantee of employment even after passing NZREX:

They say that there is no guarantee for us to employ you even after you clear your NZREX – it's there in the official website, we do understand that. But moving to a new country, spending so much energy and effort studying, clearing all those exams – some people will be earning, but other people will be dependent on their husband or their wife to take the exam...that money is not simple money, it's more than NZD\$5,000.

The financial implications of the NZREX licensing process thus extend beyond examination fees, encompassing living expenses in a new country while being unable to work as a doctor. IMG 4 echoed these sentiments, emphasising the expenses incurred from relocating, taking the examination, and waiting for a job placement. Furthermore, he wondered about the fee

structure for the NZREX examination compared to other international clinical skills (OSCE) examinations:

I could not justify why it [NZREX] was so expensive, compared to a lot of other exams, especially when it happens only a couple of times per year. All they do is hire a clinical space, some actors, and the supervisors. There'll be like 30 people sitting the exam paying that fee [NZD\$5,500]. That's a lot of money. I don't know what they [MCNZ] do with it in the end.

The implication that the examination fee was unjustifiable was also shared by one questionnaire respondent, who commented that: "in one sentence: NZREX is good money for MCNZ". The opacity surrounding the utilisation of fees added to some IMGs' frustration with the process, leaving them questioning the value of pursuing the NZREX pathway.

As indicated by Figure 29, however, financial concerns were not limited to NZREX doctors, with IMG 14 (VOC) sharing that the "dollar amounts attached to everything felt a bit frustrating, because they [MCNZ] can literally charge whatever the hell they want". This sentiment may relate to the finding (see Figure 29) that 22% of registered specialists participating in the questionnaire somewhat disagreed that the cost of medical licensing is reasonable. Hoping to avoid the costs associated with vocational (VOC) licensing, IMG 3 pursued the CHS pathway. However, this process had already cost him around NZD\$4,000 at the time of the interview, including immigration applications, and he was not yet registered. The financial burden of medical registration further compounded the practical limitations many individuals faced and did not always pay off. Ultimately, IMG 7 (NZREX) pointed out the discrepancy between the perception of a better future in Aotearoa New Zealand and the financial reality, suggesting that for some IMGs, the prospect of a better future may be more viable in their home countries. As Pineda et al. (2023) note in the context of migrant occupational therapists, such factors can result in a misalignment between the prospect of "greener pastures" and the reality of the lived migrant experience (p. 6).

6.3.3 Timing

Challenges with delays and financial concerns when seeking medical registration depended on when an individual moved to Aotearoa New Zealand. This was exemplified by IMG 22 (CA), who migrated from the U.K./Ireland in 2007 and described a relatively swift and uncomplicated process, facilitated by the assistance of her employer. However, she also believed that registration has since become more challenging. This sentiment was shared by several other participants, who noted increased delays in medical registration processes, contrasting their own experiences with the current situation. One questionnaire respondent

on the CHS pathway felt that “medical licensing in 2006 was a clear and simple process; now, it is much harder for someone with my background to obtain licensing”. Another questionnaire respondent, who arrived via the CA pathway in 2013, believed that “things have drastically changed for the worse since then, and many overseas doctors looking to move here that I speak to are generally unhappy with the remuneration and working conditions”. IMG 14 (VOC) also reported worsening working conditions, with higher patient loads and limited additional remuneration, remarking that “the workforce is being so critically affected at the moment that there’s not even supervision for new overseas doctors”. The workforce shortages discussed in [Chapter 3](#), Section 3.3 (e.g., Armah, 2022; Broughton, 2021; Ellingham, 2022; RNZCGP, 2020; Russell, 2021a, 2022; Shahtahmasebi, 2021; Spence, 2024; Tebbutt, 2021; Trigger, 2022) thus have significant impacts on the registration and work experiences of IMGs in this research.

Many NZREX doctors also shared the belief that conditions and processes were more effective and supportive historically, with one questionnaire participant (NZREX) commenting that:

I was fortunate to immigrate during a time when the wait list for the NZREX exam wasn’t long and I was extremely fortunate to get a job after passing, very quickly. I know this is not the case anymore and it is sad to see the many hurdles foreign medical graduates are needing to jump...at a time of such significant doctor shortage and a health workforce crisis.

Specifically, systemic changes that resulted in reduced support programmes and employment options for NZREX doctors occurred from 2012 (see [Chapter 3](#), Subsection 3.3.3). This observation was exemplified by IMG 4 (NZREX), who arrived just when the bridging programmes and other supports that were previously in place for NZREX doctors were discontinued. As he explained:

When I took my exam [NZREX] in 2012, that was the year when we started having issues, and I think that was probably because a few years before that New Zealand bumped up their medical school admissions...in 2011, I was told by everyone who had taken the exam before that ‘it’s amazing, you get a job straight away, you can easily come to work here’, and then when I arrived everything changed...it took me almost two years to get a job.

IMG 16 (NZREX), who now works in General Practice, also expressed frustration with the removal of the option to complete PGY1 in GP clinics from 2014 (MCNZ, 2014b). This left NZREX doctors with limited avenues for career progression and exacerbated the bottleneck in securing PGY1 positions, which she found particularly problematic for primary healthcare provision. Expert 8 (Employer) elaborated on why the PGY1 option in General Practice was

discontinued for NZREX doctors in 2014, attributing this to “poor supervision, unsupported doctors, bad press, and stressed-out doctors”, which is something that the new GP pilot pathway (MCNZ, 2022h) hopes to address. However, Expert 8 also saw risks with the lifespan of this pilot, because qualifying doctors could easily be “poached” by employers in other regions, rendering the pathway ineffective. Furthermore, a decision will not be made on the success of the pilot until 2025, meaning that any potential expansions to GP clinics around the country are unlikely to be seen before 2026. This was frustrating to some participants, such as IMG 18 (NZREX), who was aware of several GP clinics in his area who would be interested in investing in this pilot. He reflected that perhaps “they need people with my background to be inside those decision-making meetings, to have their voice heard”. While the introduction of the pilot programme does suggest a positive shift towards offering broader options for NZREX doctors to become licensed, therefore, the sustainability and long-term impacts remain to be seen.

Moreover, after 2012, NZREX doctors were also removed from the Advanced Choice of Employment (ACE) matching system, an online employment application portal now available only for NZMGs and graduates from Australia applying to PGY1 positions (Thomas, 2018). Several NZREX participants were frustrated by this (IMG 4; IMG 8; IMG 9; IMG 10; IMG 15; IMG 16), with IMG 15 explaining that prior to 2012:

...you could put your names into a common registry [ACE], and it's okay if, like, all the local graduates got placed ahead of us – because at least we'd get placements somewhere. But when I passed the NZREX exam they did away with the ACE matching scheme, and we were then left to scramble, applying all over the place, going to individual hospitals saying, 'Take me, take me!'

Literature and media reports discussed in [Chapter 3](#) (Subsection 3.3.3) highlighted how the discontinuation of the bridging programmes, the NZREX preparation course, and the PGY1 GP pathway, along with removal from the ACE matching system, negatively affected the medical registration timeline of NZREX doctors from 2012. These participant accounts offer further detail on the impact of these changes, which are likely to have contributed to the questionnaire participants' average wait time for registration of more than three years⁴⁰.

6.3.4 COVID-19

In addition to more restrictive policies and worsening working conditions over the decade prior to this research, COVID-19 was seen to exacerbate the challenges IMGs faced with medical

⁴⁰ All NZREX questionnaire participants who were registered as doctors indicated that they had achieved medical licensing from 2012 onwards.

registration and employment in Aotearoa New Zealand. Those employed as doctors felt they were under immense pressure during the pandemic (e.g., IMG 14, VOC; IMG 17, NZREX; IMG 22, CA). While Aotearoa New Zealand's initial COVID-19-free status was "touted as something that could benefit us" (IMG 14, VOC), participants did not see positive impacts of this in practice. Instead, "COVID made everything take even longer" (IMG 2, CHS) and policies that were in place to support the streamlined immigration of essential healthcare workers during COVID-19 lockdowns still saw delays. IMG 5 (LOC), for example, was advised by her recruitment company to quit her job in North America in 2021, only to experience COVID-19-related delays to her visa application that left her unemployed for several months prior to moving to Aotearoa New Zealand.

Commenting on media reports relating to skilled migrants leaving because they were unable to obtain residency visas for their family members (1 News, 2021; Bonnett, 2021a, 2021b, 2021c; Cassie, 2021a; Fonseka, 2021; O'Brien, 2021; Wade, 2021), Expert 4 (Recruitment Agent) expressed frustration with recruiting staff during the pandemic, noting a disconnect between policy and practice:

Theoretically, there were exemptions for essential workers, highly-skilled migrants, during the COVID lockdowns...but in practice it was a desperate situation to get them into the country...we could get a COVID permit for the doctor, but not for the family. [...] There was some weird thinking going on that these highly-skilled people were just going to be a drain on the system, instead of helping the system through this crisis.

Cresswell (2021) argues that the closing down of international borders during COVID-19 was related to a "sedentarist view of the world" (p. 58) that tends to be suspicious of mobility, noting that mobility came "under attack" (p. 52) during the pandemic. Expert 4's experience of "weird" and illogical thought processes limiting the mobility of essential healthcare workers during a global pandemic may be an example of Cresswell's argument in practice.

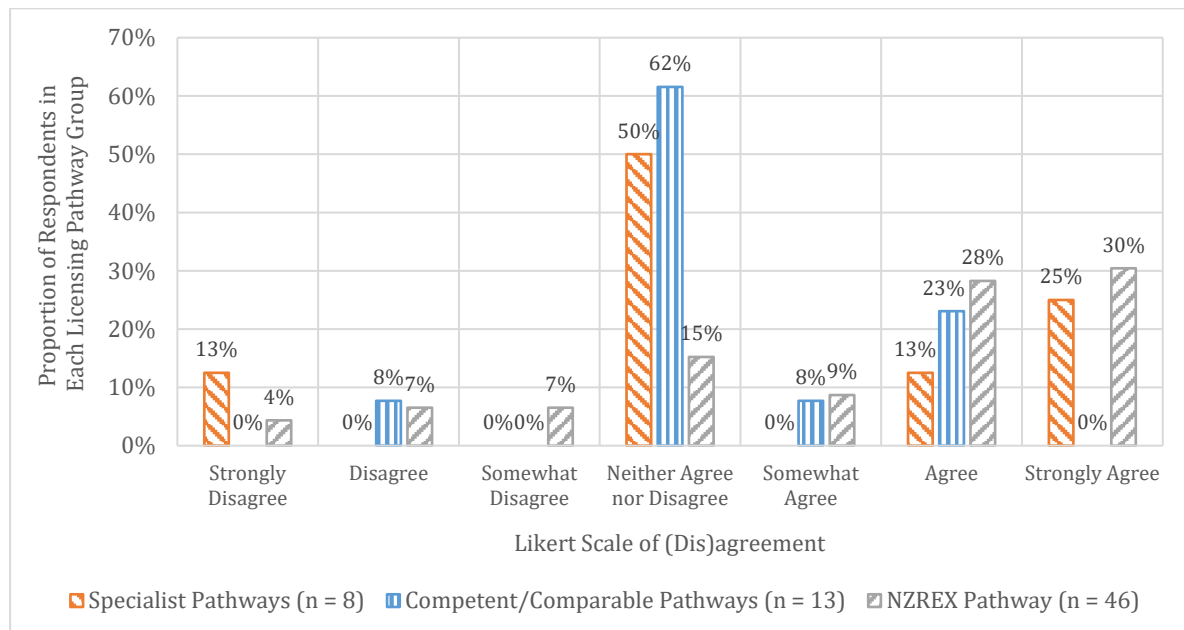
Other participants noted that it was not until towards the end of the pandemic that strict licensing and immigration processes began to improve. While NZREX doctors discussed the exacerbated delays they experienced throughout COVID-19 due to NZREX examination cancellations (IMG 6; IMG 9; IMG 12; IMG 20) and limited PGY1 opportunities (IMG 9; IMG 10), some observed improvements by 2022, the third year of the pandemic. IMG 10 directly attributed his PGY1 job offer in 2021 to COVID-19, describing how "COVID-19 was starting become so bad that we needed more people on the floor". Furthermore, Expert 1 (Employer) mentioned the increased number of NZREX doctors his hospital was looking to hire, while

Expert 8 (Employer) explained that in his region, “we have such a workforce crisis at the moment that we’re sucking up any NZREX doctor we can”. This observation is supported by workforce data (see [Chapter 2](#), Subsection 2.3.3), with 90% of IMGs who passed NZREX in 2022 already working in PGY1 positions by October 2023. However, as noted in Subsection 2.3.3, COVID-19 also resulted in reduced examination offerings, meaning there were fewer candidates in the pool of NZREX passes from 2020 onwards.

Questionnaire data relating to the impact of COVID-19 highlighted the nuanced impacts of the pandemic on IMGs in Aotearoa New Zealand. As shown in Figure 30, 30% of NZREX participants and 25% of specialist respondents strongly agreed that COVID-19 had exacerbated medical licensing challenges, while none of the Competent/Comparable pathway respondents strongly agreed. Half of the specialist respondents (50%), 62% of those on Competent/Comparable pathways, and 15% of NZREX participants neither agreed nor disagreed that COVID-19 has made registration more challenging. It is possible to speculate that these discrepancies may be because many individuals registered prior to 2020 and did not have first-hand experience with medical licensing during the pandemic. Alternatively, they may have felt unclear as to the extent to which any challenges they experienced were related to COVID-19 and not broader systemic inefficiencies as discussed above. However, NZREX participants were still more likely to report that COVID-19 had negatively impacted licensing processes, with 67% somewhat agreeing, agreeing, or strongly agreeing with the statement, compared to 38% of specialist respondents and 31% of Competent/Comparable pathway participants.

Figure 30

Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “COVID-19 Has Made It More Difficult to Register as a Doctor in New Zealand” (N = 67)



While COVID-19 may have encouraged some changes to employment and licensing processes, therefore, participants tended to agree that the pandemic has highlighted “a substantial area of neglect in the health workforce” (Expert 1, Employer), exposing a “brewing crisis” (IMG 16, NZREX). As a result, COVID-19 has had observable impacts on the wider population seeking to access healthcare (e.g., Broughton, 2021; Russell, 2021a), as well as medical practitioners in Aotearoa New Zealand (Cassie, 2022a; McGinn, 2022; RNZCGP, 2020).

6.3.5 Uneven Mobilities

The COVID-19 pandemic brought key mobility issues to the fore, impacting daily movement, temporalities, routines, and communication, and exacerbating pre-existing inequalities in mobility (Sheller, 2021). However, this observation also raises questions as to whether a pandemic should be needed to address a “brewing crisis” (IMG 16, NZREX) by hiring qualified NZREX doctors who, like patients in Aotearoa New Zealand, were essentially waiting in line. IMG 24 (NZREX) felt that “the bar is too high” for NZREX doctors and, as discussed in this chapter, IMGs from a range of backgrounds may share a similar belief. Nonetheless, the most significant concern is the way the “bar” differs depending on which licensing pathway one is eligible for. The bar is higher for NZREX doctors than it is for doctors who trained in designated Competent Authorities or Comparable Health Systems, resulting in differential access to social conversion factors that support smooth medical registration processes.

The capabilities approach, which prioritises non-tangible elements of life, offers a lens to examine both human and more-than-human mobilities and capabilities. While all IMGs in this research have exercised the capability to move to or within Aotearoa New Zealand, their professional capabilities do not always align with the conversion factors associated with this new environment, hindering their ability to reach their full potential and translate capabilities into desired functionings. In this sense, medical licensing in Aotearoa New Zealand contributes to uneven mobilities and capabilities not only between individuals from different backgrounds, but *within* the individual practitioner. Although their knowledge, skills, and experience may physically move with them, the lack of alignment with opportunities in their new environment creates a significant disconnect for some participants, particularly those on the NZREX pathway.

6.4 IMPACTS OF UNEVEN MOBILITIES, CAPABILITIES, AND RECOGNITION

A range of conversion factors stemming from the medical licensing environment of Aotearoa New Zealand play a role in determining the combined capabilities of IMGs' qualifications, training, and experience in Aotearoa New Zealand. These factors, such as delays and financial implications, are seen to be experienced unequally by participants in different licensing pathway groups, as discussed in the previous section. This section focuses on how the uneven mobilities and recognition of these capabilities and personal conversion factors compound to generate consequences both for individual IMGs and the broader population of Aotearoa New Zealand.

6.4.1 *Pull and Push Factors*

The challenges and prolonged timelines faced by many IMGs, especially those on the NZREX pathway, prompted participants to reflect on their decisions to pursue medical careers in Aotearoa New Zealand. In doing so, participants frequently compared Aotearoa New Zealand with various CHS countries. Some participants expressed the view that registering in countries such as the U.K., Australia, or Canada was comparatively easier and provided enhanced career opportunities, as exemplified by IMG 19 (NZREX):

I feel like it was the right choice to come to New Zealand for my children, but...at the same time as I've been here, my friends were preparing for exams in other countries and now they are working in the U.K. or Australia and I'm just sitting here, just waiting.

IMG 19's distress about "just waiting" underscores Taylor's (2016c) findings that NZREX doctors often felt they were "in limbo" (p. 12). IMG 1 (NZREX) shared a similar perspective

about improved prospects elsewhere, pointing out that while her friends working in countries such as Canada or the U.S.A. faced challenges, they were, at least, able to practise as doctors. The allure of improved career prospects in other countries became a noticeable factor for participants such as IMG 23, who eventually moved to the U.K., or IMG 6, who utilised the waiting period for NZREX to secure registration in the U.S.A., U.K., and Australia. Although IMG 6 received multiple job offers in the U.K., his preference was to remain in Aotearoa New Zealand:

I just got my full license in the U.K. to practise as a registered doctor last month. But the U.K. is not a country that I really want to live for my life. I really just want to come back to New Zealand because my family's here, I grew up here, I'm a New Zealand citizen...I just used these other examinations to help me keep my motivation going, to keep my medical knowledge up to date.

This inclination to explore alternative options is indicative of a broader theme to see medical licensing processes as a deterrent to prospective IMGs. IMGs' experiences in Aotearoa New Zealand often reflected either the alignment or mismatch of their preconceived notions with the reality they encountered. As discussed in [Chapter 3](#), IMG motivations for coming to Aotearoa New Zealand, and whether they remain long-term, relate to *push* and *pull* factors. IMG 2 (CHS) explained how the pull factors drawing an IMG to Aotearoa New Zealand as a country may not outweigh the deterring push factors associated with medical licensing in this context:

When you read the requirements and you have a look at the [medical licensing] process, it's a deterrent. It's not something appealing. You really need to feel that you really want to come here for the sake of New Zealand itself. Not because the process is easier, but because you really want to see the country and work there – because other options are better.

IMG 2 went on to describe her concerns with working conditions, particularly the absence of natural light in her clinic room, which impacted her quality of life. As she was pulled to Aotearoa New Zealand by the prospect of a more outdoor-based lifestyle – or, as Gauld and Horsburgh (2015) describe in relation to U.K. medical doctors in Aotearoa New Zealand, a “life in the sun” (p. 75) – she struggled to adapt to an environment where she was not able to enjoy the benefits she expected her new country would offer. Echoing this, IMG 3 (CHS) emphasised that while Aotearoa New Zealand offers a good quality of life, it might not be enough to mitigate the challenges posed by the medical system and associated registration processes, especially

when comparable options exist globally. For IMG 3, the “theoretical reputation” of Aotearoa New Zealand may be the only aspect attracting prospective IMGs.

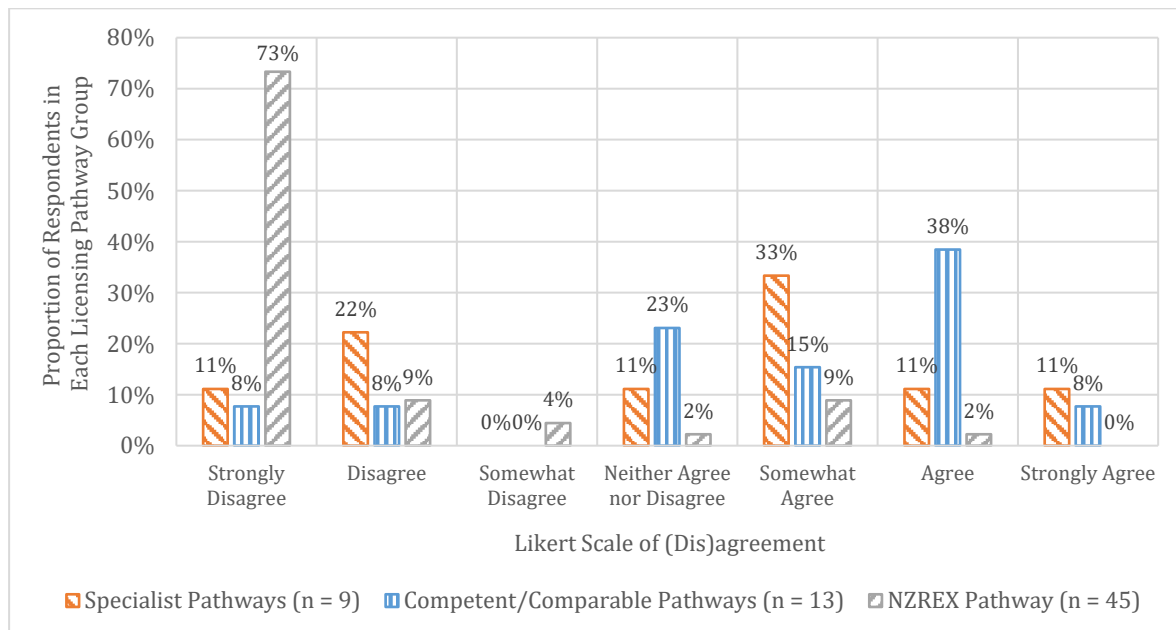
However, this “theoretical reputation” may be insufficient to pull and retain IMGs. Those already employed as doctors conveyed challenges relating to working conditions and quality of life, consistent with local literature on push factors affecting the medical workforce (ASMS, 2017; Lynch, 2008; MCNZ, 2012a; Yow et al., 2015), in addition to how well their prior experience prepared them for their new environment. As one questionnaire respondent (VOC) from Western Europe commented, “I would not come again to NZ [Aotearoa New Zealand] under these circumstances and would not recommend to fellow GPs from overseas to come here unless the regulations and rules are more accommodating!”. These restrictive medical registration processes, coupled with deteriorating working conditions, have broader impacts, as articulated by Expert 6 (Educator):

People say to me that these overseas-trained doctors come here to get training at our expense, and then just bugger off because they just took advantage of us...I don't think that's true; I think they'd be more than happy to stay here if they thought there's a future here, if people thought people cared about them and we're planning for them...career progression, training, and status are what matters...but it's got to be embedded in an overall programme of enabling them, supporting them, and just saying, 'We give a shit about you'.

Without a more accommodating and supportive system, the risk of IMGs leaving after working for a short time in Aotearoa New Zealand may persist. This observation aligns with the workforce data and policy setting introduced in Chapters 2 and 3, emphasising ongoing challenges in retaining both NZMGs and IMGs. Figure 31 highlights the impacts of the differential push and pull factors experienced by IMGs in Phase 2 of this research.

Figure 31

Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “I Would Recommend That Other Doctors, With a Similar Background to Me, Migrate to New Zealand” (N = 67)



As illustrated in Figure 31, 73% of NZREX participants strongly disagreed that they would recommend Aotearoa New Zealand as a destination for IMGs with a similar background. By contrast, 11% of specialists and 8% of Competent/Comparable pathway participants shared this sentiment. On the other hand, 62% of Competent pathway participants and 56% of recognised specialists somewhat agreed, agreed, or strongly agreed with this statement, compared to just 11% of NZREX doctors. However, only 11% of specialists and 8% of Competent/Comparable participants strongly agreed, alongside none of the NZREX doctors. While non-NZREX participants were more likely to recommend Aotearoa New Zealand to other IMGs, they were less likely to express this agreement in the strongest terms. NZREX doctors in Phase 1 of this research often described their reasons for migrating to Aotearoa New Zealand in relation to their spouses or other family members (IMG 1; IMG 7; IMG 8; IMG 9; IMG 10; IMG 11; IMG 15; IMG 16; IMG 18; IMG 19; IMG 20; IMG 21; IMG 23; IMG 24), encountering unexpected obstacles to medical licensing only after moving when they felt it was too late or too expensive to change course.

Nevertheless, many IMGs also made positive remarks about their experience of Aotearoa New Zealand. Participants cited various pull factors that met their expectations, such as the allure of a “beautiful country”, outdoor lifestyle opportunities, welcoming “Kiwi” cultural values, safety, and the predominant use of the English language. Elaborating on Jackson et al.’s (2005) argument that many skilled migrants are drawn to Aotearoa New Zealand by an enhanced

sense of safety and security, IMG 18 (NZREX) felt the country met his expectations “in terms of living in a free society” with “democracy” and the “freedom to choose your religion”. Similarly, IMG 20 (NZREX), consistent with other studies discussing pull factors related to lifestyle (e.g., Gauld & Horsburgh, 2015) considered her standard of living as higher overall, even though she could not yet work as a doctor. For IMG 4 (NZREX), Aotearoa New Zealand “absolutely met my expectations”, and he felt that once he overcame the challenges posed by NZREX and obtaining a PGY1 position, he had better prospects than he would have in his home country or other CHS countries such as the U.S.A. Similarly, IMG 10 (NZREX) felt that despite “convoluted” licensing processes, Aotearoa New Zealand “eventually” met his expectations.

However, many IMGs also grappled with significant push factors that limited the quantity and quality of opportunities afforded to them in relation to their professional capabilities. For example, some felt the pressure of an understaffed workforce and deteriorating working conditions, particularly exacerbated by the challenges posed by the COVID-19 pandemic. IMG 22 (CA) succinctly captured this sentiment:

I think that practising medicine here at the moment is quite hard; in General Practice it's busy, underfunded, and the rest of the system doesn't work terribly well...I also think the remuneration in New Zealand isn't comparable with other countries...working life at the moment isn't attractive enough to keep people. The system is stressful and underfunded.

In addition to IMG 14's apprehensions around push factors relating to an underequipped health system, IMG 2 (CHS) expressed concerns about limited professional development opportunities, echoing literature on push factors affecting retention of medical doctors in Aotearoa New Zealand (ASMS, 2017; Gorman & Brooks, 2009). IMG 14 (VOC) also reflected on the loss of potential earnings she had experienced in the 15 years since she moved from the U.K./Ireland, consistent with documented push factors relating to limited remuneration (ASMS, 2017; MCNZ, 2012a; Morton et al., 2008; Yow et al., 2015). It was thus the professional expectations of many IMGs that were sometimes not met, rather than their expectations of their new environment and country in a more general sense.

6.4.2 Unrealised Potential

As so many research participants grappled with the unexpected lack of recognition or utilisation of their qualifications and experience, some talked about pursuing alternative career options. As noted above, many specialists on the NZREX pathway felt they were disadvantaged by their postgraduate qualifications and experience, because they were overqualified. The theme of being overqualified also extended to IMGs who, driven by the need

to earn income during the NZREX process and a desire to stay occupied, sought alternative or complementary career opportunities.

However, pursuing alternative or interim career paths posed a significant challenge for many NZREX doctors. IMG 1 (NZREX) struggled to re-enter the workforce after raising children, facing obstacles even when applying for part-time roles. This sentiment was shared by IMG 6 (NZREX), who, upon returning to Aotearoa New Zealand after completing medical training overseas, found difficulty securing work in any field, explaining that:

I don't know what to do here. I even applied for [supermarket] jobs...just to do something while waiting to make a living. But even for [supermarket] jobs, it's very hard to cut down my resumé and make everything simple...even the most basic job, they deny you because you don't have any qualifications here...I am struggling with trying to survive in my own country.

This example speaks to the consequences of the disconnect between an individual's physical mobilities and ability to move and live in Aotearoa New Zealand, and their professional (im)mobilities. While local and international literature discusses the ways that IMGs unable to practise medicine sometimes find work in fields that do not require formal qualifications (e.g., Bourgeault & Neiterman, 2013; Motala & Van Wyk, 2019; Mpofu & Hocking, 2013; Peterson et al., 2014; Russell, 2021b), IMG 6's case highlights the challenges of seeking even that kind of employment.

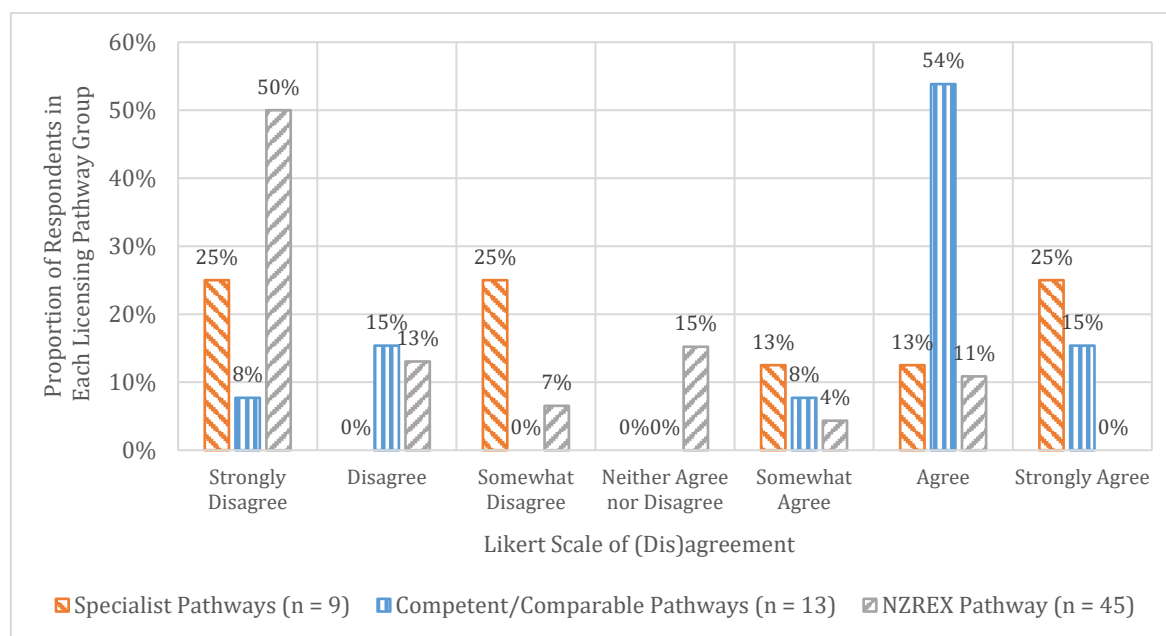
Facing these challenges due to the lack of recognised local qualifications, several NZREX doctors opted for further tertiary education. IMG 10 and IMG 20 completed Postgraduate Diplomas, which opened doors for IMG 20, albeit in an unconventional way. She noted how she was rejected from 200 jobs, including at McDonalds, because she was told she was overqualified. However, when she omitted her medical degree from her resumé and just included her Postgraduate Diploma, she reported improved success in obtaining unqualified roles. IMG 20 also found her new qualification to be beneficial in providing foundational knowledge of the health system, broader social services, and enhancing cultural awareness, which eventually enabled her to find work in occupational therapy. Likewise, IMG 10 (NZREX) felt his Postgraduate Diploma in Public Health contributed to successfully securing a PGY1 position, because his interview focused on Te Tiriti o Waitangi and culturally safe practice, which he had studied in this qualification.

Participant accounts in this research highlight the impacts of the underutilisation of some IMGs' skillsets and experience, and how this limits their ability to utilise their full potential as medical professionals. Figure 32 summarises questionnaire participants' perceptions of the

utilisation of their professional potential, a key component of converting their professional capabilities into functionings.

Figure 32

Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “I Am Able to Utilise my Full Potential as a Medical Professional in New Zealand” (N = 67)



As seen in Figure 32, 77% of Competent/Comparable general registrants either somewhat agreed, agreed, or strongly agreed that they could draw on their full potential, compared to 50% of specialists and just 15% of NZREX participants. Nevertheless, participants from all backgrounds expressed disagreement to some extent with this statement, including 50% of specialists, 23% of Competent/Comparable pathway participants, and 70% of NZREX doctors. In fact, half of NZREX participants (50%) strongly disagreed that they could utilise their full potential, along with 25% of specialists and 8% of Competent/Comparable pathway doctors. The conversion factors and push factors discussed in this chapter thus impact IMGs from a range of backgrounds in obtaining medical licensing. However, consistent with the trends in questionnaire responses to other questions introduced above, NZREX doctors tended to report a stronger level of disagreement. Uneven mobilities and combined capabilities produce differential outcomes among IMGs on different pathways to registration in Aotearoa New Zealand. Consequently, NZREX doctors were less likely to agree that their experience with medical licensing in Aotearoa New Zealand was positive overall, as exemplified by Figure 33.

Figure 33

Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “My Overall Experience of Registering as a Doctor in New Zealand Has Been Positive” (N = 68)

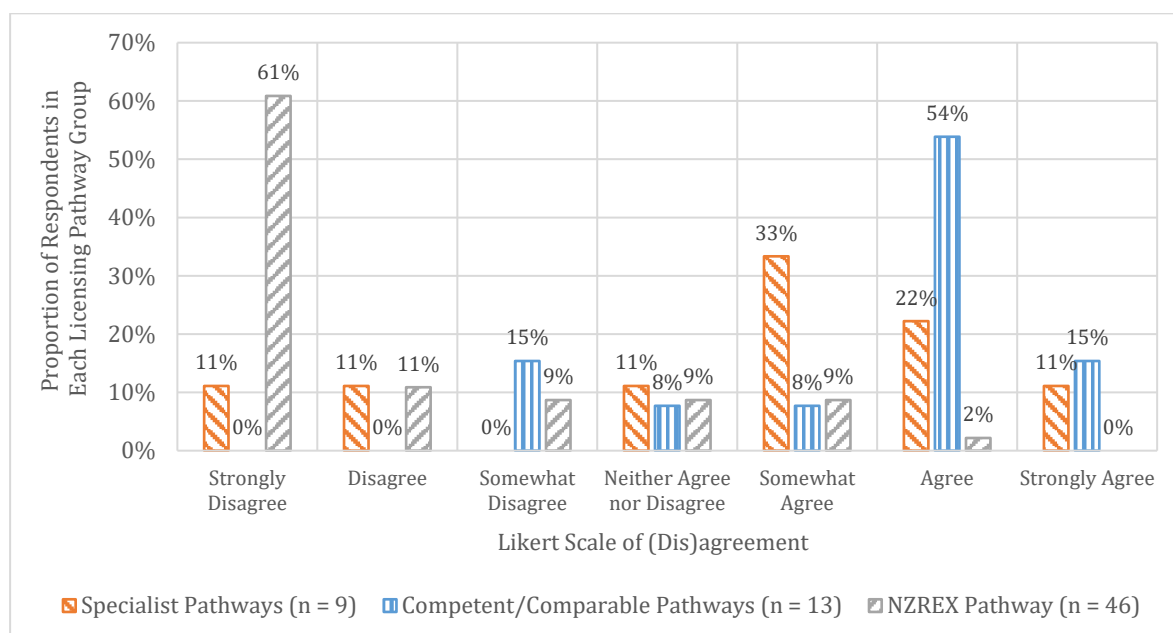


Figure 33 underscores the stark differences between licensing groups. On the one hand, 11% of specialists, 15% of Competent/Comparable general registrants and none of the NZREX participants strongly agreed that their overall experience with medical licensing was positive. On the other hand, 61% of NZREX doctors, 11% of specialists, and none of the Competent/Comparable pathway participants strongly disagreed that this experience was positive. The differential network capital, combined capabilities, incentives, and deterrents available to IMGs on different licensing pathways have impacts not only on their professional functionings – that is, whether they can practise medicine and what obstacles they must overcome to reach this – but also on their perceptions of this experience.

6.4.3 Brain Waste

The obstacles IMGs experience to practising their profession in Aotearoa New Zealand thus contribute to a broader environment characterised by worsening working conditions, inflexible structures, low remuneration compared to many CHS countries, and significant delays in converting professional capabilities into functionings. This generates dynamics of brain drain and brain waste, as seen in the workforce data in [Chapter 3](#), where 40% of IMGs stay in the country for less than two years (MCNZ, 2022a). IMG 4 (NZREX) observed this dynamic in practice:

If you think about the future, it doesn't make sense...often U.K. graduates come in their second year [PGY2]. I think that is where the biggest issue is, because they come here for like a working holiday – the moment you hire them, employ them, you know, it's a short-term thing.

The notion of British graduates coming to Aotearoa New Zealand for a “working holiday” reflects the language used by MCNZ (2022c) to describe doctors from the U.K., Ireland, and North America who come to Aotearoa New Zealand on short-term placements, a trend also observed by Gorman (2011), who referred to such IMGs as “medical-tourists”. Similar experiences with this short-term hiring approach in practice led IMG 9 (NZREX) to ask; “Why are they so willing to take someone from overseas for the short-term? Why don't they have a long-term plan? What about the doctors who are already here and want to stay but can't work?”

Furthermore, participants demonstrated awareness and concern for the broader contributions of this unrealised potential to the population of Aotearoa New Zealand. One questionnaire respondent (NZREX) emphasised the negative impacts of brain waste, commenting that “it is harmful to the overwhelmed NZ [Aotearoa New Zealand] healthcare system to have competent doctors living in New Zealand restricted from practicing their profession in any form”. For IMG 3, who faced challenges in navigating the CHS pathway, the situation was “heart-breaking”, especially considering ongoing health staff shortages and the impact of the COVID-19 pandemic. Participants were acutely aware of the health workforce crisis, with IMG 16 (NZREX) expressing concern about the imposition of additional hurdles to registration amid “a massive shortage of doctors”. Similarly, IMG 21 felt he was “really, really lucky” to work in academia while pursuing the NZREX pathway, “because I've seen people walking dogs, people being stay at home mums, which are all valuable roles, but maybe those people could be helping ease the health system pressure”. These narratives underscore the importance of considering not only individual challenges but also acknowledging the broader implications of medical licensing on healthcare delivery and workforce dynamics.

Other participants emphasised that when an IMG is deterred or pushed away from Aotearoa New Zealand, these individuals frequently relocate with highly skilled partners, magnifying the brain waste phenomenon by “losing two talented people rather than one” (IMG 4, NZREX). An illustrative example of this came from IMG 16 (NZREX), who shared the story of a friend and his wife leaving the country after he could not secure a PGY1 position, resulting in the loss of “two doctors who were really willing to invest in this country – what a waste”. Moreover, IMGs arriving with the intention of contributing to the local health system may, ironically, become a burden in other ways. IMG 10 explained that he received government unemployment benefits

while waiting to secure his PGY1 role, while Expert 5 (Local Government Representative) highlighted the broader ramifications of underutilising the skills and qualifications of IMGs. In her words:

We have to talk about the human side, because these are people. Let's talk about the impacts of this, let's talk about the cost that it will have on the health system, because when they become citizens and they're depressed, they have mental health issues, and then they'll go into the health system. These are people that came here to contribute; now they're going to become a drain because of the way we've treated them...there are flow on effects to their families and broader society.

The concept of brain waste thus extends beyond a lack of employment opportunities, encompassing the societal consequences of residents and citizens unable to convert their capabilities into functionings, or find alternative career options. IMGs who are affected by brain waste may inadvertently contribute to an internal "drain" of resources if they are unable to find another way to meet their professional goals or practical living expenses.

Attempting to make sense of this situation, IMG 6 (NZREX) raised the question of whether there is reluctance to support NZREX doctors owing to concerns about their moving overseas after becoming registered. He suggested the possibility of signing contracts committing to stay in Aotearoa New Zealand for a fixed period after completing PGY1. Paradoxically, however, he noted that the current system incentivises NZREX doctors to go abroad:

I think they're afraid that once you're trained here, you will actually go overseas...but the ironic thing is I got my license in the U.K. while waiting for NZREX...and I know that if I go to the U.K. for 36 months, I can still come back here [on the CHS pathway]. But why? Why are you letting me do this? I am a New Zealand citizen...why do you have to wait for me to go there for 36 months and then give me a very easy pathway back into New Zealand? What if I decide not to come back?

Local experts also expressed their reservations about the alignment of current medical licensing processes with the workforce needs of Aotearoa New Zealand. Expert 1 (Employer) was concerned about the heavy reliance on specialists registering through the Locum Tenens (LOC) pathway at his hospital. These IMGs can only stay for up to 12 months, leading to a continuous turnover that incurs higher costs overall. Expanding on this, Expert 4 (Recruitment Agent) highlighted how LOC specialists, eligible for a short-term visa, face obstacles when considering staying in the country longer-term. Instead of a straightforward visa extension,

they must reapply for a visa and switch to the more costly and time-consuming VOC licensing pathway. This bureaucratic process deters many individuals who might have otherwise chosen to prolong their stay in Aotearoa New Zealand.

Expert 4 attributed these unintended consequences to inflexible policies, emphasising the need for policymakers to be more adaptable to the current situation and medical workforce shortages. Other inflexible licensing processes he observed related to the option to submit “special cases” to MCNZ asking them to offer registration if an IMG is very close to having met, for example, the 33-month full-time work threshold for the CHS pathway. However, in his experience these “special cases” are often denied, which he attributed to “archaic and non-flexible bureaucracy”. Such “bureaucracy” speaks to the broader mobilities and capabilities power regimes influencing IMG experiences in Aotearoa New Zealand, raising concerns that existing policies and practices may not align appropriately with the contemporary context.

IMG 5, who entered the workforce on the LOC pathway, shared this frustration with the lack of change and flexibility, emphasising the need to simplify the process to encourage IMGs to settle in Aotearoa New Zealand. IMG 10 (NZREX) also noticed the lack of growth in medical licensing policies, commenting that “we haven’t continued to adapt the way other countries that we compare ourselves to have”. As discussed in [Chapter 2](#) (Section 2.4), Aotearoa New Zealand performs less favourably in the CHS criteria than many of the “countries that we compare ourselves to”. This observation suggests there may be problematic assumptions underpinning medical registration for IMGs in this context.

These accounts underscore the importance of considering not only the “migrant and mobile person” in studies focused on mobilities and movement, but also “those who stay put” (Fortier, 2014, p. 66). The general sentiment in this research was that doctors who wished to stay in Aotearoa New Zealand long-term, often due to family reasons or unfavourable conditions in their home countries, tended to encounter the most barriers to translating their professional capabilities into functionings. As IMG 12 (NZREX) argued, most doctors “from Third World countries will stay, so if you invest in them, they will do amazing things – it seems really logical, right?”. However, for IMGs with Global North training and experience, who had smoother pathways to licensing, the pull factors in Aotearoa New Zealand were often seen as insufficient to encourage them to stay longer than a “working holiday”. In short, the doctors who want to work in the country long-term often cannot, and the ones who can, often do not wish to.

6.5 CONCLUSION

The participant accounts presented in this chapter highlight a paradox in the recognition of capabilities. While IMGs on specialist or Competent/Comparable general registration pathways, who tick “all the right boxes” (Expert 4, Recruitment Agent), can generally secure medical registration, those on the NZREX pathway often find themselves caught between being underqualified for medical roles and overqualified for alternative careers. As summarised by IMG 24 (NZREX), this contradiction often means that “these skills are just wasting away”. Such brain waste is a form of injustice that not only hinders individual IMGs but also impacts the already understaffed health system of Aotearoa New Zealand.

Mobilities and capabilities power regimes at play in this context provide uneven opportunities to IMGs that connect strongly to their licensing pathway. While recognised specialists tended to express more dissatisfaction with medical licensing than Competent/Comparable general registrants, the examples discussed in this chapter suggest that these concerns are more related to the recognition of subspecialist qualifications and working conditions, than whether they are able to work at all. For NZREX doctors, however, the barriers to registration impacted their ability to become registered and limited their alternative career options. Specialist IMGs were more likely to be dissatisfied with the quality of the opportunities afforded to them by their network capital and combined capabilities, while NZREX doctors struggled with having any opportunity at all. The differential mobilities and opportunities of IMGs based on whether their health system of training is considered Competent or Comparable thus contribute to arbitrary exclusions that disproportionately impact doctors on the NZREX pathway.

Nevertheless, even those IMGs able to migrate and practise medicine in Aotearoa New Zealand often faced challenges in feeling that their full range of prior training and experience was valued and recognised during medical licensing. Oberman (2016) argues that true equality of opportunity comes from access to a full range of options. However, in [Chapter 4](#) (Subsection 4.4.2), a distinction was drawn between the quantity and quality of opportunities and their interaction with an individual’s knowledge, skills, and experience. This is consistent with Robeyns’s (2017) emphasis on refraining from attributing inherent value to concepts such as “capabilities” or “functionings”. In this context, Competent/Comparable pathway IMGs, whose combined capabilities may offer enhanced network capital compared to NZREX doctors in terms of the availability of employment and medical registration opportunities, still reported mixed experiences with the perceived quality of the resulting functionings or outcomes. They thus have access to a wider range of options than NZREX doctors, but this does not mean they are able to capitalise on their full potential or achieve the functionings that they perceive as valuable.

Overall, the uneven mobilities of professional capabilities in this context do not simply relate to whether or not an individual can migrate to a country and practise medicine, but whether they can convert their capabilities into functionings in a meaningful and rewarding way. This in turn relates to converting one's capabilities in alignment with the concept of human dignity. While the notion of human dignity is fluid and context-dependent, the distinction between the quantity and quality of professional opportunities available to IMGs when registering in Aotearoa New Zealand suggests that greater acknowledgement of the human impacts of registration processes should be taken into consideration. However, mobility and capabilities injustices in this context do not simply exist in the way that registering and working as a medical professional in Aotearoa New Zealand often involve challenging and inefficient processes. Rather, mobility and capabilities injustices are produced by licensing pathways that generate arbitrary exclusions, disproportionately affecting individuals on the NZREX pathway, who do not have training or experience in a select list of Global North countries.

7 IDENTITY, (MIS)RECOGNITION, AND CULTURE: (INTER)PERSONAL MOBILITIES AND CAPABILITIES

7.1 INTRODUCTION

Chapter 6 explored the social conversion factors associated with the policy environment of medical licensing in Aotearoa New Zealand, discussing how uneven mobilities and capabilities in this context can create a misalignment between an individual's personal mobilities and ability to migrate, and conversion of their professional capabilities into their desired functionings.

This chapter extends the exploration of conversion factors – that is, one's ability to translate capabilities into “functionings” or outcomes – by examining how the personal and interpersonal aspects of IMGs' lives influence their medical registration and work experiences in Aotearoa New Zealand. Specifically, the chapter investigates how medical migration and licensing are experienced on an (inter)personal level, delving into the second of the 4Ps. As introduced in Chapter 4 (Subsection 4.5.2), P2 considers a range of “personal conversion factors”, such as health, age, and personality, and “social conversion factors” encompassing ethnicity, gender, and culture (Robeyns, 2017, p. 46).

This chapter contains four sections. The initial focus is on exploring prevalent characteristics of IMG identity. This includes the relationship between their personal conversion factors, professional identity, and sense of self. Second, the chapter considers forms of (mis)recognition related to discrimination and Othering processes, before examining the influence of gender and family on medical registration in Aotearoa New Zealand. Finally, the chapter addresses the interpersonal dynamics of language, communication, and cultural adaptation of IMGs as both migrants and medical practitioners, and the practice of culturally safe healthcare.

Overall, the chapter illustrates how in Aotearoa New Zealand, mobilities and capabilities power regimes not only privilege IMGs from certain educational backgrounds, but also from certain sociocultural and ethnic backgrounds. This promulgates arbitrary exclusions, limiting the potential of individuals based on personal and interpersonal characteristics and thus contributing to mobility and capabilities injustices.

7.2 IDENTITY AND (MIS)RECOGNITION

For many IMGs in this research, being a medical doctor transcended making a living or seeking professional success. Being a doctor was a fundamental aspect of their identity they had dedicated much, if not most, of their lives to pursuing, with the result that, as explained by IMG 11 (NZREX), “you’re a doctor in your soul”. Consequently, for those IMGs who found themselves unable to practise medicine upon arriving in Aotearoa New Zealand, this sometimes resulted in a destabilisation of their confidence, challenging their preconceived notions of what it means to be a doctor and impacting their overall sense of self. As noted in [Chapter 4](#) (Subsection 4.2.1), lack of recognition and associated “status injuries” (Fraser, 1998, p. 25) can hinder the formation of a positive sense of self-worth, identity, and human dignity, producing potential injustices. In this research, these status injuries were connected to personal conversion factors that played a role in IMGs’ medical registration, such as health, age, and personality.

7.2.1 *Personal Conversion Factors*

Personal conversion factors, such as age and health, combined in ways that affected IMGs’ ability to translate their professional capabilities into functionings in this context. Age, for example, played a significant role in navigating the medical licensing processes in Aotearoa New Zealand. IMG 1, IMG 8, and IMG 11 reflected on the challenges they faced in the NZREX process because they did not have the advantage of youth. In the case of IMG 11, he elaborated on how he was offered work in Australia but could not obtain the appropriate skilled-migrant visa, due to age restrictions. This limited his options, leading him to stay in Aotearoa New Zealand, where his wife had established her career. Experiences with the impact of age were often intertwined with personal conversion factors relating to health. IMG 1 shared her challenges in preparing for the NZREX examination while dealing with ongoing health issues that worsened over time. She highlighted the absence of allowances for health issues, such as “sick leave”, as there would be in the formal workforce. Similarly, IMG 2 expressed her frustration with the CHS licensing pathway, noting how the time she took off work to recover from a surgery had impacted her ability to meet the required hours of prior fulltime work in the past four years.

The limitations posed by some health- and age-related conversion factors reflected a broader trend observed by research participants of strict and inflexible licensing processes that seemingly overlooked the “human element” (IMG 14, VOC). IMG 8 (NZREX) contrasted the perceived lack of understanding and flexibility of MCNZ with his home country, stating that “back home, the Medical Council is more understanding and more, you know, flexible – they understand your human needs”. Similarly, IMG 3 (CHS) criticised the impersonal nature not

only of medical licensing but also of immigration processes, noting the intrusive inquiries about serious medical conditions for visa applications:

I also found it quite disgusting to ask if you have a serious medical condition. So what, you cannot work if you do? One of the doctors in the clinic from the U.S. has to leave the country, because she has a medical condition, and even though she has the means to pay for her treatment, they won't let her stay. And yet New Zealand says they need doctors.

For IMG 24 (NZREX), such anecdotes illustrated the lack of support or recognition for IMGs dealing with health conditions or starting families, emphasising the perceived absence of dignity and respect in the treatment of some IMGs in Aotearoa New Zealand. For these IMGs, feeling misrecognised or undervalued as medical practitioners in Aotearoa New Zealand constituted a status injury that, according to Fraser (1998), amounts to an injustice by misrecognition, impacting an individual's dignity and self-worth.

Noting that certain types of people seem to be more likely to successfully adapt to working in Aotearoa New Zealand, IMG 14 (VOC) pondered the potential benefits of personality testing in recruitment processes, given the tendency of doctors on Competent/Comparable pathways to remain in the country for only a short time. While the idea of considering an individual's broader qualities, such as personality or interpersonal skills, may be worth exploring to broaden the recognition of IMGs beyond professional qualifications, there is a risk of excluding individuals who are less assertive or ambitious, but are committed to staying in the country. Moreover, some participants noted that the implementation of personality testing may inadvertently favour certain qualities that are not cultivated in some cultures, further excluding IMGs from "non-Western" backgrounds (Expert 7, Policy Advisor).

As explained by IMG 10 (NZREX):

People from cultural backgrounds where it's not appropriate to be upfront, maybe more conservative cultures, might find it hard to place themselves out there and say, 'Hey, hire me!' – but that's important from a New Zealand point of view, you know, that's how we do things. If you don't put your hand up, you are most likely not going to be seen...I feel that New Zealand should be a better place in terms of appreciating other cultures and where they must be coming from. But, you know, maybe we're just not there yet.

This sentiment was echoed by Expert 8 (Employer), who reflected on the challenges faced by some NZREX doctors from cultural backgrounds that do not typically encourage individuals to be outspoken:

There are cultural factors...we get quite a few times, doctors from [Eastern Asia], particularly female doctors, who will get low ratings on their knowledge, because their supervisors rate them as having low knowledge, when you really find out it's because they were silent and obedient. They never asked questions.

These examples highlight how, even without a formal personality testing process, character traits and cultural norms already play a role the experiences of IMGs, particularly those on the NZREX pathway, in terms of medical registration and employment in Aotearoa New Zealand. Formalising assessment of such personal conversion factors risks enshrining mobility and capabilities injustices through the arbitrary exclusion of individuals whose reticence may have no relationship with their ability to work as an effective medical doctor in this context.

7.2.2 Identity and Status Injuries

As a result of lack of recognition of their qualifications, training, experience, or personal conversion factors, many IMGs who struggled to navigate the medical licensing processes in place in Aotearoa New Zealand underwent a grieving process for their professional identity and sense of self. Conveying this sentiment, IMG 24 (NZREX) shared her personal struggle:

I used to be a medical doctor, but I'm not sure if I can call myself that anymore. I've had to go through a grieving process – I've had to come to terms with the fact I might never be a doctor again.

Similarly, IMG 21 (NZREX) reflected on the challenges of reconciling his professional identity while working in an educational setting with regular exposure to New Zealand medical students. He described the frustration of recounting his migrant story every time he met new people, emphasising the identity aspect of being a doctor beyond employment status:

It's weird here, because when I meet people I shouldn't say my background is as a General Practitioner, because if I say I'm a GP, they're going to say, 'Cool, where do you work?' – and then I have to explain, 'No, I was a GP, well, I still *am* a GP...but not here'. [...] When I talked to people, especially friends or newly made friends here, I got really frustrated every time I tell to say the 'sad, sad story of the migrant'.

In his view, he did not stop being a doctor simply because he was no longer practising. However, he grappled with the dilemma of not wanting barriers to medical registration to define his identity when meeting new people.

For others, this loss of professional identity clashed with preconceived notions of the expectations and status of a doctor. As noted in [Chapter 3](#) (Subsection 3.4.3), status and respect

are discussed in literature relating to the identity formation of medical professionals, with concerns about a perceived reduction in status among medical doctors in general (e.g., Lipworth et al., 2013). In the case of IMGs who struggle to have their qualifications and experience recognised, this effect on their identity is compounded. IMG 4 (NZREX) remarked that; “in my country, if you’re trained to be a doctor, you don’t expect to be unemployed – then all of a sudden you come here and you’re begging for a job”. Similarly, IMG 1 (NZREX) also spoke of the sense of pride instilled in her during medical school, with her class being told they were the “cream of society”, while IMG 20 (NZREX) discussed the dissonance of obtaining a medical degree and expecting it to be a pinnacle moment, only to find that degree “is not given respect or appreciation, or even value”. These experiences contradicted everything these doctors had believed and understood about their professional qualifications and identity in their home countries.

For IMG 12 (NZREX), on the other hand, coming to Aotearoa New Zealand and working in other industries was a positive experience, providing an opportunity to broaden her sense of self beyond her professional identity as a doctor. She emphasised the potential arrogance associated with being a doctor in many societies, noting that living in Aotearoa New Zealand encouraged her to feel like a “whole person”, even without practising medicine. She expressed a firm belief that no one should have to be a doctor or an engineer to attain status. As noted in [Chapter 6](#) (Section 6.4), many NZREX doctors move to Aotearoa New Zealand because of family members, and do not expect to encounter such barriers to registration before agreeing to move. IMG 12 thus offers a candid piece of advice to other NZREX candidates: “If New Zealand isn’t the sole purpose of your life, don’t come. Go to Canada, go to Australia. Don’t come here”.

Furthermore, IMG 12’s words shed light on the dynamics of brain waste, and the push factors discouraging prospective IMGs (see [Chapter 6](#), Section 6.4), while underscoring the interplay between her personal qualities and professional identity. Her ability to reframe the loss of professional status and unrealised capabilities upon arriving in Aotearoa New Zealand indicated a sense of resilience and self-confidence that some other IMGs found challenging to maintain. IMG 15 (NZREX) elaborated on how the loss of professional identity not only impacted her self-confidence, but also affected her ability to navigate the complex NZREX licensing pathway:

It was a horrendous time for the first few years I was sitting here in this country, no better than a high schooler, because I knew everything I did from 2003 does not matter. That’s how little my life matters here. Your mind plays tricks on you during this time – as doctors we often ascribe a lot of importance to our careers, to give us the self-confidence we need to get through life. It’s like part

of your identity, so to not be able to practise medicine takes a huge toll of us. It involves a lot of swallowing of one's pride and having to do other jobs. And that destruction of one's self-confidence plays a huge role in whether or not you assert yourself, which you need to do to get through the process here.

For IMG 15, the impacts of not being able to work as a doctor thus created a vicious circle. On the one hand, she deemed assertiveness necessary to ensure her professional success. On the other hand, the demoralising effects of feeling insignificant in her new country impacted her self-confidence and ability to advocate for herself. IMG 4 (NZREX) reiterated this sentiment, reflecting on his visits to every public hospital in the country in search of a PGY1 position. He acknowledged that the experience was "disheartening", "demoralising", and difficult to continue with after numerous rejections, pushing him far beyond his comfort zone. Similarly, IMG 7 (NZREX) reflected on her perceived "lack of ambition" as a key contributor to her lack of success with medical registration, which was compounded by decreased confidence and the devaluation of her prior training and experience.

By misrecognising and undervaluing certain capabilities and behaviours, "status injuries" (Fraser, 1998, p. 25) can generate psychological impacts that further harm or constrain people's capabilities, as well as impacting their sense of self-worth. Questionnaire participants on the NZREX pathway also reported that medical licensing processes were "demoralising" and "frustrating". One respondent, trained in Eastern Asia, described attempting to become registered in Aotearoa New Zealand as "the most harrowing, disheartening and depressing experience of my life". Another respondent felt that the inability to navigate the NZREX licensing process left a "void in my heart", and a third expressed how "the whole process has been very demoralising and I almost lost complete hope". IMG 24 (NZREX) described medical licensing as part of "an evil system that is crushing my soul", while IMG 10 (NZREX) shared that:

You feel very incompetent...I probably was rejected like 150 times in total...every time you get an unsuccessful reply email, it just pulls you down a little more...a lot of times you start thinking about, you know, bad things like ending your life.

These participant accounts underscore the psychological impacts of the lack of recognition of their prior training and experience, leaving them struggling to convert their professional capabilities into functionings. This research thus continues to build on Mpofu and Hocking's (2013) observations that IMGs from non-English-speaking backgrounds tended to experience negative emotional impacts related to barriers to registration, such as frustration, isolation,

and disappointment. In this research, however, the relationship between these negative experiences and licensing pathway is more apparent than whether a person trained in an English-speaking country.

According to Fraser (1998), it is not only the infliction of psychological harm that is significant in producing injustices, but also the victim's perception of misrecognition. IMG 24 (NZREX) questioned how these doctors, who often face hostility from health and medical institutions, could be expected to provide quality care:

How are these doctors expected to give the best treatment to New Zealand patients when they have been treated like dirt? There is a danger that these people will grow into the kind of doctors who will perpetuate this patriarchal, manipulative system...how are we supposed to be empathetic to people if they're so hostile to us? Dignity and respect are missing...if you treat people like dirt, they will treat people the same.

For IMG 24, behavioural traits and qualities influencing IMGs' experiences in registering and working as doctors in Aotearoa New Zealand are not necessarily an innate or immutable part of one's personality. As such, this section highlights how IMGs often have to redefine themselves and their professional identities, with some feeling the need to adopt behaviours that do not come naturally to them to navigate the challenging environment.

In this way, the personal and professional identities of IMGs are shaped and remade as "differential subjects" (Sheller, 2018a, p. 21) through inflexible licensing pathways many perceive as overlooking the human element. While medical registration policies emphasise the value and recognition of capabilities associated with particular qualifications and experience, rather than an individual IMG, personal conversion factors are inevitably intertwined with more-than-human professional mobilities. The social conversion factors associated with medical licensing pathways are compounded by personal conversion factors that further promulgate uneven combined capabilities. IMGs find themselves caught in a cycle of repeating "constellations of mobility" (Cresswell, 2010, p. 17) that constitute and are constitutive of social formations, including status and identity.

7.3 DISCRIMINATION AND OTHERING

In addition to the professional and emotional impacts of misrecognition, some research participants considered the role of social norms and conversion factors associated with their national and ethnic background in allowing them to achieve their professional goals as medical doctors in Aotearoa New Zealand. Bridging the perceived disconnect between personal

mobilities and the more-than-human mobilities and capabilities associated with an individual's training and experience, this section considers how one's personal background and heritage play a role in producing uneven professional mobilities and capabilities.

7.3.1 *Citizenship and Fear of the Other*

A minority of participants explicitly used the language of discrimination when describing their medical licensing experiences. For example, a questionnaire participant (CHS), who trained in Western Europe, expressed deep frustration at what she perceived as “insulting” behaviour, recounting experiences of being suspected of fraudulent credentials due to her non-English-speaking country of origin. This example lends support to Mpofu and Hocking's (2013) observation of an “occupational apartheid” (p. 132) between overseas-trained health professionals from English and non-English-speaking countries. Furthermore, another questionnaire respondent (NZREX) from Southern Africa commented that “I feel discriminated against in that my ‘competence’ and the barriers I face are based on where I am from, and not what I am capable of”. This case echoes Musoke's (2012) findings that non-European IMGs in Sweden felt standards for IMGs were determined on a country rather than an individual level, highlighting the additional occupational divide formed by medical licensing pathways.

Similarly, many research participants on the NZREX pathway, who had New Zealand citizenship at the time of interview, did not feel they were treated equally compared to citizens who were born in Aotearoa New Zealand. The term “second-class” or “second-rate” citizen came up several times, with IMG 16 (NZREX) explaining that “New Zealand's actually not treating me very well as a migrant – and I'm a Kiwi now, I've got my citizenship – but I'm still a second-rate citizen, because I'm a migrant”. IMG 9 (NZREX) highlighted the sense of contradiction he experienced, stating:

When you pass NZREX you are equivalent to local graduates...but you're treated as a second-class citizen here. You're competent, but you still aren't local...we are treated like second-class citizens here and it doesn't make sense – they should be trying to upskill their citizens. Why do they want to downgrade us? It's discrimination.

IMG 9's use of the term “discrimination” to describe his experience was also echoed by one questionnaire respondent (NZREX), trained in Eastern Europe, who felt that medical licensing processes are “unfair and racist”, while another respondent (NZREX), who trained in Southern Asia, suggested that the Race Relations Commissioner should review the NZREX and other MCNZ processes.

However, the distinction Musoke (2012) notes between IMGs feeling “discriminated against” and “disadvantaged” (see [Chapter 3](#), Subsection 3.4.2), was also prevalent in this research. Many IMGs used more cautious language to describe the impact of medical licensing processes on people with similar backgrounds to them, favouring terms such as “discouragement” or “disadvantage”. IMG 1 (NZREX) exemplified this phenomenon with her comment that, “I won’t say it’s racism, but it is a bit of discouragement from the Council [MCNZ]”. IMG 15 (NZREX), on the other hand, described how she felt she was still at a “disadvantage” as an IMG from an ethnic minority background, even after navigating the NZREX process and having worked as a doctor in Aotearoa New Zealand for several years:

Unfortunately, the world over, people tend to mentor those who remind them of themselves at that age, right? So I’ve noticed that I am at a disadvantage as a result of that, in a situation where the consultants are all white and local [NZMGs]. [...] The fact that you have an overseas degree never goes away. You think that at some point things equalise, but they really don’t, and it shocked me really as a registrar to find that out – I had thought that would be an equaliser once you’ve been chosen for the [specialist training] programme. But it’s not. Definitely not...they allow local graduates to get onto the training programme without having to take another exam, but I had to take it.

IMG 15’s experience sheds light on how social formations, such as national and ethnic background, intersect with the “constellations of mobility” (Cresswell, 2010, p. 17) that influence professional opportunities and continuing medical education for IMGs in Aotearoa New Zealand. While she acknowledged the benefits of being able to work as a medical doctor through the NZREX process, she underscored the challenges associated with the perceived quality of opportunities based on social conversion factors associated with national and ethnic background. Similarly, IMG 24 (NZREX) described her observation of a pervasive fear of the “Other” in Aotearoa New Zealand, portraying IMGs as outsiders seeking acceptance:

In New Zealand there is this fear of the ‘Other’; ‘we are a small island, and we are okay without you, but once you’re in, we love you and you’re accepted forever’. Switching from the outside to the inside – that’s the hard rub. Once you’re in the system in New Zealand, you’re treated well – within the system there is respect, but for international doctors coming in, you’re a beggar at the door, begging to be let in.

Despite the transformative potential of moving from “the outside to the inside”, not all participants felt that entering the system had an equalising effect, even after working in the New Zealand health system for several years (e.g., IMG 15, NZREX).

These examples underscore the complex interplay between citizenship, inclusion or exclusion, and the broader experiences of migrants in Aotearoa New Zealand. A *citizen* is “a member of a political community who enjoys the rights and assumes the duties of membership” (Leydet, 2017, para. 1), with the implication that obtaining citizenship as a migrant would allow an individual to overcome prior exclusions on legal movement and mobility they experienced as non-citizens (Sheller, 2018a). However, as Verstraete (2003) explains, the “freedom of mobility for some...could only be made possible through the organized exclusion of others forced to move around as illegal ‘aliens’, migrants, or refugees” (p. 229).

IMGs on the NZREX pathway, particularly those who have become naturalised New Zealand citizens, may therefore experience a misalignment between their legal citizenship status and the professional mobilities and combined capabilities afforded to them. This is related to the fact that their overseas background, in the words of IMG 15, “never goes away”, and formal citizenship processes do not guarantee acceptance or inclusion in all areas of life, as noted by IMG 24.

For Carens (2013), Global North countries are similar to the landed nobility and gentry of Medieval Europe, in that “citizenship in Western democracies is the modern equivalent of feudal class privilege – an inherited status that greatly enhances one’s life chances” (p. 226). This “inherited status” may not be as readily available to naturalised citizens, and it is notable that doctors on the Competent/Comparable registration pathways tend to originate from Global North, “high-income” (United Nations, 2019, p. 4) countries that may offer them additional privileges as citizens of a contemporary “feudal class”. By contrast, almost all NZREX participants in this research trained in countries classified as “middle-income” (United Nations, 2019, pp. 4-5). The relationship between licensing pathways and the Global North and South is further explored in [Chapter 9](#).

The examples discussed in this subsection, of perceived discrimination and fear of the Other, highlight how in this context mobility and capabilities regimes not only create “differential subjects” (Sheller, 2018a, p. 21) in terms of IMGs from contrasting backgrounds, but also differential citizens. While some participants preferred to describe their challenging experiences as forms of disadvantage, rather than discrimination, the uneven professional outcomes they describe suggest these disadvantages do produce mobility and capabilities injustices through discrimination and/or misrecognition. As a result, formally included

members of Aotearoa New Zealand's political community – residents and even citizens – may continue to experience uneven professional outcomes based on immutable characteristics such as where they originally came from, as discussed in the following subsection.

7.3.2 Othering and Systemic Processes

Positive or negative perceptions and experiences were closely related to a person's origin and ethnicity. Participants from Western or Northern European heritage tended to have much more favourable experiences and were, at times, aware of the negative experiences of others. IMG 22 (CA), originating from the U.K./Ireland, perceived the local health system as inclusive, expressing satisfaction with the welcoming and accepting nature of Aotearoa New Zealand society. On the other hand, IMG 24 (NZREX), also of European heritage, found her ethnic and cultural background was often described as an advantage, with locals reassuring her that “you're just the kind of person we would choose”. Her experience was thus that hospitals and other employers tend to choose people they perceive as “fitting in” or matching a “particular profile” which, despite the potential benefits for her, implied racial bias that she found unacceptable.

Similarly, IMG 14 (VOC), from the U.K./Ireland, conveyed surprise at the level of racial discrimination she observed in Aotearoa New Zealand, especially as the country is often perceived as open-minded and friendly. IMG 12 (NZREX), from South America, noticed this too, and felt she had an advantage over other NZREX doctors because of her European phenotype:

I think there might be some sort of ethnic preferences...every time I've thought about it, I feel like, at least I'm from the right background. It's a factor that's beyond my control and it's working for me. So I'm not going to complain...I think I've always had this crazy vision of New Zealand where there's no racism and everything's beautiful. But nowadays, I do realise that there is [racism] – it's just not towards me.

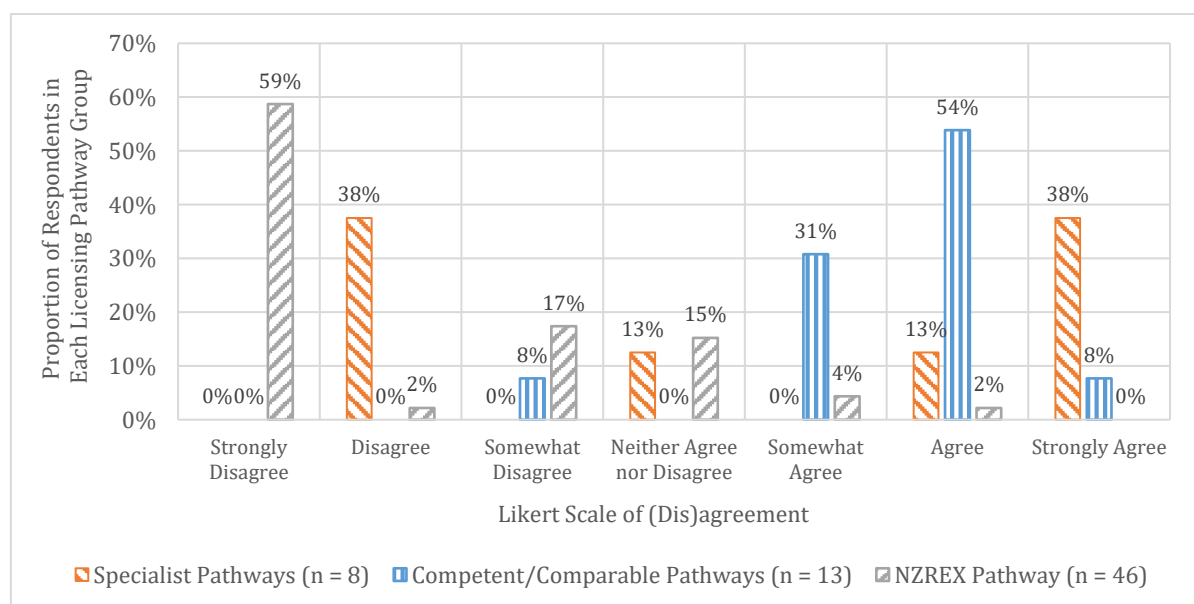
The result of these observations was that doctors from ethnic or cultural minority backgrounds were more likely to share not only how they felt like “second-class” citizens, as discussed above, but also how they felt “unwelcome”. IMG 5 (LOC), originally from a Middle Eastern country before she attended medical school in North America, found that the local people in the rural town where she first worked were “not welcoming”. Similarly, a questionnaire respondent (NZREX), who trained in Eastern Europe, expressed regret for ever believing that she would be “welcomed or valued” in Aotearoa New Zealand, while another respondent (NZREX) from

Eastern Asia described medical registration processes as “very unwelcoming for overseas trained doctors”.

Despite these examples, it is important to note that not all participants shared this experience. IMG 17 (NZREX), from the Middle East, and IMG 4 (NZREX), from Southern Asia, both felt the system was open and welcoming after they had achieved registration. The prevalence of descriptions of feeling “(un)welcome” in Aotearoa New Zealand during Phase 1 interviews prompted me to ask questionnaire participants to reflect on how “welcome” they felt as medical professionals in Aotearoa New Zealand. As depicted in Figure 34, the correlation between the sense of feeling welcome and participants’ licensing pathways is evident, revealing stark differences. A striking 92% of Competent/Comparable generalists somewhat agreed, agreed, or strongly agreed that they felt welcome, compared to 50% of recognised specialists and only 7% of NZREX doctors. A significant 59% of NZREX participants strongly disagreed that they felt welcome as medical professionals, as opposed to none of the specialist or Competent/Comparable pathway participants.

Figure 34

Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “As a Medical Professional, I Feel Welcome in New Zealand” (N = 67)



The experiences shared in this research, of individuals feeling unwelcome, disadvantaged, or even discriminated against, shed light on concerns about ethnic or cultural bias extending beyond medical licensing pathways. As noted, IMGs eligible for specialist or Competent/Comparable general licensing pathways are generally required to have training or experience in specific Global North countries. Consequently, it is unsurprising that NZREX participants, more likely to originate in Global South countries with distinct ethnic and cultural

compositions from many Global North, CHS countries, could face different discriminatory challenges.

Expert 5 (Local Government Representative) categorically labelled these challenges as “discrimination” against individuals from certain parts of the world, describing medical licensing policies and processes as “a tool to keep people out”. Medical licensing can thus be seen to mirror the patterns of inclusion and exclusion associated with citizenship (e.g., Sheller, 2018a; Verstraete, 2003), as discussed above (Subsection 7.3.1). Furthermore, Expert 5 referenced a governmental strategy currently in place to support ethnic communities, with a particular focus on ensuring these individuals can “be gainfully and meaningfully employed in jobs that match their skills and experience” (Ministry for Ethnic Communities, 2022, p. 51). This policy suggests that government representatives see a relationship between occupational licensing processes, of which medicine is one example, and the exclusion of individuals from some ethnic backgrounds. Despite this awareness, as further explored in [Chapter 9](#), ambiguous institutional boundaries and accountability structure may contribute to a disconnect between policy intentions and practical outcomes in this context.

Consequently, it may be that processes of direct or indirect misrecognition take place at the systemic level, generating mobilities and capabilities injustices. This would explain the ways that many participants avoided the language of discrimination; processes of creating differential subjects in this context may operate in unseen ways. This was IMG 8’s (NZREX) perspective, who suggested that unwritten discrimination based on racial or cultural factors may influence medical licensing pathways without being explicitly stated. As he explained:

I hate to say this, but there seems to be a black box phenomenon; there is some hidden story which nobody tells and probably nobody knows – so maybe it actually stems from sort of racial or cultural factors. I don’t know what type of actual background they want but it’s probably, you know, they want people of such and such a colour and race, and from the ‘West’, and then they differentiate basically on those things, rather than the qualification or the competence or anything like that...so there is something which is unwritten – a discrimination of some kind which actually informs all of these pathways, but doesn’t actually get to the surface...it just drives the whole thing.

IMG 8’s notion of a “hidden story” of medical licensing speaks to broader power regimes that create uneven mobilities and capabilities for IMGs in this context. Mobility justice requires consideration of “longer histories of colonial, racial, imperial, and military mobility” (Sheller, 2018b, p. 29). The idea of a “hidden story” thus shifts the dialogue beyond medical licensing

and healthcare in Aotearoa New Zealand, to broader considerations of the country's colonial background and the ways Othering can be seen in historical migration policies that prioritised migrants of European backgrounds (see [Chapter 3](#), Section 3.4). IMGs who already experience challenges being recognised as medical professionals in Aotearoa New Zealand may have these unequal burdens compounded by social formations relating to race and ethnicity. Furthermore, experiences of Othering and discrimination, both at the individual and systemic level, speak to the bodily scale of Sheller's (2018a) mobility justice framework, whereby mobilities and capabilities power regimes create "racialized minorities" who do not have access to the full range of freedoms available to other ethnic groups (p. 65). Understanding these broader dynamics is crucial in this context, as mobility and capabilities injustices extend beyond medical licensing to encompass larger societal structures, colonial legacies, and systems of exclusion (Kotef, 2015; Sheller, 2018a). This will be explored further in [Chapter 9](#).

7.4 THE (IN)DIRECT IMPACT OF GENDER AND FAMILY ON MEDICAL LICENSING

In addition to the personal and social conversion factors discussed above, IMGs reflected extensively on the importance of family and home life in their medical licensing and professional journeys in Aotearoa New Zealand. This section considers the direct and indirect impacts of family on IMG experiences with medical licensing, and how these intertwined with gender in often unacknowledged ways.

7.4.1 Family and Gender Roles

For some IMGs, family played a role in their medical licensing processes because they felt indebted to family members such as parents (IMG 15, NZREX) or spouses (IMG 4, NZREX; IMG 7, NZREX; IMG 13, NZREX), who provided financial support that enabled them to pursue their medical career and licensing in Aotearoa New Zealand. In other cases, these reflections related to the impact their children had on their motivations for being in Aotearoa New Zealand, and whether or not they had successfully registered as doctors. IMG 1 (NZREX), for example, commented on the challenges of being migrant parents in a country without the intergenerational support systems available to someone whose family and friends all reside there. Other IMGs felt that the professional sacrifices they made in coming to Aotearoa New Zealand were worthwhile for the lifestyle and stability their children had access to (IMG 7, NZREX; IMG 20, NZREX; IMG 22, CA).

Underlying these reflections on the role of family and children were notions relating to gender. This was a topic that some research participants explicitly discussed in relation to their professional experiences, but for the most part, it came across as an unacknowledged factor in

their professional lives. IMG 7, for example, described her first unsuccessful attempt of the NZREX examination, which she had not attempted since:

I wanted to sit the exam and I tried to prepare. But it was a bit rushed because I had just come back from [my home country] and then I was pregnant. I had my daughter and of course I couldn't study as much. But my family was so keen on me doing the exam that I sat it anyways, when my daughter was three months old, and I definitely didn't work as hard as I should have to make it. [...] It was so hard...I felt like a burden on my husband for taking his money for my exam, for childcare, and yet I still can't work.

In this quote, IMG 7 expressed a sense of disappointment and regret regarding her perception that she did not work hard enough to prepare for an examination while being the primary caregiver for a new-born infant. Similarly, IMG 20 (NZREX) explained how, during the COVID-19 pandemic, she was working, taking care of her child, and studying for the NZREX examination until midnight each day:

With men it is different, like they don't have to wait for having a family or anything. For men, it's like; 'let me become a doctor first, and then let me have a family'. Maybe that is a cultural thing as well...it's so hard for women. Even if the process was not hard, by nature because of the age we are in, we are starting families – this impacts women more than men because of gender expectations, and we can't get maternity leave because we're not in the system.

These women both struggled to balance their responsibilities to their families and children, with their professional goals, with IMG 7 also noting that she felt pressured by her family to take the NZREX examination. IMG 19 (NZREX) felt her career was secondary to her obligations to her children, sharing that “as a mum, I have more responsibility and have to look after my kids as a priority – I can work only after meeting their needs”. Similarly, IMG 1 (NZREX) did not regret coming to Aotearoa New Zealand in the 1990s despite never achieving medical registration, because she believed her children have had access to greater opportunities. However, now that they are grown, IMG 1 felt uncertain about how to proceed with her career after being out of the workforce for more than two decades, commenting that “only God knows if I will carry on with my profession again”.

Having encountered many similar anecdotes among the PGY1 hires he has worked with, Expert 8 (Employer) observed that women were disproportionately affected by the challenges of pursuing the NZREX licensing pathway, noting:

That's where I think the unfairness comes in, is women...the countries that people come from often have hierarchical systems where women must, you know, be responsible for the children. So it's the women NZREX doctors who take a long time to get into medicine. [...] Female doctors, because they've been out of practice a long time, can have quite significant skill, competency, and knowledge gaps.

While Expert 8 did reflect on the anecdotal nature of his perspective on female NZREX doctors, it is noteworthy that so many of the NZREX interview participants facing challenges with medical licensing were female doctors who had taken time off to raise their children (IMG 1; IMG 7; IMG 19; IMG 20; IMG 23; IMG 24). IMG 8 (NZREX), for example, explained that:

Many NZREX candidates are in New Zealand because of their partner, and this often affects women. In our case, I supported my wife to complete her NZREX, but it could have been the other way around. There's no way we both could have done it at the same time while raising our family...PGY1 doesn't give you enough money to sustain a whole family. So I was working full time and didn't have time to prepare for the NZREX.

These anecdotal accounts in relation to gender and family prompted the inclusion of a question asking participants to indicate their gender in the Phase 2 questionnaire. While there were slightly more female IMG interviewees than men (58% female), eight out of nine (89%) experts interviewed identified as men. During the online questionnaire, however, 74% of respondents who chose to indicate their gender identified as female ($n = 55$), with 25% ($n = 20$) identifying as males and 6% ($n = 5$) preferring not to specify their gender⁴¹. This may suggest that the online questionnaire achieved its aim of allowing a broader pool of individuals to provide a snapshot of their experiences in an anonymous setting where they may have felt less vulnerable. Alternatively, as discussed in the following subsection, this discrepancy may also be understood in relation to the licensing pathway these IMGs were eligible for.

7.4.2 Gender and Medical Registration

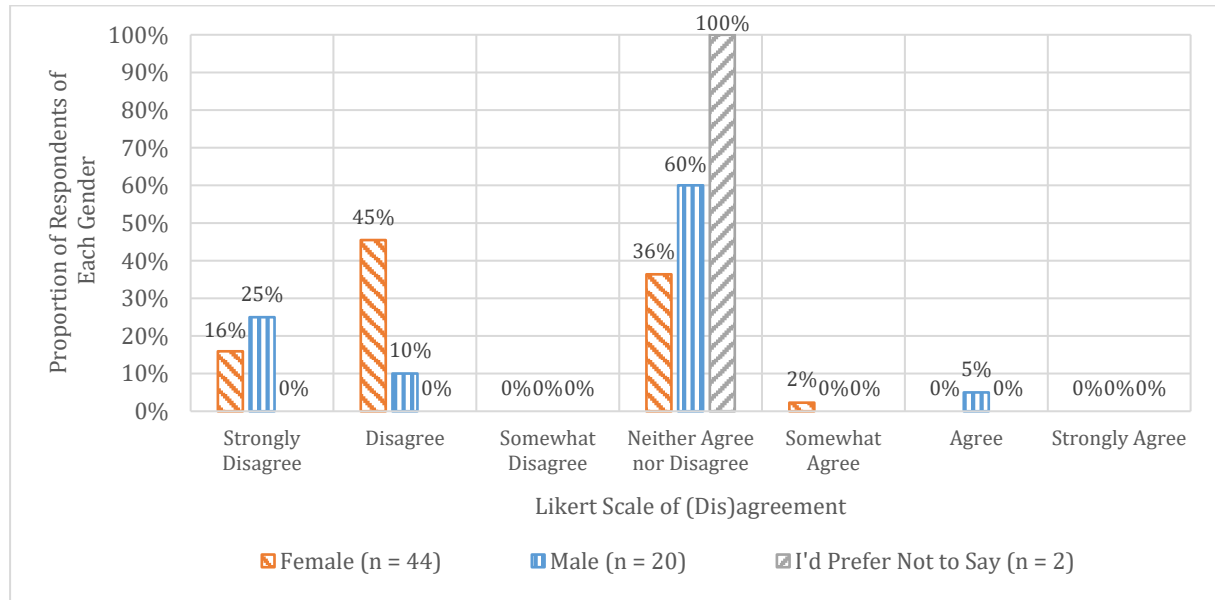
Despite anecdotal accounts in Phase 1 on the potential limitations that women may encounter during medical licensing, it is remarkable that only two questionnaire respondents (3% of those who answered this question) agreed or somewhat agreed that gender played a role in their medical licensing process – of these, one respondent was female, and the other was male. Additionally, as depicted in Figure 35, female respondents were more likely to disagree that

⁴¹ Of these five respondents who did not indicate their gender, four selected the option "I'd prefer not to say", while the other declined to answer this question.

their gender had any impact on their experiences, with 61% strongly disagreeing or disagreeing, compared to 35% of male respondents.

Figure 35

Proportion of Questionnaire Respondents of Each Gender According to Their Responses to “My Gender Has Played a Role in My Medical Licensing Experiences in New Zealand” (N = 66)



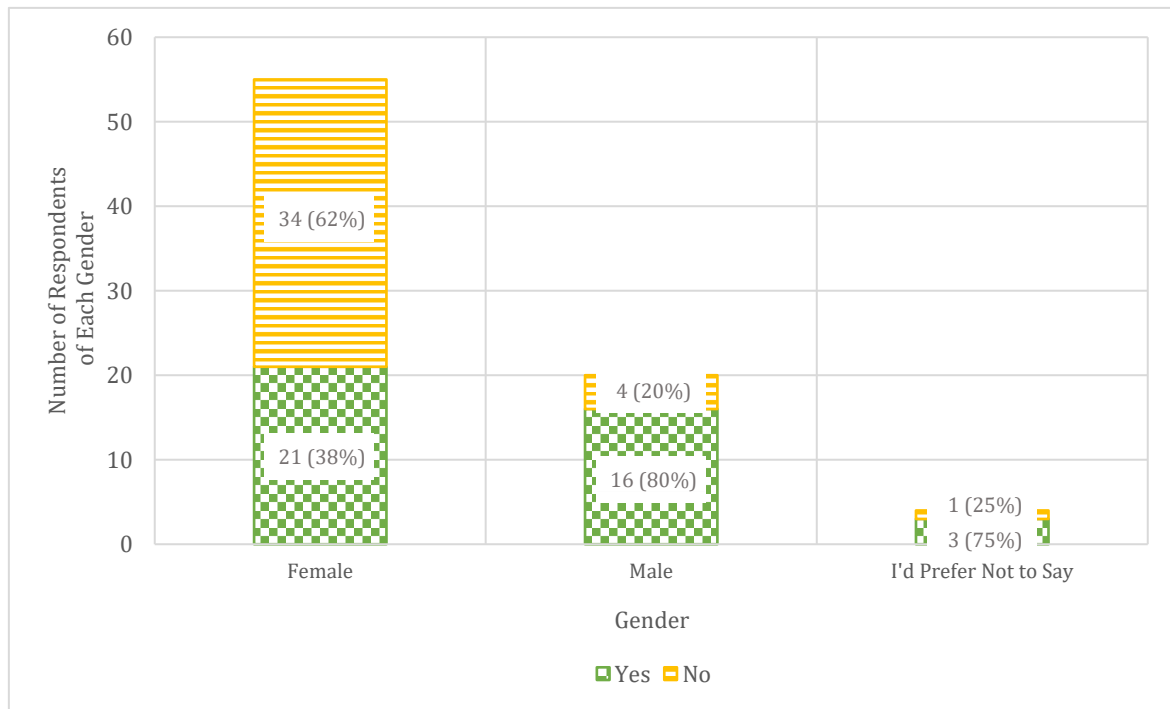
Nevertheless, the correlation between gender and successful medical registration in Aotearoa New Zealand was striking⁴², with 38% of female respondents ($n = 21$) obtaining licensing compared to 80% of male respondents ($n = 16$), as illustrated in Figure 36⁴³.

⁴² The Cramér's V effect size is 0.38, which is considered large when there are up to three groups in at least one variable. There is thus a strong statistical correlation between gender and whether questionnaire respondents had achieved medical licensing in Aotearoa New Zealand.

⁴³ Please note that the option to self-describe gender was also provided, but none of the respondents selected that option.

Figure 36

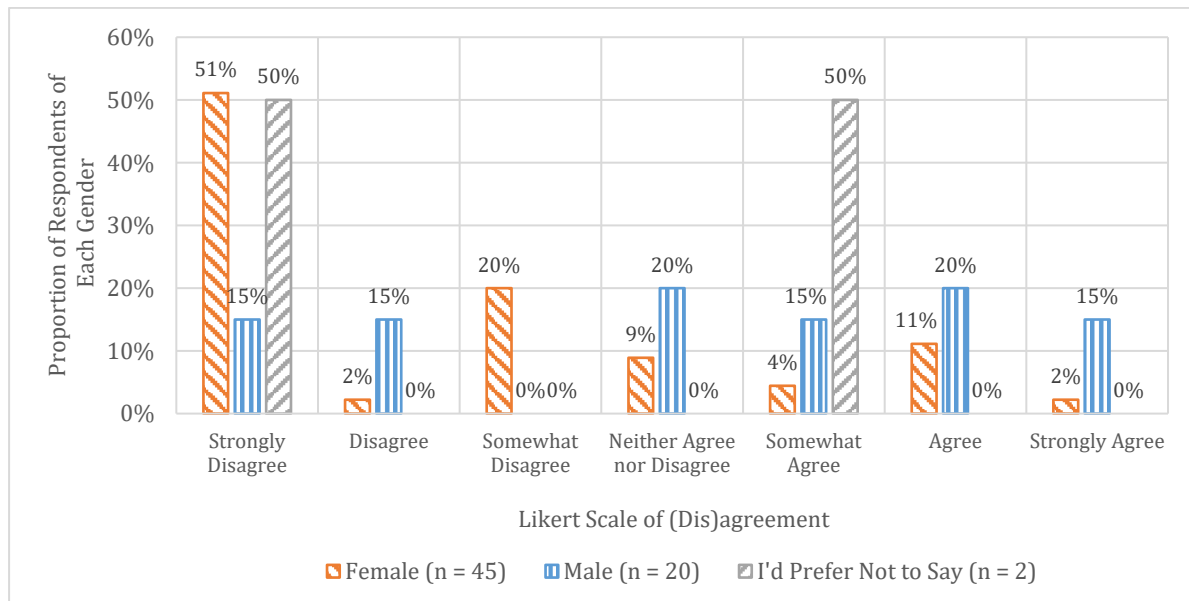
Questionnaire Responses to “Have You Ever Achieved Provisional or Full Registration to Work as a Medical Doctor in New Zealand?” by Respondents’ Indicated Gender (N = 79)



Gendered disparities were also evident in questionnaire responses relating to various aspects of IMG experiences with medical registration in Aotearoa New Zealand. For example, as seen in Figure 37, 73% of female respondents either somewhat disagreed, disagreed, or strongly disagreed that they felt welcome as medical professionals in Aotearoa New Zealand, compared to 30% of male respondents. By contrast, just 2% of female respondents strongly agreed that they felt welcome, as opposed to 15% of male respondents.

Figure 37

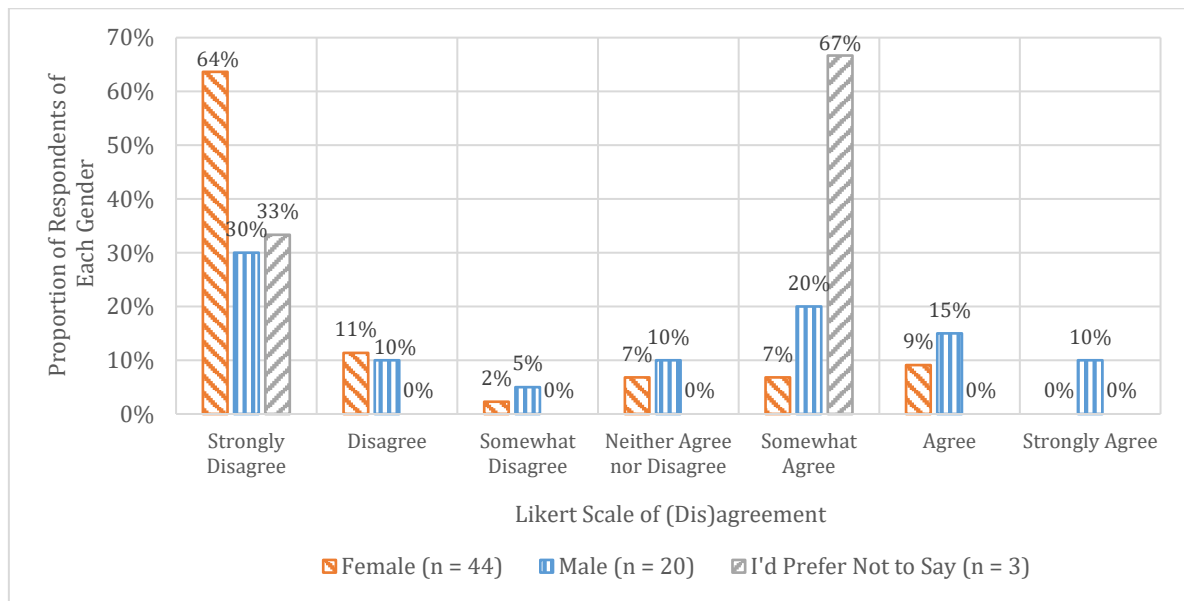
Proportion of Questionnaire Respondents of Each Gender Group According to Their Responses to “As a Medical Professional, I Feel Welcome in New Zealand” (N = 67)



Similarly, as shown in Figure 38, 64% of female respondents strongly disagreed that they would recommend other IMGs with a similar background migrate to Aotearoa New Zealand, compared to 30% of males. By the same token, 45% of male respondents somewhat agreed, agreed, or strongly agreed that they would recommend Aotearoa New Zealand to IMGs similar to them, as opposed to just 16% of females.

Figure 38

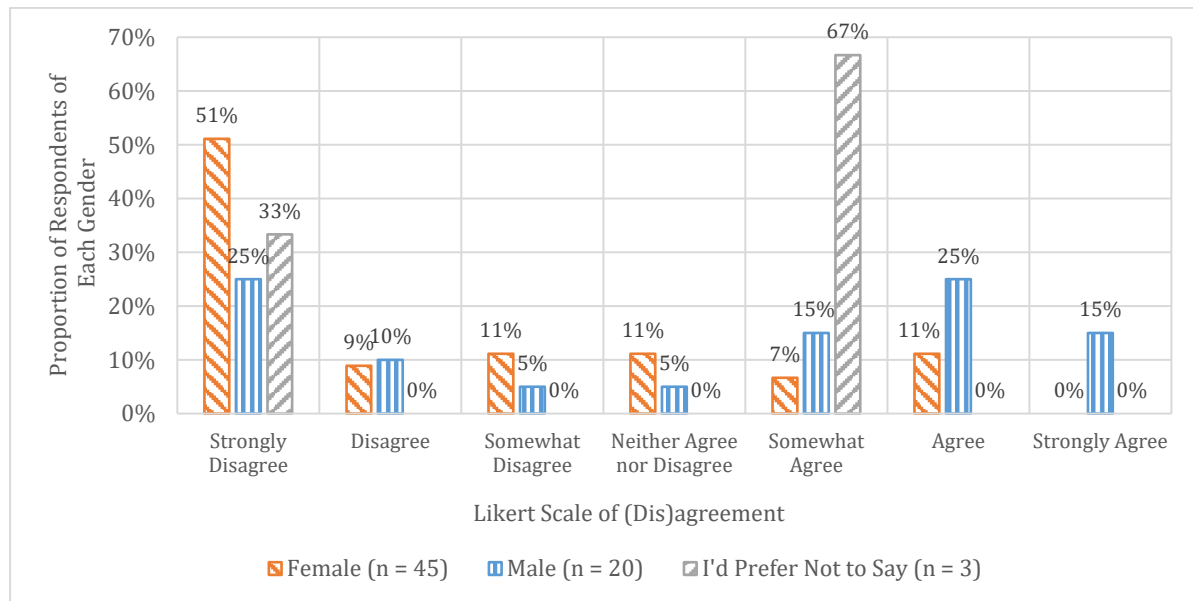
Proportion of Questionnaire Respondents of Each Gender According to Their Responses to “I Would Recommend That Other Doctors, With a Similar Background to Me, Migrate to New Zealand” (N = 67)



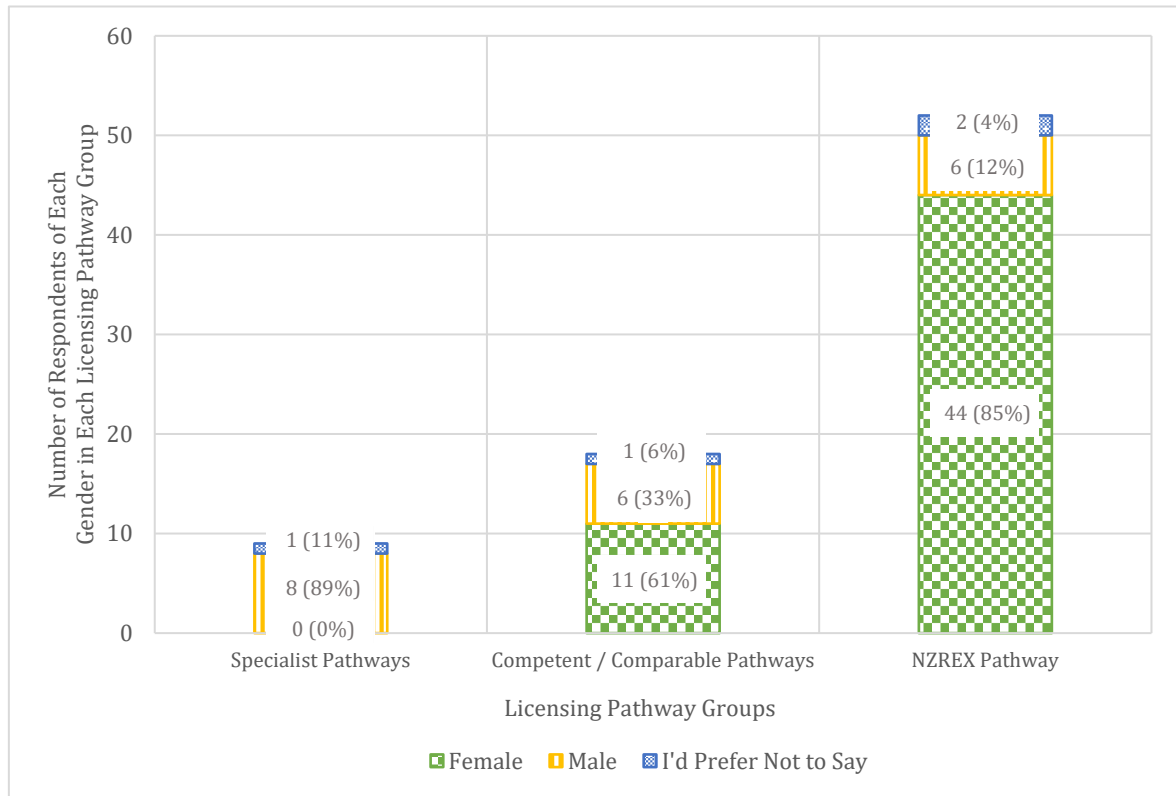
An overview of the gendered dynamics of all seventeen questions asked on the Likert scale in the second phase of this research can be found in [Appendix P](#). Overall, female respondents tended to report lower satisfaction on average in this section of the questionnaire, and were also less likely, for example, to agree that the time and cost of medical licensing is reasonable or that their skills and experience are valued, than their male counterparts. Furthermore, as summarised in Figure 39, 51% of female respondents strongly disagreed that their experiences with medical licensing in Aotearoa New Zealand were positive, compared to 25% of males, while 55% of males somewhat agreed, agreed, or strongly agreed that their experience was positive, as opposed to 18% of females.

Figure 39

Proportion of Questionnaire Respondents of Each Gender According to Their Responses to “My Overall Experience of Registering as a Doctor in New Zealand Has Been Positive” (N = 68)



These findings thus present contradictory trends in relation to gendered experiences. Although there seems to be a connection between gender and medical licensing experiences, it is crucial to recognise that very few individuals attributed this correlation to gender itself (refer to Figure 35), suggesting correlation, rather than causation. It is therefore important to understand the relationship between gender and licensing pathways among the respondents of this questionnaire. Notably, as illustrated in Figure 40, a significant majority of NZREX respondents identified as female (85%, $n = 44$), while none of the nine recognised specialist respondents identified as female. Among Competent/Comparable pathway participants, 61% ($n = 11$) identified as female, while one third ($n = 6$) identified as male.

Figure 40*Relationship Between Respondents' Gender and Licensing Pathway Eligibility (N = 79)*

The preponderance of female respondents on the NZREX pathway may be related to the way that many individuals not originally from Aotearoa New Zealand moved to the country with partners or spouses. A common theme from the interviews, as noted in [Chapter 6](#), was that IMGs on the NZREX pathway would often migrate with family to Aotearoa New Zealand before seeking medical registration. If, for example, an IMG's non-medical spouse can secure a highly-skilled migrant visa or another type of visa, medical registration is not usually required for those IMGs to relocate. This trend aligns with Expert 8's observation that cultural gender norms could contribute to a higher likelihood of female candidates on the NZREX pathway, especially those accompanying skilled-migrant spouses on partner visas.

Moreover, Expert 3 (Researcher) described how regulatory mechanisms contribute to gender inequities in medical workforce outcomes. Despite women constituting more than half of Australian and New Zealand medical graduates by 1991, they comprised only a third of registered specialists almost two decades later. Expert 3 further noted that women of colour, including Māori and Pacific women, face greater disadvantages. While it may be coincidence, this context may also explain why none of the questionnaire respondents identifying as recognised specialists also identified as female. This sentiment was reiterated by Expert 5

(Local Government Representative), who emphasised the need for more efforts to reintegrate women into the workforce, particularly after childbirth.

While the two female registered specialists interviewed in Phase 1 (IMG 5, LOC; IMG 14, VOC) did not attribute their challenges to gender, they also did not have children at the time of the interview. Conversely, for IMG 2, following the CHS licensing pathway proved disadvantageous to women due to the requirement for a minimum number of hours worked in a Comparable Health System:

Only for being a woman, you have more difficulties. For example, if she has a baby then that reduces her 4,000 hours. Even when you apply for your visa, they ask you if you are pregnant, and who is going to pay for the baby or the pregnancy? So if you are pregnant, you can't work here?

Expert 8 (Employer) also provided insights into how IMGs recruited on specialist or Competent/Comparable general pathways are often in their early thirties, coinciding with family-building years and creating potential disadvantages for women. Similarly, Expert 2 (Political Commentator) noted the importance of workforce planning to accommodate the increasing number of women entering the medical workforce, considering factors such as maternity leave and other temporary absences. While local experts tended to express stronger views on the impacts of gender on medical licensing and employment, IMG 24 (NZREX) was among the minority of IMG participants who considered gender a clear hindrance for women, stating that it is “100% a disadvantage for women”.

Although the majority of questionnaire participants did not perceive gender as a significant factor in their medical licensing experiences (see Figure 35), therefore, interview data and strong correlations in the questionnaire between licensing pathway, overall licensing experiences, and gender suggest that women might face some indirect disadvantages, particularly if they are new mothers. The mobilities and capabilities power regimes in place on the CHS pathway, with the minimum threshold of hours worked, would inevitably disadvantage anyone who takes up the role of primary caregiver for young children; and even if the birthing person is not the primary caregiver, a leave of absence would be required for pregnancy and childbirth. Furthermore, it is not difficult to see how female IMGs accompanying spouses eligible for highly-skilled migrant visas in other fields, could adopt a homemaking role upon arrival in Aotearoa New Zealand, with the belief that they will be able to work through the NZREX process once their childcare responsibilities have reduced as the children grow older.

7.4.3 *Invisibility as Misrecognition*

The impact of gender in medical licensing may thus be indirect or inadvertent – so much so that many IMGs do not consider it to be a factor – but could still constitute a form of mobility and capabilities injustice. As noted in [Chapter 4](#) (Subsection 4.3.1), social formations such as gender both constitute and are constitutive of “constellations of mobility” (Cresswell, 2010, p. 17). This conceptualisation would explain the correlation between gender and medical licensing experiences, without participants tending to attribute these experiences to gender. If the constellations of mobility associated with medical licensing in a new environment are both constituted by and constitutive of gendered dynamics, then both aspects could be seen to influence each other in a cyclical way. Unlike medical licensing policies that directly produce differential mobilities and capabilities depending on one’s country of training and experience, the interaction between medical licensing and gender is likely to be unintentional, indirect, and, as a result, often unacknowledged.

Regardless of policy intent, therefore, the social conversion factor of gender tends to combine with an IMGs’ capabilities in ways that may result, on average, in reduced professional motility and greater challenges for women in achieving professional functionings. Fraser (1998) notes how injustices can occur through misrecognition when individuals or groups are devalued, as seen with the qualifications of NZREX doctors, or rendered invisible. The limited acknowledgement of gendered dynamics in medical licensing in Aotearoa New Zealand suggests that unintentional – but equally problematic – processes of misrecognition may render the medical registration experiences associated with gender as largely invisible.

Sheller (2018a) discusses gendered mobility regimes, noting that “uneven and differential mobility produces racialized/gendered/disabling spaces and identities, including the dominant positioning of able-bodied, white masculinity as the default mobile subject whose needs are designed for” (p. 77). The intersectionality of ethnicity and gender among participants in this research, alongside other personal conversion factors discussed in this chapter relating to health, age, and personality, suggest there is a compounding effect of reduced “network capital” (Elliott & Urry, 2010, p. 11) among people of colour, especially women, and those who may not be as able-bodied as others. These obstacles are exacerbated by challenges associated with specific licensing pathways, particularly NZREX. The “default mobile subject” that Aotearoa New Zealand’s medical registration processes are designed for is unlikely to be a woman of colour from a Global South country with a young baby. Rather, medical registration currently facilitates the migration of IMGs from 24 Global North countries classified as Comparable Health Systems, who are statistically more likely to be of European heritage and/or white ethnicity. Furthermore, the CHS licensing pathway is designed for

individuals who meet a threshold of fulltime work experience in the past four years, which is more likely to preclude young mothers than men their age. In practice, therefore, the “default mobile subject” that benefits most from medical registration processes in their current state is the healthy, white man from a Global North country.

In applying a capabilities approach to mobility justice, questions are again raised about the dehumanisation that can occur by creating licensing pathways exclusively determined by the more-than-human capabilities associated with one’s training and experience, rather than the individual themselves. Introducing the missing “human element” (IMG 14, VOC) to medical registration would involve acknowledging that processes that treat all IMGs equally, by neglecting to acknowledge the compounding effects of personal and social conversion factors, may produce mobility and capabilities injustices. To create more equitable processes, medical registration should more clearly take into account an individual’s personal circumstances, and provide additional support to those who may experience comparative disadvantages due to conversion factors beyond their control. This, in turn, would have positive implications for the maximisation not just of IMGs’ capabilities and potential, but their human dignity in this context.

7.5 LANGUAGE, COMMUNICATION, AND CULTURE

If there is indeed a “hidden story” (IMG 8, NZREX) that intentionally or inadvertently excludes individuals from backgrounds that do not align with “default mobility subject” (Sheller, 2018a, p. 77) medical licensing pathways are designed for, then measures of other capabilities related to language, communication, and culture could also be viewed as a means to exclude IMGs who do not “fit in” or have a “particular profile” (IMG 24, NZREX). While medical registration requirements aim to uphold standards for safe medical practice (e.g., MCNZ, 2022a), participants in this research questioned the purpose and impact of “ticking all the right boxes” (Expert 4, Recruitment Agent), particularly in relation to language and communication. Requirements relating to language and communication create arbitrary exclusions of some IMGs over others, pointing to mobility and capabilities injustices.

7.5.1 English Language Requirements

As noted in the timeline of medical licensing history (see [Appendix A](#)), MCNZ’s English language policy requirements were updated in December 2022. Between 2009 and December 2022, when the majority of participants in both Phase 1 and Phase 2 of this research were pursuing medical licensing in Aotearoa New Zealand, MCNZ required a score of 7.5 out of 9 in both the Speaking and Listening components of the International English Language Testing System (IELTS), and at least 7 in Reading and Writing, for all IMGs who were required to demonstrate

English proficiency. Although the option to take the alternative Occupational English Test (OET) with a score of 350 (Grade B) was also introduced in the past decade, this examination presents challenges such as higher cost, limited testing opportunities and centres, and delayed delivery of results compared to IELTS. Consequently, most IMGs required to demonstrate English competency tended to opt for the IELTS examination.

Notably, the standard required in IELTS between 2009 and 2022, specifically 7.5 in Speaking and Listening, surpassed the requirements of other English-speaking countries Aotearoa New Zealand considers to be Comparable Health Systems. Australia, for example, requires a score of 7 overall, with no component less than 6.5 (Medical Board of Australia, 2015), while the U.K. requires an overall score of 7.5 and no less than 7 in any one component (General Medical Council, 2023a). The impacts of the higher requirements in Aotearoa New Zealand were observed in Mpofu and Hocking's (2013) study, with participants in this research elaborating on this experience. Several IMGs reported the relative ease of obtaining very high scores in the Reading and Listening components, but found that the requirement of 7.5 in Speaking and/or Writing, which is not required in Australia or the U.K., was challenging and restrictive.

The only non-NZREX interviewee who had not yet achieved licensing at the time of this research was IMG 3 (CHS). Despite achieving an overall score of 8 out of 9 in IELTS, he struggled to obtain the necessary 7.5 in the Speaking component, repeatedly achieving a 7. Frustrated by this hurdle, he explained that "with my IELTS score I can go work in Ireland, England, Australia...I can work in any other English-speaking country in the world, apart from New Zealand". This sentiment resonated with others, such as IMG 23 (NZREX), who attempted IELTS three times without success, but excelled in her first OET attempt. A questionnaire participant, trained in Western Europe (CHS), shared this dissatisfaction with IELTS, asserting that she consistently missed the Writing mark by 0.5. She questioned the integrity of IELTS, describing it as a "scam" and expressed frustration that despite holding a master's degree from a U.K. university, she was required to "dumb down" her English skills to the "high-school level" required by IELTS. Ultimately, she had to travel to London to take the OET, as it was not available in her home country in Western Europe, causing a nine-month delay in her application. This experience not only highlights the difficulties faced by some IMGs in "ticking all the right boxes" (Expert 4, Recruitment Agent), but also brings attention to mobility issues, as the participant had to travel overseas for the costlier OET exam, which was not available in her country of residence.

These challenges prompt questions about the credibility and purpose of language proficiency examinations. Undoubtedly, ensuring overseas-trained medical professionals can communicate competently in English is crucial to MCNZ's overarching aim of protecting the

public and maintaining rigorous standards of care (e.g., MCNZ, 2022a). However, participants questioned whether IELTS, while assessing language skills, was the most effective measure of an IMG's competence in communicating as a doctor. As discussed in [Chapter 3](#) (Subsection 3.4.4), other studies in Aotearoa New Zealand have suggested that interpersonal and communication skills are more relevant to a doctor's ability to engage effectively with patients than academic English assessments (Narasimhan et al., 2006; Narayanan, Vayro, et al., 2022; Sheehan et al., 2006). Additionally, the requirement to retake the IELTS examination every two years, as noted by IMG 20 (NZREX), added an extra layer of inconvenience and cost. Furthermore, IMGs 10 and 12 (NZREX), for example, found themselves compelled to take the examination despite completing two years of tertiary education in Aotearoa New Zealand. For IMG 2 (CHS), the stringent English language requirements thus represented an unnecessary obstacle⁴⁴, discouraging potential IMGs from choosing New Zealand as a destination:

New Zealand has the highest requirements in the world for English language, and it's not actually about your skills as a doctor, it's just a certain exam. No other country in the world requires what the New Zealand Medical Council [MCNZ] requires. So, to be honest, if someone asks us if we really want to continue, I would say it's better to opt for other options because the salary is not the highest either, and if you go to Ireland or Australia you're going to be paid more.

The challenges IMGs experienced were thus related to the specific English language standards, rather than the requirement to demonstrate their English skills in general. Several participants even voiced concerns that, despite passing IELTS or OET, they still felt unprepared for patient interactions in Aotearoa New Zealand. IMG 11 (NZREX) shared his realisation that upon arrival in Aotearoa New Zealand, he struggled to speak and understand people, and people had difficulty understanding him. IMG 20 (NZREX), who successfully passed IELTS several times, discussed her challenges with local pronunciation, giving the example of the word “better” and emphasising the importance of considering local idiomatic expressions and communication styles in medical practice. Several IMGs (IMG 2, CHS; IMG 11, NZREX; IMG 1, NZREX; IMG 6, NZREX) expressed the importance of (re)learning medical terminology in English, with IMG 16 (NZREX) explaining how helpful she found the prerequisite international medical knowledge examinations she had to take before being eligible to sit NZREX. These observations underscore the need for a nuanced approach to evaluating the language and communication

⁴⁴ Our interview was held four months before MCNZ's IELTS requirements changed in December 2022.

capabilities of IMGs (e.g., Sheehan et al., 2006), taking into account the practical requirements of medical practice and effective patient-doctor interactions.

These examples highlight how mobilities and capabilities power regimes in this context have tended to demand higher language standards of doctors who did not train in Australia, the U.K., Ireland, Canada, or the U.S.A., despite many of these individuals having the scores required to work in those countries. Furthermore, English-language requirements are extended to all doctors who trained outside of those countries, including those who trained in English in Southern Asian countries such as India or Pakistan. While doctors from non-English-speaking Global North countries also reported negative experiences with such barriers, these individuals are not required to demonstrate the medical English assessed in the international medical knowledge examinations that NZREX doctors must take. This discrepancy points to broader assumptions that doctors from non-English-speaking Global North countries will inherently be familiar with medical English. These language policies thus contribute to the overall privileging doctors who trained in a subset of Global North countries, creating uneven professional mobilities and capabilities that generate arbitrary exclusions of some IMGs, particularly those on the NZREX pathway. While it is crucial that medical professionals are competent in English before commencing work in Aotearoa New Zealand, the tools in place for assessing these skills apply unevenly and may not represent the most effective strategies to consistently ensure all IMGs are able to communicate successfully with patients.

7.5.2 Communication and Cultural Safety

The NZREX examination may be one tool currently employed to assess the nuances of communication beyond English language, with many participants suggesting that the NZREX examination focuses more on interpersonal skills than medical knowledge. IMG 16 (NZREX) felt the NZREX “was a veiled way of...checking to see how polished you are and how clear your English is”, while IMG 21 (NZREX) shared his experience that NZREX “is more focused on communication...because you can get the diagnosis wrong and pass the station, provided that you explain your rationale”. IMG 11 (NZREX) felt he was unsuccessful in his first NZREX attempt because his approach was “too focused on medicine” and for him, NZREX is “a little bit of medicine, but more about conversation and cultural competency”. He explained that the biggest cultural difference for him was needing to offer reassurance in patient interactions:

If you start reassuring [someone from my country], he will say, ‘Okay, nothing is wrong’, so sometimes we need to scare him about the consequences of his condition, otherwise he will refuse to do anything, especially surgery. So sometimes it’s a weird situation where I’m talking with the patient for 15 or 20 minutes, encouraging him or her that they need a surgical procedure, and they

will be reluctant; 'No Doctor, maybe next year'. So you have to say, 'You will die in three months'. But in New Zealand, you can't start with that.

IMG 23 (NZREX) also felt that communication style was the most significant difference she had to learn upon preparing for the NZREX, giving the following example:

In New Zealand, if a patient is diagnosed with cancer, you have to break it into parts; you cannot just go straight away and say, 'You have cancer'. But in [my country], we say, 'You have cancer, I'm so sorry.' But in New Zealand, you have to say, 'Oh John, I'm afraid that I have some news for you. Is it okay if we talk today, or do you want to bring someone else to the next consultation, where we can discuss this in further detail?'

Some participants were thus supportive of the perceived benefits of the NZREX examination in evaluating these kind of communication styles and interpersonal skills that are expected in the Aotearoa New Zealand healthcare context. However, IMG 16 (NZREX) explained how when she passed NZREX on the second attempt this was related to her increased level of confidence, and that she had failed the first time because "I wasn't, essentially, dancing to the tune they wanted me to dance to". Similarly, IMG 21 (NZREX) likened preparing for the NZREX to "practising a script", and IMG 12 (NZREX) mentioned a perceived disparity between her examination "persona" and her actual self as a doctor. Reflecting back on IMG 14's (VOC) suggestion of incorporating personality testing into registration processes, these comments indicate that the NZREX examination may already act as a proxy for assessing personality, alongside cultural norms that shape interpersonal interactions.

While NZREX may assess IMGs on the suitability of their communication skills in the Aotearoa New Zealand healthcare context, the examination still serves as a tool to create differential subjects. Only doctors on the NZREX pathway are required to pass international medical knowledge examinations in English and undergo a clinical examination in Aotearoa New Zealand that focuses on communication skills, in addition to demonstrating English language proficiency. Furthermore, there is an assumption that doctors from both English-speaking and non-English-speaking CHS countries already possess the required communication skillsets and styles assessed in the NZREX examination. This assumption is problematic, particularly when considering the experiences of IMG 14 (VOC), a doctor from the U.K./Ireland who was not required to demonstrate any communication skills prior to obtaining medical licensing:

I think I underestimated the cultural change that I had to kind of adapt to because, you know, we all speak the same language, right? It took me about a year to do that, which I definitely underestimated. [...] Like there are little cues

in a consult in the way that someone is trying to explain something that definitely took me a little while to figure out what the significance of that was.

This comment underscores the cultural and communication style adjustments necessary even when individuals share a common first language, illustrating the nuanced nature of communication and the need for cultural understanding. These concerns are part of a broader issue pertaining to “culturally safe” care, particularly in the context of working with Māori or Pacific patients (e.g. Curtis et al., 2019). NZREX participants expressed mixed views on the way the examination process prepared them to work with Indigenous patients. For instance, IMG 23 (NZREX) and IMG 10 (NZREX) felt there was limited emphasis on Māori and Pacific health inequities in the NZREX, indicating that cultural safety was something they had to learn for themselves. IMG 21 (NZREX) believed that “you can sit the NZREX exam and pass without having much understanding of Māori culture”, while IMG 6 (NZREX), on the other hand, felt that:

In the way they set up the scenarios [for NZREX], they did involve a lot of Māori and Pacific health, but not medical wise – it was more like interpersonal skills and communication that you have to face, like with Māori patients you have to know how to address them, how to pronounce their names correctly and how to say ‘*Kia ora*’ [hello] and other basic Māori terms that make them feel comfortable.

Inconsistencies in participant experiences with the cultural components of NZREX may suggest a continued lack of clarity around what constitutes cultural safety in this context. The relationship between culture and communication has been explored by Mannes et al. (2023a, 2023b), who note the limited educational opportunities for IMGs regarding cultural adaptation. Local Expert 4 (Recruitment Agent) also reported the absence of requirements related to cultural competency or safety prior to medical licensing for individuals arriving via non-NZREX pathways. This observation led Expert 8 (Employer) to conclude that it was more important to ensure all doctors, including NZMGs, go through cultural safety training on the ground, rather than attempting to assess it:

Whenever I interview foreign doctors around cultural safety, they all quote to me the details of the Treaty of Waitangi...they can rattle off all the historical facts they’ve learned on the internet, and they throw in a few Māori words as well...we shouldn’t make any assumptions about the level of cultural safety when people come in, and so we put them through courses. We try to put everyone on a more equal footing, and we put our Māori and Pacific doctors

through it as well...cultural sensitivity is not just about cultural sensitivity for a Māori person, but it's about LGBT, disabilities – it's about any perceived injustice or inequality that needs to be addressed. We put everyone through it so that everyone's on an equal footing.

The challenge, however, lies in the fact that there are no consistent standards or courses on cultural safety required for medical doctors – both locally-trained and IMGs – to practise medicine in Aotearoa New Zealand. IMG 2 (CHS) and IMG 22 (CA) both shared experiences where the availability of cultural safety training varied based on the clinic or location of work. IMG 2 stressed the importance of these courses and suggested that every doctor should undergo them in their first year in Aotearoa New Zealand, while IMG 22 expressed the need for centralised cultural training facilitated by MCNZ.

Although MCNZ (2022a, 2022b) have introduced pilot workshops for IMGs (“Welcome to practice in Aotearoa New Zealand”), there are still long strides to go in ensuring consistent, standardised cultural safety training is available to all IMGs prior to commencement of work. Expert 4 (Recruitment Agent) suggested the idea of a *marae* (traditional meeting place) experience, possibly lasting five days, that includes concepts related to Te Tiriti o Waitangi, what is *tapu* (sacred / forbidden), and other aspects of the Māori worldview. However, the practicality and costs of implementing such an initiative across the country remains a concern. Furthermore, while cultural safety and *mātauranga Māori* (Māori knowledge / worldview) are incorporated into local medical education, NZMGs are not specifically required to demonstrate competence in *te reo* (Māori language) in order to graduate (Expert 6, Educator). In 2021, for example, a student-led *te reo* programme was organised at the University of Otago to meet a perceived gap in formal learning opportunities (McRae, 2021).

For Expert 6 (Educator), no IMG should be assumed to be prepared to practise in a culturally safe way upon arrival in Aotearoa New Zealand. While he views IMGs as contributors of diverse perspectives to enrich the local provider community, when they make up more than 40% of the workforce, this could undermine the extensive investment in training local healthcare professionals to be culturally safe. For Expert 6, this represents a “dilution” that has broader consequences for the competency and stability of the medical workforce, especially as many IMGs on Competent/Comparable pathways may not stay in the country long enough to acquire the skills they need to provide culturally safe care. As highlighted in [Chapter 3](#) (Section 3.3), NZREX doctors, and those from Global South backgrounds more generally, tend to stay in the country longer than their Global North counterparts. Therefore, there is a case for reconsidering restrictive NZREX licensing processes to benefit both individuals facing barriers and the overall stability of the New Zealand medical workforce. Such an approach would

provide an opportunity for IMGs not to “dilute” culturally safe practices but to integrate and contribute their unique skills and capabilities in a culturally sensitive manner over a longer period of time.

7.5.3 *Licensing Pathways and Differential Subjects*

The effective implementation of training relating to cultural safety to protect Indigenous Māori patients and other vulnerable groups is a concern that has flow on effects for a significant and important proportion of Aotearoa New Zealand’s population. Nevertheless, mobility and capabilities injustices are seen most clearly in this context in the way that related policies do not apply evenly across groups of IMGs. IMGs from accepted Global North countries are not required to undergo the same level of English medical terminology and communication skills assessment as doctors required to take the NZREX licensing pathway. Expert 5 (Local Government Representative) highlighted this discrepancy:

We have to acknowledge the Treaty of Waitangi...but I think there’s also a lot of fear in ethnic communities that they don’t want to speak up, because they feel that Māori should take precedence...[Aotearoa New Zealand] is both bicultural and multicultural. We are bicultural, because we can recognise the Treaty that was signed in 1840, and we are multicultural because New Zealand is now a very diverse place...why, if you come from the U.K., do you not have to go through the competency training somebody for Asia or Africa does, where they actually have kind of parallel beliefs to Māori? That’s what discrimination is, because it’s almost like you’re saying one person can come in and go straight to work, and the other person does not know. Everybody should have to do that.

For Expert 5, therefore, while she believed there are broader issues with ethnic communities feeling they have a voice in Aotearoa New Zealand, the significant problem for her with viewing medical licensing through a cultural safety lens was the way that these policies applied unequally. Doctors from select Global North countries have, as Expert 4 explained, “zero” cultural requirements prior to licensing and, as discussed by Mannes et al. (2023a, 2023b), inconsistent training on arrival. This discrepancy suggests an underlying assumption in medical licensing pathways that doctors on, for example, the CA, VOC, or CHS licensing pathways will be automatically equipped to demonstrate effective communication skills and cultural safety.

IMG 22 (CA) further noted that the medical workforce was not representative of the local population, both in terms of Indigenous and Pacific medical professionals, and those of other multicultural backgrounds. This lack of diversity could result in healthcare practices that are

disconnected from the cultural realities of the communities they serve (Curtis et al., 2019). Furthermore, as Expert 5 pointed out, IMGs from some Global South backgrounds may actually be better equipped to tackle cultural safety issues specifically relating to Māori health inequities and colonisation than those from CHS countries. Expert 7 (Policy Advisor) also emphasised that graduates from “non-Western, middle-income, English-speaking countries”, with appropriate support or training, may excel in practising cultural safety due to their experience in “multi-ethnic, multilingual, and multiracial societies”. He believed they are more likely to have a better understanding of the impacts of colonisation, and share some holistic perspectives on health, family values, and spirituality with the Māori worldview. Such notions were also seen in Mpofu and Hocking’s (2013) research into IMGs and internationally trained dentists in Aotearoa New Zealand, who felt their transcultural skills were being overlooked (see [Chapter 3](#), Subsection 3.4.2).

This perspective was echoed by several participants. Expert 6 (Educator) thought that individuals from the Middle East might be better placed to work with Māori patients, due to shared values such as family orientation and joint responsibility. IMG 19 (NZREX) and IMG 18 (NZREX), both from the Middle East, expressed similar sentiments, pointing out the similarities in health risks and cultural values. While IMG 21 (NZREX) argued that doctors from postcolonial societies might be part of the “elite” and less aware of the marginalised, he did feel that as ethnic minorities in Aotearoa New Zealand such IMGs were likely to be more sympathetic to underrepresented groups. Similarly, IMG 18 (NZREX) shared that “I think as a migrant, you might have a kind of bias to be more supportive, unintentionally, of minorities like Māori and Pacific – we get feedback from our patients...and I have higher scores from Māori”. Similarly, IMG 8 (NZREX) suggested that individuals from countries such as South Africa, Pakistan, and India might have a better understanding of the sensitivities and cultural needs of Māori people due to awareness of the effects of colonisation and racial discrimination. In his words, “our ancestors have gone through what they are going through or have gone through – it’s very relatable”.

These examples illustrate the multi-faceted nature of cultural safety and the importance of recognising and leveraging the cultural capabilities of doctors from diverse backgrounds. As Expert 8 highlighted, cultural safety discourse extends beyond interactions with Indigenous populations to include representation and understanding of diverse ethnic communities and other underrepresented groups within the healthcare system. IMG 9 (NZREX) explained how his knowledge of four languages was an underappreciated skill that could play a crucial role in providing healthcare to diverse communities. Additionally, IMG 19 (NZREX) shared her

experience as a Muslim woman, drawing attention to the need for healthcare providers who can understand and meet the cultural needs of specific communities. She explained that:

As Muslim women we need female doctors, and we are just suffering with this.
I know a lot of people who are struggling because they can't find a doctor to
meet their cultural needs. This is something I could offer.

IMG 19's description of the cultural challenges faced by Muslim women in accessing healthcare connects to Expert 5's observation that ethnic communities may find it difficult to speak up about issues that affect them in Aotearoa New Zealand. As seen in relation to ethnicity and gender, social conversion factors that provide limited opportunities for the inclusion of underrepresented voices have a compounding effect on both IMGs from these backgrounds, and these communities more broadly. This compounding effect results in potentially unjust arbitrary exclusions of marginalised groups rendered invisible by misrecognition; actively shaping policies to recognise the potential contributions of IMGs from such backgrounds would not only benefit these individuals, but could also set a precedent for enhanced inclusion of underrepresented communities. In this way, this capabilities approach to mobility justice underscores the interconnectedness of individuals within broader societal structures.

7.6 CONCLUSION

In examining P2 of my capabilities approach to mobility justice, this chapter has delved into the ways in which personal attributes and interpersonal dynamics influence the professional journeys of IMGs navigating medical licensing in Aotearoa New Zealand. While participants articulated the impacts of their designated medical registration pathways on their experiences and outcomes, (inter)personal conversion factors were often perceived as having an indirect impact on their ability to translate their capabilities into functionings.

Gender, ethnicity, culture, and language emerged as key examples of how social formations interacted with "constellations of mobility" (Cresswell, 2010, p. 17) in this context. While some participants expressed their concerns that these factors directly impacted their experiences, others discussed these qualities in passing. However, women in this study were far more likely to experience professional obstacles and delays associated with childbearing and family obligations. Furthermore, interview participants who were not of European heritage often expressed feelings of being "unwelcome" or treated as "second-rate citizens". This tendency was particularly pronounced among IMGs on the NZREX pathway, underscoring the intersectionality of medical licensing pathways with personal and social conversion factors.

Moreover, the prevalent emphasis on communication styles aligned with often undefined cultural norms raises questions about whether policies and structures silently advocate for a “hidden story” (IMG 8, NZREX) about the preferred type of IMG in Aotearoa New Zealand – or, as Simon-Kumar (2015) phrases it, the “desirable migrant” (p. 1172). These policies impact the local population by failing to formalise cultural safety training for IMGs from all backgrounds. Furthermore, medical licensing pathways undervalue the contributions of IMGs who may possess a unique understanding of the needs of ethnic communities, while simultaneously facilitating the migration and motility of IMGs from CHS countries. This “arbitrary exclusion” (Sheller, 2018a, p. 174) evokes a (post)colonial mentality, where individuals from the Global North are presumed to be inherently equipped to address the contextual concerns of a foreign country (McEwan, 2019). As a result, current medical licensing policies appear to disproportionately disadvantage and misrecognise some groups, including those who trained in the Global South, female doctors, and/or those from ethnic or cultural backgrounds that were historically excluded in Aotearoa New Zealand, generating mobility and capabilities injustices.

Both Chapter 6 and 7 have explored the implementation of personal and social conversion factors in relation to IMGs’ professional capabilities and mobilities. Robeyns (2017) distinguishes between “personal” conversion factors as being internal to the individual, and “social” conversion factors relating to social norms, policies, and power relations. However, as explored in these chapters, the personal elements and qualities that impact IMGs’ capabilities and functionings as medical professionals in Aotearoa New Zealand are inseparable from the interpersonal aspects – that is, how they interact with this environment and the professional motility and network capital afforded to them. Personal conversion factors are thus also interpersonal or social, in that their impact cannot be understood independently from the context in which they are drawn upon. As a result, P2 has been conceptualised as (inter)personal mobilities and capabilities.

Furthermore, these chapters highlight how a critical examination of policies and associated social and cultural norms is essential to explore how the regimes of medical registration in Aotearoa New Zealand may reflect historical legacies and dominant discourses about the disparities between medical competencies in the Global North and Global South. To this end, the following two chapters consider the way medical licensing policies translate from paper into practice (Chapter 8) and further explore the histories and narratives that have shaped the mobilities and capabilities regimes associated with medical licensing in this context (Chapter 9).

8 WORKING (IN) THE SYSTEM: MOBILITIES AND CAPABILITIES IN PRACTICE

8.1 INTRODUCTION

The preceding chapters explored the interplay between the professional capabilities, personal qualities, and interpersonal skills of IMGs in the medical licensing environment of Aotearoa New Zealand. This chapter shifts its focus to broader themes underlying these discussions, emphasising institutional transparency and the strategies employed by IMGs to become registered that go beyond “ticking all the right boxes” (Expert 4, Recruitment Agent). In this way, the chapter connects back to the opening quote of this thesis, where IMG 9 (NZREX) described the “broken pathway” that exists for NZREX doctors in Aotearoa New Zealand. Success is not guaranteed by adherence to a set process; instead, individuals must navigate uncertainties, jump through loopholes, and rely on luck. As a result, some individuals resort to subversive mobilities, employing advocacy, networking, and other innovative approaches to traverse this “broken” system. In examining the third of the 4Ps, mobilities and capabilities in practice, this chapter addresses the challenges IMGs face in translating medical registration policies from paper into practice.

The chapter unfolds in four main sections. First, I explore how a lack of transparency and clarity in policy and available information pervaded many research participant accounts, perpetuating uneven mobilities and capabilities. Second, the chapter examines the formal and informal strategies employed by research participants to enhance their network capital and combined capabilities, through movement and space, and other opportunities such as observerships or alternative healthcare roles. Next, I discuss how some IMGs look for strategies and ways to subvert the system within these “broken” pathways in order to achieve their professional functionings. Finally, the chapter synthesises key recommendations and suggestions from both phases of the research for the improvement of the existing system, incorporating insights from the current chapter, as well as those derived from [Chapters 6 and 7](#).

The overarching argument is that “broken” pathways disproportionately affect IMGs who did not train in CHS countries, exacerbating the uneven mobilities and capabilities previously discussed in this thesis. The mobility and capabilities injustices experienced by these IMGs are thus not only a result of policies that create differential subjects on paper. Rather, as I

demonstrate in this chapter, these injustices also stem from the reinforcement of inequalities in the inconsistent implementation of policies in practice.

8.2 TRANSPARENCY AND (IN)CONSISTENCY

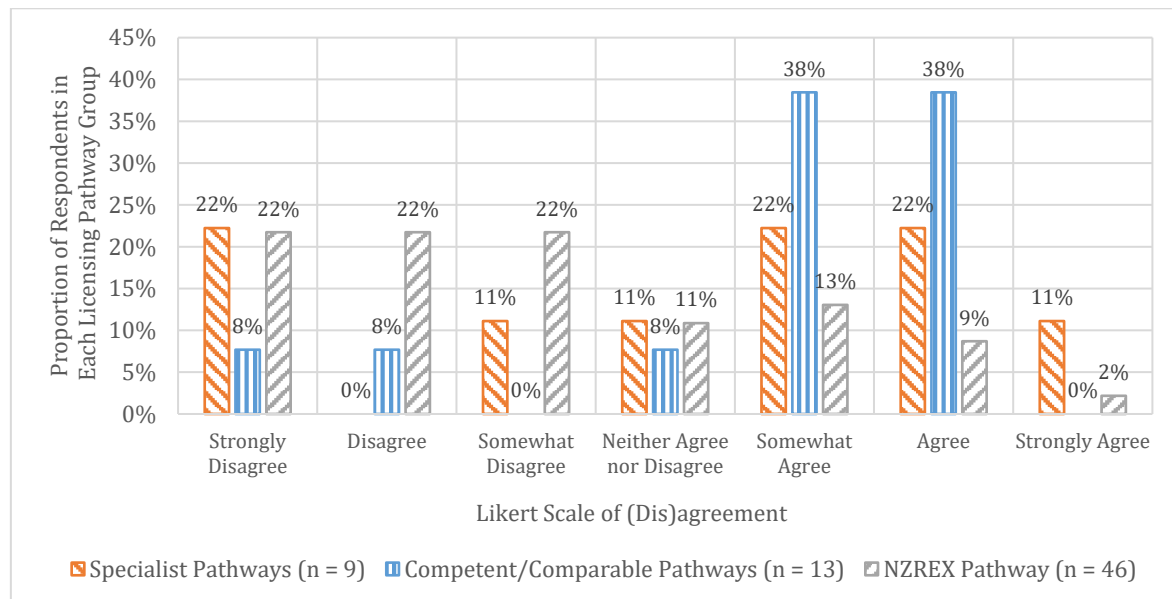
In [Chapter 7](#) (Subsection 7.3.2), I introduced the idea of a “hidden story” (IMG 8, NZREX) of the mobilities and capabilities power regimes behind medical licensing in Aotearoa New Zealand. This section focuses on research participants’ experiences with trying to understand this “hidden story” amidst a lack of clarity and information surrounding medical licensing processes. Participants from all backgrounds and licensing pathways faced challenges due to the limited availability of information and data regarding medical licensing for IMGs.

8.2.1 Understanding Registration Processes

Prompted by anecdotes from the Phase 1 interviews, I asked participants in the online questionnaire if they felt that medical licensing processes in Aotearoa New Zealand were easy to follow. As shown in Figure 41, 77% of Competent/Comparable general registrants somewhat agreed, agreed, or strongly agreed with this statement, compared to 56% of specialists and just 24% of NZREX respondents. Twenty-two percent of both specialists and NZREX doctors strongly disagreed, however, along with 8% of Competent/Comparable pathway participants. While NZREX doctors were the most likely to disagree that licensing pathways are clear and easy to follow, therefore, the diversity in responses among the other participant groups suggests there may be challenges associated with clarity around these processes across a range of IMGs seeking to practise medicine in Aotearoa New Zealand.

Figure 41

Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “Medical Licensing Processes in New Zealand Are Clear and Easy to Follow” (N = 68)



Interviews with IMGs shed further light on respondents' experiences with understanding medical licensing processes in Aotearoa New Zealand. For one questionnaire respondent (VOC) who trained in the U.K./Ireland, the process was “very straightforward when I did it as a vocationally trained GP”. Similarly, IMG 14 (VOC) shared how she managed her own paperwork without relying on any intermediary, emphasising the relative ease of the process. Another respondent (CA) who trained in the U.K./Ireland endorsed a specific recruitment company for their assistance in the licensing process, emphasising how they “made the entire process seem extremely simple”. For IMG 5 and IMG 2, on the other hand, the assistance of a recruitment agency proved crucial in navigating the LOC and CHS licensing pathways, respectively. IMG 2 went as far as stating that “if we wouldn't have had help from the agency, I think it would be impossible”. However, Expert 4 (Recruitment Agent) clarified that this support was not extended to IMGs on the NZREX pathway, a trend observed across other medical staffing companies in Aotearoa New Zealand (see [Chapter 2](#), Subsection 2.3.3).

As a result, NZREX doctors were more likely to share experiences with struggling to obtain the necessary information about medical licensing. Several NZREX participants felt misled by the limited online information available before their arrival in Aotearoa New Zealand. Prior to migrating, IMG 21 (NZREX), for example, believed he was eligible for the vocational (VOC3) licensing pathway based on MCNZ's online self-assessment tool. However, he later discovered that eligibility was determined on a case-by-case basis, leading to unexpected obstacles:

I'm not going to say the word 'easy', but I thought it would be straightforward, like 'you do this, you do that'. So when we got here, I got all the documents ready and I sent them and they [MCNZ] were like 'no, you can't register on the vocational pathway because [your country] is not accepted' ...GP training in [my country] is two years and in New Zealand it is three, so this made me think, 'okay, make me do a year or two maybe'? They're like, 'no, go through the NZREX pathway'.

From this quote, it is clear that IMG 21 found the availability of information for specialists inadequate and confusing. Furthermore, his case suggests there may be a lack of retraining opportunities for IMGs with extensive specialist training and experience, as mentioned in [Chapter 6](#). IMG 10 (NZREX) also felt there were things he wished he had known before moving to Aotearoa New Zealand. He regretted not having commenced the NZREX process while still working as a doctor in the Pacific – by sitting the international medical knowledge examinations and booking his NZREX slot before migrating, he might have reduced his five year wait time for registration on arrival in Aotearoa New Zealand.

In response to what they perceived as limited or confusing information, some participants described their experiences with contacting MCNZ for further details. One questionnaire respondent (NZREX) explained that “every time I speak to someone at [MCNZ] they tell me something different”, while IMG 24 (NZREX) felt distressed by her attempts to obtain further information because “the tone of their emails to me was degrading and disrespectful – I felt like I was dirt, when all I was trying to do was find out more information”. IMG 4 (NZREX), on the other hand, felt that communication and transparency from MCNZ had improved in the past decade. He explained that when he arrived in 2012, the MCNZ website had very limited information about NZREX, but this has since changed:

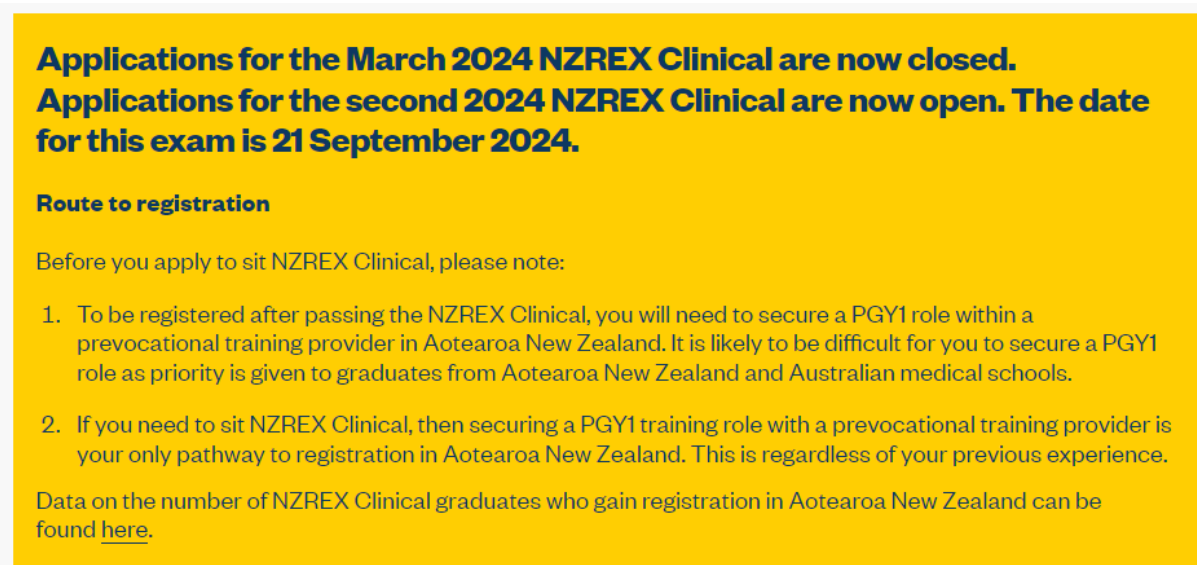
Now the Medical Council [MCNZ] website is quite good. It tells you what the examination is and...gives you details, even tells you that once you pass the exam, you probably won't get a job. [...] But at that time [2012], the website was very basic: like, there's an exam, these are the dates. That's it, nothing else...only recently they [MCNZ] have started telling you what kinds of books you could use, which wasn't there before.

Some participants agreed there has been improved transparency from MCNZ, particularly with a clear disclaimer in a “giant yellow box” (IMG 24, NZREX) with “big letters” (IMG 11, NZREX) at the top of the page, stating that passing NZREX does not guarantee registration and a PGY1 position. As shown in Figure 42, this disclaimer specifically states that “it is likely to be difficult

for you to secure a PGY1 role as priority is given to graduates from Aotearoa New Zealand and Australian medical schools” (MCNZ, 2024n). This led some IMGs to question the purpose of such a declaration, with IMG 6 (NZREX) wondering if the aim is to provide greater transparency or simply to prevent complaints.

Figure 42

Disclaimer for NZREX Candidates, as of January 2024 (MCNZ, 2024n)



Applications for the March 2024 NZREX Clinical are now closed. Applications for the second 2024 NZREX Clinical are now open. The date for this exam is 21 September 2024.

Route to registration

Before you apply to sit NZREX Clinical, please note:

1. To be registered after passing the NZREX Clinical, you will need to secure a PGY1 role within a prevocational training provider in Aotearoa New Zealand. It is likely to be difficult for you to secure a PGY1 role as priority is given to graduates from Aotearoa New Zealand and Australian medical schools.
2. If you need to sit NZREX Clinical, then securing a PGY1 training role with a prevocational training provider is your only pathway to registration in Aotearoa New Zealand. This is regardless of your previous experience.

Data on the number of NZREX Clinical graduates who gain registration in Aotearoa New Zealand can be found [here](#).

For IMG 11 (NZREX), the “discouraging” nature of this disclaimer also made little sense. As he explained, “they show us that they don’t really need us, but we’ve heard a lot about this extreme shortage...they ask for almost NZD\$6,000 and then say, ‘we cannot guarantee you a job’”. While there may now be greater transparency regarding the challenges faced by NZREX candidates on the MCNZ website, this raises questions, as IMG 11 suggested, about why a process that costs thousands of dollars is even being promoted. In fact, by explicitly stating that the process “is likely to be difficult” and there is no guarantee of success, MCNZ is, in “big letters” (IMG 11, NZREX), acknowledging the “broken” (IMG 9, NZREX) nature of the NZREX licensing pathway and normalising the resultant uneven mobilities and capabilities.

Nevertheless, some NZREX doctors did feel that the licensing pathway benefited their ability to contribute and adapt to the local health system once they had secured employment. For instance, IMG 23 believed that the NZREX examination process prepared her for working in a different health system and shaping her approach to patient care. IMG 8 (NZREX) shared how his wife had access to full maternity leave and employee rights during her PGY1 year, and felt she was protected by the system. IMG 17 also highlighted the importance of PGY1, explaining how it made him a “safe practising doctor”, by providing exposure to various hospital departments and the inner workings of the health system. Participant concerns thus tended to

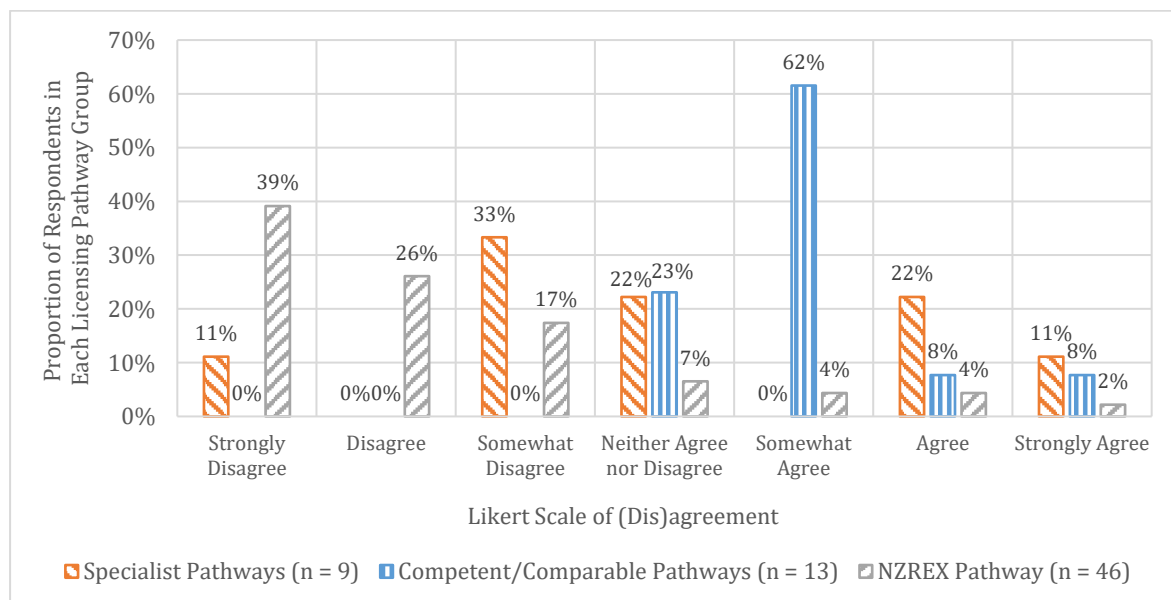
relate more to the process than the existence of the NZREX examination, with IMG 11 (NZREX) remarking that “I agree with high standards...but if you reach the standards, you should have an opportunity”. While NZREX participants struggled with understanding the mobilities and capabilities regimes shaping medical licensing in Aotearoa New Zealand, they did understand and support the purpose of such regulatory mechanisms overall. In practice, however, the policies in effect in this context produce uneven professional outcomes and experiences for IMGs without a clear explanation of the rationale behind this.

8.2.2 NZREX Examination Processes

NZREX participants also reported challenges with understanding and accessing the necessary resources and materials to prepare for the NZREX examination. IMG 8 (NZREX), for example, characterised the entire NZREX process as a “black box situation” where the evaluation criteria and marking methods remained unclear. Questionnaire respondents from all pathways were asked to reflect on their own experiences with accessing materials and resources, as highlighted in Figure 43.

Figure 43

Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “All Necessary Resources and Materials Are Readily Available for Overseas-Trained Doctors to Navigate the Medical Licensing Process in New Zealand” (N = 68)



While 83% of NZREX respondents, and 44% of specialists, either somewhat disagreed, disagreed, or strongly disagreed that the necessary materials and resources were available for navigating medical licensing in Aotearoa New Zealand, 77% of Competent/Comparable participants, 33% of specialists, and 11% of NZREX doctors either somewhat agreed, agreed, or strongly agreed. There was significant diversity in responses among specialists, therefore,

while NZREX participants tended to disagree, and Competent/Comparable respondents tended to agree.

Qualitative data from both phases of the research offer further insight into the challenges experienced by NZREX doctors in particular. Despite improvements in the description of examination criteria and available materials over the past decade, participants consistently reported difficulties in understanding how to prepare for NZREX. Candidates are referred to the guidelines relating to “Good Medical Practice” (MCNZ, 2021b), but IMG 8 (NZREX) felt that the notions of “good practice” or “best practice” appeared to be “buzzwords” without clear definitions. Similarly, IMG 6 (NZREX) shared his experience, highlighting the lack of resources for NZREX preparation and his reliance on training materials from the U.K.:

There were no resources to prepare for NZREX, mainly just some past experiences from previous candidates...I think I got lucky because I actually was preparing for the PLAB 2 [U.K. clinical skills examination], where there is actually a systemic way to prepare for the exams. There are a lot of academies that provide support for you. There's the BMA, the British Medical Association, that actually provides support for the international medical graduates because that's what they rely on in the U.K. – the IMGs. So they do have a lot of support for them. So because I had experienced that there, I was comfortable taking the New Zealand Registration Examination, because it was very similar.

IMG 23 (NZREX) also found that her training for the U.K. PLAB 2 examination was useful in preparing for NZREX. However, IMG 16 (NZREX) followed the curriculum of the U.S. clinical skills examination (USMLE Step 2 CS) and expressed disappointment at not succeeding in her first attempt at NZREX, having been unaware that NZREX would share more similarities with the U.K. PLAB 2, than the U.S. equivalent. It is only since June 2023, with MCNZ's (2023c) decision to accept PLAB 2 as an alternative to NZREX, that the similarities between the examinations and their criteria have been clearly acknowledged. This led IMG 11 to convey frustration and anger at the lack of information that could have ensured his success:

Unfortunately, I failed this exam [NZREX]...my approach was too much focused on medicine...when I got this feedback, I was very angry – frustrated and angry – because how can I know about this? [...] If you start searching about preparing for NZREX, you find nothing, so you can't understand what they want from you...there's just a general description, in two pages, nothing more...the problem is that there are no preparation courses, no materials...I realised that the best preparation is to sit the exam...but even the feedback was very poor.

Local experts also observed this phenomenon, with Expert 1 (Employer) expressing concern about the lack of structured tutorials and programmes available from MCNZ. One participant, IMG 15 (NZREX), had the opportunity to partake in the three-month NZREX preparation course before its cancellation in 2013. This programme, a paid position encompassing hospital experience, lectures, and simulation practice, aimed to prepare participants to take the NZREX. IMG 15 explained that everyone she studied with passed the NZREX and that:

One of the things we were told on the course is that the NZREX exam is not necessarily figuring out how much knowledge you have...the NZREX exam is to see if you will fit into the system...being able to be a part of the system before attempting the exam was hugely beneficial.

Reduced institutional support for NZREX doctors has thus furthered disadvantaged IMGs seeking to adequately prepare for an examination that provides their only opportunity for converting their professional capabilities into functionings in Aotearoa New Zealand.

8.2.3 NZREX Employment Processes

Participants also expressed confusion and frustration regarding the employment process after passing the NZREX examination. IMG 6 (NZREX) encapsulated this struggle, emphasising his post-examination anxiety about job security:

After the exam, you pass, and you're happy. And then the next day, you're starting to worry about how you're going to secure a job here in New Zealand, because nobody wants you...there's only about 50 or 60 NZREX graduates each year, which isn't many. But we have just got two or three vacancies for us left after the New Zealand graduates apply...I've applied to DHBs [hospitals] everywhere for PGY1 positions. But it's always the same response or no response: 'No vacancies, we always prioritise New Zealand graduates, Australian graduates, British and Irish graduates'.

This quote not only highlights the challenges NZREX doctors face with competing with NZMGs, but also the uneven professional mobilities they experience compared to IMGs who trained in Australia, the U.K. or Ireland.

Some doctors, such as IMG 4 (NZREX), wondered whether hospitals might have specific times when they actively seek PGY1 applicants outside of the Advanced Choice of Employment (ACE) matching scheme for NZMGs and Australian medical graduates. However, if this is the case, employers do not always make this information public, leaving candidates in the dark about when to apply. This lack of transparency was illustrated by IMG 15 (NZREX), who only learned

about a PGY1 vacancy through a chance encounter with a friend working at the hospital where her father was admitted, as the position was not advertised. IMG 16 and IMG 18 also noted they obtained PGY1 roles that were not publicly advertised⁴⁵. These kinds of situations led IMG 9 (NZREX) to voice frustration around the absence of a clear employment process:

I think there should at least be some kind of reassurance – like you’ll get something within a year or two, but just not now. But it’s all random and it’s so unfair and you don’t have a clear picture of who is waiting and how long they’ve been waiting.

This sentiment was reiterated by a questionnaire respondent (NZREX), who explained that “it’s hard to understand why some doctors are given preference to work while some like me are left with no options”. IMG 4 (NZREX) also noted that “it doesn’t make sense” when qualified individuals are unable to work, while less experienced and less qualified candidates secure PGY1 positions. Similarly, IMG 23 (NZREX) wondered “how international medical graduates in New Zealand get a job and secure employment...I mean seriously, where is the proper pathway? What happens behind the screens?”. To address such inconsistencies, IMG 10 suggested the establishment of a checklist for candidates who pass the examination, to enhance transparency about the steps needed to improve their chances of being hired. However, he observed that “it doesn’t seem like it’s a standard thing”, making it difficult to discern the criteria that employers prioritise.

Local experts shared this belief, pointing out the inconsistencies between policies on paper and their practical implications. Expert 6 (Educator) emphasised the arbitrary nature of many hurdles in the licensing process, suggesting that certain requirements, beyond ensuring an IMG has a genuine medical degree, is not a criminal, and can speak English, “don’t serve any real purpose”. For both IMGs and local experts such as employers or policy advisors, understanding licensing processes in Aotearoa New Zealand involves more than simply knowing which IMGs are eligible for which pathway. Lack of clarity was seen in not only understanding how to navigate these pathways, but also in why they are structured in such a way. In this way, some participants were seen to directly question the seemingly arbitrary nature with which some IMGs were excluded from practising medicine over others.

⁴⁵ When I requested data from all public hospitals in Aotearoa New Zealand in 2022 regarding their PGY1 hiring history, under the Official Information Act (discussed in [Chapter 2](#)), I also asked for information on the number of vacancies that were advertised outside of the ACE matching scheme. However, inconsistent and incomplete responses to this question meant these findings could not be reported on in this thesis. These anecdotes from research participants suggest that some hospitals may have chosen not to provide this information because these positions are not always publicly advertised.

Furthermore, IMG 15 (NZREX) felt this dynamic of systemic exclusion was evident even after successfully obtaining a PGY1 position. When she was initially contracted for PGY1, she was only offered roles for three months at a time, despite needing to complete a full year to progress to PGY2. She had to advocate for herself and her employee rights, and it took her almost two years to complete the one year required for PGY1. This phenomenon was also observed by IMG 9 (NZREX), who noted that the data on the MCNZ website (MCNZ, 2024l) only indicates the number of NZREX graduates with provisional registration. Provisional registration is available to any NZREX doctor who has been contracted to complete at least one three-month placement of the required four for the full PGY1 year. Some IMGs may thus find themselves stuck in another invisible bottleneck after the first three-month placement, similar to IMG 15's experience, with IMG 9 remarking that:

I know friends who have done six months [of PGY1], but they're still waiting...[MCNZ] has a lot of statistics, but you don't have any complete information, like how many of the doctors got the full registration or actually completed PGY1?

Expert 8 (Employer) explained that the practice of offering short, fixed-term contracts, as opposed to the permanent contracts typical for most NZMGs, has faced criticism from NZREX doctors. However, he felt that his hands were tied with regard to providing more stable employment:

They say that 'by offering a fixed term contract and not the typical permanent contract that most New Zealand graduates have, you're not allowing us to have a fair chance'. But on the other hand, we can only offer contracts when we've employed New Zealand graduates and they've, say, gone off on paternity or maternity leave, or extended sick leave. So we say, 'Do you want to have a 13-week attachment signed off? It's better than nothing'.

While a 13-week placement may be "better than nothing", this does not mean it is just or equitable that NZREX doctors are offered different employment contracts and conditions than NZMGs employed in exactly the same role, completing exactly the same work.

As with IMG 5 and IMG 18, who expressed a sense of powerlessness in advocating for themselves, these examples underscore how mobilities and capabilities power regimes create uneven opportunities for migrant workers. Furthermore, employers, such as Expert 8, may feel equally powerless to effect change in a system that perpetuates such disparities.

These perspectives highlight how the primary concerns of research participants were not only with the existence of licensing pathways or assessment processes. Rather, their frustration

stemmed from the uneven and unpredictable application of these pathways, coupled with the lack of occupational stability and institutional support, particularly for NZREX doctors. These anecdotes thus bring attention to the multifaceted challenges faced by IMGs navigating both medical registration and employment in Aotearoa New Zealand. The obstacles they encountered in accessing information, resources, and institutional support underscore the inconsistencies and uncertainties within these processes.

While some IMGs acknowledged the benefits of the NZREX licensing pathway in enhancing their readiness for the local health system, a prevailing theme was the perceived arbitrariness and unpredictability in the availability and quality of opportunities once licensing requirements are met. Inconsistencies in licensing and employment thus perpetuate a sense of randomness or reliance on “luck”, a “black box situation” (IMG 8, NZREX) that diverts attention from the underlying mobilities and capabilities power regimes guiding IMG experiences in this context. These power regimes tend to disadvantage and arbitrarily exclude individuals who did not train in Global North countries on the CHS list.

8.2.4 Systemic Barriers and Enablers

Sheller (2018a) describes the way mobility regimes can create uneven healthcare access and health outcomes for patients across the scales of mobility justice. However, this research brings attention to the mobilities that create and shape spaces such as hospitals not only for patients, but for healthcare professionals.

PGY1 hiring processes provide insights into how Sheller’s (2018a, 2018b) scales of mobility justice overlap and intersect in this context. While the differential mobilities of IMGs at the transnational scale can be seen here, with the prioritisation of certain migrant and non-migrant groups for PGY1 roles, the hospitals themselves can be seen to relate to the urban or infrastructure scale of mobility justice. IMGs from CA or CHS backgrounds are afforded greater professional motility, in that their migration to Aotearoa New Zealand at the transnational scale tends to align with their professional functionings in obtaining employment at this local scale of urban infrastructure. The uneven mobilities some NZREX doctors experience, between migrating to Aotearoa New Zealand and working as medical doctors, are compounded by structural limitations imposed not only by medical licensing pathways, but also by employment policies.

Furthermore, the regulatory nature of MCNZ, distinct from public institutions such as District Health Boards / Te Whatu Ora | Health New Zealand, poses a notable challenge to ensuring transparency and clarity in medical registration processes. As outlined by Expert 2 (Political Commentator) and Expert 7 (Policy Advisor), MCNZ, not being a public entity, is not obligated

to provide data or information to the public under the Official Information Act (OIA). This absence of recourse to request data from MCNZ aligns with concerns raised in previous studies regarding the limited availability of information surrounding some of MCNZ's processes (CHRE, 2010; Lillis et al., 2006; Lillis et al., 2012; Mpofu & Hocking, 2013; Pande, 2015).

While MCNZ may be transparent about some of the obstacles NZREX doctors are likely to face, and the stringent requirements of their policies for the CHS pathway, there appears to be a general lack of transparency in their decision-making processes and understanding why these restrictions are in place. Such observations led IMG 20 (NZREX) to conclude that “nobody’s questioning it” with regard to these processes, stating that “we’re just doing it because we’re told to do so”. It is difficult to question the decisions of an organisation that has no legal obligation to provide the fine details of their decision-making processes to members of the public. The challenges faced by applicants from all licensing pathways, who are seeking clarification or exemptions, thus underscore the systemic issues at play in this context.

Furthermore, Expert 7 (Policy Advisor) worried that current processes could be justified with incomplete, “cherry-picked” data taken out of context. In his view, current medical licensing processes and the rationale behind them are “not robust”, pointing to a need to critically examine and reform existing policies. IMG participants made similar remarks, with one questionnaire respondent (NZREX) questioning the relevance and appropriateness of the criteria set for IMGs, while another (VOC) felt that the way in which NZREX candidates are “stuck” after passing the examination is “indictable”. IMG 8 (NZREX) observed that the current processes seem to imply that NZREX candidates are perceived as not meeting the required standards, despite successfully passing the examination. He speculated that:

If there is a problem with the NZREX doctors after they have passed the exam, then I see the problem with the exam itself. Because they’ve met the standard you laid out...if someone is not, you know, making progress or is not competent, as described by you, then your standard is actually problematic.

According to his reasoning, if candidates meet the standard set by the exam, any subsequent issues with competency or progress may indicate a flaw in the established standard. This suggests inconsistency not only in the availability of information and resources, but in the specified standards and criteria of medical licensing processes themselves. IMG 19 (NZREX) thought these inconsistencies may result from a lack of systemic awareness of the obstacles on the NZREX licensing pathway:

I think that the system doesn’t realise what the problem is that we are facing...and that they actually have experienced overseas doctors here and they

can use us, instead of saying we have a shortage of doctors. We're actually living here. We are aware of the culture too, but instead they just hire someone from overseas, someone just coming now.

In addition to expressing concerns about systemic ignorance to the challenges many IMGs face, research participants from a range of licensing pathways also reported challenges with being able to speak up and feel heard. For instance, IMG 5 (LOC) felt she was exploited in her first role in Aotearoa New Zealand, articulating a sense of powerlessness as a migrant worker. She was asked to begin working before she was ready, expected to work beyond her contracted hours, and felt she had no one to turn to for support. She perceived her experience as akin to being in a "sweatshop" and was frustrated by her inability to advocate for herself as a foreigner, asking; "between the New Zealander and the foreigner – who are they going to believe?". Similarly, IMG 18 (NZREX) recounted a lack of institutional support as a GP, sharing the challenges he faced as a foreign graduate navigating the system. In one of his first positions after PGY1 and PGY2, he found himself running a walk-in clinic with only five minutes for patient consultations, as opposed to the legally required 15 minutes. When he approached his supervisor about it, he was threatened and assaulted, and he explained that:

I'm coming from a Third World country, but I was never treated like this. I had my rights; nobody was forcing me to do something that I wasn't comfortable with...so I contacted the GP College and they said they were going to support me...but there was no support...everybody knows what's happening, everybody knows what they're doing is wrong, but nobody does anything.

IMG 18's narrative contrasts with IMG 1's comment around the lack of systemic awareness. Participants had different experiences with feeling that the obstacles affecting IMGs were institutionally acknowledged or recognised. Nevertheless, these examples all speak to the way that forms of misrecognition can result in the devaluation and invisibility of some groups and individuals. While IMG 1 felt NZREX doctors were simply overlooked in the system, IMG 5 suggested these dynamics might be equally prevalent among all overseas-trained doctors seeking to feel heard or recognised within a new professional environment. Furthermore, IMG 18 did not feel that lack of awareness was the issue in this case – rather, he felt misrecognised despite bringing his negative experience to the appropriate authorities.

These varied experiences generate status injuries for these IMGs in different ways, impacting their confidence to speak up as well as their sense of integration and being welcomed as medical professionals in Aotearoa New Zealand. While challenges with accessing institutional support are not uncommon for migrant workers (Fortier, 2014; Sheller, 2018a), these issues

compound with the other social and personal conversion factors discussed in [Chapters 6 and 7](#) to produce uneven mobilities and capabilities between IMGs and NZMGs, and among IMGs on different licensing pathways.

As a result, the prevalent confusion and frustration among participants with processes that feel illogical and misleading, extends beyond mere inconvenience. A broader lack of transparency gives rise to processes that participants perceive as “random” and “broken”, leading some to conclude that success in medical registration in Aotearoa New Zealand is determined by being “in the right place at the right time” (IMG 9, NZREX) or simply a matter of “pure dumb luck” (IMG 15, NZREX). However, these seemingly random processes do disproportionately affect individuals who did not train in CHS countries. Despite the appearance of randomness, therefore, some consistently observable patterns have emerged among participants in this research that indicate uneven mobilities and capabilities among IMGs from CHS and non-CHS backgrounds.

8.3 ENHANCING COMBINED CAPABILITIES

In an attempt to overcome the challenges identified with medical licensing in Aotearoa New Zealand, IMGs, and particularly NZREX doctors, identified several options for improving the likelihood of converting their capabilities into their desired professional functionings. This was described as “knowing how to play the game” (IMG 15, NZREX) in translating policies from paper into practice, and included both formal and informal strategies.

8.3.1 *The Significance of Context*

For some participants, space and place were significant contributors to enhancing their network capital and combined professional capabilities in Aotearoa New Zealand. IMG 5 (LOC), for example, highlighted the shift in behaviour and atmosphere in her second job, with an approachable manager and an open-door policy. She expressed gratitude for not returning home immediately after her first negative experience, as the change in employer and location would allow her to remember Aotearoa New Zealand more positively. Similarly, IMG 2 (CHS) attributed the positive aspects of her experience more to her specific place of work than the broader health system in Aotearoa New Zealand, commenting that her experience would have been different if she were at a “less helpful” clinic. IMG 16 (NZREX) also valued completing her PGY1 placement in a smaller hospital, suggesting that House Officers often tend to be “paper pushers” in “bigger hospitals”. This was a sentiment shared by Expert 6 (Educator), who described the role of a PGY1 in a large hospital as akin to a “handmaiden”, where “you’re not really practising medicine”. That being said, IMG 10 (NZREX), who was completing his PGY1 placement in a “bigger hospital” at the time of our interview, shared that:

The approachability of people who are supervising you here is generally very good. It could be a cultural thing as well. I come from the Pacific and there is slightly more hierarchy in a few of the departments, whereas here, while there are departments which have hierarchy, generally the approachability is always here. [...] I feel that you're very protected...and you can approach your bosses for, you know, emotional support as well, which is important for PGY1.

These narratives underscore the impact of the physical and organisational context on the experiences of IMGs within the healthcare system. Sometimes participant experiences were differential not simply because of social and personal conversion factors that impacted the recognition of their professional training, qualifications, and experience – but because they were simply in different settings. IMG 18 (NZREX) and IMG 5 (LOC) both stressed the importance of having been able to relocate to new roles in another part of the country.

In order to access the contextual benefits of working in a clinic or hospital with a supportive environment, NZREX doctors described the necessity of mobility and “motility” (Kaufmann et al., 2004, p. 745) as crucial capabilities in seeking employment. IMG 4 (NZREX) recounted his experience of personally visiting every public hospital in the country in search of a PGY1 position. His perseverance paid off when he received the awaited job offer, and he explained how “I actually screamed – it was probably the best moment of my life”. However, this mobility also comes with challenges, as noted by IMG 1 and IMG 24, who expressed concerns about uprooting their families for such a short-term position. Similarly, IMG 21 (NZREX) was eager to apply for the 2023 GP pathway pilot in the Waikato (MCNZ, 2022h) but worried about living away from his spouse and incurring additional expenses.

The sacrifices made by NZREX doctors, such as IMG 23 (NZREX), who arranged childcare with family abroad so she could travel in Aotearoa New Zealand in search of PGY1 roles, underscore the lengths individuals will go to navigate the system. Unfortunately, these efforts do not always yield success, as exemplified by IMG 23, who, despite her sacrifice, ended up moving to the U.K. to obtain the minimum work experience required for her to return as a practising doctor, while her child remained with her husband in Aotearoa New Zealand.

Physical mobility and motility within Aotearoa New Zealand were thus viewed as valuable capabilities in supporting the NZREX licensing process. However, other participants who adopted this approach of visiting hospitals in person, still struggled to find work. One questionnaire respondent wrote that:

I passed NZREX in 2015 and never got a job for the five years that my exam was valid. I visited multiple hospitals, HR departments, begging for the job. It did

not make any difference...moving forward the only option that I have to ever work as a doctor in my life is to move countries which I will be doing shortly.

Despite their resourcefulness, therefore, NZREX doctors reported that their efforts were unevenly rewarded, with no clear guidelines or structure in place for obtaining PGY1 roles. IMG 10 (NZREX) expressed the emotional strain of witnessing others securing positions:

Every month they [MCNZ] update the number of people who have successfully gotten into a [PGY1] role...it is very depressing. I couldn't stop myself from going and checking that every month...and every time there would a change in numbers and someone who'd done the exam after me got a job. So I would wonder, 'what have I not done? What have I not done so far to be able to get a job?'

This unpredictability in outcomes adds to the challenges faced by NZREX doctors. The impacts of this on career progression were also evident, as illustrated by IMG 8 (NZREX), where he and his wife, both IMGs, faced divergent trajectories. While he had not yet achieved medical licensing after nine years in Aotearoa New Zealand, his wife did manage to complete the NZREX process. When they left their home country, she was working as a registrar, training in a specialist field:

...and it's only now, nine years later, that she's a Year One registrar in [the same specialty] again in New Zealand; so that's nine years of deficit in her career progression and still, she's lucky...she's an example of a lucky one and I'm one of the unlucky ones.

Mobilities and capabilities power regimes in this context thus create inequitable opportunities and social conversion factors not only between IMGs from CHS and non-CHS countries, but also within these licensing pathway groupings. Doctors from CHS countries, such as IMG 5 (LOC) and IMG 2 (CHS) stressed the importance of employment context and high motility to relocate if required to improve one's chances of a satisfactory work-life balance. NZREX participants, on the other hand, had mixed success with employing strategies relating to flexibility and high mobility in seeking PGY1 positions.

These examples also highlight how the new mobilities paradigm is useful in conceptualising context and space in this research. Rather than spaces and places existing simply as "containers" where people, things, and ideas go to and come from (Soja, 2010), mobilities can be seen to shape these spaces (Sheller, 2018a; Sheller & Urry, 2006). By travelling to every public hospital in Aotearoa New Zealand, IMG 4 (NZREX) was able to influence the trajectory of his life and that of the hospital in which he found employment. Similarly, contexts where

participants felt they were exploited or mistreated resulted in their leaving for another place; thereby shaping the nature of these spaces and places through their arrivals and departures. However, these spaces also impacted the mobility of these IMGs – by encouraging them to stay or go. While mobilities of people and resources may be a “precondition for the emergence of difference kinds of...spaces” (Sheller, 2018a, p. 9), these spaces, once created, also impact the mobilities of the people that enter them. Therefore, it is perhaps more useful in this context to think of spaces and mobilities as mutually shaping each other, in a similar cyclical relationship to that of “constellations of mobility” (Cresswell, 2010, p. 17) and social formations (see Figure 17 in [Chapter 4](#), Subsection 4.3.1).

8.3.2 Formal Strategies for Enhancing Professional Network Capital

In addition to enhancing their professional network capital and experiences in Aotearoa New Zealand through intranational mobility, IMGs on the NZREX pathway also discussed more formal professional opportunities that were available, including observerships, bridging programmes, and alternative healthcare roles. However, sentiments relating to these options were mixed due to a lack of consistency, standardisation, and equitable availability of these opportunities.

An *observership* refers to a short-term, unpaid hospital placement, typically two to four weeks in duration, which offers “a way to shadow the teams in different specialties, learn how things go, [and] make you more prepared for the hospital setting” (IMG 17, NZREX). Most NZREX doctors who participated in interviews for this research mentioned being advised to seek such placements while waiting for a PGY1 role, as a way to build professional networks and improve their resumé. IMG 10, IMG 16, and IMG 17 all found that their observerships ultimately aided them in obtaining a PGY1 role and subsequent medical registration. While IMG 16 (NZREX) explained that she was “floundering” in her first observership, where the team she was with did not appear to understand her role, her second observership helped her secure her PGY1 position:

Because I had done an observership in [a regional hospital], I just emailed the coordinator there saying, ‘Hey, look, I’ve passed the exam, how do I look for a job? I don’t actually know how it works’. And within days of passing the exam, she emailed me back saying [a nearby hospital] had a job going there, and would I like to interview? So I had a job within a week, which is amazing compared to what I’ve heard other NZREX colleagues all talk about.

IMG 16’s account reiterates the importance of context in enhancing one’s combined capabilities in Aotearoa New Zealand. Furthermore, her example highlights the impact of the reduced

institutional support available to NZREX candidates after 2012. While doctors who arrived in Aotearoa New Zealand before 2012, such as IMG 16, found it relatively easy to secure observerships and experienced the associated benefits, those who began the process after 2012 highlighted challenges in finding such opportunities. IMG 4 (NZREX) expressed concerns about observerships offering “false hope”, emphasising the scarcity of these opportunities, which was reiterated by IMG 9’s (NZREX) struggle to find any observerships in his area.

Although observerships represent a potential strategy for IMGs to enhance their combined capabilities in pursuing medical practice in Aotearoa New Zealand, the unreliable availability, benefits, and structure of these unpaid opportunities raise questions about national standards and consistency, a recurring theme of this chapter. Expert 1 (Employer), for example, shared that his team was developing a framework and policy for observerships specifically designed for NZREX graduates in their region. While this is promising for NZREX doctors in that area, this also highlights the broader issue of the lack of national standards or consistency for such positions.

A more structured and standardised alternative, or supplement, to observerships are *bridging programmes*. As outlined in [Chapter 3](#) (Subsection 3.3.3), bridging programmes and related courses tailored for NZREX doctors have a variable history, with formal bridging programmes being discontinued in 2013 (Taylor, 2016a). At the time of this research, some participants felt that taking – and potentially failing – the NZREX examination was their only recourse in lieu of a bridging programme or NZREX preparation course (see Subsection 8.2.2). Many participants thus expressed a strong interest in the new pilot bridging programme confirmed in late 2022 (Cassie, 2022d), although they were disappointed by the limited places available – just 10 in total. IMG 6 (NZREX) expressed his concerns about the competitive selection process for these places out of around 100 NZREX doctors, while Expert 5 (Local Government Representative) conveyed the sentiment of NZREX doctors in her community, stating that they found this availability “ridiculous” and “a joke”. Expanding the reach of bridging programmes and/or NZREX preparation courses was thus a key recommendation for improving medical licensing options for IMGs in Aotearoa New Zealand (refer to Section 8.5).

A third and relatively new option that came up in this research was the role of *Medical Assistants*, also known as *Physician’s Assistants* depending on the employer. These positions are related to the existing role of *Healthcare Assistant* and are generally targeted towards IMGs whose medical qualifications are not yet recognised in Aotearoa New Zealand. Typically employed in General Practice (GP) settings, Medical/Physician’s Assistants often undertake administrative tasks that require clinical knowledge, such as sorting laboratory results,

gathering patient information to advise their supervising GP, or conducting supervised patient consultations.

However, these positions lack standardisation, and Expert 1 (Employer) acknowledged the absence of clear oversight on what the role would entail in his region. Nonetheless, NZREX participants reported positive experiences in these positions, speaking highly of the opportunity to work in the health sector, engage with patients, gain insights into the local health system, and earn an income while awaiting full registration. IMG 10 (NZREX) especially appreciated having patient interaction after five years out of the medical workforce, explaining that:

While I was doing the observerships, there was some interaction, but it's nothing compared to when I was in [the Medical/Physician's Assistant role] because I could do phone consults, I could discuss it with my supervising GP, and then come up with a plan and it would just need to be, you know, authorised by him. The only thing I wasn't allowed to do was prescribe, which is fine, because I didn't have a registration...I think it made my CV look very versatile as well.

Similarly, IMG 6 (NZREX) found his experience in a Medical/Physician's Assistant role was beneficial for understanding local practice, with the hands-on experience providing context crucial for effective communication, particularly with Māori patients. However, similar to bridging programmes and observerships, these roles do not guarantee subsequent placement in a PGY1 position. IMG 11 (NZREX) declined a job offer in such a role due to the inadequacy of the salary to support his family, while IMG 9 (NZREX) described the work as “using your skills as a doctor without getting paid as a doctor”. For IMG 24 (NZREX), these roles are akin to “medical prostitution”, by paying minimum wage and exploiting vulnerable people who are desperate to maintain their clinical skills while navigating “broken” medical licensing pathways. Expert 2 (Political Commentator) echoed this sentiment, highlighting the potentially exploitative nature of these positions by drawing parallels with “adjuncts” in academia, where individuals are paid “a pittance” with the promise of future opportunities. However, as these roles provide no guarantees of aiding in the medical registration process, for Expert 2, “you're basically requiring years of indentured servitude before you *might* be allowed to take the exam or work as a doctor...now, it's better than never being allowed, but it's pretty exploitative”.

For Expert 8 (Employer), the solution is to formalise these positions and create a legal structure to support them. He noted the current lack of medical legal cover and mechanisms for recourse

or complaints for individuals in these roles, suggesting that additional regulations could mitigate these issues. Expert 3 (Researcher), however, argued that there was a potential risk associated with added regulation, which could intensify existing bottlenecks and delays, especially for NZREX doctors. Increased regulation of Medical/Physician's Assistant roles may thus exacerbate the uneven mobilities and combined capabilities experienced by NZREX doctors, as opposed to addressing these. IMG 9 (NZREX) captured the inconsistent and arbitrary nature of these options by pointing out that, "once I get registered, I can do everything as a doctor. I can go straight from working as an Assistant one day...to being a doctor the next. Is this just how the system is?".

Instead of providing coherent opportunities to facilitate NZREX doctors in achieving their desired professional functionings, observerships, bridging programmes, and Medical/Physician's Assistant roles thus offer unpredictable and uneven opportunities and outcomes, seemingly benefiting individuals in an arbitrary manner. These inconsistencies led IMG 19 (NZREX) to wonder how NZREX candidates could acquire the local work experience that would make them more competitive for roles, while simultaneously not being allowed to work. However, these options continue to be sought with a mentality reminiscent of Expert 8's approach to PGY1 contracting, that "it's better than nothing", raising the question of whether such strategies truly support a coherent pathway to support IMGs in achieving their professional functionings or whether they are a form of "false hope" (IMG 4, NZREX) that inadvertently perpetuate arbitrary outcomes and systemic inequities in medical licensing. Despite this inconsistency, participants maintained that the pursuit of these roles and pilot programmes are a pragmatic response to the challenges faced by NZREX doctors in Aotearoa New Zealand.

8.4 SUBVERSIVE MOBILITIES: SEEKING WORKAROUNDS AND CHANGE

In addition to these more established strategies to enhance their combined professional capabilities in Aotearoa New Zealand, research participants also discussed ways to overcome barriers by subverting the system or finding "workarounds" (IMG 8, NZREX). IMG 15's description of these approaches as "knowing how to play the game" was shared by other participants (IMG 11, NZREX; IMG 18, NZREX), while others described navigating the process as a "dance" (IMG 13, NZREX; IMG 16, NZREX). IMG 8 (NZREX) felt the only way to succeed on the NZREX pathway was to find "workarounds", citing examples of specialist IMGs who achieve licensing "by hook or by crook", and noting that registration processes "are so convoluted that if you follow them to the letter, you are 100% sure to fail". This section sheds light on the more

“subversive mobilities” (Sheller, 2018a) of navigating medical licensing, underscoring the need for an evaluation of existing policies and how they translate from paper into practice.

8.4.1 Peer Support: Collaboration Versus Competition

IMGs on the NZREX pathway frequently cited peer support as a crucial workaround to navigate the challenges inherent in the system. Participants highlighted the invaluable role of colleagues who had previously undergone the NZREX process (IMG 4; IMG 12; IMG 16; IMG 17), providing essential information and insights. There was, however, a fine line between collaboration and violation of MCNZ regulations surrounding the NZREX. Specifically, candidates are forbidden from sharing the scenarios they encountered in the NZREX, as many of these are reused in future examination offerings. As IMG 12 (NZREX) explained:

They terrorise you at the end of the exam. They say if you share this knowledge and we find out, we can make things hard for you. You have to sign a contract saying you’re not going to talk about it. And I understand, because they repeat everything...there’s only one or two new cases.

For some participants, this barrier to sharing information and resources about the examination was “unfair” because, as discussed above (Subsection 8.2.2), “there’s no proper framework for the exam” (IMG 20, NZREX), meaning IMGs “have to scratch for resources” (IMG 19, NZREX). The absence of official guidance from MCNZ left candidates to create their own communities for sharing questions and clinical scenarios, with IMG 18 (NZREX) arguing that peer collaboration is the only way for NZREX candidates to understand what is required to pass the examination. This was elaborated on by IMG 21 (NZREX), who expressed awareness of the way that these peer support networks are not “official”, but could not see a viable alternative:

It’s not official, but this is what happens, because you’re not supposed to talk about your exam after you take it. [...] But on the [MCNZ] website they have like six questions...for the exam, just like in life, you need to know the content...you need to practise for the exam too.

As seen in these examples, the lack of direction from MCNZ has led IMGs to depend on past candidates who successfully passed the examination. This dilemma reflects the inherent uncertainty and need for clarity in the NZREX examination process and has resulted in an extensive network of NZREX doctors in Aotearoa New Zealand on social media. NZREX participants stressed the importance of this group for their preparation (IMG 19; IMG 4; IMG 12; IMG 19; IMG 20; IMG 21), as well as local peer study groups (IMG 12; IMG 16; IMG 17; IMG 21).

Nevertheless, the reliance on informal peer support within the NZREX pathway, though beneficial, introduced challenges stemming from the lack of regulation and oversight. Some participants reported instances of exploitation within this system, where individuals shared notes or information with others who failed to reciprocate (IMG 12; IMG 20), highlighting the absence of a structured framework for collaboration. Such experiences underscore the vulnerability of IMGs navigating a complex process without clear institutional guidance and support.

The competitive nature of the NZREX pathway also surfaced as a significant issue within peer networks. With a limited number of PGY1 positions available, successful candidates found themselves in competition for coveted roles, creating tension among peers. As IMG 4 (NZREX) explained:

We have a group of like 100 people who have all passed NZREX and there's a list going around, like a petition, where everyone adds their name while they're waiting for a job...but the challenge is that the moment, you know, there's a job, you have to ask yourself if you actually want to share it with everyone.

Echoing this dilemma, IMG 9 (NZREX) felt there was a "division" among the members of the social media group, noting that:

Some people totally disappear from the group when they get a job and don't share information on how they got it...we are still competing against each other and it shouldn't be like that because in the exam, we don't have any marking system. All doctors who pass the exam are equally competent and they can work.

These examples thus highlight that while peer support from IMGs was found to be the most helpful way to navigate the NZREX licensing process, translating the "confusing" and "random" policies from paper into practice in a workable way, the system also pits these individuals against each other. On the one hand, these individuals depend on their peers to access vital information for examination preparation, leveraging shared resources and strategies to demonstrate clinical skills in the NZREX. On the other hand, the competitive nature of the licensing process transforms peer relationships into a pool of contenders for a limited number of positions, fostering a sense of isolation for some individuals (IMG 1, NZREX; IMG 10, NZREX). In this way, the subversive mobilities undertaken by IMGs seeking to bolster their combined capabilities and "luck" in the medical registration process create a fundamental contradiction for NZREX doctors, with the potential to be as disadvantageous as they are advantageous.

MCNZ emphasises that licensing policies aim to protect “public safety” (e.g., MCNZ, 2022a), aligning with international literature on licensure regulations (e.g., Peterson et al., 2014). While these peer support networks could serve as an effective tool for maximising the combined capabilities of IMGs and ensuring culturally safe medical care, the fear instilled by MCNZ regarding the sharing of examination-related information creates an atmosphere where candidates feel they are engaged in something “unofficial” or illegitimate. This fear is heightened by the explicit threat that such actions could negatively impact future employment prospects in Aotearoa New Zealand. IMG 8 (NZREX), for example, expressed his frustration at feeling that he needed to act “outside of my moral ethics” in order to become licensed. These peer networks, which already exist among this group of individuals, thus represent a missed opportunity that creates further division not only between IMGs on the NZREX pathway and other licensing pathways, but within this group.

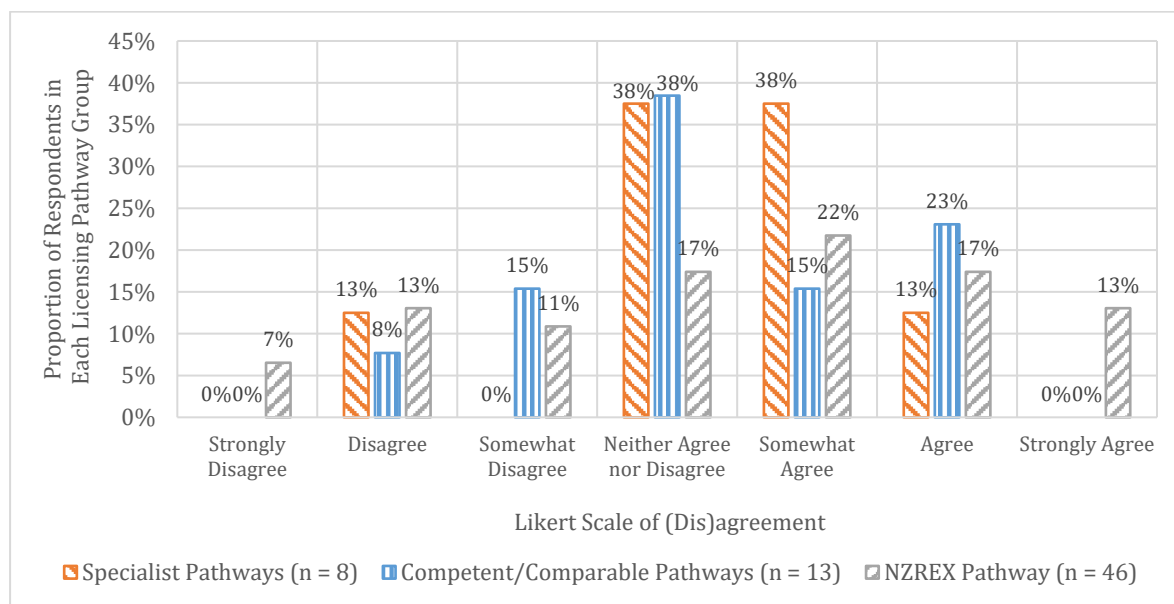
For IMG 14 (VOC), this points to a broader issue with the absence of peer support networks for IMGs from all backgrounds. She pointed out the surprising lack of initiatives by entities such as MCNZ or the specialist Colleges to facilitate connections among doctors who have relocated to Aotearoa New Zealand. Suggesting the simple step of creating formal forums or networks for IMGs in the same region, she highlighted the potential for building a supportive community that might encourage IMG retention, because “a lot of people don’t know anyone locally, so they don’t stay long”. She went on to explain how she initiated a peer support network in one of her former roles which allowed IMGs to “share experiences” and “really helped people process something that’s quite a big change”. This local and informal approach, similar to the unofficial NZREX peer support group, paid attention to the “human element” by allowing IMGs to empathise with and support others undergoing significant, and similar, lifestyle changes. As such, the absence of broader, more formalised peer network initiatives represents a missed opportunity to address the challenges not only experienced by NZREX doctors, but also by IMGs on specialist and Competent/Comparable general pathways, especially in terms of encouraging retention beyond short-term employment.

The diverse perspectives on the role of peer support networks that came up frequently during the Phase 1 interviews led me to include a question relating to this in the Phase 2 questionnaire. Figure 44 highlights the nuanced perspectives on the benefits of networking with other IMGs, with 38% of both specialist and Competent/Comparable pathway respondents, and 17% of NZREX participants, neither agreeing nor disagreeing that networking with peers was useful to their medical licensing process. There was a significant range in NZREX responses, with a number of participants selecting each one of the Likert scale agreement options, and 52% either somewhat agreed, agreed, or strongly agreed, while 30% somewhat disagreed,

disagreed, or strongly disagreed. Half (50%) of the specialist respondents also strongly agreed or agreed, compared to 38% of Competent/Comparable pathway participants. While NZREX and specialist respondents were more likely to feel that networking with other IMGs was useful to their registration experience, the range of responses reflects the variability and inconsistency of these peer support networks among IMGs.

Figure 44

Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “Networking with Other Doctors Who Trained Overseas Has Been Important to My Licensing Process in New Zealand” (N = 67)



8.4.2 Connecting with Employers: Networking Versus Nepotism

Interviews revealed a recurring theme that successful medical registration often hinges on “who you know”, extending not only to peer relationships but to interactions with potential employers. Participants expressed the view that connections and networks play a crucial role, and obtaining opportunities can be subjective, based on personal associations rather than solely merit. This notion was captured by IMG 16 (NZREX), who remarked that “the truth for medicine all over the world is unless you have a foot in the door, you can’t get in”. IMG 15 (NZREX) had a similar experience, noting a tendency for medical professionals to form cliques that make it challenging for those outside these circles to gain acceptance.

Instances of individuals securing PGY1 positions through personal connections (IMG 15; IMG 16; IMG 18) underscored the perceived unfairness of a system where networking may carry more weight than merit alone. Despite benefiting from a personal connection, for example, IMG 18 commented that it felt “so wrong”. IMG 12 (NZREX) also reflected on how these

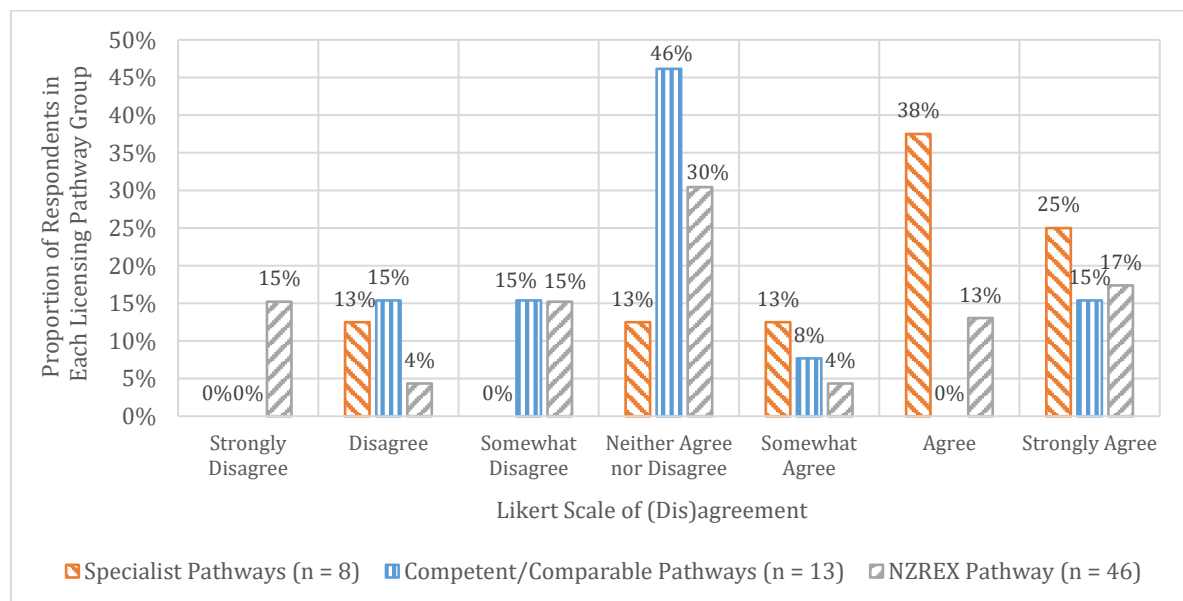
dynamics mean that becoming licensed in Aotearoa New Zealand “takes more than just being good – you have to know people”. By contrast, she went on to explain that:

In [my country], it’s all exam-based. There’s nothing subjective because we know how corrupt our government is, so we try to make exams so it’s less corrupt...but here...the current system is kind of a half-assed measure. It’s like, ‘Oh I guess we can maybe have people from overseas’, but, at the end of the day apparently, who gets jobs is just about who you know. But when I apply, they say, ‘We might keep your CV if something comes up’. Just be fair and actually advertise the position, put it out there. Don’t bullshit me. Don’t lie to my face.

This quote brings attention to the impacts of processes and pathways with limited transparency and clarity, noting how this is experienced in practice. As a result of these examples from the Phase 1 anecdotes, questionnaire participants were also asked about their experiences with networking with employers, as shown in Figure 45. Among licensing pathway groups, specialists were most likely to feel that networking with employers was useful to their registration process, with 75% either somewhat agreeing, agreeing, or strongly agreeing with this statement, compared to 35% of NZREX doctors and 23% of Competent/Comparable pathway respondents.

Figure 45

Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “Networking With Potential Employers has Been Important to My Licensing Process in New Zealand” (N = 67)



While NZREX doctors were slightly more likely to agree that networking with peers was useful for their medical registration process, Figure 45 highlights the significance of networking with

employers among specialists. As specialist questionnaire respondents were most likely to have been registered via one of the vocational pathways, this may suggest a degree of influence from employers on these case-by-case specialist registration processes that is not publicly disclosed in MCNZ's (2024q) online description of vocational licensing. This may relate to IMG 8's (NZREX) observation that some specialists who would normally be eligible only for the NZREX pathway manage to achieve vocational registration "by hook or by crook". Alternatively, this may simply suggest that specialist registration requires strong support from a prospective employer in making an IMG's case for medical licensing to both MCNZ and the respective specialist College. Overall, however, the anecdotes highlighted in this subsection reveal a blurred line between processes of strategic networking to enhance one's professional combined capabilities, and dynamics of nepotism and uneven distribution of network capital and opportunities among prospective IMGs. These dynamics serve to underscore the uneven mobilities and capabilities experienced by IMGs in this context.

8.4.3 Advocacy and Political Engagement

In response to the pervasive challenges and inconsistencies discussed in the preceding chapters, some IMGs sought alternative avenues for exercising subversive mobilities and advocating for change, such as engaging with the media. For example, one questionnaire respondent (GR) shared her experience of facing registration challenges and how, after her application was initially declined, she contacted the media, who ran a story about her case. This increased public awareness, and political support from the National Party (who were the Opposition party at the time), prompted the Council to re-evaluate their decision. Similarly, IMG 23 (NZREX) expressed her desire to share her story with the media, particularly now that she is working in the U.K. while her family awaits her return to Aotearoa New Zealand after she has completed the minimum clinical experience required for the CHS or GR pathways.

Raising political and public awareness of the barriers faced by IMGs seeking medical registration in Aotearoa New Zealand was also seen as a useful strategy for advocacy. For example, some participants explored channels such as being in contact with Members of Parliament (Questionnaire Respondent, NZREX; IMG 9, NZREX) signing petitions (IMG 4, NZREX; IMG 20, NZREX), or engaging in public awareness campaigns (Expert 2, Political Commentator; Expert 5, Local Government Representative).

However, the fear of repercussions and reluctance to speak up were also evident among participant narratives. Expert 5 (Local Government Representative) noted that even doctors contributing to media articles often preferred to remain anonymous, fearing potential negative consequences for their current positions or future opportunities. This fear of speaking up was echoed by IMG 24 (NZREX), who highlighted a general culture of conformity within the medical

profession and the hesitancy to be perceived as a “troublemaker”. Despite this, she also felt that greater awareness of the issue was the key to effecting positive changes in medical licensing, explaining that:

The system is like a grumpy old man who doesn’t want to change, and calling him a racist doesn’t help at all. You need to show him what he’s missing...in order for change to happen, the public needs to be outraged – but it will still take time.

In response to these interview accounts highlighting the importance of advocating for change, questionnaire participants were asked about their involvement in advocacy efforts. Of the 24% of respondents ($n = 19$) who indicated they had been involved in some kind of advocacy for change, 89% ($n = 17$) were NZREX respondents. The most common forms of advocacy reported were signing petitions, contacting Members of Parliament, and reaching out to the Ministry of Health. The breakdown is presented in Table 11.

Table 11

Forms of Advocacy From Questionnaire Respondents Who Indicated They Had Been Involved in Advocacy Efforts (N = 19)

Forms of advocacy	Proportion of Responses
Signing a petition	63% ($n = 12$)
Contacting Members of Parliament	58% ($n = 11$)
Contacting the Ministry of Health	37% ($n = 7$)
Talking to the media (e.g., for newspaper articles, radio, TV)	26% ($n = 5$)
Legal action	5% ($n = 1$)

Additionally, five respondents provided further details about their advocacy efforts. These included using social media to build support networks, contacting the Ombudsman, reaching out to MCNZ and other organisations (GenPro and potential employers), participating in online dialogues with Te Whatu Ora | Health New Zealand, and advocating through Australasian specialist Colleges.

Despite the potential importance of increasing awareness to bring about change in the complex and confusing medical registration processes, existing mobilities and capabilities power regimes often discourage individuals from speaking up. IMGs, particularly those on the NZREX pathway, found themselves in a challenging situation where their support networks and strategies to overcome obstacles may actually work against them, and they tended to feel reluctant or unable to voice their concerns openly. This reluctance to speak up further emphasises the necessity for greater transparency, equity, and supportive networks for IMGs across all licensing pathways in Aotearoa New Zealand. Advocacy efforts, as identified in the

online questionnaire, underscore a growing desire for change and the need for a more inclusive, transparent, and fair medical registration processes that recognise the diverse capabilities and experiences of IMGs from a broader range of backgrounds.

8.5 AN IDEAL FUTURE

While the accounts of IMG experiences discussed thus far speak to complex barriers and obstacles to licensing, a common sentiment expressed by many participants was that these challenges are “eminently solvable” (Expert 9, Policy Advisor) and should have “simple solutions” (IMG 24, NZREX). Participants felt there should be more institutional “collaboration”, “transparency”, “fairness”, “flexibility”, “awareness”, clear standards and requirements, increased employment opportunities for NZREX candidates, greater “diversity” in the workforce, and an overall “culture shift” towards medical licensing that considers the “human element”. Many of the suggestions included have a clear link to the challenges experienced by participants in this chapter, and [Chapters 6](#) and [7](#), and the purpose of this section is to synthesise these recommendations and suggestions for an ideal future.

8.5.1 Governance and Institutions

There was an overall plea for transparency, fairness, and a culture shift in perceptions of IMGs, along with an expressed need for greater collaboration between MCNZ and employers to address areas of neglect in the health workforce, particularly in General Practice. IMGs also emphasised the need for improved mentorship structures and formal cultural safety and orientation courses for all those starting work in Aotearoa New Zealand. Other suggestions spoke to the need to look at related models and systems internationally, such as Australia’s licensing pathways, including the Work-Based Assessment (WBA) programme, and the U.K.’s approach of allowing IMGs to work in non-training jobs (as an alternative to mandatory PGY1 training positions). There was also a call for dedicated, accessible support for IMGs, drawing inspiration from how other professions, such as the Occupational Therapy Board of New Zealand, regulate overseas practitioners.

In addition, emphasis was placed on the importance of professional development opportunities to attract more migrant doctors, alongside ideas relating to a centralised database for IMGs from all backgrounds, more transparent advertising of positions, and encouraging IMGs to work in rural settings as a means of addressing workforce shortages. Similarly, participants suggested changes to medical school structures, potentially favouring postgraduate entry programmes and a more rural-focused curriculum. Finally, participants discussed the need to address discrimination and inequities in medical licensing, with a suggestion being made for the Race Relations Commissioner to conduct a review of medical

licensing pathways for transparency and fairness. This related to other recommendations for enhancing the overall diversity in the medical workforce.

8.5.2 NZREX Pathway

There were also a significant number of recommendations related to NZREX doctors. This included a call for more streamlined pathways to provisional registration for IMGs who have passed NZREX or equivalent examinations, with a number of participants suggesting that NZREX candidates be readmitted to the online ACE matching portal. IMGs also expressed the need for financial support on the NZREX pathway, suggesting reduced fees or access to loans. By contrast, the idea of offering unpaid PGY1 rotations for gaining experience and addressing financial constraints for employers was also proposed as a way of overcoming the current bottleneck caused by limited House Officer positions. This was accompanied by suggestions to run more NZREX examinations and offer more practical options such as observerships, clinical attachments, and a standardised, comprehensive bridging programme available for all NZREX graduates, to ensure they understand the health system and possess the required skills when entering the workforce.

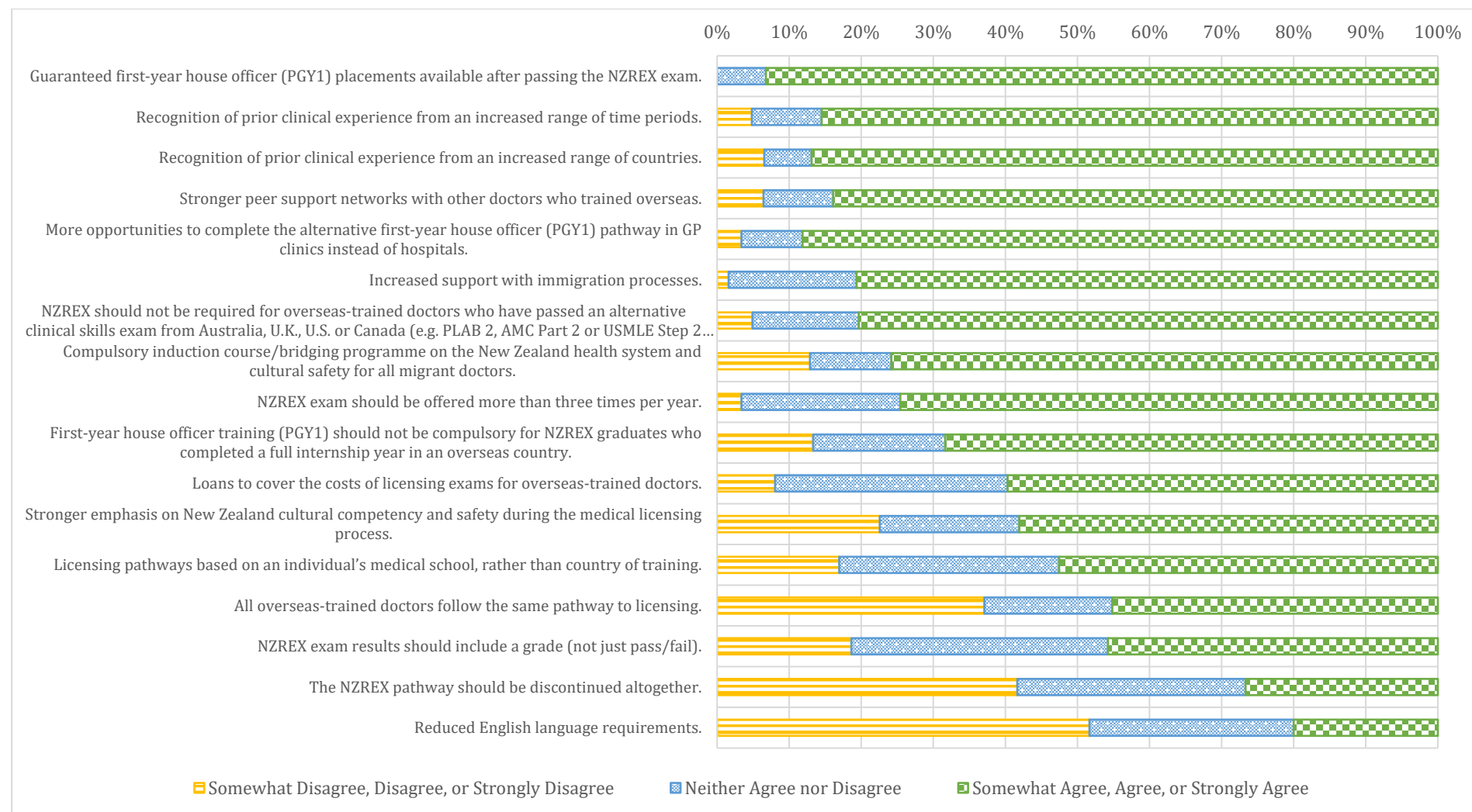
Calls for dedicated courses for NZREX candidates in cultural training, and establishing a direct pathway into general practice were also prominent, as well as a proposal to remove the five-year expiration date for the NZREX pass. Participants also suggested a New Zealand medical knowledge or theory examination be developed as a standard requirement for all IMGs, instead of the reliance on international theory examinations as a prerequisite to NZREX. Finally, a suggestion was made that MCNZ should review all NZREX applications on a case-by-case basis, considering Comparable components of health systems and training that may not be visible on a national scale, given intranational diversity in quality of medical education in many middle-income countries. This speaks to the general sentiment that MCNZ and the specialist Colleges should adopt a more open approach to assessing qualifications from a broader range of countries.

8.5.3 Online Questionnaire

Overall, themes relating to suggestions for change revolved around creating more inclusive and efficient pathways for IMGs to achieve licensing, addressing forms of systemic discrimination and financial barriers, exploring international models, providing mentorship and support, and promoting diversity in the medical workforce. These themes were compiled into the online questionnaire, giving participants the opportunity to express the extent of their agreement with seventeen options for change, as shown in Figure 46.

Figure 46

Suggestions for Change According to the Extent of Agreement of Questionnaire Respondents (N ≈ 59 to 62)



There were no strong correlations between these responses and the respondents' licensing pathway eligibility, so the findings are presented in Figure 46 and this subsection as the total responses from IMGs of all backgrounds⁴⁶.

The most popular suggestions for change related to enhanced recognition of prior clinical experience and improved opportunities for NZREX candidates in their pursuit of employment and training. Participants also tended to agree with suggestions to improve immigration, institutional, and peer support. Furthermore, there was strong support for the prospect of completing PGY1, either partially or entirely, in a General Practice (GP) setting. This points to the potential benefits of expanding the current GP pilot programme in the Waikato. Respondents may have been most likely to agree with these suggestions because they emphasise recognition. In accordance with the reconfigured "rule of mutuality" (Sheller, 2018a, p. 173), where an individual's freedom of mobility should not trample, endanger, or deprive others of their capability for mobility, these suggestions do not have any obvious implications for IMGs' whose qualifications are currently recognised in Aotearoa New Zealand.

In contrast, some of the proposals made in this section of the questionnaire may impact not only the NZREX licensing pathway, but some of the smoother registration processes that currently exist among doctors with training and/or experience in CHS countries. These suggestions, such as standardising medical licensing for IMGs from all backgrounds, placing a greater emphasis on cultural safety within the licensing process rather than post-registration, and potentially reducing English language requirements⁴⁷, were met with mixed responses among participants. Respondents may have disagreed with the notion of standardising medical licensing for all IMGs because of concerns relating to upholding the standards and quality required for public safety in Aotearoa New Zealand. Additionally, participants may have been inclined to disagree with such suggestions because they imply greater levels of restriction or bureaucracy. As participants from a range of backgrounds expressed concerns with delays and inefficiencies in licensing processes (refer to [Chapter 6](#), Subsection 6.3.1), they may not have seen additional regulation as a viable option for change to medical registration.

Sheller (2018a) argues that "the freedom of mobility is at once an exploitation of others whose self-movement is coerced by bodily control and domination in service of others" (p. 49). In

⁴⁶ Note the Likert scale has been simplified for the visual representation of the data in Figure 46 to include just three categories (Strongly disagree, disagree, or somewhat disagree; Neither agree nor disagree; Somewhat agree, agree, or strongly agree). The full extent of (dis)agreement among questionnaire respondents can be found in [Appendix Q](#). The total number of respondents varied per question, ranging from 59 participants, to 62.

⁴⁷ Note that this suggestion became less relevant with the adjustment of MCNZ's English language policy from December 2022. The timing of the questionnaire data collection between March and May 2023 may have impacted responses to this question, with people potentially more likely to disagree that further changes were necessary.

other words, having access to greater professional mobilities and capabilities may come at the expense of the deprivation of others' professional mobilities and capabilities. As noted in these three findings and discussion chapters, uneven mobilities and capabilities can be seen among IMG participants, which result in differential outcomes and experiences in relation to different personal and social conversion factors. In particular, participant accounts and responses to the questionnaire highlight the impact of medical licensing pathways as a key social conversion factor determining the (mis)recognition of professional capabilities. It stands to reason, therefore, that participants with recognised specialist or Competent/Comparable qualifications and experience would not support the standardisation of medical licensing pathways if this involved more restrictive processes for individuals who currently benefit from the uneven mobilities and capabilities regimes in place. Research participants were more likely to support suggestions for change that involve increased recognition and acceptance of qualifications from a wider range of backgrounds without requiring changes to, or restrictions on, processes that already facilitate the smooth registration of IMGs from CHS countries.

8.6 CONCLUSION

This chapter has explored the complex and multifaceted nature of translating medical licensing policies from paper into practice for IMGs in Aotearoa New Zealand. Participants struggled with their perceptions of inconsistent, non-transparent, and at times seemingly illogical processes associated with registering and working as medical professional in Aotearoa New Zealand. Furthermore, the significance of peer support networks emerged as a recurring theme, with IMGs on the NZREX pathway relying heavily on informal channels to navigate the complexities of medical licensing, especially in the absence of clear guidelines and comprehensive support structures. The lack of centralised support and formalised initiatives was also seen to hinder the integration of IMGs from all licensing pathways into the Aotearoa New Zealand health system, contributing to a transient and disconnected experience for many practitioners.

In addition, participants recounted the advocacy efforts they had undertaken in exercising subversive mobilities, reflecting a collective desire for systemic change, and increased public awareness of the obstacles encountered by IMGs, particularly on the NZREX pathway. However, a prevailing fear of speaking out and potential repercussions pointed to a general reluctance to publicly challenge the status quo. Moreover, the diverse range of suggestions for improving medical licensing and employment for IMGs, while sharing a common sentiment around encouraging more equitable, inclusive, transparent, and supportive processes, highlight the challenges of balancing equitable registration processes with avoiding additional

bureaucratic limitations for those currently benefiting from the mobilities and capabilities regimes in place. Research participants were hesitant to support greater regulation for IMGs from CHS countries, instead emphasising the need to reform the NZREX pathway.

However, participant accounts have also suggested that the way health systems and countries are classified as CA or CHS may generate unjust arbitrary exclusions. It is thus imperative to delve deeper into the mobilities and capabilities power regimes underlying these structures and systems, asking why such perceived arbitrary exclusions exist, and whether current policies can indeed be justified with an argument for avoiding the exacerbation of the medical workforce crisis. This is the focus of [Chapter 9](#).

9 COMPARABILITY, AMBIGUITY, AND COLONIALISM: MOBILITIES AND CAPABILITIES POWER REGIMES

9.1 INTRODUCTION

The previous three chapters have highlighted the differential experiences and outcomes of IMGs navigating medical registration processes in Aotearoa New Zealand. Medical licensing pathways have demonstrable connections with IMGs' professional and (inter)personal experiences, raising questions around how well policies translate into practice in supporting – or hindering – these individuals. While the underlying mobilities and capabilities power regimes shaping these experiences have been alluded to in prior chapters, this chapter explicitly addresses the power regimes component of the 4Ps framework. The chapter engages in a candid discussion about the policies, processes, and institutions influencing medical licensing and the experiences of IMGs in Aotearoa New Zealand.

This chapter discusses three key insights that emerged from this research. First, the correlation between IMG experiences and the income level of their country of primary qualification is explored. Questionnaire data revealed how doctors who did not train in high-income countries were more likely to report negative experiences, suggesting the existence of a geopolitical “hidden story” (IMG 8, NZREX) within the medical licensing landscape of Aotearoa New Zealand. Second, the research findings highlight how institutional ambiguity of the actors involved in medical registration creates a system where it is challenging for both IMGs and the general public to demand transparency and accountability regarding the registration of medical professionals. This raises questions about who ultimately benefits from medical regulation in the way it currently operates. Finally, the chapter reflects on the role of colonial legacies in shaping medical registration policy, as discussed in [Chapter 2](#) (Section 2.5), examining how some participants perceived this recurring pattern of abandoning and subsequently returning to policies similar to those employed in the past.

In summary, this chapter contends that a recurring cycle of misaligned expectations, conflicting goals, inconsistent roles, and postcolonial legacies has fostered mobilities and capabilities power regimes that establish and reinforce “arbitrary exclusions” (Sheller, 2018a, p. 174) of certain individuals and their capabilities. These dynamics contribute to the contemporary mobility and capabilities injustices faced by IMGs in this research. Mobilities and capabilities power regimes operating in this context thus extend beyond individual attitudes, to

institutionalised assumptions and generalisations about medical practitioners from different professional backgrounds and countries of training.

9.2 COMPARABILITY, GEOPOLITICS, AND ARBITRARY EXCLUSIONS

Mobility justice and capabilities theories encourage the consideration of intersectional approaches that extend beyond human experiences to encompass more-than-human mobilities and capabilities. As Sheller (2018a) observes, innovations and forms of knowledge from the Global South are often perceived as less valuable than those from the Global North, and this was a prevalent theme that emerged across all phases of the research. The integrated analysis of policies, grey literature, and participant accounts in this research consistently underscores the divergent experiences of IMGs who trained in a subset of 24 Global North countries compared to those from the Global South. This section explores how IMG experiences correlated with the income level of their country of primary qualification, with IMGs who trained in middle-income countries more likely to feel that their skills and knowledge are undervalued and underutilised, compared to doctors who trained in the Global North. As such, this raises further questions about the purpose of the licensing pathway criteria in distinguishing between IMGs of different backgrounds, and how these processes may contribute to systemic (mis)recognition.

9.2.1 *Country of Primary Qualification*

This subsection examines the emergence of a correlation between IMG experiences and the income level of their country of training. Questionnaire respondents were organised by whether their country of primary qualification was classified as “low-income”, “middle-income”, or “high-income” by the United Nations (2019, pp. 4-5). Two-thirds of respondents ($n = 54$) completed their primary medical qualification in middle-income countries, while the remaining third ($n = 26$) completed their qualifications in high-income countries. None of the respondents trained in low-income countries.

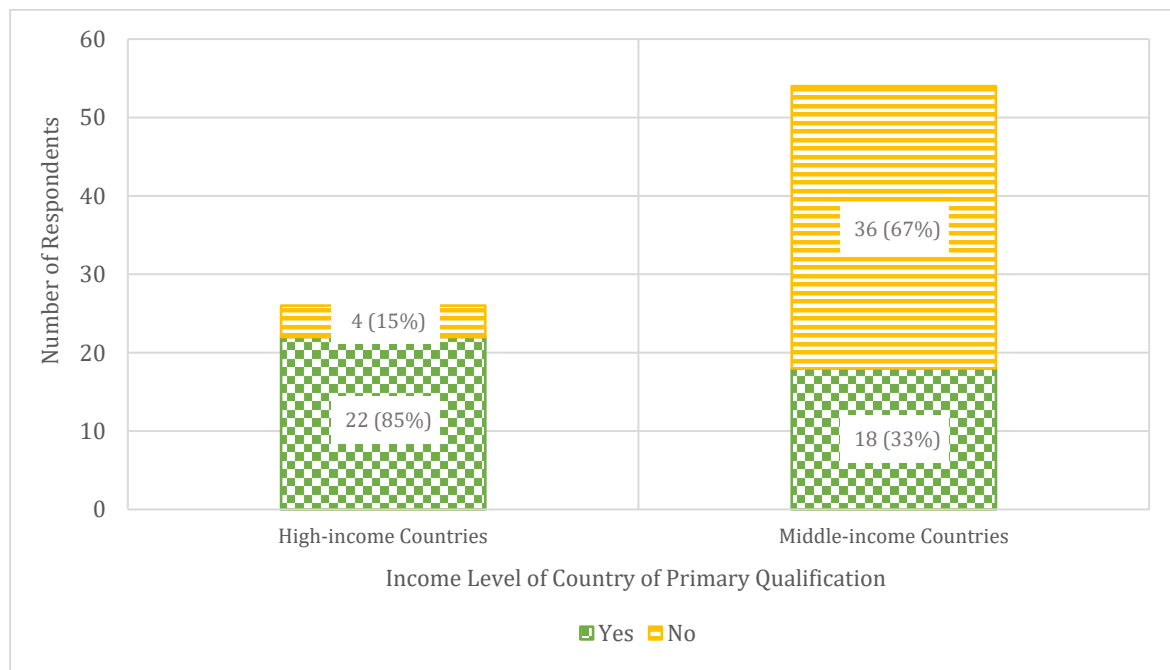
In accordance with the design of medical licensing pathways, the primary medical qualifications of NZREX respondents tended to be from middle-income countries, while respondents on the other four pathways generally trained in high-income countries. Some exceptions existed, such as respondents from countries classified as “high-income” by the United Nations (2019) but not considered Comparable Health Systems by MCNZ (see CHS analysis in [Chapter 2](#), Subsection 2.4.3). This led these respondents to be only eligible for the NZREX pathway. Conversely, some respondents on the CHS and GR pathways worked in a CHS country after graduation from a middle-income country, making them exceptions to the NZREX pathway. Similarly, one respondent on the vocational pathway whose primary medical

qualification was from a middle-income country, completed their specialist qualification in the U.K./Ireland, making them eligible for the VOC pathway.

Despite these exceptions, a strong correlation between the income level of the country of primary qualification and the likelihood of achieving medical registration in Aotearoa New Zealand is evident in the data collated for this research. Almost 85% ($n = 22$) of those with primary medical qualifications from high-income countries indicated they had successfully achieved registration, compared to just one-third ($n = 18$) of those with qualifications from middle-income countries, as shown in Figure 47.

Figure 47

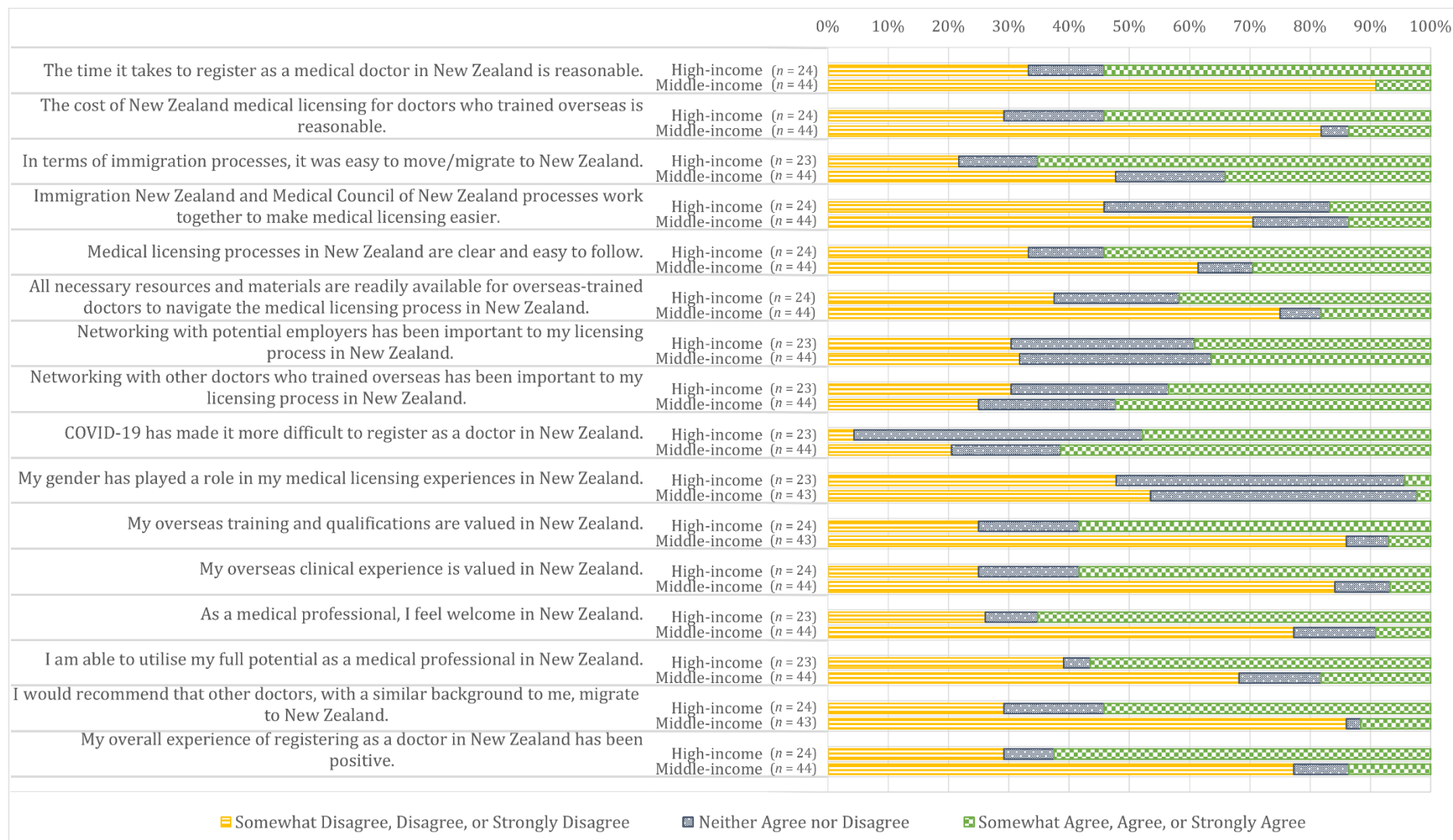
Relationship Between Income Level of Country of Primary Qualification and Responses to “Have You Ever Achieved Provisional or Full Registration to Work as a Medical Doctor in New Zealand?” ($N = 80$)



This correlation between income level of country of primary qualification and medical registration experiences is further reflected in the questionnaire, as summarised in Figure 48 (see [Appendix R](#) for more detailed statistical analysis of these relationships).

Figure 48

Extent of Agreement Among Respondents With the Given Statements, by Income Level of Country of Primary Qualification (N ≈ 66 to 68)



As illustrated in Figure 48, more than half of respondents with primary medical qualifications from high-income countries reported positive experiences, finding the time and cost of licensing reasonable, processes clear, and their training valued. On the other hand, respondents from middle-income countries expressed lower satisfaction, with only a small percentage feeling that their qualifications and experience were valued, and few agreeing that their registration experience was positive overall. The most striking difference was seen in how welcome IMGs felt in Aotearoa New Zealand, with 65% of those whose primary qualification was from a high-income country feeling welcome, compared to just 9% of those who trained in middle-income countries. The “occupational apartheid” (Mpofu & Hocking, 2013, p. 132) among IMGs across different medical licensing pathways has a clear correlation with the income status of their country of primary qualification.

9.2.2 *Comparability and Arbitrary Exclusions*

As highlighted in [Chapter 2](#) (Section 2.4), MCNZ’s criteria for defining a Competent Authority (CA) and a Comparable Health System (CHS) leave room for uncertainty around how these result in the current lists of approved countries. The CA criteria, such as having a publicly available register of qualified medical practitioners or clear ways to monitor the performance of doctors, are met by many health systems globally, making it unclear why only the U.K. and Ireland are classified as Competent Authorities in Aotearoa New Zealand. Additionally, analysis of the health system indicators specified on MCNZ’s website (MCNZ, 2024a) revealed inconsistencies in understanding whether Comparable refers to “similar” (MCNZ, 2000, p. 10; 2004a, p. 9) or “equivalent” (BSI Group New Zealand Limited, 2021, p. 6; MCNZ, 1985, p. 10), or has another meaning entirely in this context.

As introduced in the previous three chapters, participants also struggled to understand why some skills and qualifications were not recognised. IMG 10 (NZREX) acknowledged some technological differences in medical practice in the Pacific compared to Aotearoa New Zealand but emphasised that there is “no difference in practising medicine itself”. Another participant, IMG 8 (NZREX), saw a potential advantage for IMGs from the U.K., Ireland, or Australia, citing the origin of Aotearoa New Zealand’s medical I.T. systems in these countries. However, he still felt the value of his training in Southern Asia was overlooked:

It’s very unfortunate that New Zealand looks upon us as ‘non-comparable’. Everything is comparable and some of our training programmes, especially specialist training programmes, are actually recognised by the U.K. and Ireland. If I go to Ireland, I don’t have to do any exams.

As mentioned in [Chapter 6](#) (Subsection 6.4.3), there was a tendency for participants to discuss the ways that medical licensing processes were easier in “the countries that we compare ourselves to” (IMG 10, NZREX). Some participants not only perceived registration in Aotearoa New Zealand as more challenging than in other CHS countries but also questioned the need for such stringent restrictions, expressing doubts about the quality of the health system in New Zealand. IMG 5 (LOC), for example, expected Aotearoa New Zealand to be more advanced than North America but discovered the system to be “more backwards unfortunately, [and] old-fashioned when it comes to medicine”. IMG 2, who registered on the CHS pathway, also reflected on the comparability of Aotearoa New Zealand to her Southern European country, emphasising the impact of social or demographic conditions on treatment availability in Aotearoa New Zealand and a preference for “treatment options that would be considered outdated in Europe”.

Similarly, IMG 22 (CA), from the U.K./Ireland, expressed surprise at the presence of conditions such as rheumatic fever in Aotearoa New Zealand, which she associated with poverty and had only ever seen in a textbook before migrating. Furthermore, Expert 3 (Researcher) reflected on differences in educational models for medical training in Australia compared to Aotearoa New Zealand, noting that NZMGs initially “come out kind of more senior than the graduates of Australia”, although this distinction diminishes after about a year. Nevertheless, Australian medical graduates are treated as equivalent to NZMGs (MCNZ, 2024e). These findings highlight the perceived differences participants experienced between Aotearoa New Zealand and the countries MCNZ considers to be Comparable. While some IMGs acknowledged challenges, discrepancies, and “dodgy stuff” (IMG 20, NZREX) in their home countries that might justify exclusion from the CHS list (e.g., IMG 6, NZREX; IMG 12, NZREX; IMG 13, NZREX), they still questioned the necessity of the extensive barriers they faced on the NZREX pathway. They emphasised the thorough processes involved in verifying their medical qualifications through the U.S. ECFMG portal and stressed how the international medical knowledge examinations taken before the NZREX examination also act as a filter for unqualified practitioners (IMG 4, NZREX).

For many participants, as discussed in earlier chapters, the challenges experienced in Aotearoa New Zealand related more to culture and communication than to the practice of medicine itself. IMG 5 (LOC) asserted that “medicine is medicine”, and IMG 10 (NZREX) felt there was “no difference in practising medicine itself” in Aotearoa New Zealand. Similarly, IMG 16 (NZREX) reflected that “medicine is medicine anywhere”, and IMG 21 (NZREX) argued that “medicine is the same everywhere”. While participants saw a clear distinction between medicine as a science, and the cultural and interpersonal skills sought after in Aotearoa New Zealand, their

responses also reflect the paradox highlighted in [Chapter 3](#) (Subsection 3.4.3) related to the Western, biomedical model.

Challenges are seen in the literature with the privileging of clinical aspects of medicine over “humanistic” approaches that involve caring for and building relationships with patients (e.g., Johansen et al., 2012). Participants in this research tended to uncritically reinforce the differences they perceived between the biomedical and interpersonal aspects of working as a medical practitioner which, in practice, are inextricably intertwined with patient care (Apker & Eggly, 2004). In addition to medical licensing processes favouring the capabilities of doctors from certain Global North backgrounds, therefore, there was a tendency for research participants to privilege the Western, allopathic model of medicine with limited consideration of how culturally safe medicine in a different context may not be “the same everywhere”.

Furthermore, the privileging of such approaches by both medical licensing policies and IMGs in this research points to the ongoing challenges with considering alternative, traditional healing practices such as Rongoā Māori, which were previously suppressed under colonial administration (refer to [Chapter 2](#), Subsection 2.5.2). The Tohunga Suppression Act 1907 sought to impose the Western biomedical model in ways that undermined Indigenous sovereignty and culture (Kapa, 2022). This trend was mirrored around the world, despite the mutual influence of a range of cultural healing practices in contributing to contemporary understandings of medicine (Tucker, 2003). Processes favouring the Western biomedical model thus reflect ongoing colonial legacies in Aotearoa New Zealand, as well as the pervasiveness of Global North hegemony. Despite training in Global South contexts with diverse cultural backgrounds, doctors on the NZREX pathway were eager to emphasise the universality of medicine, and their orientation in the Western, allopathic model. Claims that “medicine is the same everywhere” point to a need to decolonise medicine not only in the Aotearoa New Zealand context, but also globally.

Nevertheless, medical registration processes in Aotearoa New Zealand do apply unevenly to IMGs from different backgrounds. IMGs may possess a shared or similar biomedical knowledge base, but personal, social, and environmental factors play a crucial role in converting these capabilities into professional functionings. For IMGs from Comparable Health Systems, overseas clinical experience is not only considered acceptable but is also deemed necessary for medical registration (MCNZ, 2024a) and subsequent residency visa applications (Immigration New Zealand, 2024). Conversely, for doctors on the NZREX pathway, overseas experience is extraneous, and they are required to start at the level of an NZMG (MCNZ, 2024n). The acceptance of individuals with primary medical qualifications from certain Global North countries, irrespective of experience, highlights the perception that knowledge from these

regions is considered more legitimate by MCNZ in this context. Although Escobar (2018) argues that design and innovative knowledge is perceived as more or less legitimate depending on *where* it originates, this could be further expounded by noting that even the same or similar knowledge can be seen as either acceptable or unacceptable depending on *who* knows it, *where* it was acquired, and associated processes of movement.

Mobilities and capabilities power regimes create differential combined capabilities for IMGs from different backgrounds in this context. Policies that arbitrarily exclude “similar” (MCNZ, 2000, p. 10; 2004a, p. 9) or “equivalent” (BSI Group New Zealand Limited, 2021, p. 6; MCNZ, 1985, p. 10) medical knowledge and experience in Aotearoa New Zealand contribute to unjust “status injuries” (Fraser, 1998), disproportionately affecting doctors trained in Global South countries. These structural inequities reflect deeper issues within the licensing system that perpetuate differential treatment based on geographical and socioeconomic factors.

9.2.3 Systemic (Mis)recognition

As highlighted in [Chapter 7](#) (Subsection 7.3.2), IMG 8 (NZREX) felt there was a “hidden story” behind the decision-making processes that result in arbitrary exclusions and inclusions of IMGs in Aotearoa New Zealand. This “hidden story” points towards institutionalised and/or structural discrimination, not necessarily driven by unkind or prejudiced individuals (Expert 3, Researcher; Expert 7, Policy Advisor), but by deeply ingrained mobilities and capabilities power regimes that have influenced medical regulation since colonial times. Expert 7 (Policy Advisor) critiqued the “flimsy assumptions” underpinning current medical licensing pathways in Aotearoa New Zealand, suggesting these assumptions are “dangerously close to discrimination and unconscious bias” and warrant further exploration. Medical licensing policies can be seen to create both arbitrary exclusions of some individuals and arbitrary *inclusions* of others, with policies based on potentially “flimsy assumptions” (Expert 7, Policy Advisor) that have (post)colonial and geopolitical roots.

One questionnaire respondent (NZREX) directly addressed these dynamics, asserting that the MCNZ operates a “very racist process” that selectively accepts qualifications only from the Global North, including European nations where English is not spoken as a first language, “under the guise of an ‘equivalent’ medical education and health system”. Noting a lack of independent corroboration of MCNZ’s claims of equivalency with these countries, the respondent concluded that “it is simply that if you are white your pathway to medicine is guaranteed”, with medical licensing in Aotearoa New Zealand representing a form of “institutionalised racism at its finest”. IMG 21 (NZREX) also felt there were racist and political undercurrents in the exclusion of some countries from the list of CHS countries. Remarking that some countries that may be Comparable on paper are not places MCNZ “want people to

come from”, he cited Cuba as an example of a system that he felt was similar to New Zealand but not included. Likewise, Expert 2 (Political Commentator) felt that it was not “a coincidence at all” that licensing policies tended to exclude IMGs from Global South countries. He tied this trend to Aotearoa New Zealand’s colonial and geopolitical history, suggesting that these policies may not be arbitrary but rather rooted in historical power dynamics.

IMG 16 (NZREX) also connected licensing policies to geopolitics, speculating that the list of CHS countries is more of a political choice that favours alliances with “rich European countries” rather than being based on the merit of medical practitioners. Another questionnaire respondent (NZREX) commented on the irony that, despite Aotearoa New Zealand’s heavy reliance on IMGs, MCNZ “does not show any effort to create fair opportunities for migrant doctors” who are not from “Commonwealth countries”. These examples highlight the ways that arbitrary exclusions in medical registration processes in Aotearoa New Zealand not only have negative impacts for some IMGs, but are also perceived as exclusionary, geopolitical, and related to (post)colonialism.

The historical examination of geopolitical dynamics, as discussed in [Chapter 3](#) (Subsection 3.4.1), revealed a pattern where “hostile alien medical men” (“Notices,” 1919, p. 2) trained in countries such as Germany or Japan were excluded in accordance with war and shifting allegiances (Sainsbury, 2015). It is unclear whether this history directly correlates with the ongoing exclusion of Japan from the list of CHS countries despite high performance in WHO health indicators. However, these examples highlight how geopolitical dynamics may contribute to the seemingly arbitrary inclusions and exclusions of certain countries in Aotearoa New Zealand’s medical licensing policies.

The potentially arbitrary inclusion of the U.S.A. as a Comparable Health System, despite vastly different health system indicators, may also be attributed to geopolitical dynamics. The International Association of Medical Regulatory Authorities (IAMRA) comprises members from global medical councils and regulatory bodies, and MCNZ has had an active role in IAMRA since its establishment in the 1990s (Campbell, 2007; MCNZ, 2020a). At the time of writing, the CEO of MCNZ, Joan Simeon, currently sits on the IAMRA Board and is the Chair of IAMRA’s Regulatory Best Practice Working Group (IAMRA, 2023a), which aims to provide guidelines relating to emerging issues in regulation and best practice, including cultural safety and equitable healthcare (IAMRA, 2022). Concerns have been raised about the influence of the IAMRA’s relationship with the Federation of State Medical Boards (FSMB) in the U.S.A. on medical regulation in Aotearoa New Zealand (Dooley, 2022). However, while U.S.-trained medical doctors have a range of options available for registration in Aotearoa, they still experience challenges meeting the requirement to have worked in the “same” or “similar” field

of medicine when applying for the CHS pathway (MCNZ, 2022g, p. 1). As noted in [Chapter 6](#) (Subsection 6.2.2), these requirements are particularly challenging because U.S. training programmes and specialisation requirements do not always align with processes in Aotearoa New Zealand (IMG 5, LOC; Expert 4, Recruitment Agent).

Nevertheless, MCNZ's relationship with the IAMRA may still offer an explanation for the inclusion of U.S.A., the least Comparable Health System according to the publicly available indicators, as seen in [Chapter 2](#) (Section 2.4). Notably, the initial participants in IAMRA conferences in 1994 included the U.S.A., Canada, Australia, Aotearoa New Zealand, the U.K., Ireland, and South Africa (IAMRA, 2023b), all of which were initially exempt from the NZREX pathway (MCNZ, 1998b) before the formal CHS pathway was established. Despite differences in public health indicators, the relationship and shared history between the U.S.A. and Aotearoa New Zealand, both geopolitically and in terms of medical regulation, may have played a role in the acceptance of U.S. qualifications in Aotearoa New Zealand.

Fraser (1998) argues that injustices occur when misrecognition renders some individuals or groups as invisible, which can be seen at both a structural and an individual level in this research. Furthermore, from a mobility justice perspective, these processes are attributed to power regimes that create “differential subjects” (Sheller, 2018a, p. 21), while a capabilities approach adds consideration of how an individual's personal and social “conversion factors” (Robeyns, 2017, p. 113) interact with their environment, influencing their sense of dignity. Processes of misrecognition and Othering can occur at both an individual and systemic scale, and can result in arbitrary exclusions that produce injustices. In this research, these injustices are seen both at the level of individual IMGs, and also at the systemic and institutional levels of the mobilities and capabilities power regimes shaping medical licensing in Aotearoa New Zealand. Medical licensing pathways act as a proxy for arbitrarily excluding IMGs from the Global South.

9.3 INSTITUTIONAL AMBIGUITY AND UNEVEN ACCOUNTABILITY

In the 1990s, a significant number of IMGs who gained New Zealand residency faced challenges in obtaining medical licensing, as discussed in [Chapter 3](#) (Subsection 3.3.3). In response to public concerns about these doctors, MCNZ expressed dissatisfaction with being “unfairly accused of racist and protectionist attitudes” (MCNZ, 1997, p. 57). Successive statements reflected a firm stance on maintaining current policies because they would “not be coerced into action by political tactics” (1998a, p. 30) and did “not see lowering the standard to below that of a New Zealand doctor as the solution to the problem” (2000, p. 11). These responses from MCNZ suggest underlying beliefs that will be explored in this section. There is an implication

in these statements that creating a more practically viable licensing pathway for NZREX doctors would involve “lowering” the country’s standards. Moreover, MCNZ explicitly stated that they would not alter their policies in response to political or public pressure.

However, historical examination shows that medical licensing policies in Aotearoa New Zealand have been responsive to public pressure and workforce needs. The restriction of refugee IMGs during World War II led to stringent policies (e.g., “Licensing of alien doctors,” 1943) that were only eased in the 1970s in response to a medical workforce crisis (e.g., “Wider scope for overseas doctors,” 1970). Public critiques in the 1980s may have contributed to increased restrictions on IMGs (“N.Z. an easy place for ‘sub-standard doctors’,” 1988), resulting in the situation where hundreds of doctors who arrived in the 1990s could not work (Selvarajah, 2004). The Medical Practitioners Act 1995 mandated the NZREX examination pathway for all IMGs, but an exemption for doctors from the Old White Commonwealth and the U.S.A. was created due to employer concerns about staffing shortages (Aggett, 1997; MCNZ, 1998b). Furthermore, MCNZ’s (2008a) statement that policies relating to PGY1 must consider workforce shortages further supports the idea that medical licensing standards are adaptable based on the country’s workforce needs. Moreover, the NZREX pathway was further restricted between 2012 and 2014 (MCNZ, 2014b; Taylor, 2016a) in response to observed limitations in PGY1 positions (Taylor, 2016b), demonstrating a clear link between MCNZ’s licensing standards and Aotearoa New Zealand’s workforce demands. This suggests that MCNZ’s standards are in fact influenced by public opinion and political considerations, and changing policies tend to reflect changing workforce needs. While MCNZ may be authorised to operate as an independent regulatory body on paper, the mobilities and capabilities power regimes shaping medical registration in practice are more complex and institutionally intertwined.

Given MCNZ’s responsiveness to public and political pressure in the past, this prompts consideration of why NZREX doctors continue to face bottlenecks to registration in a context of post-pandemic workforce shortages and waiting lists (see [Chapter 3](#), Subsection 3.3.3). The purpose of medical regulation has historically involved establishing who is appropriately qualified to call themselves a medical doctor and keeping certain people, such as “barbers” and “charlatans”, out (Archer et al., 2016, p. 1). The historical context of medical regulation in Aotearoa New Zealand, dating back to as early as 1872, reveals ongoing debates about the balance between protecting the public and ensuring professional freedom. As one zealous commentator remarked:

The battle of medical reform has to be fought, and we must marshal our forces and be ready for the fray. [...] Year by year this effete worn-out system of the “Old Physic” asks for more stringent laws to be passed in her favour. [...]

Medicine has become the victim of a craze through over-protection. Medicine and medical practice ought to be free from State influence and State protection. Every system that cannot stand by itself without being propped up by Acts of Parliament deserves to fall and be heard of no more. (“Medical freedom,” 1872, p. 3)

This historical perspective raises questions about whose interests are considered in the evolving medical licensing policies that impact the experiences and outcomes of IMGs at the time of writing. While occupational licensing could be used to generate a monopoly in the industry, as Ayres (1889) argued in response to an early proposal to create a Medical Council to oversee regulation, registration policies can also serve to ensure practitioners are competent and capable (Kugler & Sauer, 2005; Leland, 1979). Even if medicine is a “victim of a craze through over-protection” (“Medical freedom,” 1872, p. 3), this point can readily be countered – and has been many times throughout the past decades – with the argument that regulatory “over-protection” is crucial to the protection of the public. As noted in [Chapter 3](#) (Subsection 3.3.3), this sentiment is evident in MCNZ’s annual reports, which tend to emphasise public protection (e.g., MCNZ, 2021a).

The notion of public protection is ambiguous, however. Elkin (2015) notes that nothing in the HPCA Act (“Health Practitioners Competence Assurance Act,” 2003) obligates MCNZ “to take wider public interest considerations (such as availability of medical services) into account when making regulatory decisions” (p. S163). While this is an expressed aim of MCNZ, it is not a legal, enforceable, or auditable requirement, as explained by Expert 9 (Policy Advisor):

Because MCNZ is self-regulating, their incentives are asymmetrical...it’s much worse from their point of view if they let in, you know, one bad doctor than if they keep out ten good ones. That doesn’t fall back on them, so their incentives are misaligned...it’s much worse for them if they make a big public mistake than the unseen things that don’t get through their process.

The fear of reputational risk and a decline in public confidence may motivate MCNZ to prioritise avoiding public mistakes, even if it means creating bottlenecks and inefficiencies in the medical workforce (see [Chapters 2](#) and [6](#)), particularly for NZREX doctors. Echoing this sentiment, IMG 12 (NZREX) noted that “in the public system, you’re afraid of making a mistake, and making no move is better than making a move that might be criticised afterwards”.

Furthermore, Expert 1 (Employer), in commenting on the changing medical licensing policies throughout recent history, explained that policymakers are hoping to “avoid a repeat of what happened in the 1980s”. This prompted, in part, the historical policy and media analysis (refer

to [Chapters 2](#) and [3](#)) that has been so important in contextualising IMG experiences in this research. MCNZ faced a plethora of complaints and challenges during the 1980s, before licensing processes became more stringent. Although no specific examples of medical malpractice from these “sub-standard” IMGs were identified (“N.Z. an easy place for ‘sub-standard doctors’,” 1988), as noted in [Chapter 2](#), an “occupational apartheid” (Mpofu & Hocking, 2013, p. 132) between doctors on the NZREX and other licensing pathways was formed and further entrenched in the decades since. This historical context suggests that MCNZ has a strong incentive to avoid potential reputational damage, even at the cost of creating bottlenecks that limit the supply of medical professionals in Aotearoa New Zealand. The balancing act between ensuring public safety, maintaining professional standards, and addressing workforce shortages remains a complex challenge in the realm of medical licensing.

9.3.1 *The “Ping Pong”⁴⁸ Phenomenon*

This balancing act has occurred in part because MCNZ does not act alone. MCNZ operates in conjunction with a number of organisations based in both Aotearoa New Zealand and Australia (see Figure 1 in [Chapter 2](#), Section 2.2), and this contributes to institutional ambiguity. This ambiguity, where it is unclear which institution or organisation should be approached in particular situations, was a recurring theme among IMG accounts in this research.

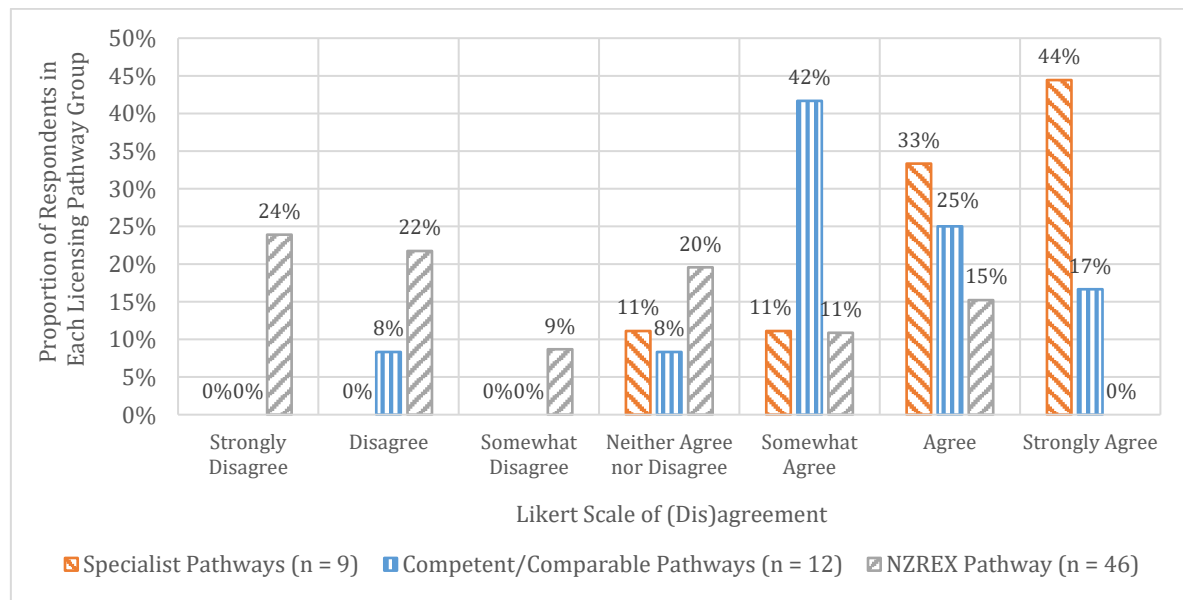
One illustration of this ambiguity is highlighted by IMG 19 (NZREX), who pointed out a contradiction in her situation. Despite her medical degree being considered in her husband’s skilled migrant visa application, which brought them to Aotearoa New Zealand, she had been trying to navigate the NZREX process for six years at the time of our interview. Although skilled migrant residency or visas are no longer granted to IMGs without MCNZ registration (Immigration New Zealand, 2024), it is notable that a joint application with a highly-skilled partner can still be enhanced by an overseas medical degree, independent of MCNZ recognition. This suggests a disconnect between immigration services and MCNZ, which led to the inclusion of two questions relating to immigration in the online questionnaire. As indicated in Figure 49, none of the specialist respondents, and only 8% of Competent/Comparable doctors either strongly disagreed, disagreed, or somewhat disagreed that immigration processes made it easy to move to Aotearoa New Zealand, compared to 54% of NZREX participants. By the same token, 44% of specialists and 17% of Competent/Comparable pathway respondents strongly agreed with this statement, while none of the NZREX participants strongly agreed. These findings suggest a disconnect between medical registration and immigration processes that create not only uneven professional mobilities

⁴⁸ (IMG 8, NZREX; IMG 19, NZREX)

and capabilities that disadvantage NZREX doctors, but also uneven physical mobility and motility in terms of immigration.

Figure 49

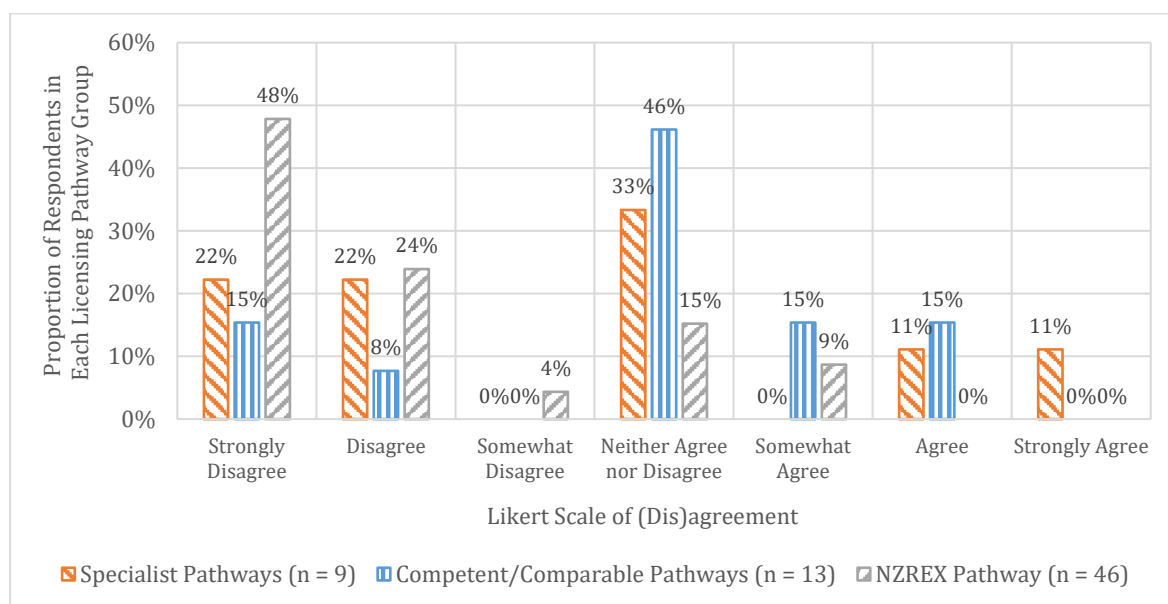
Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “In Terms of Immigration Processes, It Was Easy to Move/Migrate to New Zealand” (N = 67)



Questionnaire respondents were also asked to directly reflect on how well they felt Immigration New Zealand and MCNZ processes work together to facilitate medical registration. As shown in Figure 50, only 31% of Competent/Comparable pathway participants, 22% of specialists, and 9% of NZREX doctors somewhat agreed, agreed, or strongly agreed that these institutional processes align. This suggests that institutional ambiguity may be seen across licensing pathways in relation to medical registration and immigration processes.

Figure 50

Proportion of Questionnaire Respondents in Each Licensing Pathway Group According to Their Responses to “Immigration New Zealand and Medical Council of New Zealand Processes Work Together to Make Medical Licensing Easier” (N = 68)



Interview data shed further light on these observations. IMG 5 (LOC) shared her confusion over the temporary visa granted for the LOC pathway and Immigration New Zealand's concerns about her seeking long-term employment. She noted that she had to be “careful” when entering the country to not suggest anything that may be interpreted as an intent to migrate permanently, which she felt contradicted local workforce needs:

It doesn't make any sense to me, because if you are looking for professionals, it's better if your professionals are settling in the country, because the longer you are here, the better ability you have to understand the local situation.

A questionnaire respondent (VOC) echoed this sentiment, describing a lack of communication between Immigration and the Medical Council and expressing doubt about Immigration New Zealand's grasp of the current workforce crisis.

A “ping pong” phenomenon, described by IMG 8 and IMG 19, reflects the challenges faced by IMGs as they are referred back and forth between different entities, such as employers, the Ministry of Health, and MCNZ. This phenomenon was evident during the COVID-19 pandemic, where IMG 19 (NZREX) navigated various institutions in an attempt to secure temporary work as a vaccinator. IMG 8 (NZREX) attributed the challenges NZREX doctors face to a lack of leadership, describing the situation as responsibility being tossed back and forth without anyone taking charge. He explained how “they just play ping pong with the responsibility...no one wants to actually take responsibility, it's too big a ship to steer”. The “ping pong”

experience reflects the frustration and inefficiencies in the system that IMGs encounter in their attempts to navigate complex pathways for licensure and employment.

Other participants recounted instances where different institutions shifted responsibility, creating confusion, and thwarting their licensing and employment progress. For instance, one questionnaire respondent (NZREX) was informed by their local Member of Parliament (MP) that MCNZ was solely responsible for the PGY1 bottleneck, while others, such as IMG 4 (NZREX), were told by MCNZ that concerns about PGY1 employment are “not our problem”. IMG 2 (CHS) described how her employer pressed her for paperwork while she was waiting for MCNZ to provide the necessary approvals. Similarly, when the new pilot programmes were introduced in 2022, IMG 21 (NZREX) observed that MCNZ distanced themselves, explicitly stating that the matter was not within their purview. These experiences left participants uncertain about whom to contact and where accountability lay at each stage of their licensing journeys.

Expert 5 (Local Government Representative) observed a lack of collaboration among institutions, describing them as working “in silence” rather than in partnership. This sentiment was echoed by IMG 9 (NZREX), who attributed systemic challenges to the absence of coordination between MCNZ, the Ministry of Health, and employers. He explained that “everyone is putting blame on each other...but it’s actually everyone’s fault”. For IMG 9, institutional ambiguity does not simply generate confusion, but is also a tool for avoiding accountability, a sentiment that was shared by IMG 8 (NZREX), who noted that:

The Medical Council of New Zealand [MCNZ] knows nothing about human rights and equity. These two terms are not known to them. And if they can prove me wrong, I will be surprised...there is no clinical governance or governance over them – no parliamentary authority over them, no minister over them. They are outside of the jurisdiction of the Health Minister...they don’t want accountability or governance over them.

Expert 5 (Local Government Representative) reiterated this notion, questioning the lack of transparency in the governance and structures of these large institutions and wondering “whether it’s deliberate or whether it’s an oversight”.

The themes of institutional ambiguity and lack of accountability were not unique to participant narratives. Historical statements from MCNZ, as well as responses from the Minister of Health and MCNZ during the COVID-19 pandemic, illustrated a consistent pattern of institutions deflecting responsibility. With regards to IMG immigration, MCNZ has made it clear that this is beyond their purview, with statements such as “the immigration requirements are of course

not our concern” (MCNZ, 1989, p. 19) and that “New Zealand’s inadequate immigration and resettlement policies” are responsible for the stresses IMGs are experiencing (MCNZ, 1997, p. 57). Similarly, the Minister of Health, in responding to questions about the lack of employment for IMGs who have passed MCNZ’s registration examination (NZREX), said “questions about why DHBs [hospitals] haven’t taken up these opportunities should be directed at them” (Russell, 2021b, para. 20). When concerns were raised about IMGs who have passed NZREX struggling to find work during the COVID-19 pandemic (Armah, 2022; Bhatia, 2022a) MCNZ explained that they “are not involved in, or have any control over the employment processes” (Bhatia, 2022b, para. 11).

Local experts interviewed in this research reiterated this sentiment, tending to direct me to institutions or organisations other than the ones they were representing, when asked about why barriers to licensing exist for some IMGs (Expert 1, Employer; Expert 4, Recruitment Agent; Expert 6, Educator). This tendency to redirect questions and responsibility exacerbates the lack of clarity around accountability for the challenges faced by IMGs. These observations provide insight into the mobilities and capabilities power regimes at play in this context. While MCNZ may be the formal leading institution in determining and shaping specific medical licensing policies, the separation of powers that could be a benefit to ensuring mutual accountability between MCNZ and other governmental organisations or employers instead appears to cause confusion and uneven accountability structures. The overall sentiment from participants and experts suggests a need for greater transparency, collaboration, and accountability among the key institutions involved in the licensing and employment processes for IMGs in Aotearoa New Zealand.

9.3.2 Institutional Absences

Associated with institutional ambiguity, Expert 7 (Policy Advisor) also drew attention to a notable institutional absence in the landscape of medical regulation and employment in Aotearoa New Zealand. The New Zealand Medical Association (NZMA), which had been in existence since 1886 as a branch of the British Medical Association (BMA), faced financial insolvency and was eventually disestablished in May 2022. Despite critiques of its role and philosophy by some medical practitioners, the NZMA aimed to “speak for all physicians, general practitioners and medical specialists alike” (Older, 2022, para. 2).

With the NZMA’s dissolution, this voice was lost. Throughout the decades, the NZMA played a role in questioning policy decisions made by the government, MCNZ, and related institutions, offering a counter perspective on various contentious issues. For instance, in 1970, the NZMA took a stance against the “adverse political climate” for health services in Aotearoa New Zealand, advising overseas members not to return until conditions improved (“M.A.N.Z.

explains stand over doctors' salaries," 1970, p. 13). This generated some reluctance among prospective IMGs (e.g., Laurenson, 1972) and prompted the government and employers to consider increasing salaries for medical doctors. Additionally, the NZMA disagreed with some MCNZ decisions, such as allowing unsuccessful PRENZ/NZREX candidates to finish their temporary registration term ("Board backs its foreign doctors," 1989) and resisting an MCNZ proposal to expand PGY1 positions for NZREX candidates into other specialty fields (Peterson, 2013), because this opportunity would not have been offered to NZMGs. This suggestion was taken on board by MCNZ when PGY1 options were further limited for NZREX candidates from 2014 (MCNZ, 2014b). The disestablishment of the NZMA was thus seen as a significant loss by Expert 7 (Policy Advisor), who highlighted the fragmentation within the health system and the importance of having multiple voices. The long-term implications of the loss of such a significant medical institution are yet to be understood. This may, however, suggest a shift towards the "monopoly" of medical regulation that Ayres (1889) feared would result from the formation of a Medical Council more than a century ago.

Another notable absence in the institutional landscape is Health Workforce New Zealand (HWNZ), an organisation established in 2009 to provide national guidance and leadership in planning and developing the health and disability workforce (Gorman, 2011). HWNZ was mentioned by several participants (IMG 15, NZREX; Expert 6, Educator; Expert 9, Policy Advisor) as having played a role in addressing health workforce shortages, contributing to innovative approaches, and understanding current and future trends in healthcare workforce demands. However, HWNZ was disestablished in 2018, with the responsibility for managing the health workforce transferred to the Ministry of Health.

The disestablishment of HWNZ, as noted by Rees (2019), was attributed to limited success in translating expertise into practical solutions for workforce challenges. The lack of measurable outputs from HWNZ was seen as a result of "policy and accountability tensions", reflecting the "fragmented nature of health care and...conflicting priorities" (Rees, 2019, p. 4). Institutional ambiguity is thus not only a symptom of cyclical and recurring processes and policy changes relating to medical licensing throughout Aotearoa New Zealand's history, but is in fact a contributing factor to the reproduction of these processes. This is an example of how, as mentioned in [Chapter 4](#) (Subsection 4.3.1), the interwoven "constellations of mobility" (Cresswell, 2010, p. 17) that shape IMG experiences, and social formations such as institutions and policies, are mutually constitutive and cannot be understood without the other (Sheller, 2018a).

9.3.3 *In Whose Best Interests?*

The varied experiences reported by research participants regarding institutional clarity and accountability prompt a broader question: who truly benefits from these policies? Officially, medical licensing policies are designed to benefit the public, with the primary aim of ensuring that all doctors in Aotearoa New Zealand meet a suitable standard of practice (e.g., MCNZ, 2021a). However, this research highlights instances where the public is disadvantaged by workforce shortages that could potentially be alleviated by allowing certain doctors, such as those on the NZREX pathway who already reside in the country, to practise medicine. Moreover, participant accounts draw attention to challenges faced by individuals on the CHS and LOC pathways (Expert 4, Recruitment Agent; IMG 3, CHS; IMG 5, LOC), suggesting the existence of an additional bottleneck for practitioners from CHS countries, who may be excluded due to technicalities, such as being too specialised for General Practice, or justifiable gaps in clinical experience due to health or childrearing.

While some participants speculated about the reputational risk faced by MCNZ in potentially registering incompetent practitioners, as noted above, others adopted a more critical perspective, pointing to potential protectionism and anti-competitive motives. IMG 12 (NZREX) suggested that limiting the number of doctors through stringent licensing processes might be a strategic move to create higher demand than the supply of doctors, ensuring better job opportunities for those already registered. This sentiment was echoed by Expert 2 (Political Commentator), who emphasised the challenges of setting standards for a profession that requires expert knowledge for effective regulation. He highlighted the dual nature of standard setting in a self-regulated profession, which can be used to prevent the entry of incompetent doctors but can also be wielded in anti-competitive ways to limit the number of individuals entering the profession, potentially keeping salaries higher. As he explained:

You wind up with a system that has the effect of substantially limiting entry into the profession and consequently restricting competition. Even if that wasn't the intent of it, it is certainly now the effect. [...] The system isn't really set up to accommodate increases in supply...and that seems to be almost by design.

Other participants shared the belief that medical licensing processes, intentionally or inadvertently, contribute to maintaining a limited supply of medical doctors and ensuring higher incomes for those already in the profession (Expert 6, Educator; IMG 3, CHS). Expert 6 attributed this to a desire to sustain a constrained market to protect incomes and “an abhorrence of unemployed doctors”. Expert 2 (Political Commentator), on the other hand, pointed out that while a lower supply of doctors might lead to the maintenance of higher salaries, it comes at the cost of a stressed and overburdened medical workforce, as

corroborated by other reports (e.g., Cassie, 2023c; McGinn, 2022) and participant accounts (IMG 14, VOC; IMG 17, NZREX). However, he also acknowledged the resistance to change among doctors, questioning whether many would be willing to accept potential salary reductions in exchange for a more manageable workload. These examples highlight the complexity of the mobilities and capabilities regimes that shaped medical licensing policies in Aotearoa New Zealand make it challenging to pinpoint who benefits the most.

Moreover, experts stressed the difficulty of holding self-regulating institutions, such as MCNZ, accountable. Expert 2 (Political Commentator) explained how MCNZ operates as a “statutory regime”, exempt from Commerce Commission policies designed to prevent anti-competitive practices, as they do in other industries. Expert 3 (Researcher) shared this view, noting that while there are plenty of altruistic individuals involved in medical regulation, the institutions themselves are not “primarily centred around balancing the public interest and community needs”. IMG 13 (NZREX) also highlighted the contrast between the “really nice” individuals working within the system and the exclusive and protective nature of the system itself. These examples underscore the challenges of achieving a balance between market constraints, the wellbeing of the healthcare workforce and the needs of the public.

MCNZ is not alone in such critiques around incentives and motivation. Literature from the U.S.A. speaks to the challenges in balancing the professional protection of medical practitioners with concerns about public safety. Rickert (2021), for example, notes that less than 1% of patient complaints result in medical license revocation in California, while C. G. Roy (2021) reflects on the need to pay careful attention to the operations of medical regulatory authorities to avoid potential professional protectionism. Similarly, the GMC in the U.K. has faced concerns with fostering public and institutional trust in their regulatory mechanisms (Cao, 2010; Smith, 2000). Striking the balance between competing interests in medical regulation, particularly when the profession is largely self-regulated, is an ongoing point of tension locally and internationally.

Specialist Colleges also exemplify the intricate interests involved in medical licensing in Aotearoa New Zealand, with some participants referring to them as “Guilds” that primarily serve their members (Questionnaire Respondent, VOC; Expert 3, Researcher; Expert 6, Educator). Expert 6 explained that “Colleges don’t exist for the welfare of society, or the betterment of mankind, even if they say they do”. Rather, he argued that these Colleges essentially work to maintain themselves and protect their members, and successive governments have been hesitant to challenge them due to their considerable influence. Furthermore, Expert 3 provided insight into how specialist Colleges maintain a “monopoly” on training and regulation in both Australia and Aotearoa New Zealand. For example, standards

for registration in Paediatrics are set by the Royal Australasian College of Physicians (RACP), which advises the Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ). Although the Colleges are accredited by AMC and MCNZ, they are “not regulated in and of themselves”, and with AMC taking the lead on these joint accreditation processes, “the system is not structured around New Zealand’s needs at all” (Expert 3, Researcher). Noting how the Australian influence plays out in a day-to-day setting, IMG 4 (NZREX) also questioned the preference given to Australian medical graduates over NZMGs without New Zealand residency or citizenship in PGY1 hiring processes.

Despite these dynamics, many participants who faced barriers in Aotearoa New Zealand were eligible for licensing in Australia. As IMG 3 (CHS) pointed out that “I don’t think the Australian Government is less aware of patient safety than New Zealand, but we can work there”. This raises the question of whether the way that Australia benefits from Aotearoa New Zealand’s restrictive policies, by attracting some of Aotearoa New Zealand’s IMGs (e.g., ASMS, 2017; Elkin, 2013, 2015), may in fact be by design.

Regardless of who stands to gain from these dynamics, one thing several participants were clear about was that they believed the barriers to licensing faced by some IMGs, particularly on the NZREX pathway, did not benefit or protect the public. IMG 1 (NZREX) felt that the health system in general neglects the voice of the public and patients in decision-making processes, while IMG 8 (NZREX) argued that MCNZ is “hiding under the buzzword of ‘public safety’”, while, in his view “doing the opposite”. He believed current systems and processes were inequitable and complicated in ways that disadvantage patients in Aotearoa New Zealand. Despite these concerns, medical regulation in Aotearoa New Zealand is, as Expert 3 (Researcher) explained, “fairly autonomous, and the ability of Parliament, under the current structure, to do anything about that appears to be limited”. While a separation of powers might be argued to be a useful strategy for avoiding the monopolisation of power (e.g., Martenet, 2021) in the medical field, in practice the mobilities and capabilities power regimes at work in this context create a disconnect between key institutions that makes it difficult to hold any of them to account.

Mobility and capabilities injustices can thus be seen in the way that these policies are maintained by power regimes with limited accountability and transparency, disadvantaging IMGs from certain backgrounds, the broader health workforce, and the broader public of Aotearoa New Zealand. This situation underscores the intricate balance required in medical regulation to protect the public while also facilitating a fair and competitive workforce environment – a balance that this research suggests is not being met. Furthermore, important questions are raised about the intent and effects of licensing processes, emphasising the need

for ongoing evaluation and adjustments to ensure alignment with the overarching goal of providing quality, equitable healthcare to the public.

9.4 REINVENTING THE WHEEL: THE CYCLICAL NATURE OF MEDICAL LICENSING

Mulgan et al. (2021) emphasise the opportunity presented by the post-pandemic era to make meaningful changes to existing structures and systems, fostering more sustainable and just futures. Their argument centres on building resilience in local communities before crises can occur, aligning with the need for a robust healthcare system and workforce. However, the recurrent and cyclical nature of medical licensing policies in Aotearoa New Zealand, observed since 1849, poses a challenge to sustained and impactful changes post-COVID-19. Shifts from stringent to relaxed regulations, and back to stringency, have occurred over the decades, while maintaining categories that differentiate between doctors from the U.K./Ireland, countries deemed “equal in status” (“Medical Practitioners Registration Act,” 1905) or “Comparable” (MCNZ, 2024a; New Zealand Medical Journal, 1970b, p. 164), and the rest of the world.

Research participants aptly described this situation as “reinventing the wheel” (IMG 16, NZREX) “over and over again” (Questionnaire Respondent, VOC). Similarly, Expert 9 (Policy Advisor) noted “how often that exact story plays out in a lot of different areas of government – there’s something we used to do, so let’s change it, change it again, and then change it back”. This research highlights how mobility and capabilities injustices faced by IMGs cannot be fully comprehended without acknowledging this repetitive cycle of policies shaping their experiences and directly impacting the medical staffing capabilities of Aotearoa New Zealand.

9.4.1 *Labels Matter*

Sardar (1999) asserts that the real power of the Global North can be found less in economic and technological growth and more in the power to define, represent, and theorise in a way that becomes dominant and, in essence, has a colonising effect. In short, as Slade (2019) explains in relation to labels such as “refugee” (see [Chapter 2](#), Section 2.5), “words matter” (p. 192). The labels assigned to certain groups, such as the term “Third World”, carry negative connotations that emphasise difference, imply an unalterable hierarchy, and highlight the dominance of the Global North in categorising and defining foreign Others as perpetually unequal to those from the “First World” (McEwan, 2014). Historical terms used in reference to IMGs from outside the Old White Commonwealth, such as “alien” (“Licensing of alien doctors,” 1943), “sub-standard” (“N.Z. an easy place for ‘sub-standard doctors’,” 1988), “[in]adequate” (“Prerequisites for medical registration to be tightened,” 1982) and “Third World” (“N.Z. an easy place for ‘sub-standard doctors’,” 1988) not only contribute to processes

of Othering, as discussed in [Chapter 3](#) (Section 3.4), but also perpetuate a narrative of Global North hegemony.

The contemporary terminology employed by MCNZ in defining medical licensing pathways carries similar connotations. As noted in [Chapter 2](#) (Section 2.5), the CHS pathway echoes the notion of qualifications being considered “equal in status” by the Governor General in 1905 (“Medical Practitioners Registration Act,” 1905). MCNZ’s replacement of the term “equal” with “Comparable” (MCNZ, 2024a) and “Competent” (MCNZ, 2024b) implies that those ineligible for the CA or CHS pathways are somehow incompetent or, as Mannes et al. (2023a) suggest, “incomparable”. Embedded in policy frameworks, such terminology not only restricts professional mobilities and capabilities but also replaces the harmful categorisation of the Third World with alternative phrases bearing similarly negative connotations.

These terms are detrimental not only owing to the accompanying connotations but also because they support assumptions justifying the existence of medical licensing pathways that result in the unjust differential experiences discussed in this thesis. IMGs from the Global South are more likely to feel undervalued, unwelcome, disadvantaged, and discriminated against. They described their experiences as “second-class” (IMG 9, NZREX) or “second-rate” (IMG 16, NZREX) citizens, echoing the observation made by Barnett (1991a) that IMGs are afforded a “second class status” (p. 459) in Aotearoa New Zealand. The impact of these labels extends beyond individual “status injuries” (Fraser, 1998, p. 25), shaping policies that perpetuate systemic inequalities.

9.4.2 Colonial Legacies

Given the historical distinctions made by MCNZ between British and Irish medical graduates/practitioners and other IMGs since 1849, coupled with MCNZ’s lack of clarity in defining a Competent Authority, questions also arise about whether the CA pathway has been retrospectively defined to reinforce a historical assumption that the U.K. and Ireland produce the most competent doctors to work in Aotearoa New Zealand. Similarly, the criteria for Comparable Health Systems might have been retroactively defined to favour IMGs from North America and “rich European countries” (IMG 16, NZREX), leading to the arbitrary exclusion of other health systems that perform well in the specified national health indicators.

While medical education and healthcare in Aotearoa New Zealand have evolved in association with British policies and approaches (Sainsbury, 2015), owing to the country’s colonial history and ongoing relationship with the U.K., MCNZ’s (2024b) explanation of the Competent Authority pathway lacks acknowledgment of this shared history. The oversight in recognising these historical ties and linguistic similarities in medical training raises concerns about the

justification for offering a separate registration category for British and Irish doctors without addressing the potential (post)colonial influences in the existing medical licensing framework. The absence of publicly available psychometric data on the performance of IMGs, coupled with growing emphasis on culturally safe practice (Curtis et al., 2019), further underscores the need for a re-evaluation of historical approaches. Examining the historical context and potential postcolonial influences on medical licensing is crucial for addressing the cyclical nature of the policy landscape and working towards a more equitable and just approach that considers the capabilities and contributions of IMGs from diverse backgrounds.

Despite immigration policies shifting towards attracting highly-skilled professionals from diverse backgrounds in the 1990s (Simon-Kumar, 2015), medical licensing does not appear to have followed this same pattern. The formalisation of distinctions between IMGs from Australia, the U.K., and Ireland, and those from other Comparable Health Systems, raises questions about the alignment of licensing practices with contemporary values of diversity and inclusion. While there may be arguments to support the automatic recognition of British and Irish qualifications, such as the way medical education in Aotearoa New Zealand was modelled largely on the U.K. system, there are no publicly available data to support the claim that this makes doctors from the U.K. and Ireland better equipped to work as medical practitioners in Aotearoa New Zealand, particularly with the Indigenous Māori population. Therefore, the Competent Authority criteria provided by MCNZ (2024b) do not adequately justify the decision to reproduce a recurring distinction made in medical licensing policies since 1849, pointing to underlying assumptions and colonial vestiges that produce arbitrary inclusions of British and Irish IMGs at the expense of other IMGs.

Medical licensing pathways in Aotearoa New Zealand perpetuate uneven experiences and outcomes, disproportionately affecting those trained in the Global South in terms of practical, professional, and (inter)personal mobilities and capabilities. [Chapter 2](#) (Section 2.5) highlighted the colonial origins of distinctions between IMGs of different backgrounds, which have been conceptualised in this chapter as contributing to arbitrary exclusions of certain IMGs and their capabilities. The challenges faced by IMGs do not represent a new phenomenon, therefore, but are a product of an ongoing cycle of policy changes, assumptions, and mismatched expectations – a cycle that policymakers, IMGs, and the broader public who are impacted by medical workforce shortages, do not seem to be able to break free from. It is this cyclical and recurring nature that points to the power of colonial vestiges in producing and reproducing mobilities and capabilities power regimes and, in so doing, (re)producing mobility and capabilities injustices.

9.5 CONCLUSION

MCNZ (1994) explain that “the line between protection of the public and council’s other obligations is not always clear” (p. 24), and this chapter has highlighted the ways in which this can be seen in medical registration for IMGs in Aotearoa New Zealand. While the chapter calls into question policies and decisions relating to medical licensing in Aotearoa New Zealand, much of which falls under the purview of the MCNZ, the purpose is not to make a claim that MCNZ is a fundamentally discriminatory or ineffectual institution. Rather, as noted in a recent independent review of the organisation, MCNZ “complies with the functions set out in the HPCA Act”, by registering doctors and ensuring they are competent, setting standards and promoting medical education and training (BSI Group New Zealand Limited, 2021, p. 8).

MCNZ is but one actor in a complex web of institutions that must navigate colonial legacies, geopolitical pressures, public needs, and reputational risks, with a strong incentive to err on the side of caution by implementing policies less likely to clash with perceived public attitudes towards IMGs. It is no wonder, therefore, that research participants consistently expressed distress around knowing who should be held accountable and where to seek information.

The mobilities and capabilities power regimes that shape medical licensing experiences and outcomes for IMGs in Aotearoa New Zealand need to be understood, and addressed, at the higher level of intersecting actors and institutions, rather than simply making superficial changes to licensing pathways, such as the implementation of bridging programmes or the GP alternative to PGY1. Such changes may offer temporary solutions to the problem of brain waste, brain drain, and low IMG retention but more innovative solutions are required to avoid reinventing a wheel laden with colonial legacies. Policymakers need to find a way to break the wheel and establish equitable medical registration policies that protect the public and avoid arbitrary exclusions.

10 CONCLUSIONS

This thesis has explored the experiences of international medical graduates (IMGs) who are practising or seeking to practise medicine in Aotearoa New Zealand. In doing so, I have examined and contextualised the registration experiences and outcomes of IMGs from a range of backgrounds through interviews, an online questionnaire, and a comprehensive policy and grey literature review. Overall, the research highlights how medical licensing pathways with clear links to former colonial ideologies create uneven professional mobilities and capabilities among doctors who trained overseas. With some exceptions, registration processes facilitate the migration and combined professional capabilities of IMGs with qualifications, training, or experience in 24 Global North countries, while doctors from the rest of the world face uneven and unjust barriers to registration that compound with other aspects of their identity such as age, gender, ethnicity, or cultural background.

IMGs, particularly those caught in the various bureaucratic bottlenecks or otherwise arbitrarily excluded from being able to convert their professional capabilities into functionings, are an underrepresented and under-researched group in Aotearoa New Zealand. This research addresses a gap in the literature regarding the experiences of different groups of IMGs, by recognising how licensing pathways that distinguish between IMGs based on the development indicators of their country of training contribute to an “occupational apartheid” (Mpofu & Hocking, 2013, p. 132) between those who trained in the Global North and the Global South.

In seeking to make sense of this phenomenon, this thesis has applied a theoretical lens developed throughout the research process, informed by literature, contextual analysis, and a sequential mixed methods data collection strategy. This capabilities approach to mobility justice has been crucial in conceptualising and framing the research into IMG experiences by not only considering these experiences and outcomes at the level of the individual, but also seeking to understand the broader mobilities and capabilities power regimes that have shaped medical licensing and migration throughout Aotearoa New Zealand’s history. Implementing this approach led to the development of the 4Ps that have shaped the structure of the second half of the thesis, by incorporating insights from mobility justice and capabilities literature, as well as emphasising the role of recognition and dignity in questions of justice.

This concluding chapter reflects on the research as a whole. First, the chapter examines the potential contributions of my capabilities approach to mobility justice and the 4Ps to broader theoretical literature, before discussing prospective directions for medical licensing in

Aotearoa New Zealand. The chapter then considers implications for further research, finishing with some final reflections on the project.

10.1 THEORETICAL REFLECTIONS

My capabilities approach to mobility justice evolved in conjunction with the research design, data collection, and analysis during this project. In [Chapter 4](#), I synthesised the key aspects of this approach based on key distinctions from the justice literature, as illustrated again in Table 12.

Table 12

Key Characteristics of a Capabilities Approach to Mobility Justice

Characteristic	Description
Guiding principle(s)	The approach seeks to protect and advance human dignity, by maximising human and more-than-human mobilities and capabilities without inhibiting the mobilities and capabilities of others, while identifying and considering ways to overcome arbitrary exclusions of individuals and/or capabilities based on immutable characteristics such as nationality, gender, or ethnicity.
Distributive, recognition, or corrective?	Emphasis is on the (un)even distribution of (im)mobilities and capabilities (<i>distribution</i>), while also bringing <i>recognition</i> to the forefront in considering the protection of human dignity.
Universalist or contextualist?	The interaction between mobilities and capabilities is unique to the context, and justice considerations cannot be made outside of this context (<i>contextualist</i>).
Comparative or non-comparative?	The reconfigured rule of mutuality means that justice issues surrounding mobilities and capabilities are considered in relation to others (<i>comparative</i>), rather than emphasising the prescription of a minimum threshold of capabilities and/or mobilities.
Monist or pluralist?	Multiple perspectives and theorisations can exist in relation to a capabilities approach to mobility justice, although there are some key shared characteristics, making the approach <i>pluralist</i> .
Conservative or ideal?	Although a universal ideal state is not advanced, the approach aims to identify and explore the production of (in)justices and how these may be addressed, leading more towards an <i>idealist</i> stance.
Procedural or substantive?	Mobilities and capabilities are both distributed and distributive; they can represent both the means (<i>procedural</i>) and ends (<i>substantive</i>) of (in)justice.

Beginning with initial precepts from literature relating to justice, recognition, mobilities, and capabilities, as captured in Table 12, my iterative research process culminated in the development of the 4Ps – *professional* mobilities and capabilities, *(inter)personal* mobilities and capabilities, mobilities and capabilities in *practice*, and mobilities and capabilities *power*

regimes. The development of these components was made possible by adopting a sequential mixed methods research design. The following subsection reflects on some of the aspects of the approach that worked well during this process, and areas where challenges emerged, in relation to the distinctions summarised in Table 12.

10.1.1 Theoretical Distinctions in Practice

As noted in Table 12, this capabilities approach to mobility justice emphasises the advancement and protection of human dignity. Participant accounts of the need to consider the “human element” (IMG 24, NZREX) in medical registration policies connect to this notion of dignity. Human dignity in this context can be maximised not simply by providing a greater quantity of professional opportunities and viable pathways for IMGs from diverse backgrounds. Instead, human dignity comes into play in the intersection between professional opportunities, and what the Ministry for Ethnic Communities (2022) describes as ensuring people are “gainfully and meaningfully employed” (p. 47).

As value neutral concepts, not all capabilities and mobilities should be assumed to have inherent value. Rather, as seen in this research, different capabilities and mobilities have value for different IMGs. IMGs valued capabilities and mobilities that allowed them to achieve their professional goals, which entailed working in a profession they have trained for, and being afforded recognition, respect, and acceptable working conditions. Even those who were able to find work as medical doctors in Aotearoa New Zealand, did not always agree that the working conditions, professional development opportunities, and remuneration allowed them to achieve meaningful work and enhanced levels of human dignity. The stated aim of this theoretical approach, as seen in Table 12, is to seek to maximise mobilities and capabilities without limiting the mobilities and capabilities of others. However, this research has highlighted how this maximisation should not be taken to refer to ensuring the greatest number of opportunities – but rather an enhanced quality of opportunities, as perceived by individuals.

As illustrated in Table 12, this theoretical lens also examines the (un)even *distribution* of mobilities and capabilities, assessing these dynamics in relation to others (a *comparative* approach to justice). It became apparent in this research that IMGs experience a number of inconveniences while seeking medical registration in Aotearoa New Zealand. From administrative loopholes, to COVID-19 restrictions, to the seemingly random levels of inclusivity and support provided in various places of work in the country, IMGs from all backgrounds often face obstacles to achieving their professional functionings. However, where these barriers shift from arbitrary inconveniences to arbitrary exclusions, is in the way that they apply unevenly – that is, some IMGs consistently face greater obstacles to professional

registration than others. This is where the comparative approach to justice became useful in exploring mobility and capabilities (in)justices in this context.

Nussbaum (2011) argues that a minimum threshold of baseline capabilities is required to be met in order to achieve justice and dignity. In Aotearoa New Zealand, however, the capabilities, mobilities, and recognition that would allow these IMGs to experience human dignity depended on the individual and their circumstances and preferences. Nevertheless, it was clear that many IMGs perceived their experiences through a lens of arbitrary exclusion, unable to understand the lack of recognition they felt prohibited them from achieving their professional goals. This led them to ask questions about a “hidden story” (IMG 8, NZREX) of structural disadvantage and/or discrimination. In this way, processes that avoid real or perceived arbitrary exclusions or misrecognition of individuals, groups, or more-than-human capabilities based on immutable characteristics such as where they are from, their gender, or ethnicity could be considered to provide a baseline, minimum threshold for mobility and capabilities justice in this context. This approach is thus *pluralist* and *contextually* grounded, while also suggesting the existence of a *universalist* principle underlying professional mobility and capabilities justice.

One of the most significant challenges in implementing a pluralist and contextualist approach, occurred when distinguishing P1 (professional) and P3 (in practice). While the focus of P1 is on the mobilities and capabilities associated with meeting professional requirements in a new environment, P3 looks at the way policies translate from paper into practice. This is where bringing the concept of *recognition* more strongly into this mobilities and capabilities framing was helpful. In the end, P1 became more about professional recognition, while P3 was associated with formal and informal systemic processes and strategies for achieving the professional functionings participants strove towards. In this way, the concept of recognition is multifaceted in this research, referring not only to the institutional recognition of more-than-human capabilities associated with one’s qualifications, training, and experience, but also to forms of (mis)recognition relating to personal capabilities and mobilities. Misrecognition occurs among some IMGs in Aotearoa New Zealand because of the misalignment between their personal and social conversion factors, and their professional goals. In this way, the theoretical lens considered both the means (*procedural*) and ends (*substantive*) of mobility and capabilities (in)justices.

It also became clear that IMGs’ professional functionings were inseparable from both personal and social conversion factors in this context, which compounded to enable or inhibit medical registration. Per Robeyns (2017), a distinction was made between social conversion factors as norms and policies that impact the ability of IMGs to translate their capabilities into

functionings, and personal conversion factors that represent internal characteristics such as health, age, or personality. The focus on professional mobilities and capabilities of migrant medical workers in this thesis highlighted the ways that these conversion factors – the personal and the interpersonal – are inseparable. Medical registration policies formally classify individuals according to their more-than-human capabilities, based on the country of origin of their qualifications and work experience, rather than their integrated, combined merit as an individual. This creates a misalignment between the mobilities of individual IMGs, who are sometimes able to move or migrate to Aotearoa New Zealand with their family members, and the mobilities of their professional capabilities and skills to cross borders in a meaningful way. This distinction creates uneven mobilities between these individuals, while also allowing institutions to arbitrarily exclude knowledge and skills from the Global South, without acknowledging how these more-than-human capabilities and capabilities are intrinsically linked to human beings who are also being excluded.

Finally, Table 12 highlights the *idealist* tendency of this capabilities approach to mobility justice. While advocacy is relevant to both capabilities and mobilities approaches to justice (see [Chapter 4](#), Subsection 4.4.2), the aim of this research is not to provide a comprehensive list of policy recommendations in the medical licensing space. Instead, it has been important to consider participants' recommendations for change in discussing findings (see [Chapter 8](#), Section 8.5), and Section 10.2 below provides further reflection on how medical licensing processes may be enhanced in this context.

10.1.2 Other Possible Theoretical Applications

Despite the contextual focus of this capabilities approach to mobility justice, some insights could be utilised in other contexts. The approach lends itself especially to phenomena that include a clear emphasis on movement or mobility in some form. In particular, the intersection of mobilities, capabilities, and recognition would be especially applicable to research exploring the experiences of other skilled migrant populations. By shifting the focus from scales of mobility (Sheller, 2018a, 2018b) to core components of the experiences of migrant professionals, the 4Ps offers a foundation for understanding how mobilities and capabilities power regimes create (mis)alignment between an individual's physical migration, personal characteristics, skills and qualifications, and professional functionings. By emphasising the importance of quality over quantity when it comes to maximising capabilities and mobilities, this framework could be used to identify and look for ways to address injustices caused by uneven professional recognition or combined capabilities among migrant professionals in a range of fields.

Given the centrality of mobilities to virtually all aspects of human life, it is also hoped that this approach may be useful in a wider range of settings. For example, the approach may be particularly useful in understanding (in)justices during the COVID-19 pandemic, with (im)mobilities brought so clearly to the forefront during this period. Drastic changes to forms of mobility at all scales during the pandemic (Sheller, 2021) have had a strong interaction with capabilities – the ability of people, resources and information to interact with their environment in a desirable way that allows maximum potential to be reached (i.e. functionings). While this approach leaves room for more extensive development, this framing has been invaluable for this research and has allowed an exploration of how capabilities could be brought out more in mobility justice theorisations. It is hoped that further work will take place in this sphere, with consideration of other contexts and examples, in order to further refine these concepts.

10.2 BREAKING THE WHEEL

This research has revealed that medical registration in Aotearoa New Zealand is influenced by the cyclical and recurring nature of policies and processes that generate arbitrary exclusions of some individuals. Originating in colonial times in the mid- to late-19th century, medical licensing was initially afforded only to medical practitioners who were recognised in the U.K. or Ireland at the time. More than 150 years later, the Competent Authority (CA) licensing pathway continues to privilege the qualifications of doctors who trained in the U.K./Ireland, compared to the rest of the world. In a context with such discernible colonial linkages to current policy, participants were clear that change – to some extent – is needed in the medical regulatory sphere in Aotearoa New Zealand.

As discussed in [Chapter 8](#) (Section 8.5), a number of potential solutions were put forward by participants in Phases 1 and 2 of this research, with some IMGs reluctant to support options that may involve more stringent requirements on those who benefit from the current mobilities and capabilities power regimes in existence. This tension raises questions around the notion of equality or evenness in opportunities afforded to IMGs. On the one hand, uneven mobilities and capabilities can be seen to generate arbitrary exclusions of IMGs from different backgrounds, thereby contributing to mobility and capabilities injustices. On the other hand, applying policies equally – as in the case of the minimum threshold of recent clinical experience required for the CHS pathway – may disadvantage individuals such as young mothers who are more likely to require absences from work.

Therefore, a focus on equity, rather than equality, may be useful. Following Sheller's (2018a) argument that freedom of mobility comes at the expense of the restriction of others' mobility,

specialists and generalists from recognised CHS countries could be seen to experience more streamlined registration processes at the expense of doctors who are only eligible for the NZREX pathway. The existing disparities in medical licensing processes, which lead to the creation of differential subjects with uneven mobilities and capabilities, imply that a more uniform and standardised approach to registration for IMGs from all backgrounds may be more just. Equalising medical licensing processes for IMGs from Global North CHS countries, and those from non-CHS, usually Global South backgrounds, would most likely entail some kind of standardised examination or assessment process for all IMGs that leads to a viable, unbroken pathway to employment.

Archer et al. (2016) explain that while licensing examinations serve the purpose of reassuring the public that “only capable doctors who can practice safely are qualified” (p. 212), they can also act as barriers to IMGs who may be further disincentivised from pursuing registration in an already understaffed health system. As noted in [Chapter 3](#) (Subsection 3.3.2), 96% of IMGs currently gain registration without sitting an examination (RNZ, 2023). Requiring these 96% of IMGs, who make up more than 40% of the local medical workforce, to take a licensing examination, would represent a significant shift in registration processes. This was already seen historically in Aotearoa New Zealand, with a sharp decline in registrations from IMGs, particularly from the U.K./Ireland, when the NZREX was briefly required by all IMGs in the late 1990s (MCNZ, 1999). Fears of a resulting workforce crisis prompted MCNZ at the time to make an exception for the “Old White Commonwealth” (Barnett, 1991a, p. 460) countries (MCNZ, 1996a), which was formalised by the CA and CHS pathways from 2004 (MCNZ, 2004c). Requiring examinations or assessments of IMGs currently exempt from NZREX may thus be perceived as creating barriers to registration for CHS doctors that do not currently exist. This could explain the hesitancy for many research participants to agree with such a suggestion for change (see [Chapter 8](#), Section 8.5).

However, there are also a number of findings in this research that challenge the assumption that more restrictive licensing processes for doctors from CHS countries would ultimately reduce the available medical workforce. While creating more standardised and equitable processes may have the appearance of imposing greater restrictions for some individuals, having a viable pathway to licensing without the three-to-five-year delays currently associated with NZREX could facilitate the migration of an even greater number of prospective IMGs. Furthermore, workforce data highlight how doctors on the NZREX pathway, and those from Global South countries (see [Chapter 3](#), Subsection 3.3.2) are more likely to remain in Aotearoa New Zealand long-term, thereby potentially reducing workforce turnaround and enhancing patient access to continuity of care. Even if standardised licensing processes are perceived as

a push factor by Global North doctors currently benefiting from streamlined registration pathways, such processes would require all IMGs to demonstrate a required standard, including in relation to cultural safety, which has the potential to facilitate more equitable healthcare employment for IMGs as well as more equitable healthcare provision for patients in Aotearoa New Zealand.

The overarching aim of this capabilities approach to mobility justice is the maximisation of mobilities and capabilities without infringing on the mobilities and capabilities of others. It is possible, therefore, that an argument could be made for the ongoing professional exclusion of individuals from countries with lower health indicators in the name of addressing the consequences of medical brain drain. However, as highlighted in [Chapter 3](#) (Subsection 3.2.1), imposing restrictions on the mobility of individuals who originate from a certain country relies on the premise that one is responsible for the (under)development of a nation by virtue of being born or, in the case of medical doctors, attending university there. This argument ignores the broader historical mobilities and capabilities power regimes that have generated a global system of Global North or Western hegemony, putting the burden of responsibility on individuals whose fundamental right to movement is enshrined in the Universal Declaration of Human Rights. The active encouragement of migration of IMGs from Global South contexts with extremely under-resourced health systems has ethical and justice implications for potential infringement on the rights of those populations to access healthcare. Nevertheless, I would argue that there is a distinction between the active encouragement of medical brain drain and resource extraction from low- and middle-income countries, and the provision of equitable and just medical registration processes that do not generate arbitrary exclusions of individuals based on factors they cannot change – such as where they are from.

Breaking the metaphorical wheel of cyclical and recurring medical registration processes may require a radical shift in professional and public perceptions on what the medical workforce of Aotearoa New Zealand should look like. More equitable processes could result in higher recruitment of IMGs from non-CHS countries, or greater inclusion of different countries and health systems in a refined list of Comparable Health Systems. The demographic makeup of the medical workforce may also change, by generating enhanced opportunities and combined capabilities for members of underrepresented communities in Aotearoa New Zealand's contemporary, multicultural society, with the potential to contribute to greater diversity and cultural safety. Concerns about the competency of practitioners from non-CHS countries would need to be supported with clear data and, ideally, the opportunity to engage in more bridging programmes or contextually-specific training courses upon arrival in the country.

Just licensing processes would involve avoiding the brain waste of qualified individuals and citizens residing in the country who are unable to work as doctors, by facilitating the integration of these individuals into the workforce. More just medical registration pathways would thus involve not simply altering the imperfect processes and continuing the cycle of colonial legacies, but a willingness to critically examine and reconfigure policies based on clear data, contemporary inclusive values, and the healthcare needs of Aotearoa New Zealand's diverse population. Medical regulation reform would therefore contribute to a broader agenda of decolonising medical care and practice in Aotearoa New Zealand, setting an example for such processes globally.

Such changes would require significant political support. The October 2023 election resulted in a change of government, with the creation of a coalition between the National, Act, and New Zealand First parties. In the coalition agreement between National and Act, one of the stated policy agreements is to "better recognise people with overseas medical qualifications and experience for accreditation in New Zealand" (New Zealand National Party & Act New Zealand, 2023, p. 8). The explicit inclusion of occupational licensing for IMGs in such a document suggests that the uneven mobilities and capabilities experienced by IMGs in this research are gaining awareness in the political and public spheres. It is hoped that this research may contribute to decision-making and refinement of licensing policies in supporting the implementation of this aspect of the coalition agreement.

10.3 IMPLICATIONS FOR FURTHER RESEARCH

As noted in [Chapter 5](#), the online questionnaire cannot be considered as a representative sample of IMGs who are practising or seeking to practise medicine in Aotearoa New Zealand. This is because the population size of prospective IMGs caught in bureaucratic bottlenecks or who have otherwise chosen not to enter the medical field is unknown. As a result of the participant selection strategies discussed in [Chapter 5](#), there are also more NZREX research participants than IMGs on other licensing pathways, despite CHS/specialists constituting 96% of IMGs registered in Aotearoa New Zealand. In this research, the capabilities approach to mobility justice lent itself to a close examination of those individuals rendered invisible and, in terms of population size, not measurable, by the mobilities and capabilities power regimes shaping medical registration. However, this does leave room for further exploration of the nuances of specialist and CA/CHS general registrant experiences.

The focus of this research is also on medical registration, although discussion of IMG experiences working within the health system is interwoven throughout this thesis as well. A more explicit focus on differential experiences of IMGs post-registration would provide further

insights into how these mobilities and capabilities power regimes impact doctors who trained overseas at different stages of their professional integration and adaptation in Aotearoa New Zealand. Furthermore, the population size of IMGs currently registered as medical professionals could be calculated based on publicly available medical workforce data to allow research that is representative of this group who have successfully navigated medical registration. Another significant gap is comprehensive data regarding the performance of doctors from a range of backgrounds. Do NZREX doctors tend to receive lower performance reviews and/or higher levels of complaints from patients and employers? What data exist to support the distinctions made between CHS doctors and those from other countries?

Themes relating to uneven mobilities and capabilities of IMGs as a result of social conversion factors such as gender and ethnicity were also important findings (see [Chapter 7](#)). These themes could be explored in greater depth in further research by, for example, considering the experiences of medical doctors from different ethnic and cultural backgrounds who are working in Aotearoa New Zealand, including NZMGs. Similarly, research into how regulatory mechanisms (in)directly inhibit or enable professional success of doctors of different genders, including women and other underrepresented genders, could be extended beyond IMGs to consider doctors from all backgrounds in Aotearoa New Zealand. Such investigations would shed further light on the broader mobilities and capabilities power regimes, including historical influences and ideologies, that shape the local medical workforce and approaches to healthcare provision. Furthermore, it would be helpful to consider whether similar inequities occur in other professional regulation settings in the health sector – for example, nursing or allied health roles – as well as other fields that require vocational training, such as law or engineering. This would be further complemented by an exploration of strategies employed to mitigate inequities and/or injustices in these professions.

Finally, this thesis points to the importance of considering not only the perspectives of doctors and local experts, but also the general public. Dynamics of brain drain and waste can be seen to contribute to workforce shortages that impact public access to equitable and culturally safe healthcare provision. It would be useful to gain further insight into how the public, particularly Māori, Pacific, and other underrepresented ethnic communities, feel about having a workforce made up of more than 40% of overseas-trained medical professionals, and what their priorities are in a consultation with a doctor. For example, do the public prefer to have doctors from Global North, often native English-speaking countries, who tend to work in Aotearoa for less than two years, or would they prefer to have a more diverse workforce that includes individuals who may not speak English as a first language, but could be more committed to staying in the country longer-term and providing continuity of care? Do the public feel that all

IMGs should be required to undergo the same training in the local healthcare context and cultural safety concerns? Given the influence that public opinion has had on medical registration decisions over the past decades, such research may provide further support for the case for change in how IMGs are currently becoming registered – or indeed failing to become registered – in Aotearoa New Zealand.

10.4 FINAL THOUGHTS

As discussed in the [Introduction](#), this research project emerged from a personal experience with my husband's interest in registering as a medical professional in Aotearoa New Zealand. Conducting research in an area in which I have such emotional investment has been both challenging and rewarding. On the one hand, it was validating to realise that many other people have faced similar obstacles in navigating this complex medical registration landscape. On the other hand, it was challenging to hear the stories of individuals who had encountered difficulties beyond what I could have imagined. However, as noted throughout this thesis, some IMGs – from both CHS and non-CHS countries – reported positive experiences with the system overall. It was encouraging to hear accounts of IMGs overcoming the odds stacked against them, or simply conveying a sense of fulfilment and gratitude with the life they have built in Aotearoa New Zealand. Many participants also expressed awareness for the plight of IMGs they felt were less fortunate than themselves, suggesting a sense of solidarity and empathy among some members of the medical community.

Aware that my positionality could impact my analysis of the research findings, I have striven to present a range of perspectives on themes and topics relating to medical registration in Aotearoa New Zealand, including those who spoke about their experiences in mostly positive terms. However, there was an overall tendency for research participants in Phase 1 to highlight the concerns they had with their experiences, and it was important to share these narratives in this thesis. Furthermore, the choice to conduct the questionnaire in Phase 2 was another important strategy for mitigating the potential implications of my positionality and personal investment in the topic. The quantitative data, collected anonymously, revealed clear correlations between IMG experiences and their licensing pathways, as well as their country of primary qualification, and gender.

While questionnaire participants may not reflect a representative sample of practising and non-practising IMGs in Aotearoa New Zealand, these overall trends, in conjunction with the document analysis of policies, grey literature, and media reports, suggest that the personal experiences that prompted this research are certainly not unique. The purpose of this research is not to cast blame or aspersions on particular actors or organisations involved with medical

regulation, but rather to explore and understand this phenomenon and how it is experienced in the lived realities of IMGs in Aotearoa New Zealand. It is hoped that this understanding can provide a foundation for innovative and tangible changes that can improve the medical registration outcomes for IMGs, contributing to a more sustainable medical workforce that can better serve the diverse needs of the population of Aotearoa New Zealand.

11 REFERENCES

- 1 News. (2021). 'I'm being kept in limbo' - British doctor in queue with more than 25,000 people applying for residency. 1 News. <https://www.tvnz.co.nz/one-news/new-zealand/im-being-kept-in-limbo-british-doctor-queue-more-than-25-000-people-applying-residency>
- 1 News. (2023). *Programmes underway to naturalise foreign-trained doctors*. 1 News. <https://www.1news.co.nz/2023/03/19/programmes-underway-to-naturalise-foreign-trained-doctors/>
- 26,000 leave 'Godzone' in year. (1978, August 17). *New Zealand Press Association*, 6. <https://paperspast.natlib.govt.nz/newspapers/CHP19780817.2.61>
- Action on medical "exodus" sought. (1971, November 1). *New Zealand Press Association*, 16. <https://paperspast.natlib.govt.nz/newspapers/CHP19711101.2.136>
- Adey, P., Bissell, D., Hannam, K., Merriman, P., & Sheller, M. (Eds.). (2014). *The Routledge handbook of mobilities*. Routledge.
- Adler, K. G. (2018). Screening for social determinants of health: An opportunity or unreasonable burden? *Family Practice Management*, 25(3), 3.
- Adovor, E., Czaika, M., Docquier, F., & Moullan, Y. (2021). Medical brain drain: How many, where and why? *Journal of Health Economics*, 76, Article 102409. <https://doi.org/10.1016/j.jhealeco.2020.102409>
- Aggett, M.-J. (1997). *CHE pleads case over Medical Council rules*. NZ Doctor. <https://www.knowledge-basket.co.nz/databases/newztext/nz-doctor/search-nz-doctor/view/?sid=9455698&d34=magz%2Ftext%2Fdoctor%2F1997%2F05%2F000493.html>
- Ahmad, O. B. (2005). Managing medical migration from poor countries. *BMJ: British Medical Journal*, 331(7507), 43-45. <https://doi.org/10.1136/bmj.331.7507.43>
- Al-Haddad, M., Jamieson, S., & Germen, E. (2022). International medical graduates' experiences before and after migration: A meta-ethnography of qualitative studies. *Medical Education*, 56(5), 504-515. <https://doi.org/10.1111/medu.14708>
- Alien doctors. (1943, May 27). *Otago Daily Times*, 5. <https://paperspast.natlib.govt.nz/newspapers/ODT19410527.2.24.1>
- Alien doctors. (1945, January 24). *Grey River Argus*, 6. <https://paperspast.natlib.govt.nz/newspapers/GRA19450124.2.37>
- Alien doctors and public needs. (1942, January 26). *Evening Post*, 4. <https://paperspast.natlib.govt.nz/newspapers/EP19420126.2.28.3>
- Alien doctors in N.Z. (1943, June 23). *Northern Advocate*, 2. <https://paperspast.natlib.govt.nz/newspapers/NA19430623.2.30>

- Alkire, S., & Chen, L. (2006). 'Medical exceptionalism' in international migration: Should doctors and nurses be treated differently? In K. Tamas & J. Palme (Eds.), *Globalizing migration regimes: New challenges to transnational cooperation* (pp. 100-117). Ashgate.
- Aluwihare, A. P. R. (2005). Physician migration: Donor country impact. *Journal of Continuing Education in the Health Professions*, 25(1), 15-21. <https://doi.org/https://doi.org/10.1002/chp.4>
- Anjaria, K. (2019). *Number of hired PGY1 House Officers (2014 - 2019)*. MidCentral District Health Board. <https://fyi.org.nz/request/10700/response/37740/attach/html/3/Dr%20Mohammed%20A%20M%20OIA%20re%20No%20of%20Hired%20PGY1%20HOs%202014%202019%20DUE%205.8.2019.pdf.html>
- Anjaria, K. (2022). *MDHB hiring OIA Y22-499 PGY1 House Officers*. MidCentral District Health Board. <http://www.midcentralthb.govt.nz/AboutMDHB/Documents/MDHB%20Responses%20to%20OIA%20received%20Apr-Jun%202022.pdf>
- Apa, F. M. (2019). *Official Information Act (1982) request*. Counties Manukau District Health Board. <https://fyi.org.nz/request/10704/response/37850/attach/html/4/OIA%2008072019%20MAHOMMED%20RMO%20PGY1%20data%202014%202019.pdf.html>
- Apker, J., & Eggly, S. (2004). Communicating professional identity in medical socialization: Considering the ideological discourse of morning report. *Qualitative Health Research*, 14(3), 411-429. <https://doi.org/10.1177/1049732303260577>
- Archer, J., Lynn, N., Coombes, L., Roberts, M., Gale, T., Price, T., & Regan de Bere, S. (2016). The impact of large scale licensing examinations in highly developed countries: A systematic review. *BMC Medical Education*, 16(1), 212. <https://doi.org/10.1186/s12909-016-0729-7>
- Armah, M. (2022). *Migrant doctors struggling to find work despite healthcare staff shortages*. Stuff. <https://www.stuff.co.nz/national/health/129382212/migrant-doctors-struggling-to-find-work-despite-healthcare-staff-shortages>
- Ash, C. (2022). *Your Official Information Act (1982) request Te Matau a Māui Hawke's Bay Ref: OIA2022064*. Te Whatu Ora | Health New Zealand - Te Matau a Māui Hawke's Bay. https://www.ourhealthhb.nz/assets/OIA-responses/OIA2022064-PGY1-House-officer-hiring-data-FINAL-signed_Redacted.pdf
- ASMS. (2017). *International medical migration: How can New Zealand compete as specialist shortages intensify?* ASMS: Toi Mata Hauora. https://asms.org.nz/wp-content/uploads/2022/05/IMG-Research-Brief_167359.5.pdf
- Astor, A., Akhtar, T., Matallana, M. A., Muthuswamy, V., Olowu, F. A., Tallo, V., & Lie, R. K. (2005). Physician migration: Views from professionals in Colombia, Nigeria, India, Pakistan and the Philippines. *Social Science & Medicine*, 61(12), 2492-2500. <https://doi.org/10.1016/j.socscimed.2005.05.003>
- Ayres, R. (1889, June 18). The Medical Practitioners Bill. *New Zealand Times*, 2. <https://paperspast.natlib.govt.nz/newspapers/NZTIM18890618.2.6.1>

- Barnett, J. R. (1987). Manpower: Foreign medical graduates and the doctor shortage in New Zealand, 1973-1979. *New Zealand Medical Journal*, 100(829), 497-500.
- Barnett, J. R. (1988). Foreign medical graduates in New Zealand 1973-79: A test of the 'exacerbation hypothesis'. *Social Science & Medicine*, 26(10), 1049-1060. [https://doi.org/10.1016/0277-9536\(88\)90223-7](https://doi.org/10.1016/0277-9536(88)90223-7)
- Barnett, J. R. (1991a). Geographical implications of restricting foreign medical immigration: A New Zealand case study, 1976-1987. *Social Science & Medicine*, 33(4), 459-470. [https://doi.org/10.1016/0277-9536\(91\)90328-a](https://doi.org/10.1016/0277-9536(91)90328-a)
- Barnett, J. R. (1991b). Where have all the doctors gone? Changes in the geographic distribution of general practitioners in New Zealand since 1975 (3): New Zealand and foreign medical graduates compared. *New Zealand Medical Journal*, 104(918), 358-360.
- Bauman, Z. (1998). *Globalization: The human consequences*. Cambridge University Press.
- Bedford, R., Ho, E., & Lidgard, J. (2001). Immigration policy and New Zealand's development into the 21st century: Review and speculation. *Asian and Pacific Migration Journal*, 10(3-4), 585-616. <https://doi.org/10.1177/011719680101000311>
- Beine, M., Docquier, F., & Oden-Defoort, C. (2011). A panel data analysis of the brain gain. *World Development*, 39(4), 523-532. <https://doi.org/10.1016/j.worlddev.2010.03.009>
- Beladi, H., Chao, C.-C., Ee, M. S., & Hollas, D. (2015). Medical tourism and health worker migration in developing countries. *Economic Modelling*, 46, 391-396.
- Benatar, S. R. (2005). Moral imagination: The missing component in global health. *PLoS Medicine*, 2(12), e400. <https://doi.org/10.1371/journal.pmed.0020400>
- Benatar, S. R. (2007). An examination of ethical aspects of migration and recruitment of health care professionals from developing countries. *Clinical Ethics*, 2(1), 2-7. <https://doi.org/10.1258/147775007780267174>
- Bhamidipati, S. (2022a). *Migrant doctors say they're jumping through hoops to get roles*. 1 News. <https://www.1news.co.nz/2022/08/15/migrant-doctors-say-theyre-jumping-through-hoops-to-get-roles/>
- Bhamidipati, S. (2022b). *Migrant doctors worry about prospects as officials look overseas to fill workforce gaps*. RNZ. <https://www.rnz.co.nz/news/national/472858/migrant-doctors-worry-about-prospects-as-officials-look-overseas-to-fill-workforce-gaps>
- Bhatia, R. (2022a). *Migrant doctors struggle to find work despite skill shortages*. Stuff. <https://www.stuff.co.nz/pou-tiaki/300540540/migrant-doctors-struggle-to-find-work-despite-skill-shortages#:~:text=Psychiatrist%20Anil%20Channa%20is%20lobbying,Zealand%20despite%20massive%20skill%20shortages.>
- Bhatia, R. (2022b). *Renewed calls to address migrant doctor 'bottleneck' as GP shortage worsens*. Stuff. <https://www.stuff.co.nz/pou-tiaki/128839542/renewed-calls-to-address-migrant-doctor-bottleneck-as-gp-shortage-worsens>
- Blake, M. (2017). In defence of departure: Justice and the right to leave. *South African Journal of Philosophy*, 36(1), 168-176. <https://doi.org/10.1080/02580136.2017.1283740>

- Blake, M. (2020). *Justice, migration, and mercy*. Oxford University Press.
- The Medical Practitioners (Higher Overseas Qualifications) Order, No. 159 1121-1122 (1973). http://nzlii.org/nz/legis/num_reg/mpoqo1973536.pdf
- Board backs its foreign doctors. (1989, June 13). *New Zealand Press Association*, 9. <https://paperspast.natlib.govt.nz/newspapers/CHP19890613.2.61>
- Boncea, I. (2013). Medical brain drain - A theoretical approach. *Annals of the University of Oradea, Economic Science Series*, 22(1), 64-71.
- Bonnett, G. (2021a). *Departing GP warns govt failing to retain overseas medical staff*. RNZ. <https://www.rnz.co.nz/news/national/441433/departing-gp-warns-govt-failing-to-retain-overseas-medical-staff>
- Bonnett, G. (2021b). *Skilled migrants awaiting residency: 'We feel like we're being left to sink or swim'*. NZ Herald. <https://www.nzherald.co.nz/nz/skilled-migrants-awaiting-residency-we-feel-like-were-being-left-to-sink-or-swim/5NZQ7YQYNHDFG3N7OWWFQDEOW4/>
- Bonnett, G. (2021c). *'Zero response' from govt after visa delay concerns raised - Doctor's union*. RNZ. <https://www.rnz.co.nz/news/national/450373/zero-response-from-govt-after-visa-delay-concerns-raised-doctor-s-union>
- Bourgeault, I. L., & Neiterman, E. (2013). Integrating international medical graduates: The Canadian approach to the brain waste problem. In *Wanted and Welcome?* (pp. 199-217). Springer. https://doi.org/10.1007/978-1-4614-0082-0_10
- Bramley, P. (2019). *Response to a request for official information*. Nelson Marlborough District Health Board. <https://fyi.org.nz/request/10688/response/37868/attach/html/4/OIA%2012467%20Response%20NMDHB%20PGY%201%20House%20officer%20positions.pdf.html>
- Braun, V., & Clarke, V. (2020). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*, 21(1), 37-47. <https://doi.org/10.1002/capr.12360>
- Braun, V., & Clarke, V. (2021). The ebbs and flows of qualitative research: Time, change and the slow wheel of interpretation. In B. C. Clift, J. Gore, S. Gustafsson, S. Bekker, I. C. Batlle, & J. Hatchard (Eds.), *Temporality in qualitative inquiry: Theories, methods and practices* (pp. 22-38). Routledge.
- Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. SAGE.
- Braveman, P., & Gottlieb, L. (2014). The social determinants of health: it's time to consider the causes of the causes. *Public Health Reports*, 129(Suppl. 2), 19-31. <https://doi.org/10.1177/00333549141291S206>
- Bremner, N. (2022). *NZ needs more locally trained doctors - Medical school professor*. 1 News. <https://www.1news.co.nz/2022/04/17/nz-needs-more-locally-trained-doctors-medical-school-professor/>

- Bringedal, B. H., Ro, K. I., Baathe, F., Miljeteig, I., & Magelssen, M. (2022). Guidelines and clinical priority setting during the COVID-19 pandemic - Norwegian doctors' experiences. *BMC Health Services Research*, 22(1), 1192. <https://doi.org/10.1186/s12913-022-08582-2>
- Brock, G. (2015). Summary of conclusions from Part I. In G. Brock & M. Blake (Eds.), *Debating brain drain: May governments restrict emigration?* (pp. 101-110). Oxford University Press.
- Brock, G. (2017). Just responses to problems associated with the brain drain: Identity, community, and obligation in an unjust world. *South African Journal of Philosophy*, 36(1), 156-167. <https://doi.org/10.1080/02580136.2017.1278966>
- Brock, G., & Blake, M. (2015). Introduction: The brain drain and global justice. In G. Brock & M. Blake (Eds.), *Debating brain drain: May governments restrict emigration?* (pp. 1-10). Oxford University Press.
- Broughton, C. (2021). *Doctor shortage forcing GP clinics to turn away new patients*. Stuff. <https://www.stuff.co.nz/national/health/124477572/doctor-shortage-forcing-gp-clinics-to-turn-away-new-patients>
- Broughton, C. (2022). *UK-trained neurosurgeon takes legal action against Medical Council after being denied specialist role in NZ*. Stuff. <https://i.stuff.co.nz/national/health/127955802/uktrained-neurosurgeon-takes-legal-action-against-medical-council-after-being-denied-specialist-role-in-nz>
- Brown, D. (2022). *OIA request: Hiring data for PGY1 House Officers*. Bay of Plenty District Health Board.
- Brücker, H., Bertoli, S., Facchini, G., Mayda, A. M., & Peri, G. (2012). Part I: Understanding highly skilled migration in developed countries: Conclusions. In T. Boeri, H. Brücker, F. Docquier, & H. Rapoport (Eds.), *Brain drain and brain gain: The global competition to attract high-skilled migrants*. <https://doi.org/10.1093/acprof:oso/9780199654826.001.0001>
- Bryman, A. (2006). Integrating quantitative and qualitative research: How is it done? *Qualitative Research*, 6(1), 97-113. <https://doi.org/10.1177/1468794106058877>
- Bryman, A. (2008). The end of the paradigm wars. In P. Alasuutari, L. Bickman, & J. Brannen (Eds.), *The SAGE handbook of social research methods* (pp. 12-25). SAGE.
- BSI Group New Zealand Limited. (2021). *Responsible Authority core performance standards review report*. Ministry of Health. <https://www.mcnz.org.nz/assets/Publications/Reports/4c0c4e252e/MCNZ-RA-Review-Final-published-report-December-2021.pdf>
- Budget debate: Alien doctors defended. (1943, July 1). *Timaru Herald*, 6. <https://paperspast.natlib.govt.nz/newspapers/THD19430701.2.75>
- Bundred, P. E., & Levitt, C. (2000). Medical migration: Who are the real losers? *The Lancet*, 356(9225), 245-246. [https://doi.org/https://doi.org/10.1016/s0140-6736\(00\)02492-2](https://doi.org/https://doi.org/10.1016/s0140-6736(00)02492-2)
- Burfitt, J. (2023). Have skills, will travel. *Acuity*, 10(3), 24-28. <https://www.acuitymag.com/people/have-skills-will-travel>

- Call to restrict influx of doctors. (1979, January 16). *New Zealand Press Association*, 4. <https://paperspast.natlib.govt.nz/newspapers/CHP19790116.2.48>
- Callister, P., Badkar, J., & Didham, R. (2009). Doctors and romance: Not only of interest to Mills and Boon readers. *Journal of Primary Health Care*, 1(2). <https://doi.org/10.1071/hc09101>
- Callister, P., Badkar, J., & Didham, R. (2011). Globalisation, localisation and implications of a transforming nursing workforce in New Zealand: Opportunities and challenges. *Nursing Inquiry*, 18(3), 205-215. <https://doi.org/10.1111/j.1440-1800.2011.00528.x>
- Came, H. A., Cornes, R., & McCreanor, T. (2018). Treaty of Waitangi in New Zealand public health strategies and plans 2006–2016. *New Zealand Medical Journal*, 131, 32-37.
- Cameron, M. P., & Poot, J. (2019). Towards superdiverse Aotearoa: Dimensions of past and future ethnic diversity in New Zealand and its regions. *New Zealand Population Review*, 45, 18-45.
- Campbell, J. (2007). *Thinking global, sharing solutions*. NZ Doctor. <https://www.knowledge-basket.co.nz/databases/newztext/nz-doctor/search-nz-doctor/view/?sid=9455698&d31=magz%2Ftext%2Fdoctor%2F2007%2FFeb%2Fdoc0081.html>
- Cao, F. (2010). *Control of doctors in the NHS: A critical appraisal* [Doctoral thesis, University of Liverpool]. <https://livrepository.liverpool.ac.uk/3174337/1/539473.pdf>
- Carens, J. (2013). *The ethics of immigration*. Oxford University Press.
- Carey, D. (2019). *Improving well-being in New Zealand through migration* (Working Paper No. ECO/WKP(2019)35). [https://one.oecd.org/document/ECO/WKP\(2019\)35/En/pdf](https://one.oecd.org/document/ECO/WKP(2019)35/En/pdf)
- Carlbaum, S. (2021). Temporality and space in highly skilled migrants' experiences of education and work in the rural north of Sweden. *International Journal of Lifelong Education*, 40(5-6), 485-498. <https://doi.org/10.1080/02601370.2021.1984325>
- Cassie, F. (2021a). *Council's approach to overseas docs queried*. NZ Doctor. <https://www.nzdoctor.co.nz/article/news/councils-approach-overseas-docs-queried>
- Cassie, F. (2021b). *More doctors as fewer leave, more arrive - Number of new overseas doctors drops*. NZ Doctor. <https://www.nzdoctor.co.nz/article/print-archive/more-doctors-fewer-leave-more-arrive-number-new-overseas-doctors-drops>
- Cassie, F. (2022a). *Don't expect flood of overseas GPs*. NZ Doctor. <https://www.knowledge-basket.co.nz/databases/newztext/nz-doctor/search-nz-doctor/view/?sid=9455698&d28=magz%2Ftext%2Fdoctor%2F2022%2F04%2F13%2Fdoc0001.html>
- Cassie, F. (2022b). *Home and away for doctors, nurses*. NZ Doctor. <https://www.nzdoctor.co.nz/article/news/home-and-away-doctors-nurses>
- Cassie, F. (2022c). *Only 15 more GPs: 'It's appalling': Workforce survey paints sad picture for specialty*. NZ Doctor. <https://www.knowledge-basket.co.nz/databases/newztext/nz-doctor/search-nz-doctor/view/?sid=9455698&d59=magz%2Ftext%2Fdoctor%2F2022%2F11%2F23%2Fdoc0005.html>

- Cassie, F. (2022d). *Pilot of training migrant doctors in general practice probed*. NZ Doctor. <https://www.nzdoctor.co.nz/article/news/pilot-training-migrant-doctors-general-practice-probed>
- Cassie, F. (2023a). *Practices keen to host overseas-trained doctors in pilot scheme*. NZ Doctor. <https://www.nzdoctor.co.nz/article/news/practices-keen-host-overseas-trained-doctors-pilot-scheme>
- Cassie, F. (2023b). *Record number of new overseas nurses registered, record number of nurses also looking to leave*. NZ Doctor. <https://www.nzdoctor.co.nz/article/news/np-nurse/record-number-new-overseas-nurses-registered-record-number-nurses-also>
- Cassie, F. (2023c). *Working for free and burning out; College survey shows GPs' hours worked are the longest since 2014*. NZ Doctor. <https://www.nzdoctor.co.nz/article/news/cover-story/working-free-and-burning-out-college-survey-shows-gps-hours-worked-are>
- Chacko, E. (2007). From brain drain to brain gain: Reverse migration to Bangalore and Hyderabad, India's globalizing high tech cities. *GeoJournal*, 68(2), 131-140. <https://doi.org/10.1007/s>
- Chan, M. O. (2015). International medical graduates: Acculturation, repatriation and the third-culture kids of medicine. *Medical Education*, 49(9), 850-851. <https://doi.org/10.1111/medu.12802>
- Chauvet, L., Gubert, F., & Mesple-Somps, S. (2013). Aid, remittances, medical brain drain and child mortality: Evidence using inter and intra-country data. *Journal of Development Studies*, 49(6), 801-818. <https://doi.org/http://www.tandfonline.com/loi/fjds20>
- Chen, L. C., & Boufford, J. I. (2005). Fatal flows - Doctors on the move. *The New England Journal of Medicine*, 353(17), 1850-1852. <https://doi.org/10.1056/NEJMe058188>
- Cheng, C. (2018). Coda. Research design scaffolding. In C. Cheng (Ed.), *Extralegal groups in post-conflict Liberia: How trade makes the state*. Oxford University Press. <https://doi.org/10.1093/oso/9780199673346.003.0010>
- Cheong, M. (2019). *Official Information Act request*. Northland District Health Board. <https://fyi.org.nz/request/10701/response/37889/attach/html/2/Mohammed%20PGY1%2031%20Jul%2019.pdf.html>
- Chikanda, A. (2007). Medical migration from Zimbabwe: Magnitude, causes and impact on the poor. *Development Southern Africa*, 24(1), 47-60. <https://doi.org/http://www.tandfonline.com/loi/cdsa20>
- Childress, A. (2021). Fady Joudah. In N. Carlin (Ed.), *Contemporary physician-authors* (pp. 158-171). Routledge. <https://doi.org/10.4324/9781003079712-10>
- Ching, C. (2018). *The bottleneck rules: How to get more done (when working harder isn't working)*. Clarke Ching.
- Chojnicki, X., & Moullan, Y. (2018). Is there a 'pig cycle' in the labour supply of doctors? How training and immigration policies respond to physician shortages. *Social Science & Medicine*, 200, 227-237. <https://doi.org/10.1016/j.socscimed.2018.01.038>
- Choy, W. K., & Glass, H. (2002). Brain drain in New Zealand: Issues, evidence and implications. *Agenda: A Journal of Policy Analysis and Reform*, 9(1), 65-82.

- CHRE. (2010). *Performance review of the Medical Council of New Zealand: Promoting improvement in regulation through international collaboration*. Council for Healthcare Regulatory Excellence. <https://www.mcnz.org.nz/assets/Publications/Strategic-Plans/d18cdb9242/CHRE-report-June-2010.pdf>
- Claassen, R. (2014). Human dignity in the capability approach. In *The Cambridge Handbook of Human Dignity* (pp. 240-249). Cambridge University Press. <https://doi.org/10.1017/cbo9780511979033.030>
- Claire, A. (2019). *Official information request - Number of hired NZREX PGY1 House Officers*. Auckland District Health Board. <https://fyi.org.nz/request/10644/response/37254/attach/html/4/SC454E0100319072209020.pdf.html>
- Clemens, M. (2007). *Do visas kill? Health effects of African health professional emigration*. Center for Global Development.
- Clemens, M. (2011). The financial consequences of high-skilled emigration: Lessons from African doctors abroad. In S. Plaza & D. Ratha (Eds.), *Diaspora for development in Africa* (pp. 165-182). World Bank.
- Cohen, J. (1988). *Statistical power analysis for the behavioral science* (2nd ed.). Lawrence Erlbaum Associates.
- Cole, D. S. (1988). Background paper on medical registration changes contemplated in New Zealand. *New Zealand Medical Journal*, 101(847), 375-377.
- Colebatch, T. (2005, October 27). Bitter pill: Brain gain 'robs' others. *The Age (Melbourne)*, 8.
- Colegio Médico del Perú. (2024). *Conoce a tu médico*. Colegio Médico del Perú. <https://www.cmp.org.pe/conoce-a-tu-medico/>
- Coley, K. (2019). *Your Official Information Act (1982) request HBDHB REF: OIA2019086*. Hawke's Bay District Health Board. <https://fyi.org.nz/request/10692/response/37900/attach/html/4/06%20OIA2019086%20EDPS%20Signed%20Response.pdf.html>
- Connell, J. (2004). The migration of skilled health professionals: From the Pacific Islands to the world. *Asian & Pacific Migration Journal (Scalabrini Migration Center)*, 13(2), 155-177.
- Connell, J. (2009). *The global health care chain: From the Pacific to the world*. Routledge.
- Connell, J. (2010). *Migration and the globalisation of health care: The health worker exodus?* Edward Elgar.
- Connell, J. (2014). The two cultures of health worker migration: A Pacific perspective. *Social Science & Medicine*, 116, 73-81. <https://doi.org/10.1016/j.socscimed.2014.06.043>
- Connelly, E., & Künzel, S. (2018). *New approaches to disease, disability and medicine in medieval Europe*. Archaeopress Publishing Ltd.
- Constantin, A., & Sternstein, A. (2023). Healthcare workers' freedom of movement in times of pandemics: An emerging norm of customary international law. *Global Health*, 19(1), 83. <https://doi.org/10.1186/s12992-023-00985-y>

- Control of aliens. (1941, May 15). *Nelson Evening Mail*, 5. <https://paperspast.natlib.govt.nz/newspapers/NEM19410515.2.66>
- Cook, N., & Butz, D. (Eds.). (2018). *Mobilities, mobility justice and social justice*. Routledge. <https://doi.org/10.4324/9780815377047>.
- Covell, C. L., Neiterman, E., & Bourgeault, I. L. (2016). Scoping review about the professional integration of internationally educated health professionals. *Human Resources for Health*, 14(1), 38. <https://doi.org/10.1186/s12960-016-0135-6>
- Craig, A. T., Beek, K., Gilbert, K., Soakai, T. S., Liaw, S. T., & Hall, J. J. (2022). Universal health coverage and the Pacific islands: An overview of senior leaders' discussions, challenges, priorities and solutions, 2015-2020. *International Journal of Environmental Research and Public Health*, 19(7), Article 4108. <https://doi.org/10.3390/ijerph19074108>
- Crampton, E. (2022). *Foreign doctors' exclusion makes little sense during pandemic*. Stuff. <https://i.stuff.co.nz/business/128110925/foreign-doctors-exclusion-makes-little-sense-during-pandemic>
- Cranston, S. (2017). Expatriate as a 'good' migrant: Thinking through skilled international migrant categories. *Population, Space and Place*, 23(6). <https://doi.org/10.1002/psp.2058>
- Cresswell, T. (2010). Towards a politics of mobility. *Environment and Planning D: Society and Space*, 28(1), 17-31. <https://doi.org/10.1068/d11407>
- Cresswell, T. (2021). Valuing mobility in a post COVID-19 world. *Mobilities*, 16(1), 51-65. <https://doi.org/10.1080/17450101.2020.1863550>
- Creswell, J. W. (2010). Mapping the developing landscape of mixed methods research. In A. Tashakkori & C. Teddlie (Eds.), *SAGE handbook of mixed methods in social & behavioral research* (2nd ed., pp. 45-68). SAGE.
- Creswell, J. W. (2015). *A concise introduction to mixed methods research*. SAGE.
- Creswell, J. W., & Plano Clark, V. L. (2018). *Designing and conducting mixed methods research* (3rd ed.). SAGE.
- Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S. J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health*, 18(1), 174. <https://doi.org/10.1186/s12939-019-1082-3>
- Cuts in medical student intakes recommended. (1979, May 25). *New Zealand Press Association*, 3. <https://paperspast.natlib.govt.nz/newspapers/CHP19790525.2.27>
- Dauphinee, W. D. (2005). Physician migration to and from Canada: The challenge of finding the ethical and political balance between the individual's right to mobility and recruitment to underserved communities. *The Journal of Continuing Education in the Health Professions*, 25(1), 22-29. <https://doi.org/10.1002/chp.5>
- Demystifying Rongoā Māori: Traditional Māori healing. (2008). *Best Practice Journal*(13), 32-36. https://bpac.org.nz/magazine/2008/may/docs/bpj13_rongoa_pages_32-36_pf.pdf

- Dept. blamed over hospital staffing. (1966, April 29). *New Zealand Press Association*, 1. <https://paperspast.natlib.govt.nz/newspapers/CHP19660429.2.12>
- DeVellis, R. F. (2017). *Scale development: Theory and applications* (4th ed.). SAGE.
- Dickinson, B. L., Gibson, K., VanDerKolk, K., Greene, J., Rosu, C. A., Navedo, D. D., Porter-Stransky, K. A., & Graves, L. E. (2020). "It is this very knowledge that makes us doctors": An applied thematic analysis of how medical students perceive the relevance of biomedical science knowledge to clinical medicine. *BMC Medical Education*, 20, Article 356. <https://doi.org/10.1186/s12909-020-02251-w>
- Difficulties over doctors. (1977, August 27). *New Zealand Press Association*, 2. <https://paperspast.natlib.govt.nz/newspapers/CHP19770827.2.16>
- Dilger, H., Kane, A., & Langwick, S. A. (2012). Transnational medicine, mobile experts. In H. Dilger, A. Kane, & S. A. Langwick (Eds.), *Medicine, mobility, and power in global Africa: Transnational health and healing* (pp. 1-27). Indiana University Press.
- A doctor's complaint. (1928, March 9). *Evening Star*, 7. <https://paperspast.natlib.govt.nz/newspapers/ESD19280309.2.79>
- Doctor surplus suggested. (1975, July 24). *New Zealand Press Association*, 3. <https://paperspast.natlib.govt.nz/newspapers/CHP19750724.2.24>
- Donoso, A., & Mancilla, A. (2017). Doctors with borders? An authority-based approach to the brain drain. *South African Journal of Philosophy*, 36(1), 69-77. <https://doi.org/10.1080/02580136.2016.1265375>
- Dooley, B. (2022). *The dark truth of America's Federation of State Medical Boards*. Rumble. <https://rumble.com/v1lbjvd-the-dark-truth-of-americas-federation-of-state-medical-boards.html>
- Dougan, F. (2022). *Official Information Act 1982 (OIA) – Response OIA2022053103*. Capital & Coast and Hutt Valley District Health Boards.
- Dovlo, D. (2005a). Taking more than a fair share? The migration of health professionals from poor to rich countries. *PLoS Medicine*, 2(5), Article e109. <https://doi.org/10.1371/journal.pmed.0020109>
- Dovlo, D. (2005b). Wastage in the health workforce: Some perspectives from African countries. *Human Resources for Health*, 3, 6. <https://doi.org/10.1186/1478-4491-3-6>
- Doyle, L., Brady, A.-M., & Byrne, G. (2019). An overview of mixed methods research – Revisited. In *SAGE mixed methods research*. SAGE. <https://doi.org/10.4135/9781526498137>
- Driouchi, A. (Ed.). (2014). *Labor and health economics in the Mediterranean Region: Migration and mobility of medical doctors*. IGI Global.
- Dywili, S., Bonner, A., Anderson, J., & L, O. B. (2012). Experience of overseas-trained health professionals in rural and remote areas of destination countries: A literature review. *Australian Journal of Rural Health*, 20(4), 175-184. <https://doi.org/10.1111/j.1440-1584.2012.01281.x>
- EHINZ. (2023). *Ethnic profile*. Massey University. <https://www.ehinz.ac.nz/indicators/population-vulnerability/ethnic->

- profile/#:~:text=to%20environmental%20risks-,New%20Zealand%20has%20a%20diverse%20ethnic%20mix,was%20born%20overseas%20(27.4%25).
- Elkin, K. J. (2013). *Protecting the public? An analysis of complaints and disciplinary proceedings against doctors in Australia and New Zealand* [Doctoral thesis, University of Melbourne].
- Elkin, K. J. (2015). Registration decision-making, and public protection: International medical graduates in Australia and New Zealand. *Canadian Public Policy*, 41(Supplement 1), S162-S172. <https://doi.org/10.3138/cpp.2013-049>
- Ellingham, J. (2022). *Patient left in emergency department for whole day before being moved to ward.* RNZ. <https://www.rnz.co.nz/news/national/461673/patient-left-in-emergency-department-for-whole-day-before-being-moved-to-ward>
- Elliott, A., & Urry, J. (2010). *Mobile lives: Self, excess and nature*. Routledge.
- Emery-Whittington, I. G. (2021). Occupational justice - Colonial business as usual? Indigenous observations from Aotearoa New Zealand: La justice occupationnelle: Sous regime colonial comme d'habitude? Observations d'autochtones d'Aotearoa en Nouvelle-Zelande. *Canadian Journal of Occupational Therapy*, 88(2), 153-162. <https://doi.org/10.1177/00084174211005891>
- Escobar, A. (2018). *Designs for the pluriverse: Radical interdependence, autonomy, and the making of worlds*. Duke University Press.
- Eyal, N., & Hurst, S. A. (2008). Physician brain drain: Can nothing be done? *Public Health Ethics*, 1(2), 180-192. <https://doi.org/https://doi.org/10.1093/phe/phn026>
- Facchini, G., & Lodigiani, E. (2014). Attracting skilled immigrants: An overview of recent policy developments in advanced countries. *National Institute Economic Review*(229), R3-R21. <https://doi.org/https://doi.org/10.1177/002795011422900102>
- Federation of State Medical Boards. (2024). *About physician licensure*. <https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/guide-to-medical-regulation-in-the-united-states/about-physician-licensure/>
- Fenton, E., & Chillag, K. (2022). We want to help: Ethical challenges of medical migration and brain waste during a pandemic. *Journal of Medical Ethics*, 0, 1-4. <https://doi.org/10.1136/medethics-2022-108311>
- Ferracioli, L., & De Lora, P. (2015). Primum Nocere: Medical brain drain and the duty to stay. *Journal of Medicine and Philosophy*, 40(5), 601-619. <https://doi.org/10.1093/jmp/jhv022>
- Fife, W. (2005). *Doing fieldwork: Ethnographic methods for research in developing countries and beyond*. Palgrave Macmillan.
- Fleming, C. (2019). *Official Information Act request*. Southern District Health Board. <https://fyi.org.nz/request/10648/response/37205/attach/html/3/1783%20Mohammed%20A%20M%2018.07.2019.pdf.html>
- Fleming, C. (2022). *Official Information Act request #2422*. Piki Te Ora - Southern District Health Board.

- Fonseka, D. (2021). *Skilled migrants are leaving in droves, frustrated by lengthy residency delays*. Stuff. <https://www.stuff.co.nz/business/125796584/skilled-migrants-are-leaving-in-droves-frustrated-by-lengthy-residency-delays>
- Forbes, S. (2022). *Junior doctor denied Medical Council registration in NZ calls for change*. Stuff. <https://www.stuff.co.nz/national/politics/local-democracy-reporting/300720651/junior-doctor-denied-medical-council-registration-in-nz-calls-for-change>
- Foreign doctors. (1938, June 2). *Wairarapa Times-Age*, 7. <https://paperspast.natlib.govt.nz/newspapers/WAITA19380602.2.60>
- Fortier, A.-M. (2014). Migration studies. In P. Adey, D. Bissell, K. Hannam, P. Merriman, & M. Sheller (Eds.), *The Routledge handbook of mobilities* (pp. 64-73). Routledge.
- Fountain, B. (2022). *Competency not enough to keep patients safe*. NZ Doctor. <https://www.nzdoctor.co.nz/article/competency-not-enough-keep-patients-safe-0>
- Fowler Jr., F. J. (2014). *Survey research methods* (5th ed.). SAGE.
- Fox, R. C. (2014). *Doctors without borders: Humanitarian quests, impossible dreams of Médecins sans frontières*. Johns Hopkins University Press.
- Franklyn, G. (2023). "We're IMGs, and we're often seen as human garbage outside of primary care": A qualitative investigation of dynamic status hierarchy construction online by medical trainees. *Social Science & Medicine*, 317, Article 115611. <https://doi.org/10.1016/j.socscimed.2022.115611>
- Fraser, N. (1995). Recognition or redistribution? A critical reading of Iris Young's Justice and the politics of difference. *Journal of Political Philosophy*, 3(2), 166-180. <https://doi.org/10.1111/j.1467-9760.1995.tb00033.x>
- Fraser, N. (1998). *Social justice in the age of identity politics: Redistribution, recognition, and participation* (WZB Discussion Paper, Issue FS I 98-108). Wissenschaftszentrum Berlin für Sozialforschung (WZB). <https://hdl.handle.net/10419/44061>
- Fraser, N. (2009). *Scales of justice: Reimagining political space in a globalizing world*. Colombia University Press.
- Gaillard, J., & Gaillard, A. M. (1997). Introduction: The international mobility of brains: Exodus or circulation? *Science, Technology and Society*, 2(2), 195-228. <https://doi.org/https://doi.org/10.1177/097172189700200202>
- Gaillard, J., Gaillard, A. M., & Krishna, V. V. (2015). Return from migration and circulation of highly educated people: The never-ending brain drain. *Science, Technology and Society*, 20(3), 269-278. <https://doi.org/10.1177/0971721815597168>
- Garces-Ozanne, A., Yow, A., & Audas, R. (2011). Rural practice and retention in New Zealand: An examination of New Zealand-trained and foreign-trained doctors. *New Zealand Medical Journal*, 124(1330), 14-23.
- Gasper, D. (2002). Is Sen's capability approach an adequate basis for considering human development? *Review of Political Economy*, 14(4), 435-461. <https://doi.org/10.1080/0953825022000009898>

- Gauld, R., & Horsburgh, S. (2015). What motivates doctors to leave the UK NHS for a “life in the sun” in New Zealand; and, once there, why don’t they stay? *Human Resources for Health*, 13, 75. <https://doi.org/10.1186/s12960-015-0069-4>
- Gauld, R., & Horsburgh, S. (2016). Does a host country capture knowledge of migrant doctors and how might it? A study of UK doctors in New Zealand. *International Journal of Public Health*, 61(1), 1-8. <https://doi.org/10.1007/s00038-015-0770-z>
- General Medical Council. (2021). *GMC targets elimination of disproportionate complaints and training inequalities*. <https://www.gmc-uk.org/news/news-archive/gmc-targets-elimination-of-disproportionate-complaints-and-training-inequalities>
- General Medical Council. (2023a). *Using your IELTS certificate*. <https://www.gmc-uk.org/registration-and-licensing/join-the-register/before-you-apply/evidence-of-your-knowledge-of-english/using-your-ielts-certificate>
- General Medical Council. (2023b). *When and where can you take PLAB 2?* <https://www.gmc-uk.org/registration-and-licensing/join-the-register/plab/plab-2-guide/when-and-where-can-you-take-plab-2>
- Germeten, S. (2013). Personal narratives in life history research. *Scandinavian Journal of Educational Research*, 57(6), 612-624. <https://doi.org/10.1080/00313831.2013.838998>
- Ghiara, V. (2020). Disambiguating the role of paradigms in mixed methods research. *Journal of Mixed Methods Research*, 14(1), 11-25. <https://doi.org/10.1177/1558689818819928>
- Gorman, D. (2011). The disposition and mobility of medical practitioners in New Zealand. *New Zealand Medical Journal*, 124(1330), 11-13.
- Gorman, D. F., & Brooks, P. M. (2009). On solutions to the shortage of doctors in Australia and New Zealand. *Medical Journal of Australia*, 190(3), 152-156. <https://doi.org/10.5694/j.1326-5377.2009.tb02320.x>
- Green, J. (2022). *Official Information Act request – House Officer recruitment*. Hauora Tairāwhiti. https://www.hauoratairawhiti.org.nz/assets/Response-14352-House-Officer-Recruitment_Redacted.pdf
- Greene, J. C. (2006). Toward a methodology of mixed methods social inquiry. *Research in the Schools*, 13(1), 94-99.
- Greene, J. C. (2007). *Mixed methods in social inquiry*. Jossey-Bass.
- Greene, J. C., Caracelli, V. J., & Graham, W. F. (1989). Toward a conceptual framework for mixed-method evaluation designs. *Educational Evaluation and Policy Analysis*, 11(3), 255-274. <https://doi.org/10.3102/01623737011003255>
- Griffiths, M. (2019). *Number of hired PGY1 House Officers (2014 -2019)*. Bay of Plenty District Health Board. <https://fyi.org.nz/request/10691-number-of-hired-pgy1-house-officers-2014-2019>
- Grimmond, D., Martin, G., & Tu, D. (2021). *2021 GP future workforce requirements report*. Allen+Clarke. <https://www.rnzcgp.org.nz/gpdocs/new-website/publications/2021-GP-future-workforce-report-FINAL.pdf>

- Groot, S., & Van Ommen, C. (2017). Part 3: Arrivals past and present: Introduction. In S. Groot, C. Van Ommen, B. Masters-Awatere, & N. Tassell-Matamua (Eds.), *Precarity: Uncertain, insecure and unequal lives in Aotearoa New Zealand* (pp. 178-182). Massey University Press.
- Gullery, C. (2019). *Official Information Request Act request CDHB 10133*. Canterbury District Health Board. <https://fyi.org.nz/request/10647/response/37701/attach/html/3/CDHB%2010133%20Response%2029%207%202019.pdf.html>
- Gunia, A. (2021). *Why New Zealand's coronavirus elimination strategy is unlikely to work in most other places*. Time. <https://time.com/5824042/new-zealand-coronavirus-elimination/>
- Hahn, S. (2017). Precarious refuge: A conversation with Abann Kamyay Ajak Yor. In S. Groot, C. Van Ommen, B. Masters-Awatere, & N. Tassell-Matamua (Eds.), *Precarity: Uncertain, insecure and unequal lives in Aotearoa New Zealand* (pp. 229-240). Massey University Press.
- Haivas, I. (2005). Stairway to New Zealand. *BMJ: British Medical Journal*, 331(Suppl. S6), Article 0512454. <https://doi.org/10.1136/sbmj.0512454>
- Hammett, D. (2014). Physician migration in the global south between Cuba and South Africa. *International Migration*, 52(4), 41-52. <https://doi.org/10.1111/imig.12127>
- 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. <https://doi.org/10.1111/j.1440-1584.2005.00708.x>
- Hannah, A. (1996). *The New Zealand medical practitioner workforce 1995*. Ministry of Health. [https://www.moh.govt.nz/notebook/nbbooks.nsf/0/3CAA4BB7AE9284D84C2565D7000E4C31/\\$file/Medical%20Pract%20Wkforce%201995.pdf](https://www.moh.govt.nz/notebook/nbbooks.nsf/0/3CAA4BB7AE9284D84C2565D7000E4C31/$file/Medical%20Pract%20Wkforce%201995.pdf)
- Hannah, A., Roser, B., & Linton, M. (1991). *The New Zealand health workforce 1990*. Department of Health - Te Tari Ora. [https://www.moh.govt.nz/notebook/nbbooks.nsf/0/74FEDD30C19DED134C2565D7000E3D38/\\$file/1990part1.pdf](https://www.moh.govt.nz/notebook/nbbooks.nsf/0/74FEDD30C19DED134C2565D7000E3D38/$file/1990part1.pdf)
- Harbitz, M. B., Stensland, P. S., & Abelsen, B. (2021). Medical malpractice in Norway: Frequency and distribution of disciplinary actions for medical doctors 2011-2018. *BMC Health Services Research*, 21(1), 324. <https://doi.org/10.1186/s12913-021-06334-2>
- Hatcher, S., Handrinis, D., & Lakra, V. (2007). The first year of the RANZCP Exemptions Candidates Examination. *Australasian Psychiatry*, 15(6), 494-498. <https://doi.org/10.1080/10398560701636948>
- Hawken, S. (2005a). Overseas-trained doctors' evaluation of a New Zealand course in professional development. *New Zealand Medical Journal*, 118(1219), 40-46.
- Hawken, S. (2005b). Where to now with programmes for overseas-trained doctors? *New Zealand Medical Journal*, 118(1219), 61-65.
- Hazou, R. (2017). Performing the precariat: Acting for asylum seekers and refugees in Aotearoa New Zealand. In S. Groot, C. Van Ommen, B. Masters-Awatere, & N. Tassell-Matamua

- (Eds.), *Precarity: Uncertain, insecure and unequal lives in Aotearoa New Zealand* (pp. 241-253). Massey University Press.
- Health Practitioners Competence Assurance Act, No. 48, Parliament of New Zealand (2003). <https://www.legislation.govt.nz/act/public/2003/0048/latest/whole.html#DLM203312>
- Helble, M. (2011). The movement of patients across borders: Challenges and opportunities for public health. *Bulletin of the World Health Organization*, 89(1), 68-72. <https://doi.org/10.2471/BLT.10.076612>
- Hidalgo, J. S. (2013). The active recruitment of health workers: A defence. *Journal of Medical Ethics*, 39(10), 603-609. <https://doi.org/10.1136/medethics-2012-100927>
- Holloway, P., Bain-Donohue, S., & Moore, M. (2020). Why do doctors work in rural areas in high-income countries? A qualitative systematic review of recruitment and retention. *Australian Journal of Rural Health*, 28(6), 543-554. <https://doi.org/10.1111/ajr.12675>
- Holmes, J. (1981). Medical immigration. *New Zealand Medical Journal*, 94(696), 395.
- Honneth, A. (2004). Recognition and justice. *Acta Sociologica*, 47(4), 351-364. <https://doi.org/10.1177/0001699304048668>
- Hood, C. M., Gennuso, K. P., Swain, G. R., & Catlin, B. B. (2016). County health rankings: Relationships between determinant factors and health outcomes. *American Journal of Preventative Medicine*, 50(2), 129-135. <https://doi.org/10.1016/j.amepre.2015.08.024>
- Hooper, C. R. (2008). Adding insult to injury: The healthcare brain drain. *Journal of Medical Ethics*, 34(9), 684-687. <https://doi.org/10.1136/jme.2007.023143>
- Hooper, C. R. (2013). Reply to Hidalgo's 'The active recruitment of health workers: A defence' article. *Journal of Medical Ethics*, 39(10), 611-612. <https://doi.org/10.1136/medethics-2012-101132>
- Houlahan, M. (2022). 'Ready to help', if appeal won. Otago Daily Times. <https://www.odt.co.nz/news/dunedin/health/%E2%80%98ready-help%E2%80%99-if-appeal-won>
- Hsu, E. (2012). Mobility and connectedness: Chinese medical doctors in Kenya. In H. Dilger, A. Kane, & S. A. Langwick (Eds.), *Medicine, mobility, and power in global Africa: Transnational health and healing* (pp. 295-315). Indiana University Press.
- Hudson, K. (2019). OIA: 2019/118. Capital & Coast District Health Board. <https://fyi.org.nz/request/10693/response/37860/attach/html/3/OIA%202019%20118%20Response.pdf.html>
- Huijskens, E. G., Hooshiaran, A., Scherpbier, A., & van der Horst, F. (2010). Barriers and facilitating factors in the professional careers of international medical graduates. *Medical Education*, 44(8), 795-804. <https://doi.org/10.1111/j.1365-2923.2010.03706.x>
- Hunter, B. (2019). Official Information Act. Hauora Tairāwhiti. <https://fyi.org.nz/request/10702/response/37228/attach/html/2/12482%20number%20of%20hired%20PGY1%20House%20Officers%202013%202019%20TDH.pdf.html>

- IAMRA. (2022). *IAMRA regulatory best practice working group charge*. <https://www.iamra.com/resources/Documents/Regulatory%20Best%20Practice%20Working%20Group%20Charge%20-%202022.pdf>
- IAMRA. (2023a). *Board of Directors*. <https://www.iamra.com/Board-of-Directors>
- IAMRA. (2023b). *IAMRA history*. <https://www.iamra.com/history>
- Immigration New Zealand. (2024). *Green List roles*. <https://www.immigration.govt.nz/new-zealand-visas/preparing-a-visa-application/working-in-nz/qualifications-for-work/green-list-occupations>
- Jackson, D. J. R., Carr, S. C., Edwards, M., Thorn, K., Allfree, N., Hooks, J., & Inkson, K. (2005). Exploring the dynamics of New Zealand's talent flow. *New Zealand Journal of Psychology*, 34(2), 110-116.
- Jirovsky, E., Hoffmann, K., Maier, M., & Kutalek, R. (2015). "Why should I have come here?"- A qualitative investigation of migration reasons and experiences of health workers from sub-Saharan Africa in Austria. *BMC Health Services Research*, 15, Article 74. <https://doi.org/10.1186/s12913-015-0737-z>
- Johansen, M. L., Høltedahl, K. A., Davidsen, A. S., & Rudebeck, C. E. (2012). 'I deal with the small things': The doctor-patient relationship and professional identity in GPs' stories of cancer care. *Health (London)*, 16(6), 569-584. <https://doi.org/10.1177/1363459312438565>
- Johnson, C. (2019). *Official Information Act request*. South Canterbury District Health Board. <https://fyi.org.nz/request/10649/response/36511/attach/html/4/Response%20letter%2064.19.pdf.html>
- Johnson, J. (2005). Stopping Africa's medical brain drain: The rich countries of the north must stop looting doctors and nurses from developing countries. *BMJ: British Medical Journal*, 331(7507), 2-3. <https://doi.org/10.1136/bmj.331.7507.2>
- Johnson, J. L., Bottorff, J. L., Browne, A. J., Grewal, S., Hilton, B. A., & Clarke, H. (2004). Othering and being othered in the context of health care services. *Health Communication*, 16(2), 255-271. https://doi.org/10.1207/S15327027HC1602_7
- Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a definition of mixed methods research. *Journal of Mixed Methods Research*, 1(2), 112-133. <https://doi.org/10.1177/1558689806298224>
- Jon and Jon Medical Recruitment Consulting. (2024). *Working in Australia & New Zealand: A guide for international doctors*. <https://cdn-01.cms-ap-v2i.applyflow.com/jon-jon/wp-content/uploads/2022/06/Working-in-Australia-and-New-Zealand-small-1.pdf>
- Jones, G. (2002). *The Medical Council of New Zealand: A personal and informal perspective of events during my time as Chief Executive/Secretary/Registrar from 1986 to 2000*. MCNZ.
- Kabutaulaka, T. (2021). Keynote speaker 1: Associate Professor Tarcisius Kabutaulaka, the University of Hawai'i at Mānoa In *DevNet Symposium 2021: Rethinking development research & practice in the time of Covid-19 and beyond*.
- Kai Tiaki Nursing New Zealand. (2014). High dependence on overseas doctors. *Nursing New Zealand*, 20(9), 7.

- Kapa, A. (2022). Disconnection from Manawa: Moral distress through a Māori lens. *Aotearoa New Zealand Midwife*(105), 26-29.
- Kaufmann, V., Bergman, M. M., & Joye, D. (2004). Motility: Mobility as capital. *International Journal of Urban and Regional Research*, 28(4), 745-756. <https://doi.org/10.1111/j.0309-1317.2004.00549.x>
- Kearns, R., Myers, J., Adair, V., Coster, H., & Coster, G. (2006). What makes 'place' attractive to overseas-trained doctors in rural New Zealand? *Health and Social Care in the Community*, 14(6), 532-540. <https://doi.org/10.1111/j.1365-2524.2006.00641.x>
- Kehoe, A., McLachlan, J., Metcalf, J., Forrest, S., Carter, M., & Illing, J. (2016). Supporting international medical graduates' transition to their host-country: Realist synthesis. *Medical Education*, 50(10), 1015-1032. <https://doi.org/10.1111/medu.13071>
- Keil, R. (2014). Diseased. In P. Adey, D. Bissell, K. Hannam, P. Merriman, & M. Sheller (Eds.), *The Routledge handbook of mobilities* (pp. 388-397). Routledge.
- King, A. (2002). *Address to Overseas Doctors' Association* <https://www.beehive.govt.nz/node/14298>
- Klingler, C., & Marckmann, G. (2016). Difficulties experienced by migrant physicians working in German hospitals: A qualitative interview study. *Human Resources for Health*, 14(1), 57. <https://doi.org/10.1186/s12960-016-0153-4>
- Kollar, E., & Buyx, A. (2013). Ethics and policy of medical brain drain: A review. *Swiss Medical Weekly*, 143, w13845. <https://doi.org/10.4414/smw.2013.13845>
- Kotef, H. (2015). *Movement and the ordering of freedom: On liberal governances of mobility*. Duke University Press.
- Koutonin, M. (2015). *Why are white people expats when the rest of us are immigrants?* The Guardian. <https://www.theguardian.com/global-development-professionals-network/2015/mar/13/white-people-expats-immigrants-migration>
- Krämer, H., & Schindler, L. (2016). (Im-)mobilities, air, critique: An interview with Peter Adey. *Österreichische Zeitschrift für Soziologie*, 41(1), 5-14. <https://doi.org/10.1007/s11614-016-0190-1>
- Kugler, Adriana D., & Sauer, Robert M. (2005). Doctors without borders? Relicensing requirements and negative selection in the market for physicians. *Journal of Labor Economics*, 23(3), 437-465. <https://doi.org/10.1086/430283>
- Kumar, R. (2021). Indian medical graduates in New Zealand: Does anyone win? *Postgraduate Medical Journal*, 97(1147), 275-279. <https://doi.org/10.1136/postgradmedj-2020-138295>
- La Salle, R. (2022). *Official Information Act request WCDHB 9707*. West Coast District Health Board - Te Poari Hauora a Rohe o Tai Poutini. <https://www.wcdhb.health.nz/about-us/document-library/wcdhb-9707-pgy1-house-officers/>
- Laurenson, J. G. (1972). Immigration problem. *New Zealand Medical Journal*, 75(480), 310.
- Lawrenson, R. (2023). *New Zealand's reliance on foreign doctors to plug gaps highlights the need for another medical school*. The Conversation. <https://theconversation.com/new->

- zealands-reliance-on-foreign-doctors-to-plug-gaps-highlights-the-need-for-another-medical-school-204668
- Lawrenson, R., Town, I., Strasser, R., Strasser, S., McKimm, J., Tapsell, R., & Murray, N. (2017). The proposal for a third medical school in New Zealand: A community-engaged graduate entry medical program. *New Zealand Medical Journal*, 130(1453), 63-70.
- Leland, H. E. (1979). Quacks, lemons, and licensing: A theory of minimum quality standards. *Journal of Political Economy*, 87(6), 1328-1346.
- Letters to the editor: Alien doctors. (1944, September 5). *New Zealand Herald*, 4. <https://paperspast.natlib.govt.nz/newspapers/NZH19440905.2.24>
- Levy, L. F. (2003). The first world's role in the third world brain drain. *BMJ: British Medical Journal*, 327(7407), 170-170.
- Leydet, D. (2017). Citizenship. *The Stanford Encyclopedia of Philosophy*. <https://plato.stanford.edu/archives/fall2017/entries/citizenship/>
- Licensing of alien doctors. (1943, February 1). *New Zealand Press Association*, 6. <https://paperspast.natlib.govt.nz/newspapers/CHP19430201.2.64>
- Lichtman, M. (2014). *Qualitative research for the social sciences*. SAGE. <https://doi.org/10.4135/9781544307756>
- Lillis, S., & Roblin, H. (2014). Progress of successful New Zealand Registration Examination (NZREX Clinical) candidates during their first year of supervised clinical practice in New Zealand. *New Zealand Medical Journal*, 127(1399), 36-42.
- Lillis, S., St George, I., & Upsdell, R. (2006). Perceptions of migrant doctors joining the New Zealand medical workforce. *New Zealand Medical Journal*, 119(1219), 46-54.
- Lillis, S., Stuart, M., Sidonie, & Stuart, N. (2012). New Zealand Registration Examination (NZREX Clinical): 6 years of experience as an Objective Structured Clinical Examination (OSCE). *New Zealand Medical Journal*, 125(1361), 74-80.
- Lillis, S., & Van Dyk, V. (2014). Workplace-based assessment for vocational registration of international medical graduates. *Journal of Continuing Education in the Health Professions*, 34(4), 260-264. <https://doi.org/10.1002/chp.21251>
- Lipworth, W., Little, M., Markham, P., Gordon, J., & Kerridge, I. (2013). Doctors on status and respect: A qualitative study. *Journal of Bioethical Inquiry*, 10(2), 205-217. <https://doi.org/10.1007/s11673-013-9430-2>
- Loss of doctors will equal graduates. (1968, January 4). *New Zealand Press Association*, 18. <https://paperspast.natlib.govt.nz/newspapers/CHP19680104.2.188>
- Low, S. (2022). *Official Information Act request*. South Canterbury District Health Board.
- Lynch, A. C. (2008). So why are New Zealand-trained doctors leaving? *New Zealand Medical Journal*, 121(1273), 6-8.
- M.A.N.Z. explains stand over doctors' salaries. (1970, December 17). *New Zealand Press Association*, 13. <https://paperspast.natlib.govt.nz/newspapers/CHP19701217.2.84>

- Mackey, T. K., & Liang, B. A. (2012). Rebalancing brain drain: Exploring resource reallocation to address health worker migration and promote global health. *Health Policy*, 107(1), 66-73. <https://doi.org/10.1016/j.healthpol.2012.04.006>
- Mahat, A., Dhillon, I. S., Benton, D. C., Fletcher, M., & Wafula, F. (2023). Health practitioner regulation and national health goals. *Bulletin of the World Health Organization*, 101(9), 595-604. <https://doi.org/10.2471/BLT.21.287728>
- Mannes, M. M., Thornley, D. J., & Wilkinson, T. J. (2023a). The consequences of cultural difference: The international medical graduate journey in New Zealand. *International Journal of Medical Education*, 14, 43-54. <https://doi.org/10.5116/ijme.6440.0e37>
- Mannes, M. M., Thornley, D. J., & Wilkinson, T. J. (2023b). Cross-cultural code-switching - The impact on international medical graduates in New Zealand. *BMC Medical Education*, 23(1), Article 920. <https://doi.org/10.1186/s12909-023-04900-2>
- Martenet, V. (2021). Separation of powers and antitrust: On common grounds? *SSRN Electronic Journal*. <https://doi.org/10.2139/ssrn.3764424>
- Martineau, T., Decker, K., & Bundred, P. (2004). "Brain drain" of health professionals: From rhetoric to responsible action. *Health Policy*, 70(1), 1-10. <https://doi.org/10.1016/j.healthpol.2004.01.006>
- Maxwell, J. A., & Mittapalli, K. (2010). Realism as a stance for mixed methods research. In A. Tashakkori & C. Teddlie (Eds.), *Sage handbook of mixed methods in social & behavioral research* (2nd ed., pp. 145-168). SAGE.
- Maynard, K. (2007). The vicissitudes of medical identity in Cameroon: Kedjom 'traditional doctors' and an ambivalent clientele. In K. Maynard (Ed.), *Medical identities: Working at medicine, working at self* (pp. 61-83). Berghahn Books. <https://doi.org/https://doi.org/10.2307/j.ctv287sdb4.8>
- McCarthy, F. (2019). *Official Information Act request - Total number of hired PGY1 House Officers*. Waitematā District Health Board. <https://fyi.org.nz/request/10645/response/37324/attach/html/4/OIA%20response%2019106.pdf.html>
- McCarthy, F. (2022). *OIA request - PGY1 House Officer positions*. Waitematā District Health Board. <https://www.waitematah.govt.nz/assets/Documents/news/OIA-publications/2022/June/Publish-OIA-Response-Hiring-data-for-PGY1-House-officers.pdf>
- McClure, T. (2021). *Even as New Zealand battles Covid, trust in government bucks global trend*. The Guardian. <https://www.theguardian.com/world/2021/aug/30/even-as-new-zealand-battles-covid-trust-in-government-bucks-global-trend>
- McCluskey, H. J., & Spilg, E. G. (2012). Why do a significant proportion of UK medical graduates leave the NHS to undertake medical employment in New Zealand? *New Zealand Medical Journal*, 125(1366), 83-84.
- McDermott, C., Sheridan, M., Moore, K., & Gosbell, A. (2014). The medical boomerang: Will it come back? *Emergency Medical Journal*, 32(4), 330-332. <https://doi.org/10.1136/emered-2014-204129>

- McEwan, C. (2014). Postcolonialism. In V. Desai & R. Potter (Eds.), *The companion to development studies* (pp. 137-141). Routledge.
- McEwan, C. (2019). *Postcolonialism, decoloniality and development* (2nd ed.). Routledge.
- McGinn, O. (2022). *Workforce crisis survey 2022*. New Zealand Women in Medicine Charitable Trust. <https://www.nzdoctor.co.nz/sites/default/files/2022-07/NZWIM%20workforce%20crisis%20survey%2011%20July%202022%20%20%281%29.pdf>
- McGrath, B. P. (2004). Integration of overseas-trained doctors into the Australian medical workforce. *Medical Journal of Australia*, 181(11-12), 640-642. <https://doi.org/10.5694/j.1326-5377.2004.tb06498.x>
- McKimm, J., & Wilkinson, T. (2015). "Doctors on the move": Exploring professionalism in the light of cultural transitions. *Medical Teacher*, 37(9), 837-843. <https://doi.org/10.3109/0142159X.2015.1044953>
- McKinnon, A. (2022). *Official Information Act request - OIA 14352 hiring data for PGY1 House Officers*. Whanganui District Health Board - Te Poari Hauora o Whanganui.
- McLennan, S., Huish, R., & Werle, C. (2020). The gift of health: Cuba's development assistance in the Pacific. *Pacific Review*. <https://doi.org/10.1080/09512748.2020.1808053>
- MCNZ. (1983). *Annual report 1983*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/2c3d64665d/MCNZ-Annual-Report-1983.pdf>
- MCNZ. (1984). *Annual report 1984*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/3df016a981/MCNZ-Annual-Report-1984.pdf>
- MCNZ. (1985). *Annual report 1985*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/12ead89def/MCNZ-Annual-Report-1985.pdf>
- MCNZ. (1986). *Annual report 1986*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/3db8d6cb79/MCNZ-Annual-Report-1986.pdf>
- MCNZ. (1987). *Annual report 1987*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/103e0bfbe4/MCNZ-Annual-Report-1987.pdf>
- MCNZ. (1988). *Annual report 1988*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/b8ed304363/MCNZ-Annual-Report-1988.pdf>
- MCNZ. (1989). *Annual report 1989*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/827b5313c2/MCNZ-Annual-Report-1989.pdf>
- MCNZ. (1990). *Annual report 1990*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/8abb2af3ad/MCNZ-Annual-Report-1990.pdf>
- MCNZ. (1991). *Annual report 1991*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/8fc35e672b/MCNZ-Annual-Report-1991.pdf>
- MCNZ. (1992). *Annual report 1992*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/7758cfd7f0/MCNZ-Annual-Report-1992.pdf>

- MCNZ. (1993). *Annual report 1993*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/c8368f2f65/MCNZ-Annual-Report-1993.pdf>
- MCNZ. (1994). *Annual report 1994*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/cdf6c313a2/MCNZ-Annual-Report-1994.pdf>
- MCNZ. (1995). *Annual report 1995*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/8b65655515/MCNZ-Annual-Report-1995.pdf>
- MCNZ. (1996a). *Annual report 1996*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/261ff5a866/MCNZ-Annual-Report-1996.pdf>
- MCNZ. (1996b). *Approved medical schools and universities pursuant to section 4 of the Medical Practitioners Act 1995*. New Zealand Gazette. <https://gazette.govt.nz/notice/id/1996-gn3485>
- MCNZ. (1997). *Annual report 1997*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/9a10d40b1f/MCNZ-Annual-Report-1997.pdf>
- MCNZ. (1998a). *Annual report 1998*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/f7a152a9bf/MCNZ-Annual-Report-1998.pdf>
- MCNZ. (1998b). *Approved medical schools and universities*. New Zealand Gazette. <https://gazette.govt.nz/notice/id/1998-gn4404>
- MCNZ. (1999). *Annual report 1999*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/a3b837f83d/MCNZ-Annual-Report-1999.pdf>
- MCNZ. (2000). *Annual report 2000*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/9917600af9/MCNZ-Annual-Report-2000.pdf>
- MCNZ. (2001a). *Annual report 2001*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/448d31dd84/MCNZ-Annual-Report-2001.pdf>
- MCNZ. (2001b). *Approved medical schools and universities notice 2001*. New Zealand Gazette. <https://gazette.govt.nz/notice/id/2001-gs4592>
- MCNZ. (2002a). *Annual report 2002*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/cfc5f59890/MCNZ-Annual-Report-2002.pdf>
- MCNZ. (2002b). *Approved medical schools and universities notice 2002*. New Zealand Gazette. <https://gazette.govt.nz/notice/id/2002-gs1762>
- MCNZ. (2003). *Annual report 2003*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/363bee65d7/MCNZ-Annual-Report-2003.pdf>
- MCNZ. (2004a). *Annual report 2004*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/4cde9d235e/MCNZ-Annual-Report-2004.pdf>
- MCNZ. (2004b). *Approved medical schools and universities notice 2004*. New Zealand Gazette. <https://gazette.govt.nz/notice/id/2004-gs2244>
- MCNZ. (2004c). *Notice of prescribed scopes of practice and related qualifications for health practitioners*. New Zealand Gazette. <https://gazette.govt.nz/notice/id/2004-gs6259>

- MCNZ. (2005a). *Annual report 2005*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/43e393a443/MCNZ-Annual-Report-2005.pdf>
- MCNZ. (2005b). *The New Zealand medical workforce in 2003*. <https://www.mcnz.org.nz/assets/Publications/Workforce-Survey/0855bb191a/Workforce-Survey-2003.pdf>
- MCNZ. (2005c). *The New Zealand medical workforce in 2004*. <https://www.mcnz.org.nz/assets/Publications/Workforce-Survey/c6a50ecd01/Workforce-Survey-2004.pdf>
- MCNZ. (2005d). *The New Zealand medical workforce in 2005*. <https://www.mcnz.org.nz/assets/Publications/Workforce-Survey/c7b74d39c5/Workforce-Survey-2005.pdf>
- MCNZ. (2006a). *Annual report 2006*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/1c07319792/MCNZ-Annual-Report-2006.pdf>
- MCNZ. (2006b). *The New Zealand medical workforce in 2006*. <https://www.mcnz.org.nz/assets/Publications/Workforce-Survey/c07aa94e48/Workforce-Survey-2006.pdf>
- MCNZ. (2007a). *Amendment to notice of new scope of practice and qualification prescribed by the Medical Council of New Zealand*. New Zealand Gazette. <https://gazette.govt.nz/notice/id/2007-gs7339>
- MCNZ. (2007b). *Annual report 2007*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/f9ef2e0228/MCNZ-Annual-Report-2007.pdf>
- MCNZ. (2008a). *Annual report 2008*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/cadadbc955/MCNZ-Annual-Report-2008.pdf>
- MCNZ. (2008b). *The New Zealand medical workforce in 2008*. <https://www.mcnz.org.nz/assets/Publications/Workforce-Survey/7a7d9620cf/Workforce-Survey-2008.pdf>
- MCNZ. (2008c). *Notice of new scope of practice and qualification prescribed by the Medical Council of New Zealand (June)*. New Zealand Gazette. <https://gazette.govt.nz/notice/id/2008-gs3907>
- MCNZ. (2008d). *Notice of new scope of practice and qualification prescribed by the Medical Council of New Zealand (May)*. New Zealand Gazette. <https://gazette.govt.nz/notice/id/2008-gs3671>
- MCNZ. (2009a). *Annual report 2009*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/b1a5868188/MCNZ-Annual-Report-2009.pdf>
- MCNZ. (2009b). *The New Zealand medical workforce in 2009*. <https://www.mcnz.org.nz/assets/Publications/Workforce-Survey/eeea662cdf/Workforce-Survey-2009.pdf>
- MCNZ. (2010a). *Annual report 2010*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/aae2ab01ba/MCNZ-Annual-Report-2010.pdf>

- MCNZ. (2010b). *Medical Council of New Zealand Scopes of practice and prescribed qualifications for the practice of medicine in New Zealand pursuant to Sections 11 and 12 of the Health Practitioners Competence Assurance Act 2003*. New Zealand Gazette. <https://gazette.govt.nz/notice/id/2010-gs854>
- MCNZ. (2010c). *The New Zealand medical workforce in 2010*. <https://www.mcnz.org.nz/assets/Publications/Workforce-Survey/d4015f0bac/Workforce-Survey-2010.pdf>
- MCNZ. (2011a). *Annual report 2011*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/667277f9b0/MCNZ-Annual-Report-2011.pdf>
- MCNZ. (2011b). *Orientation, induction and supervision for international medical graduates (IMGs) – Best practice guidelines for employers and supervisors of IMGs*. <https://www.mcnz.org.nz/assets/Publications/Booklets/Orientation-Induction-and-Supervision-for-International-Medical-Graduates.pdf>
- MCNZ. (2012a). *Annual report 2012*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/339197de02/MCNZ-Annual-Report-2012.pdf>
- MCNZ. (2012b). *Medical Council of New Zealand Scopes of practice and prescribed qualifications for the practice of medicine in New Zealand pursuant to Sections 11 and 12 of the Health Practitioners Competence Assurance Act 2003*. New Zealand Gazette. <https://gazette.govt.nz/notice/id/2012-gs641>
- MCNZ. (2013a). *Annual Report 2013*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/09f4ee848c/MCNZ-Annual-Report-2013.pdf>
- MCNZ. (2013b). *Medical Council of New Zealand - Scopes of practice and prescribed qualifications*. New Zealand Gazette. <https://gazette.govt.nz/notice/id/2013-gs6459?year=2013&pageNumber=3761>
- MCNZ. (2014a). *Annual report 2014*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/5adec178b6/MCNZ-Annual-Report-2014.pdf>
- MCNZ. (2014b). *Scopes of practice and prescribed qualifications for the practice of medicine in New Zealand*. New Zealand Gazette. <https://gazette.govt.nz/notice/id/2014-gs7072>
- MCNZ. (2015a). *Annual report 2015*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/168b238957/MCNZ-Annual-Report-2015.pdf>
- MCNZ. (2015b). *List of approved qualifications for locum tenens specialist appointments - February 2015*. <https://www.mcnz.org.nz/assets/Policies/1f8183e705/List-of-approved-qualifications-for-locum-tenens-specialist-appointments.pdf>
- MCNZ. (2016). *Annual report 2016*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/956bca6617/MCNZ-Annual-Report-2016.pdf>
- MCNZ. (2017a). *Annual Report 2017*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/21711dcbe6/MCNZ-Annual-Report-2017.pdf>
- MCNZ. (2017b). *Scopes of practice and prescribed qualifications for the practice of medicine in New Zealand*. New Zealand Gazette. <https://gazette.govt.nz/notice/id/2017-gs8>

- MCNZ. (2018a). *Annual report 2018*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/7080513fe1/MCNZ-Annual-Report-2018.pdf>
- MCNZ. (2018b). *Policy on registration within the General scope of practice*. <https://www.mcnz.org.nz/assets/Policies/83558c1e29/Policy-on-registration-within-the-general-scope-of-practice.pdf>
- MCNZ. (2018c). *Scopes of practice and prescribed qualifications for the practice of medicine in New Zealand 2018*. New Zealand Gazette. <https://gazette.govt.nz/notice/id/2018-gs2124>
- MCNZ. (2019). *Annual report 2019*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/c9587f0cbf/MCNZ-Annual-Report-2019.pdf>
- MCNZ. (2020a). *Annual report 2020*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/7060d941de/MCNZ-Annual-Report-2020.pdf>
- MCNZ. (2020b). *NZREX clinical: Pass rates and subsequent provisional general registration - April*. <https://www.mcnz.org.nz/assets/NZREX/47a6129c68/NZREX-Clinical-Pass-Rates-and-Subsequent-Registration.pdf>
- MCNZ. (2021a). *Annual report 2021*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/3111cbe4c8/MCNZ-Annual-Report-2021.pdf>
- MCNZ. (2021b). *Good medical practice*. <https://www.mcnz.org.nz/assets/standards/b3ad8bfba4/Good-Medical-Practice.pdf>
- MCNZ. (2022a). *Annual report 2022*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/MCNZ-Annual-Report-2022.pdf>
- MCNZ. (2022b). *Medical Council news: May 2022*. <https://mailchi.mp/dd8270a94ca9/medical-council-news-july-14142248>
- MCNZ. (2022c). *The New Zealand medical workforce in 2022*. <https://www.mcnz.org.nz/assets/Publications/Workforce-Survey/64f90670c8/Workforce-Survey-Report-2022.pdf>
- MCNZ. (2022d). *NZREX clinical: Pass rates and subsequent provisional general registration - April*. <https://www.mcnz.org.nz/assets/NZREX/47a6129c68/NZREX-Clinical-Pass-Rates-and-Subsequent-Registration.pdf>
- MCNZ. (2022e). *NZREX clinical: Pass rates and subsequent provisional general registration - January*. <https://www.mcnz.org.nz/assets/NZREX/47a6129c68/NZREX-Clinical-Pass-Rates-and-Subsequent-Registration.pdf>
- MCNZ. (2022f). *Policy on English language requirements (1 December 2022)*. <https://www.mcnz.org.nz/assets/Policies/English-language-policy.pdf>
- MCNZ. (2022g). *Scopes of practice and prescribed qualifications for the practice of medicine in New Zealand*. New Zealand Gazette. <https://gazette.govt.nz/notice/id/2022-gs5210>
- MCNZ. (2022h). *Te Whatu Ora programmes for NZREX graduates*. <https://www.mcnz.org.nz/about-us/news-and-updates/te-whatu-ora-pilot-for-programmes-for-nzrex-graduates/>

- MCNZ. (2023a). *Annual report 2023*. <https://www.mcnz.org.nz/assets/Publications/Annual-Reports/2023-Annual-Report-web.pdf>
- MCNZ. (2023b). *Comparable health system criteria*. <https://www.mcnz.org.nz/registration/getting-registered/registration-policy/comparable-health-system-criteria/>
- MCNZ. (2023c). *Medical Council news: March 2023*. <https://mailchi.mp/29ab5ae7e783/medical-council-news-july-15119944>
- MCNZ. (2023d). *NZREX clinical: Pass rates and subsequent registration - March*. <https://www.mcnz.org.nz/assets/NZREX/caad4749f3/NZREX-Clinical-Pass-Rates-and-Subsequent-Registration.pdf>
- MCNZ. (2023e). *NZREX clinical: Pass rates and subsequent registration - May*. <https://www.mcnz.org.nz/assets/NZREX/caad4749f3/NZREX-Clinical-Pass-Rates-and-Subsequent-Registration.pdf>
- MCNZ. (2023f). *Outsourcing the New Zealand Registration Clinical Examination (NZREX Clinical)*. <https://www.mcnz.org.nz/about-us/news-and-updates/outsourcing-the-new-zealand-registration-clinical-examination-nzrex-clinical/>
- MCNZ. (2023g). *Scopes of practice and prescribed qualifications for the practice of medicine in New Zealand*. New Zealand Gazette. <https://gazette.govt.nz/notice/id/2023-gs1359>
- MCNZ. (2024a). *Comparable health system criteria*. <https://www.mcnz.org.nz/registration/getting-registered/registration-policy/comparable-health-system-criteria/>
- MCNZ. (2024b). *Competent authority criteria*. <https://www.mcnz.org.nz/registration/getting-registered/registration-policy/competent-authority-criteria/>
- MCNZ. (2024c). *Current standards*. <https://www.mcnz.org.nz/our-standards/current-standards/>
- MCNZ. (2024d). *Getting registered*. <https://www.mcnz.org.nz/registration/getting-registered/>
- MCNZ. (2024e). *New Zealand and Australian graduates (internship completed)*. <https://www.mcnz.org.nz/registration/getting-registered/registration-pathways/general-scope/new-zealand-and-australian-graduates-internship-completed/>
- MCNZ. (2024f). *Our data - International medical graduates*. <https://www.mcnz.org.nz/about-us/our-data/international-medical-graduates/>
- MCNZ. (2024g). *Our data - New doctor registrations - Entry pathway*. <https://www.mcnz.org.nz/about-us/our-data/new-doctor-registrations-entry-pathway/>
- MCNZ. (2024h). *Our data - Registered doctors - Snapshot*. <https://www.mcnz.org.nz/about-us/our-data/registered-doctors/>
- MCNZ. (2024i). *Our data - Retention*. <https://www.mcnz.org.nz/about-us/our-data/retention/>

- MCNZ. (2024j). *Our data - Vocational*. <https://www.mcnz.org.nz/about-us/our-data/new-registrations-vocational/>
- MCNZ. (2024k). *Our data - Vocational training*. <https://www.mcnz.org.nz/about-us/our-data/vocational-training/>
- MCNZ. (2024l). *Our data: NZREX*. <https://www.mcnz.org.nz/about-us/our-data/nzrex-overview/>
- MCNZ. (2024m). *Our people*. <https://www.mcnz.org.nz/about-us/our-people/>
- MCNZ. (2024n). *Registration exam (NZREX)*. <https://www.mcnz.org.nz/registration/getting-registered/registration-exam-nzrex/>
- MCNZ. (2024o). *Registration self assessment tool*. <https://www.mcnz.org.nz/registration/getting-registered/tool/>
- MCNZ. (2024p). *Types of vocational scope*. <https://www.mcnz.org.nz/registration/scopes-of-practice/vocational-and-provisional-vocational/types-of-vocational-scope/>
- MCNZ. (2024q). *VOC3 Vocational (specialist) registration*. <https://www.mcnz.org.nz/registration/getting-registered/registration-pathways/pathways-to-registration-in-a-vocational-scope/voc3-vocational-specialist-registration/>
- MCNZ. (2024r). *What we do*. <https://www.mcnz.org.nz/about-us/what-we-do/>
- McRae, C. (2021). *Student-led te reo Māori classes popular with peers*. University of Otago. <https://www.otago.ac.nz/news/student-led-te-reo-maori-classes-popular-with-peers>
- Medical Board of Australia. (2015). *Registration standard: English language skills*. <https://www.ahpra.gov.au/documents/default.aspx?record=WD15%2f16888&dbid=AP&chksum=Qt6fclXbe4YXYTcrrq%2fUjg%3d%3d>
- Medical Board of Australia. (2024). *Competent Authority pathway*. <https://www.medicalboard.gov.au/registration/international-medical-graduates/competent-authority-pathway.aspx>
- Medical Board Ordinance, No. 7, Wellington Provincial Ordinances 21-23 (1854). http://www.nzlii.org/nz/legis/wgn_ord/mbo1854149/mbo1854149.html
- Medical Deans Australia and New Zealand. (2021). *Student statistics report 2021: Snapshot of findings*. <https://medicaldeans.org.au/md/2021/11/MDANZ-Student-Statistics-Report-2021.pdf>
- Medical freedom. (1872, May 6). *Daily Southern Cross*, 3. <https://paperspast.natlib.govt.nz/newspapers/DSC18720506.2.24.7>
- Medical Observer. (2016). *International graduate awarded \$40,000 in landmark discrimination case*. NZ Doctor. <https://www.knowledge-basket.co.nz/databases/newztext/nz-doctor/search-nz-doctor/view/?sid=9455695&d1=magz%2Ftext%2Fdoctor%2F2016%2F07%2F04%2F75904.html>

- Medical Practitioners' Act, 31 Victoriae No 30, General Assembly of New Zealand (1867).
http://www.nzlii.org/nz/legis/hist_act/mpa186731v1867n30335/mpa186731v1867n30335.html
- Medical Practitioners' Registration Act, No. 51, General Assembly of New Zealand 169-173 (1869).
http://www.nzlii.org/nz/legis/hist_act/mpra186932a33v1869n51494/mpra186932a33v1869n51494.html
- Medical Practitioners (Registration Of Specialists) Regulations, No. 79 400-411 (1971).
http://www.nzlii.org/nz/legis/num_reg/mposr1971607/
- Medical Practitioners (Vocational Registration) Order, No. 163 836-839 (1996).
http://www.nzlii.org/nz/legis/num_reg/mpro1996494/
- Medical Practitioners Act, No. 2, New Munster Ordinances 396 (1849).
http://www.nzlii.org/nz/legis/hist_act/mpa184913v1849n2335/mpa184913v1849n2335.html
- Medical Practitioners Act, No. 74 392-402 (1914).
- Medical Practitioners Act, No. 50, General Assembly of New Zealand 586-616 (1950).
http://www.nzlii.org/nz/legis/hist_act/mpa19501950n50242/
- Medical Practitioners Act, No. 46, General Assembly of New Zealand § 417-466 (1968).
http://www.nzlii.org/nz/legis/hist_act/mpa19681968n46242/
- The Medical Practitioners Act, No. 95, Parliament of New Zealand 1196-1297 (1995).
http://www.nzlii.org/nz/legis/hist_act/mpa19951995n95242.pdf
- Medical Practitioners Amendment, No. 49-4, General Assembly of New Zealand 39-43 (1924).
http://nzlii.org/nz/legis/hist_bill/mpab1924494305.pdf
- Medical Practitioners Amendment Act, No. 30, General Assembly of New Zealand 146-148 (1964). http://www.nzlii.org/nz/legis/hist_act/mpaa19641964n30322/
- Medical Practitioners Amendment Act, No. 142, General Assembly of New Zealand 739-751 (1970). http://www.nzlii.org/nz/legis/hist_act/mpaa19701970n142322/
- Medical Practitioners Amendment Act, No. 53, General Assembly of New Zealand 757-771 (1979). http://www.nzlii.org/nz/legis/hist_act/mpaa19791979n53322/
- Medical Practitioners Bill, No. 24-1, General Assembly of New Zealand 1-18 (1889).
http://www.nzlii.org/nz/legis/hist_bill/mpb1889241225/mpb1889241225.html
- Medical Practitioners Bill, No. 171-1, General Assembly of New Zealand 1-10 (1910).
http://www.nzlii.org/nz/legis/hist_bill/mpb19101761225/mpb19101761225.html
- Medical Practitioners Registration Act, No. 31, General Assembly of New Zealand 197-198 (1905). http://www.nzlii.org/nz/legis/hist_act/mpra19055ev1905n31451/
- Medical services in "state of crisis". (1970, May 23). *New Zealand Press Association*, 18.
<https://paperspast.natlib.govt.nz/newspapers/CHP19700523.2.190>

- Medical students. (1943, February 17). *Waikato Times*, 2. <https://paperspast.natlib.govt.nz/newspapers/WT19430217.2.21>
- Medical training cuts 'crazy'. (1979, August 1). *New Zealand Press Association*, 6. <https://paperspast.natlib.govt.nz/newspapers/CHP19790801.2.43>
- Medrecruit. (2024). *IMGs in New Zealand: A comprehensive guide*. <https://medrecruit.medworld.com/articles/im-gs-in-new-zealand-a-comprehensive-guide>
- Mej'ia, A., Pizurki, H., & Royston, E. (1979). *Physician and nurse migration: Analysis and policy implications, report on a WHO study*. WHO. <https://apps.who.int/iris/handle/10665/37260>
- Meyer, J.-B., Charum, J., Bernal, D., Gaillard, J., Granés, J., Leon, J., Montenegro, A., Morales, A., Murcia, C., Narvaez-Bertheleot, N., Stella Parrado, L., & Schlemmer, B. (1997). Turning brain drain into brain gain: The Colombian experience of the diaspora option. *Science, Technology and Society*, 2(2), 285-315. <https://doi.org/10.1177/097172189700200205>
- Mikaere, A. (2011). *Colonising myths Māori realities: He rukuruku whakaaro*. Huia Publishers.
- Miller, D. (2013). Two ways to think about justice. In *Justice for earthlings: Essays in political philosophy* (pp. 40-69). Cambridge University Press. <https://doi.org/doi:10.1017/CBO9781139236898.003>
- Miller, D. (2017). Justice. *The Stanford Encyclopedia of Philosophy*. <https://plato.stanford.edu/archives/fall2017/entries/justice/>
- Ministry for Ethnic Communities. (2022). *Strategy 2022-2025*. https://www.ethniccommunities.govt.nz/assets/AboutUs/2022-2025_MEC_Strategy.pdf
- Moberly, T. (2014). Minority report: How the UK's treatment of foreign and ethnic minority doctors needs to change. *BMJ: British Medical Journal*, 348, Article g2838. <https://doi.org/10.1136/bmj.g2838>
- Morgan, D. L. (2007). Paradigms lost and pragmatism regained. *Journal of Mixed Methods Research*, 1(1), 48-76. <https://doi.org/10.1177/2345678906292462>
- Morgan, D. L. (2008). Snowball Sampling. In L. M. Given (Ed.), *The SAGE encyclopedia of qualitative research methods* (pp. 816). SAGE.
- Morgan, D. L. (2014). *Integrating qualitative and quantitative methods: A pragmatic approach*. SAGE.
- Morse, J. M. (1991). Approaches to qualitative-quantitative methodological triangulation. *Nursing Research*, 40(2), 120-123. <https://doi.org/10.1097/00006199-199103000-00014>
- Morse, J. M., & Niehaus, L. (2009). *Mixed method design: Principles and procedures*. SAGE.
- Morton, J., Hider, P., & Schaab, K. (2008). Factors influencing the departure of non-consultant hospital doctors from Christchurch, New Zealand. *New Zealand Medical Journal*, 121(1273), 13-24.

- Motala, M. I., & Van Wyk, J. M. (2019). Experiences of foreign medical graduates (FMGs), international medical graduates (IMGs) and overseas trained graduates (OTGs) on entering developing or middle-income countries like South Africa: A scoping review. *Human Resources for Health*, 17(1), Article 7. <https://doi.org/10.1186/s12960-019-0343-y>
- Mpofu, C., & Hocking, C. (2013). "Not made here": Occupational deprivation of non-English speaking background immigrant health professionals in New Zealand. *Journal of Occupational Science*, 20(2), 131-145. <https://doi.org/10.1080/14427591.2012.729500>
- Mpofu, C., Sen Gupta, T., & Hays, R. (2016). The ethics of medical practitioner migration from low-resourced countries to the developed world: A call for action by health systems and individual doctors. *Journal of Bioethical Inquiry*, 13(3), 395-406. <https://doi.org/10.1007/s11673-016-9726-0>
- Mulgan, T., Enright, S., Grix, M., Jayasuriya, U., Ka'iili, T. O., Lear, A. M., Māhina, A. N. M., Māhina, Ō., Matthewson, J., Moore, A., Parke, E. C., Schouten, V., & Watene, K. (2021). Charting just futures for Aotearoa New Zealand: Philosophy for and beyond the Covid-19 pandemic. *Journal of the Royal Society of New Zealand*, 51(Suppl. 1), S167-S178. <https://doi.org/10.1080/03036758.2021.1896559>
- Musoke, S. B. (2012). *Foreign doctors and the road to a Swedish medical license: Experienced barriers of doctors from non-EU countries* [Bachelor thesis, Södertörn University]. <https://www.diva-portal.org/smash/get/diva2:541360/FULLTEXT01.pdf>
- Mutu, M. (2019). 'To honour the treaty, we must first settle colonisation' (Moana Jackson 2015): The long road from colonial devastation to balance, peace and harmony. *Journal of the Royal Society of New Zealand*, 49(Suppl. 1), 4-18. <https://doi.org/10.1080/03036758.2019.1669670>
- N.Z. an easy place for 'sub-standard doctors'. (1988, April 22). *New Zealand Press Association*, 7. <https://paperspast.natlib.govt.nz/newspapers/CHP19880422.2.72>
- N.Z. degrees for alien doctors. (1948, January 16). *Northern Advocate*, 2. <https://paperspast.natlib.govt.nz/newspapers/NA19480116.2.22>
- Na, S. (2021). Who are the doctors of Korean medicine? Exploring the identity of a medical profession. *Korean Studies*, 45(1), 165-191. <https://doi.org/10.1353/ks.2021.0008>
- Narasimhan, S., Ranchord, A., & Weatherall, M. (2006). International medical graduates' training needs: Perceptions of New Zealand hospital staff. *New Zealand Medical Journal*, 119(1236), 49-52.
- Narayanan, A., Greco, M., Janamian, T., Fraser, T., & Archer, J. (2022). Are there differences between SIMG surgeons and locally trained surgeons in Australia and New Zealand, as rated by colleagues and themselves? *BMC Medical Education*, 22(1), 516. <https://doi.org/10.1186/s12909-022-03560-y>
- Narayanan, A., Vayro, C., Greco, M., Hanson, D., Hanson, J., Spike, N., Giddings, P., Mitchell, B., & Stewart, R. (2022). A comparison of patient appraisal of professional skills for GPs in training participating in differing education programs. *BMC Medical Education*, 22(1), Article 669. <https://doi.org/10.1186/s12909-022-03733-9>

- Negin, J. (2008). Australia and New Zealand's contribution to Pacific Island health worker brain drain. *Australian & New Zealand Journal of Public Health*, 32(6), 507-511. <https://doi.org/10.1111/j.1753-6405.2008.00300.x>
- New Zealand Medical Journal. (1970a). Medical Council of New Zealand Medical Practitioners Amendment Bill 1970. *New Zealand Medical Journal*, 73(464), 38-39.
- New Zealand Medical Journal. (1970b). Migration of doctors. *New Zealand Medical Journal*, 71(454), 164-165.
- New Zealand National Party & Act New Zealand. (2023). *Coalition agreement*. New Zealand House of Representatives. https://www.nzdoctor.co.nz/sites/default/files/2023-11/National_ACT_Agreement.pdf
- Nieuwoudt, B. (2017). *Answer to GP shortage might lie with IMGs not new medical school, says GP*. NZ Doctor. <https://www.nzdoctor.co.nz/article/print-archive/answer-gp-shortage-might-lie-imgs-not-new-medical-school-says-gp>
- Norris, P., & Beresford, R. (2024). *Medicines and remedies - Plant extracts to modern drugs, 1900 to 1930s: Tohunga Suppression Act*. Te Ara - The Encyclopedia of New Zealand. <http://www.TeAra.govt.nz/en/document/28223/tohunga-suppression-act>
- Notices. (1919, July 14). *Poverty Bay Herald*, 2. <https://paperspast.natlib.govt.nz/newspapers/PBH19190714.2.8>
- Nussbaum, A. M. (2021). Joanna Cannon. In N. Carlin (Ed.), *Contemporary physician-authors* (pp. 131-145). Routledge. <https://doi.org/10.4324/9781003079712-8>
- Nussbaum, M. C. (2006). *Frontiers of justice: Disability, nationality, species membership*. Belknap Press.
- Nussbaum, M. C. (2011). *Creating capabilities: The human development approach*. Belknap Press.
- O'Brien, T. (2021). *The unintended consequence of COVID-19 border restrictions on children of skilled migrants*. Newshub. <https://www.newshub.co.nz/home/politics/2021/07/the-unintended-consequence-of-covid-19-border-restrictions-on-children-of-skilled-migrants.html>
- O'Cathain, A. (2010). Assessing the quality of mixed methods research: Towards a comprehensive framework. In A. Tashakkori & C. Teddlie (Eds.), *SAGE handbook of mixed methods in social & behavioral research* (2nd ed., pp. 531-556). SAGE.
- O'Shea, L. (2022). *Response to a request for official information*. Te Waiora - Nelson Marlborough Health. <https://www.nmdhb.govt.nz/dmsdocument/975-postgraduate-year-1-doctors>
- O'Leary, O. (2004). *The essential guide to doing your research project*. SAGE.
- Oberman, K. (2016). Immigration as a human right. In S. Fine & L. Ypi (Eds.), *Migration in political theory* (pp. 32-56). Oxford University Press.
- Odyssey Recruitment. (2024). *Jobs in New Zealand for international medical graduates*. <https://www.odysseyrecruitment.com/global-20doctor-20jobs-20new-20zealand>

- OECD. (2010). *International migration of health workers: Improving international co-operation to address the global health workforce crisis*. https://migrant-integration.ec.europa.eu/library-document/whoecd-policy-brief-international-migration-health-workers_en
- OECD. (2023). *Health workforce migration: Migration of doctors*. https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_WFMI
- OECD. (2024). *Life expectancy at birth*. <https://data.oecd.org/healthstat/life-expectancy-at-birth.htm>
- Older, J. (2022). *The NZ Medical Association has breathed its last. So who killed it?* The Spinoff. https://thespinoff.co.nz/society/30-05-2022/the-nz-medical-association-has-breathed-its-last-so-who-killed-it?fbclid=IwAR3_vGUFLrRYUyKSICr2NeWAc87x8FjdTOUW6PhgH-6KKW3UO0etNxbSen0
- Oman, K., Bale, S., Baravilala, W., Malani, J., McCaig, E., Rogers, E., & Moulds, R. (2006). Donor countries may unintentionally become major beneficiaries of their own aid: The case of postgraduate specialist training at the Fiji School of Medicine. *Fiji Medical Journal*, 27(2), 11-18.
- Oseni, Z., & Shannon, G. (2020). The relationship between Indigenous and allopathic health practitioners in Africa and its implications for collaboration: A qualitative synthesis. *Global Health Action*, 13(1), Article 1838241. <https://doi.org/10.1080/16549716.2020.1838241>
- Pande, M. M. N. (2015). *The cross-cultural adaptation of international medical graduates to general practice in New Zealand* [Doctoral thesis, University of Otago]. <https://ourarchive.otago.ac.nz/handle/10523/6269>
- Pang, T., Lansang, M. A., & Haines, A. (2002). Brain drain and health professionals. *BMJ: British Medical Journal*, 324(7336), 499-500. <https://doi.org/10.1136/bmj.324.7336.499>
- Park, K. (2014). *Doctors and medicine in Early Renaissance Florence*. Princeton University Press.
- Patel, V. (2003). Recruiting doctors from poor countries: The great brain robbery? *BMJ: British Medical Journal*, 327(7420), 926-928.
- Pereira, R. H. M., Schwanen, T., & Banister, D. (2017). Distributive justice and equity in transportation. *Transport Reviews*, 37(2), 170-191. <https://doi.org/10.1080/01441647.2016.1257660>
- Perkins, J. A. (1966). Foreign aid and the brain drain. *Foreign Affairs*, 44(4), 608-619. <https://doi.org/10.2307/20039195>
- Peterson, B., Pandya, S., & Leblang, D. (2014). Doctors with borders: Occupational licensing as an implicit barrier to high skill migration. *Public Choice*, 160(1/2), 45-63. <https://doi.org/10.1007/s11127-014-0152-8>
- Peterson, M. (2013). *Possible alternatives to internship requirements for NZREX*. NZMA: New Zealand Medical Association. <https://www.nzma.org.nz/assets/Uploads/Documents/NZMA-Submission-to-MCNZ-on-alternatives-to-internship-requirements-for-NZREX.pdf>

- Phoenix, A. (2020). *Number of hired PGY1 House Officers (2014 - 2019)*. Whanganui District Health Board. <https://fyi.org.nz/request/10690-number-of-hired-pgy1-house-officers-2014-2019>
- Pineda, R. C., Abad-Pinlac, B., Yao, D. P. G., Toribio, F., Josephsson, S., & Sy, M. P. (2023). Unraveling the “greener pastures” concept: The phenomenology of internationally educated occupational therapists. *OTJR: Occupational Therapy Journal of Research*, 0(0). <https://doi.org/10.1177/15394492231205885>
- Plano Clark, V., & Ivankova, N. (2016). *Mixed methods research: A guide to the field*. SAGE. <https://doi.org/10.4135/9781483>
- Plano Clark, V. L., & Badiie, M. (2010). Research questions in mixed methods research. In A. Tashakkori & C. Teddlie (Eds.), *SAGE handbook of mixed methods in social & behavioral research* (2nd ed., pp. 275-304). SAGE.
- Powell, I. (2008). *Understanding the DHB workforce crisis*. NZ Doctor. <https://www.knowledge-basket.co.nz/databases/newztext/nz-doctor/search-nz-doctor/view/?sid=9455698&d32=magz%2Ftext%2Fdoctor%2F2008%2Ffeb%2Fdoc0133.html>
- Powell, I. (2013, March 27). International doctors costly on many fronts. *NZ Doctor*, 31.
- Prerequisites for medical registration to be tightened. (1982, April 22). *New Zealand Press Association*, 4. <https://paperspast.natlib.govt.nz/newspapers/CHP19820422.2.33.6>
- Price, M. (2019). *Response to OIA request - PGY1 House Officers*. Taranaki District Health Board. <https://fyi.org.nz/request/10703/response/37928/attach/html/4/20190722%20PGY1%20HouseOfficer%20OIA%20Response.pdf.html>
- Protest against alien doctors. (1945, January 24). *Manawatu Times*, 4. <https://paperspast.natlib.govt.nz/newspapers/MT19450124.2.29>
- Purewal, S., Ardiles Gamboa, P., & Encalada Grez, E. (2023). *The myth of Canada: The exclusion of internationally trained physicians*. Simon Fraser University. <https://www.sfu.ca/ceri/blog/2023/The-Myth-of-Canada.html>
- Purewal, S., Encalada Grez, E., & Ardiles Gamboa, P. (2023). *The myth of Canada: The exclusion of internationally trained physicians*. https://radiussfu.com/wp-content/uploads/2023/02/The-Myth-Of-Canada_DIGITAL.pdf
- Ragg, E., Rourke, J. O., & MacVicar, R. (2015). International medical graduates: A qualitative exploration of factors associated with success in the clinical skills assessment. *Education for Primary Care*, 26(6), 378-385. <https://doi.org/10.1080/14739879.2015.1101866>
- Rakasz v Medical Council of New Zealand [2022] NZDC 17460*. (2022). District Court at Wellington. <https://www.districtcourts.govt.nz/all-judgments/2022-nzdc-17460-rakasz-v-medical-council-of-new-zealand/>
- Rao, K. D., & Sundararaman, T. (2014). Medical pluralism and cross practice in India. *Social Science & Medicine*, 102, 203-204. <https://doi.org/10.1016/j.socscimed.2013.11.053>

- Rao, R., Lundin, R., & Hill, H. (2023). We need to make it easier to recruit addiction psychiatrists to Australia and New Zealand. *Australasian Psychiatry*, 31(3), 403. <https://doi.org/10.1177/10398562231158924>
- Rashid, M. A., Ali, S. M., & Dharanipragada, K. (2023). Decolonising medical education regulation: A global view. *BMJ: Global Health*, 8(6), Article e011622. <https://doi.org/10.1136/bmjgh-2022-011622>
- Ratcliffe, L. (2007). *An IMG's tale: From Samoa to Remuera*. NZ Doctor. <https://www.knowledge-basket.co.nz/databases/newztext/nz-doctor/search-nz-doctor/view/?sid=9455695&d11=magz%2Ftext%2Fdoctor%2F2007%2FAug%2Fdoc0706.html>
- Rawls, J. (1999). *The law of peoples*. Harvard University Press.
- Rawls, J. (2003). *A theory of justice: Revised edition* (6th ed.). Harvard University Press.
- Rees, G. H. (2019). The evolution of New Zealand's health workforce policy and planning system: A study of workforce governance and health reform. *Human Resources for Health*, 17(1), Article 51. <https://doi.org/10.1186/s12960-019-0390-4>
- Refugee medical students. (1939, December 13). *Evening Star*, 8. <https://paperspast.natlib.govt.nz/newspapers/ESD19391213.2.55>
- Reid, H. M. (2014). *Introduction to statistics: Fundamental concepts and procedures of data analysis*. SAGE. <https://doi.org/10.4135/9781071878927>
- Richardson, T. (2019). *Official Information Act request: Number of hired PGY1 House Officers (2013-2019)*. Waikato District Health Board. <https://fyi.org.nz/request/10735/response/38402/attach/html/6/Response%20to%20OIA%20Dr%20Mohammed%20AM.pdf.html>
- Rickert, J. (2021). On patient safety: How can we get more nonphysicians on Medical Boards? *Clinical Orthopaedics and Related Research*, 479(10), 2139-2141. <https://doi.org/10.1097/CORR.0000000000001956>
- RNZ. (2023). *Calls to fix registration pathways for overseas doctors*. Newshub. <https://www.newshub.co.nz/home/new-zealand/2023/09/calls-to-fix-registration-pathways-for-overseas-doctors.html>
- RNZCGP. (2020). *New Zealand's general practitioners are a workforce in crisis*. The Royal New Zealand College of General Practitioners (RNZCGP). https://www.rnzcgp.org.nz/GPPulse/RNZCGP/News/College_news/2020/New-Zealands-GPs-are%20a-workforce-in-crisis.aspx
- Roberts, J. K., Pavlakis, A. E., & Richards, M. P. (2021). It's more complicated than it seems: Virtual qualitative research in the COVID-19 era. *International Journal of Qualitative Methods*, 20. <https://doi.org/10.1177/16094069211002959>
- Robeyns, I. (2017). *Wellbeing, freedom and social justice the capability approach re-examined*. Open Book Publishers.
- Robeyns, I., & Byskov, M. F. (2020). The capability approach. *The Stanford Encyclopedia of Philosophy*. <https://plato.stanford.edu/archives/win2020/entries/capability-approach/>

- Roy, C. G. (2021). Patient safety functions of State Medical Boards in the United States. *Yale Journal of Biology and Medicine*, 94, 165-173.
- Roy, E. (2021). *Kerala best state on health parameters, Uttar Pradesh worst: Niti Aayog*. The Indian Express. <https://indianexpress.com/article/india/kerala-best-health-parameters-uttar-pradesh-worst-7692760/>
- Russell, E. (2021a). *Auckland hospitals overloaded: Patients waiting in corridors as demand skyrockets*. NZ Herald. <https://www.nzherald.co.nz/nz/auckland-hospitals-overloaded-patients-waiting-in-corridors-as-demand-skyrockets/NIU26VB3XCSZFHHGASKSXOXP2A/>
- Russell, E. (2021b). *Covid 19 Delta outbreak: Immigrant doctors denied work at 'understaffed' hospitals*. NZ Herald. <https://www.nzherald.co.nz/nz/covid-19-delta-outbreak-immigrant-doctors-denied-work-at-understaffed-hospitals/OKRC764YCBPNOUSOPRUIJ7FOVM/>
- Russell, E. (2022). *Covid-19 Omicron outbreak: Doctors' union urges Govt to declare health workforce emergency*. NZ Herald. <https://www.nzherald.co.nz/nz/covid-19-omicron-outbreak-doctors-union-urges-govt-to-declare-health-workforce-emergency/PHQXV6K2H4BS5F6LYUHEDKHD2Q/>
- Ryan, G. (2018). Introduction to positivism, interpretivism and critical theory. *Nurse Researcher*, 25(4), 14-20. <https://doi.org/10.7748/nr.2018.e1466>
- Sainsbury, R. (2015). *A history of the Medical Council of New Zealand*. Medical Council of New Zealand. <https://www.mcnz.org.nz/assets/Publications/266593c823/History-of-the-Medical-Council.pdf>
- Salami, B., & Nelson, S. (2014). The downward occupational mobility of internationally educated nurses to domestic workers. *Nursing Inquiry*, 21(2), 153-161. <https://doi.org/10.1111/nin.12029>
- Sardar, Z. (1999). *Orientalism*. Open University Press.
- Saville-Wood, N. (2019). *Official Information Act request Re: PGY1s*. Lakes District Health Board. <https://fyi.org.nz/request/10699/response/37196/attach/html/3/2019%2007%2017%20Dr%20Mohammed%20PGY1s%20OIA.pdf.html>
- Saville-Wood, N. (2022). *Official Information Act request re:PGY1s*. Lakes District Health Board.
- Schiebli, T. (2022). *Official Information Act request*. The Whatu Ora - Health New Zealand - Te Tai Tokerau. <https://www.northlanddhhb.org.nz/news-and-publications/oia-requests/oia-responses/pgy1-house-officers/>
- Schlosberg, D. (2007). Distribution and beyond: Conceptions of justice in contemporary theory and practice. In *Defining environmental justice: Theories, movements, and nature* (pp. 11-40). Oxford University Press.
- Schwandt, T. A. (2007). *The SAGE dictionary of qualitative inquiry* (3rd ed.). SAGE.
- Selvarajah, C. (2004). Equal employment opportunity: Acculturation experience of immigrant medical professionals in New Zealand in the period 1995 to 2000. *Equal Opportunities International*, 23(6), 50-73. <https://doi.org/10.1108/02610150410787693>

- Sen, A. (1984). Rights and capabilities. In *Resources, values and development* (pp. 307-324). Harvard University Press.
- Sen, A. (1985). *Commodities and capabilities*. Oxford University Press.
- Sen, A. (2009). *The idea of justice*. Belknap Press of Harvard University Press.
- Sen, A. (2015). The idea of justice: A response. *Philosophy & Social Criticism*, 41(1), 77-88. <https://doi.org/10.1177/0191453714553501>
- Serour, G. I. (2009). Healthcare workers and the brain drain. *International Journal of Gynecology and Obstetrics*, 106(2), 175-178. <https://doi.org/10.1016/j.ijgo.2009.03.035>
- Shahtahmasebi, D. (2019, October 15). Migration to NZ: Guilty until proven innocent. *The Dominion Post*, 19.
- Shahtahmasebi, Z. (2021). 'We are drowning': GP workforce survey. *NZ Doctor*.
- Shakil, S. S. (2016). Stemming the medical brain drain: A personal perspective on a global problem. *Einstein Journal of Biology & Medicine*, 31(1/2), 11-16.
- Shannon-Baker, P. (2016). Making paradigms meaningful in mixed methods research. *Journal of Mixed Methods Research*, 10(4), 319-334. <https://doi.org/10.1177/1558689815575861>
- Sharma, A., Lambert, T. W., & Goldacre, M. J. (2012). Why UK-trained doctors leave the UK: Cross-sectional survey of doctors in New Zealand. *Journal of the Royal Society of Medicine*, 105(1), 25-34. <https://doi.org/10.1258/jrsm.2011.110146>
- Sheehan, D., Gartly, A., & Thwaites, J. (2006). Development and trial of tools to assess the oral language and communication skills of international medical graduates. *Focus on Health Professional Education: A Multi-disciplinary Journal*, 8(2), 58-68. <https://doi.org/10.3316/informit.038731668268829>
- Sheffield, K. (2022). *Official Information Act*. Taranaki District Health Board. https://www.tdhub.org.nz/dhb/documents/OIA/2022/2022-06-28_hiring-data-for-PGY1-House-Officers.pdf
- Sheller, M. (2011). *Mobility*. *Sociopedia*. <https://www.isaportal.org/resources/resource/mobility/>
- Sheller, M. (2018a). *Mobility justice: The politics of movement in an age of extremes*. Verso.
- Sheller, M. (2018b). Theorising mobility justice. *Tempo Social*, 30(2), 17-34. <https://doi.org/10.11606/0103-2070.ts.2018.142763>
- Sheller, M. (2021). *Advanced introduction to mobilities*. Edward Elgar Publishing.
- Sheller, M., & Urry, J. (2006). The new mobilities paradigm. *Environment and Planning A: Economy and Space*, 38(2), 207-226. <https://doi.org/10.1068/a37268>
- Sheller, M., & Urry, J. (2016). Mobilizing the new mobilities paradigm. *Applied Mobilities*, 1(1), 10-25. <https://doi.org/10.1080/23800127.2016.1151216>

- Shepherd, M. (2022). *Official information request – PGY1 House Officer positions - Auckland DHB Ref. 20220530-1234*. Auckland District Health Board. <https://www.adhb.health.nz/assets/Documents/OIA/2022/04/PGY1-House-Officer-Positions.pdf>
- Sherborne, J. (2022). *Official Information Act request*. Waikato District Health Board. <https://www.waikatodhb.health.nz/assets/Docs/About-Us/OIA/2022/OIA-response-PGY1-House-Officers.pdf>
- Short, S. D., Marcus, K., & Balasubramanian, M. (2016). Health workforce migration in the Asia Pacific: Implications for the achievement of Sustainable Development Goals. *Asia Pacific Journal of Health Management*, 11(3), 58-64.
- Simard, M. (2009). Retention and departure factors influencing highly skilled immigrants in rural areas: Medical professionals in Quebec, Canada. In B. Jentsch & M. Simard (Eds.), *International migration and rural areas: Cross-national comparative perspectives* (pp. 43-73). Ashgate.
- Simon-Kumar, R. (2015). Neoliberalism and the new race politics of migration policy: Changing profiles of the desirable migrant in New Zealand. *Journal of Ethnic and Migration Studies*, 41(7), 1172-1191. <https://doi.org/10.1080/1369183x.2014.936838>
- Skjeggstad, E., Gerwing, J., & Gulbrandsen, P. (2017). Language barriers and professional identity: A qualitative interview study of newly employed international medical doctors and Norwegian colleagues. *Patient Education and Counseling*, 100(8), 1466-1472. <https://doi.org/10.1016/j.pec.2017.03.007>
- Skjeggstad, E., Norvoll, R., Sandal, G. M., & Gulbrandsen, P. (2017). How do international medical graduates and colleagues perceive and deal with difficulties in everyday collaboration? A qualitative study. *Scandinavian Journal of Public Health*, 45(4), 428-435. <https://doi.org/10.1177/1403494817698286>
- Slade, N. F. (2019). *(De)constructing 'refugeeness': Exploring mediated discourses of solidarity, welcome and refugee (self)representation in New Zealand* [Doctoral thesis, Massey University]. <https://mro.massey.ac.nz/items/b3be4139-7363-40ca-8452-9201bd2b56a6>
- Smith, J. K., & Heshusius, L. (1985). Closing down the conversation: The end of the quantitative-qualitative debate among educational inquirers. *Educational Researcher*, 15(1), 4-12. <https://doi.org/10.3102/0013189x015001004>
- Smith, R. (2000). The GMC: Where now? . *BMJ: British Medical Journal*, 320(7246), 1356. <https://doi.org/10.1136/bmj.320.7246.1356>
- Smitheram, K. (2022). *Official Information Act request CDHB 10887*. Canterbury District Health Board. <https://www.cdhb.health.nz/about-us/document-library/pgy1-house-officers/>
- Snyder, J. (2017). Restricting health worker migration in the name of solidarity. *South African Journal of Philosophy*, 36(1), 4-12. <https://doi.org/10.1080/02580136.2016.1261443>
- Soja, E. W. (2010). *Seeking spatial justice*. University of Minnesota Press.
- Solomon, R. C., & Murphy, M. C. (Eds.). (2000). *What is justice? Classical and contemporary readings* (2nd ed.). Oxford University Press.

- Spence, A. (2024). *Grandad died after waiting 30 hours in ED. His family fought for months for answers*. NZ Herald. <https://www.nzherald.co.nz/nz/jim-wetere-died-after-waiting-30-hours-in-waikato-ed-his-family-fought-for-six-months-for-answers/MQIV2PR3DVBBHBPRLX5RIEIV5M/>
- Spiliopoulos, G., Cuban, S., & Broadhurst, K. (2021). Migrant care workers at the intersection of rural belonging in small English communities. *Journal of Immigrant & Refugee Studies*, 19(2), 213-226. <https://doi.org/10.1080/15562948.2020.1801941>
- Spoonley, P. (2017). Can I have a decent job? The labour market experiences of non-European immigrants. In S. Groot, C. Van Ommen, B. Masters-Awatere, & N. Tassell-Matamua (Eds.), *Precarity: Uncertain, insecure and unequal lives in Aotearoa New Zealand* (pp. 183-191). Massey University Press.
- Spoonley, P., & Bedford, R. (2012). *Welcome to our world? Immigration and the reshaping of New Zealand*. Dunmore Publishing.
- St George, I. (2003). Doctors whose competence has been reviewed under the Medical Practitioners Act 1995. *New Zealand Medical Journal*, 116(1175).
- Stein, D. I., Oo, T. H., de Francisco, A., & Hilary, J. (2002). Letters: Brain drain and health professionals. *BMJ: British Medical Journal*, 325(7357), 219-220. <https://doi.org/https://doi.org/10.1136/bmj.325.7357.219>
- Stephenson, K. L. (2018). *Disappointing day for rural health sector as Govt quashes rural medical school dreams*. NZ Doctor. <https://www.nzdoctor.co.nz/article/news/disappointing-day-rural-health-sector-govt-quashes-rural-medical-school-dreams>
- Stewart, F. (2005). Groups and capabilities. *Journal of Human Development*, 6(2), 185-204. <https://doi.org/10.1080/14649880500120517>
- Stewart, F. (2013). *Capabilities and human development: Beyond the individual - The critical role of social institutions and social competencies*. UNDP-HDRO Occasional Papers No. 2013/03. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2344469
- Stilwell, B., Diallo, K., Zurn, P., Poz, M. R. D., Adams, O., & Buchan, J. (2003). Developing evidence-based ethical policies on the migration of healthworkers: Conceptual and practical challenges. *Human Resources for Health*, 1, Article 8. <https://doi.org/https://doi.org/10.1186/1478-4491-1-8>
- Strang, B. (2022). *Covid-19: Migrant health workers need one of four vaccines to satisfy mandate*. Stuff. <https://i.stuff.co.nz/national/health/coronavirus/126919776/covid19-migrant-health-workers-need-one-of-four-vaccines-to-satisfy-mandate?cid=app-android>
- Stureson, L., Ohlander, M., Nilsson, G. H., Palmgren, P. J., & Stenfors, T. (2019). Migrant physicians' entrance and advancement in the Swedish medical labour market: A cross-sectional study. *Human Resources for Health*, 17(1), 71. <https://doi.org/10.1186/s12960-019-0414-0>
- Tashakkori, A., & Teddlie, C. (Eds.). (2010). *SAGE handbook of mixed methods in social & behavioral research* (2nd ed.). SAGE.
- Taylor, C. (2016a). Help was at hand, but not after it got in the way of NZ doctors. *NZ Doctor*, 13.

- Taylor, C. (2016b). No place like home: How well do we treat our 'foreign legion' of international doctors? *NZ Doctor*, 12-13.
- Taylor, C. (2016c). *Uncertain welcome for the 'foreign legion' despite a doctor shortage*. NZ Doctor. <https://www.knowledge-basket.co.nz/databases/newztext/nz-doctor/search-nz-doctor/view/?sid=9455695&d21=magz%2Ftext%2Fdoctor%2F2016%2F08%2F31%2F77495.html>
- Te Whatu Ora - Health New Zealand. (2011). *Interface with primary health care: Guidance for New Zealand emergency departments*, June 2011. <https://www.tewhatauora.govt.nz/our-health-system/hospitals-and-specialist-services/emergency-departments/interface-with-primary-health-care/>
- Te Whatu Ora | Health New Zealand. (2023). *Overseas doctors*. <https://www.mcnz.org.nz/about-us/news-and-updates/te-whatu-ora-pilot-for-programmes-for-nzrex-graduates/>
- Te Whatu Ora | Health New Zealand. (2024). *Resident Medical Officer (RMO) - Junior doctor*. [https://careers.tewhatauora.govt.nz/opportunities/careers-in-health/resident-medical-officers/#:~:text=Resident%20Medical%20Officer%20\(RMO\)%20%2D%20Junior%20Doctor](https://careers.tewhatauora.govt.nz/opportunities/careers-in-health/resident-medical-officers/#:~:text=Resident%20Medical%20Officer%20(RMO)%20%2D%20Junior%20Doctor)
- Tebbutt, L. (2021). *Bay of Plenty GP's 'limping through the crisis' of doctor shortage*. NZ Herald. <https://www.nzherald.co.nz/bay-of-plenty-times/news/bay-of-plenty-gps-limping-through-the-crisis-of-doctor-shortage/X3YJT2BQSPGCV2XKKZTIZDVC3Q/>
- Teddlie, C., & Tashakkori, A. (2009). *Foundations of mixed methods research: Integrating quantitative and qualitative approaches in the social and behavioral sciences*. SAGE.
- Teri, D. (2023). *NMC: Compulsory internships by foreign medical graduates validated as per MCI list as 'one-time measure'*. The Indian Express. <https://indianexpress.com/article/education/compulsory-internships-by-foreign-medical-graduates-validated-as-per-mci-list-as-one-time-measure-nmc-fmge-neet-pg-2023-nmc-org-in-8363684/>
- Terry, D., Hoang, H., Peck, B., & Lê, Q. (2021). The historic to contemporary challenges among International Medical Graduates seeking to practise in Australia. *Health and History*, 23(1), 61-78. <https://doi.org/10.1353/hah.2021.0011>
- The Lancet. (2005). Migration of health workers: An unmanaged crisis. *The Lancet*, 365(9474). [https://doi.org/10.1016/s0140-6736\(05\)66592-0](https://doi.org/10.1016/s0140-6736(05)66592-0)
- The Management Services and Research Unit. (1982). *New Zealand medical manpower statistics 1980*. Department of Health. [https://www.moh.govt.nz/notebook/nbbooks.nsf/0/74fedd30c19ded134c2565d7000e3d38/\\$FILE/Medical%20manpower%201980-part1.pdf](https://www.moh.govt.nz/notebook/nbbooks.nsf/0/74fedd30c19ded134c2565d7000e3d38/$FILE/Medical%20manpower%201980-part1.pdf)
- Thomas-Maude, J. (2022). *NZ's medical licensing system is still a major hurdle for desperately needed foreign-trained doctors*. The Conversation. <https://theconversation.com/nzs-medical-licensing-system-is-still-a-major-hurdle-for-desperately-needed-foreign-trained-doctors-196724>

- Thomas-Maude, J. (2023). Mobility justice, capabilities, and medical migration: Medical licensing pathways for overseas-trained doctors in Aotearoa New Zealand. *Australian Geographer*, 54(4), 479-497. <https://doi.org/10.1080/00049182.2023.2245620>
- Thomas-Maude, J., & McLennan, S. (2022). *Critically understaffed and with Omicron looming, why isn't NZ employing more of its foreign-trained doctors?* The Conversation. <https://theconversation.com/critically-understaffed-and-with-omicron-looming-why-isnt-nz-employing-more-of-its-foreign-trained-doctors-175914>
- Thomas, H., Mitchell, G., Rich, J., & Best, M. (2018). Definition of whole person care in general practice in the English language literature: A systematic review. *BMJ: Open*, 8(12), Article e023758. <https://doi.org/10.1136/bmjopen-2018-023758>
- Thomas, R. (2018). Foreign doctors in limbo. *The Dominion Post*, 1.
- Too many doctors coming to N.Z. (1966, May 7). *New Zealand Press Association*, 16. <https://paperspast.natlib.govt.nz/newspapers/CHP19660507.2.169>
- Trigger, S. (2022). *GP shortage: Rural medical centre says 'impossible' to recruit in NZ, immigration process must be seamless*. NZ Herald. <https://www.nzherald.co.nz/nz/gp-shortage-rural-medical-centre-says-impossible-to-recruit-in-nz-immigration-process-must-be-seamless/2QB37AJLJP5AEBHUX5UASG3ZS4/>
- Triple0 Medical Recruitment. (2021). *A specialist doctor's guide to relocating to New Zealand*. <https://www.triple0.com/wp-content/uploads/2021/10/A-Specialists-Guide-to-Relocating-to-New-Zealand.pdf>
- Tucker, J. B. (2003). Religion and medicine. In H. Selin (Ed.), *Medicine across cultures* (pp. 373-384). Springer Dordrecht.
- United Nations. (2019). *Annex II: Classification of SDG regions and income groups*. https://population.un.org/ProfilesOfAgeing2019/Docs/Annex%20%20-%20Classification%20of%20countries%20by%20region_updated%20for%20WPP%202019.pdf
- Urry, J. (2007). *Mobilities*. Polity.
- Vamos, M., & Watson, N. (2009). Coming on board: The assessment of overseas trained psychiatrists by the Royal Australian and New Zealand College of Psychiatrists. *Australasian Psychiatry*, 17(1), 38-41. <https://doi.org/10.1080/10398560802469736>
- Vandvik, P. O. (2018). Do we have trustworthy guidelines for clinical practice in Norway? *Journal of the Norwegian Medical Association (Tidsskrift for Den norske legeforening)*. <https://doi.org/10.4045/tidsskr.18.0102>
- Verstraete, G. (2003). Technological frontiers and the politics of mobility. In C. C. Sara Ahmed, Anne-Marie Fortier, Mimi Sheller (Ed.), *Uprootings/Regroundings* (pp. 225-249). Routledge.
- Wade, A. (2021). *More than 1000 registered doctors and nurses waiting in New Zealand residency queue*. Newshub. <https://www.newshub.co.nz/home/politics/2021/07/more-than-1000-registered-doctors-and-nurses-waiting-in-new-zealand-residency-queue.html>
- Waitangi Tribunal. (2023). *Hauora: Report on stage one of the health services and outcomes*
 Kaupapa inquiry. Legislation Direct.

- https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_195476216/Hauora%202023%20W.pdf
- Walker, C. (2023). *Statement from Chair on application for registration*. MCNZ. <https://www.mcnz.org.nz/about-us/publications/current-review-of-dr-rakasz-application-to-work-in-new-zealand/>
- Walzer, M. (1983). *Spheres of justice: A defence of pluralism and equality*. Martin Robertson & Company Ltd.
- Watanabe, S. (1969). The brain drain from developing to developed countries. *International Labour Review*, 99(4), 401-433.
- Watson, P. (2022). *Official Information Act request for – House Officer information*. Counties Manukau Health.
- Wearne, S. M., Brown, J. B., Kirby, C., & Snadden, D. (2019). International medical graduates and general practice training: How do educational leaders facilitate the transition from new migrant to local family doctor? *Medical Teacher*, 41(9), 1065-1072. <https://doi.org/10.1080/0142159X.2019.1616681>
- WHO. (2023). *The global health observatory: Indicators*. <https://www.who.int/data/gho/data/indicators>
- WHO. (2024). *Social determinants of health*. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1
- WHO Health Workforce. (2017). *A dynamic understanding of health worker migration*. WHO. <https://www.who.int/publications/m/item/a-dynamic-understanding-of-health-worker-migration>
- Wider scope for overseas doctors. (1970, June 26). *New Zealand Press Association*, 24. <https://paperspast.natlib.govt.nz/newspapers/CHP19700626.2.219>
- Wilson, I. K. (1972). Immigration of overseas graduates. *New Zealand Medical Journal*, 75(478), 159.
- Wong, A., & Lohfeld, L. (2008). Recertifying as a doctor in Canada: International medical graduates and the journey from entry to adaptation. *Medical Education*, 42(1), 53-60. <https://doi.org/10.1111/j.1365-2923.2007.02903.x>
- World Bank. (2023). *World Bank open data*. <https://data.worldbank.org/>
- Wright-St Clair, R. E. (1985). Provincial registration in New Zealand. *New Zealand Medical Journal*, 98(780), 440-443.
- Yakovlev, P., & Steinkopf, T. (2014). Can economic freedom cure medical brain drain? *Journal of Private Enterprise*, 29(3), 97-117.
- Yeates, N., & Pillinger, J. (2018). International healthcare worker migration in Asia Pacific: International policy responses. *Asia Pacific Viewpoint*, 59(1), 92-106. <https://doi.org/10.1111/apv.12180>

- Yeomans, N. D., Chowdhury, A., & Roberts, A. (2022). International medical graduates (IMGs) in cul-de-sacs: “lost in the labyrinth” revisited? *Medical Journal of Australia*, 216(11), 553-555. <https://doi.org/10.5694/mja2.51516>
- Young, I. M. (1990). *Justice and the politics of difference*. Princeton University Press.
- Young, I. M. (2003). *Political responsibility and structural injustice*. University of Kansas.
- Yow, A., Garces-Ozanne, A., & Audas, R. (2015). Carousel and conveyor belt: The migration of doctors in New Zealand. *Labour & Industry: a journal of the social and economic relations of work*, 25(3), 219-234. <https://doi.org/10.1080/10301763.2015.1081479>
- Yuksekdag, Y. (2018). Health without care? Vulnerability, medical brain drain, and health worker responsibilities in underserved contexts. *Health Care Analysis*, 26(1), 17-32. <https://doi.org/10.1007/s10728-017-0342-x>
- Zarocostas, J. (2006). Migration of health workers from less developed countries needs urgent solution, say experts. *BMJ: British Medical Journal*, 332(7544), 748. <https://doi.org/10.1136/bmj.332.7544.748-d>

12 APPENDICES

12.1 APPENDIX A: TIMELINE OF MEDICAL LICENSING HISTORY IN AOTEAROA NEW ZEALAND

The following timeline (see Table 13) provides a more-detailed overview of the policies behind the evolving mobilities and capabilities regimes relating to medical licensing since Aotearoa New Zealand became a British colony. The different licensing pathways are organised according to how they most correspond to what is in place at the time of writing:

- **NZMG:** New Zealand medical graduates.
- **Specialists:** The distinction between graduate (primary medical qualification), and postgraduate, specialist qualifications was not clearly established in policy until 1971. Members of a recognised British College of Surgeons, for example, would likely be considered specialists now, although no such distinction was made in 19th and early 20th century policy. Those who would now be classified as *specialists* registered through whichever available pathway applied to them at the time.
- **Australian:** This category refers to Australian medical graduates, or general registrants applying on the basis of having obtained full medical licensing in Australia.
- **U.K. / Ireland:** Doctors with primary medical qualifications and / or training in the U.K. and Ireland, or general registrants applying on the basis of having obtained full medical licensing in the U.K.
- **Comparable (CHS):** Doctors from other countries whose qualifications and/or experience were considered acceptable and / or equivalent to NZMGs.
- **NZREX:** Doctors required to retrain or take a licensing examination to work in Aotearoa New Zealand.

Pathways shaded in grey were not applicable at that time.

Table 13

Historical Overview of Key Policies Indicating Who Was Eligible for Medical Licensing in Aotearoa New Zealand Since 1849

NZMG	Specialists	Australian	U.K. / Ireland	Comparable (CHS)	NZREX
1849 (“Medical Practitioners Act,” 1849)					
			✓ Recognised by a College of Physicians or Surgeons in the <u>U.K. or Ireland</u>; and/or ✓ Served and trained in the British armed forces as a medical officer		
1869 (“Medical Practitioners’ Registration Act,” 1869)					
		✓ Australian medical graduates were entitled to registration (Pande, 2015)	✓ All practitioners registered or eligible to register in the <u>U.K. or Ireland</u>	✓ All other applicants with medical qualifications requiring at least <u>three years</u> of training <u>assessed for acceptability by the Registrar-General</u>	
1905 (“Medical Practitioners Registration Act,” 1905)					
✓ <u>NZMGs automatically</u>		✓ Same as above	✓ Same as above	✓ Governor in Council (Governor General)	✓ IMGs whose qualifications were not deemed “equal in status”

NZMG	Specialists	Australian	U.K. / Ireland	Comparable (CHS)	NZREX
<u>eligible</u> for registration				prepared a list of qualifications from foreign institutions (which provided at least five years' training) that he considered to be " <u>equal in status to that of New Zealand</u> "	could apply for registration on completion of the <u>final examination at the University of Otago</u> medical school
1914 ("Medical Practitioners Act," 1914)					
✓ Same as above		✓ Same as above	✓ Same as above	✓ A " <u>Medical Board</u> " was <u>responsible</u> for assessing individual applications from IMGs with at least <u>five years' training</u> and could refuse a candidate at their discretion	✗ No mention of the option to register after examination
1924 ("Medical Practitioners Amendment," 1924)					
✓ Same as above			✓ Same as above, but British and Irish were <u>no longer automatically entitled</u> to registration and <u>could be refused at MCNZ's discretion</u>	✓ Same as above, but the Medical Board was renamed as the Medical Council of New Zealand (MCNZ)	✓ <u>Examination option re-established</u> for those who degrees were not recognised by MCNZ ✓ MCNZ also made provisions for <u>some IMGs to complete a three-year retraining</u> programme in Otago (Sainsbury, 2015)

NZMG	Specialists	Australian	U.K. / Ireland	Comparable (CHS)	NZREX
1950 (“Medical Practitioners Act,” 1950)⁴⁹					
✓ NZMGs entitled to <u>conditional registration</u>		✓ Australian medical graduates <u>eligible for conditional registration at MCNZ’s discretion</u>	✓ Medical practitioners licensed, or eligible to be licensed in the U.K. and/or Ireland were <u>eligible for conditional registration at MCNZ’s discretion</u>	✓ There was no clear distinction between IMGs with acceptable qualifications and those required to take further examination ✓ Instead, conditional registration was available to IMGs from foreign approved universities requiring a minimum <u>of six years’ study</u> who, <u>at the discretion of MCNZ, could have been asked to take further courses or examinations</u> , or simply be refused ✓ A 1964 amendment first gave MCNZ the authority to assess IMG <u>English language competency</u> (“Medical Practitioners Amendment Act,” 1964), which has been included in all licensing policies since	
1968 (“Medical Practitioners Act,” 1968)⁵⁰					
✓ Same as above	✓ The <u>first list of approved specialist qualifications</u> was published in 1971, including those from <u>Australia, the U.K., Ireland, Canada, South Africa</u> (“Medical Practitioners	✓ Australian graduates now specifically mentioned on the list of qualifications <u>recognised for “conditional registration” at both the</u>	✓ Same as above	✓ In 1970, other (non-AUS or CA) qualifications recognised for “conditional registration” were from <u>Canada, South Africa, Hong Kong, Singapore, Sri Lanka (Ceylon) and Malta</u> (“Medical Practitioners	✓ Other IMGs were eligible for <u>“probationary registration” upon recognition by the U.S. Educational Commission for Foreign Medical Graduates (ECFMG) (Sainsbury, 2015)</u> ✓ <u>“Temporary registration”</u> of up to two years was introduced in the 1980s <u>while candidates prepared for ‘probationary’</u>

⁴⁹ The concept of “conditional registration” as a prerequisite to full registration was introduced, requiring a conditionally registered doctor to work at an approved New Zealand hospital or institution for a period laid out by the Minister of Health – in other words, this was a compulsory internship similar to modern House Officer positions (Sainsbury, 2015).

⁵⁰ In addition to “conditional registration” for those with recognised qualifications, “probationary registration” was introduced for IMGs with non-approved qualifications to register without having to go through formal retraining, upon consideration of their medical knowledge and English competency by MCNZ. “Temporary registration” was introduced for those preparing to take examinations and apply for “probationary registration”. IMGs could apply for “conditional registration” after completing their probationary period and passing required examinations and/or completing supervised work to an acceptable standard. “Temporary” and “probationary” registration were therefore only for IMGs with qualifications that were not automatically recognised for “conditional registration”.

NZMG	Specialists	Australian	U.K. / Ireland	Comparable (CHS)	NZREX
	(Registration Of Specialists) Regulations,” 1971) and <u>the U.S.A.</u> (Blundell, 1973)	<u>general and specialist level</u>		Amendment Act,” 1970) ✓ <u>By 1979, this only included Canada and South Africa</u> (“Medical Practitioners Amendment Act,” 1979)	<u>status</u> on completion of New Zealand licensing examinations: PRENZ (1984-1989) and then NZREX (1989-1997) ✓ <u>From 1990, a screening examination</u> (first part of NZREX) was also required before temporary registration was available (MCNZ, 1990)
1995 (“The Medical Practitioners Act,” 1995) ⁵¹					
✓ NZMGs <u>eligible for “probationary registration”</u> (which required the completion of an internship as a House Officer to progress to general registration, i.e., PGY1)	✓ Shift to accepting specialist qualifications on a <u>case-by-case basis</u> (“Medical Practitioners (Vocational Registration) Order,” 1996) ✓ However, <u>general registration was a prerequisite for vocational registration</u> , meaning specialists without recognised	✓ Graduates from Australian institutions were eligible to apply for temporary, probationary or general <u>registration without examination</u> , depending on their experience (MCNZ, 1996b)	✓ Officially, <u>all IMGs (except for Australian IMGs) were required to take the NZREX</u> , as doctors from the <u>U.K., Ireland, Canada, and South Africa</u> were no longer automatically eligible for registration ✓ However, MCNZ “ <u>ruled that for a limited period these doctors could still apply for temporary registration</u> under the new Act” (MCNZ, 1996a, p. 16) for up to <u>three years</u> ✓ From 1998, this also applied to doctors from <u>the U.S.A.</u> (MCNZ, 1998b) ✓ This “limited period” of exemption from NZREX lasted for the entire length of time before the new Health Practitioners Competence Assurance (HPCA) Act in 2003 (MCNZ, 2001b, 2002b, 2004b).	✓ <u>Temporary licensing option phased out</u> for candidates preparing for NZREX, who now <u>had to pass the examination before they could work as doctors</u> in any capacity (MCNZ, 1998a) ✓ The majority of doctors who took the NZREX during this time continued to be from countries outside of the U.K., Ireland, Canada, South Africa and the U.S.A. (MCNZ, 1997, 1998a, 1999, 2000, 2001a, 2002a, 2003)	

⁵¹ With the new Act in 1995, “conditional registration” was renamed as “probationary registration” for all doctors (not just IMGs) who were not yet eligible for full registration (usually less experienced practitioners).

NZMG	Specialists	Australian	U.K. / Ireland	Comparable (CHS)	NZREX
	primary qualifications were diverted to NZREX (Selvarajah, 2004)	✓ From 2000, NZMGs and Australian graduates with completed <u>internships</u> <u>could apply for immediate general registration</u> on a case-by-case basis (MCNZ, 2000)	✓ “Temporary registration” thus changed in meaning from previously applying to those on the NZREX pathway preparing for probationary registration, to those from countries previously accepted for conditional or general registration, <u>in order to avoid severe workforce shortages</u> (MCNZ, 1997)		
2003 (“Health Practitioners Competence Assurance Act,” 2003; MCNZ, 2004c)⁵²					
✓ NZMGs <u>eligible for provisional registration</u> until internship requirements (PGY1 and PGY2) are complete	✓ IMGs assessed and granted <u>full vocational registration</u> or <u>provisional vocational registration</u> (pending supervision for at least twelve months and completion of any other MCNZ requirements), or <u>referred to a</u>	✓ Requirements for Australian medical graduates were now <u>identical to those of NZMGs</u>	✓ Medical degree from a list of <u>U.K. or Irish Universities</u> only, plus <u>ONE YEAR minimum experience</u> (this could include internship year, and the country where this experience should be completed was not specified)	✓ Must have <u>worked for 36 months continuously, at least 30 hours per week</u> , in a listed Comparable Health System to obtain provisional registration ✓ Must then work at least two years full time with satisfactory supervisory reports to be eligible for full general registration	✓ Hold a <u>medical degree from WHO World Directory</u> of Medical Schools or ECFMG FAIMER Directory, and have <u>passed USMLE Steps 1 and 2</u> , and <u>NZREX</u> ✓ The Australian Medical Council (AMC) multiple-choice (MCQ) examination was accepted from 2006 as an alternative to USMLE Steps 1 and 2 (MCNZ, 2006a), with the first mention of acceptance of the U.K. PLAB 1 examination from 2009 (MCNZ, 2009a)

⁵² “Probationary registration” is now referred to as “provisional registration”.

NZMG	Specialists	Australian	U.K. / Ireland	Comparable (CHS)	NZREX
	<u>general licensing pathway</u> ✓ “Special purpose registration” available for “ <u>locum tenens</u> ” specialists from <u>Australasia, U.K., Ireland, South Africa, Canada, and U.S.A.</u> to work for up to 6 months, if they worked <u>at least 30 hours per week for 24 of the past 36 months</u>			✓ In 2004, CHS countries included <u>Australia, U.K., Ireland, Canada, U.S.A., the Netherlands and Germany</u> (MCNZ, 2004c) ✓ By 2005, <u>Austria, Belgium, Denmark, Finland, France, Italy, Norway, Sweden and Switzerland</u> had been added (Haivas, 2005)	✓ After NZREX, candidates must work under supervision for at least one year (PGY1) in a <u>hospital OR general practice</u> in Aotearoa New Zealand, with satisfactory supervision reports ✓ All IMGs (including those on other licensing pathways) must pass (or be exempt from) MCNZ’s English testing policy (in 2004 this <u>was 7.5 overall in the IELTS Academic Module, with at least 7.0 in all individual components</u>)
2010 (MCNZ, 2010b)					
✓ Same as above	✓ Same as above for vocational registration (<u>case-by-case basis</u>) ✓ From 2010, specialists applying for <u>Locum tenens</u> positions were only required to have worked <u>20 hours per week</u>	✓ Same as above	✓ Primary medical degree from approved “Competent Authority” (U.K. or Irish medical councils) and one year of general medical experience ✓ Unlike earlier, it is clearly specified that the <u>one year of</u>	✓ Have worked for 36 months (minimum 30 hours per week) during the 48 hours prior to application in a Comparable Health System (listed on website) and have full or general registration in a Comparable Health System;	✓ Primary medical degree from an approved medical school listed on the website, an approved medical knowledge examination as listed on website, and completion of NZREX within five years of this ✓ NZREX candidates must then either complete the 4 rotations of PGY1 <u>OR apply for an exemption on a case-by-case basis to work directly under in</u>

NZMG	Specialists	Australian	U.K. / Ireland	Comparable (CHS)	NZREX
	<u>over 24 months of the last 36 months</u>		<u>prior work experience required must be in a “competent authority” country</u>	✓ <u>OR be satisfactorily participating in a training programme recognised by the American specialty boards or Canadian colleges</u>	<u>primary care</u> if they worked at least five years in general practice previously ✓ In 2009, <u>English</u> language policy changed to require <u>7.5 in Speaking and Listening</u> in IELTS, and 7.0 in Reading and Writing for IMGs (MCNZ, 2009a)
2012 onwards					
✓ Same as above	✓ <u>Locum tenens</u> was extended to allow special purpose registration for <u>up to 12 months</u> , instead of just 6 months in 2012 (MCNZ, 2012b). ✓ From 2013, Locum tenens applicants now only required 22 months (minimum 20 hours per week) of active clinical practice prior to application (1,760 hours worked) (MCNZ, 2013b)	✓ Same as above ✓ From 2018, <u>Australian GR</u> (general registrants) pathway introduced, where <u>doctors who completed Australian medical licensing</u> examinations and 12 months supervised practice in Australia, could apply for provisional	✓ Same as above ✓ A 2022 update states clearly for the first time that “Competent Authority” refers only to U.K. and Irish graduates (MCNZ, 2022g) ✓ From June 2023, <u>U.K. GR</u> (general registrants) pathway is introduced for IMGs who have completed <u>U.K. medical licensing examinations and PGY1 in the U.K., making them</u>	✓ From November 2013, CHS doctors were now only required to have <u>33 months recent clinical practice (minimum 30 hours per week)</u> during the past 48 months, equating to 3,950 hours (but only a maximum of 40 hours per week count) (MCNZ, 2013b) ✓ From 2023, working <u>20 hours per week is now considered sufficient</u> (for a minimum of 33 months within the past 48 months), and a wider range of experience is accepted	✓ Same as above ✓ In 2014, the <u>option to complete the PGY1 year in primary care for NZREX graduates was removed</u> , so requirements for registration were identical for NZREX candidates and recent NZMGs and Australian graduates (MCNZ, 2014b) ✓ IMGs who have completed the <u>U.K. medical knowledge and clinical examinations (PLAB 1 and 2)</u> will also not need to take NZREX to apply for PGY1 positions from June 2023 (MCNZ, 2023g) ✓ A <u>pilot programme</u> for 10 NZREX graduates to complete PGY1 in a <u>primary care</u> setting

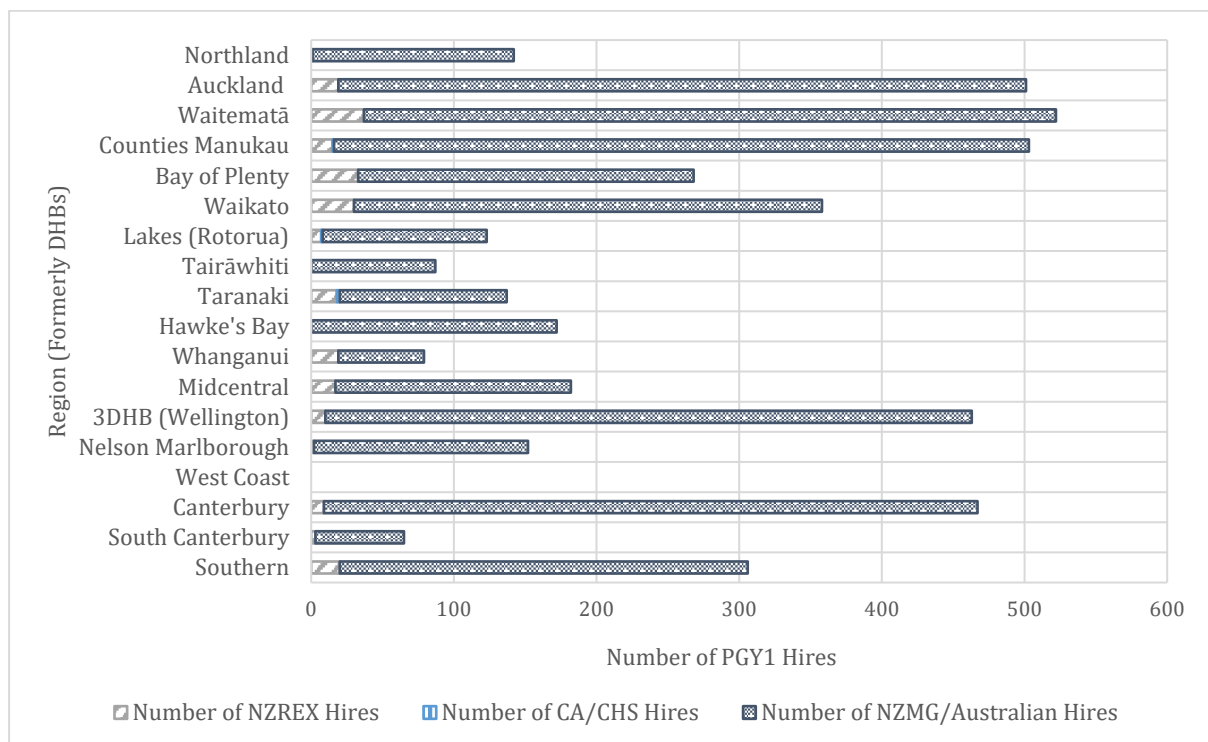
NZMG	Specialists	Australian	U.K. / Ireland	Comparable (CHS)	NZREX
	✓ Current listed approved qualifications from <u>Australasia, Canada, Ireland, South Africa, the U.K. and the U.S.A.</u> (MCNZ, 2015b)	registration (MCNZ, 2018c)	<u>eligible to bypass NZREX</u> and receive provisional registration (MCNZ, 2023g)	for doctors applying to work in rural settings (MCNZ, 2022g) ✓ CHS countries increased to 22 by 2012 with the inclusion of the <u>Czech Republic, Greece, Iceland, Israel, Singapore and Spain</u> (Pande, 2015) and 23 in 2018, with the addition of <u>Portugal</u> (MCNZ, 2018b) ✓ Currently, 24 countries are recognised, with <u>Hong Kong</u> being the most recent addition (MCNZ, 2024a) ✓ From 2022, CHS applicants need to have worked in the “<u>same</u> area” of medicine as the role they are applying for, OR a “<u>similar</u> area” (MCNZ, 2022g)	is currently underway, alongside a pilot bridging programme (MCNZ, 2023c) ✓ From December 2022, English language policy requires <u>7.0 in all four individual components of IELTS</u> or a minimum score of <u>350 in the Occupational English Test (OET) Medical Module</u> (MCNZ, 2022f). OET was also added to the policy between 2009 and 2022, but it is unclear when that change was made.

12.2 APPENDIX B: REGION OF PGY1 EMPLOYMENT FOR NZREX CANDIDATES

Between November 2013 and May 2022, an average of 5% PGY1 hires nationally were NZREX candidates. NZREX doctors were most likely to find PGY1 positions in the central North Island, Bay of Plenty, and broader Auckland region. A regional breakdown is given in Figure 51.

Figure 51

Total NZREX, ACE/CA and ACE Matching System PGY1 Hires Between 2014 and 2022, by Region (Formerly Known as District Health Boards)⁵³



⁵³ The information requests cited above were complemented by previous OIA requests made by another individual in 2019, for which all data was made publicly available (data provided by Anjaria, 2019; Apa, 2019; Bramley, 2019; Cheong, 2019; Claire, 2019; Coley, 2019; Fleming, 2019; Griffiths, 2019; Gullery, 2019; Hudson, 2019; Hunter, 2019; Johnson, 2019; McCarthy, 2019; Price, 2019; Richardson, 2019; Saville-Wood, 2019). Both datasets were compiled to present up-to-date hiring data for PGY1 candidates. Please note:

- 1) Hawke's Bay District Health Board (DHB) declined to provide NZREX hiring data for 2018-2022, so this is assumed to be zero, as an earlier information request for the years 2014-19 indicated zero NZREX hires in that time.
- 2) West Coast DHB did not hire PGY1 candidates.
- 3) Bay of Plenty DHB provided totals of hires from 2014-2019 without a year-to-year breakdown, so for years 2014-2017, these have been calculated as the mean for that four-year period. 2018-2022 data was provided year by year.

12.3 APPENDIX C: PRENZ AND NZREX CLINICAL EXAMINATION PASS RATES

The pass rates for the PRENZ (1984-1989) and NZREX clinical examinations (1990-2023) are shown in Table 14 and Figure 52, with an average pass rate of 58%. Data are compiled from MCNZ annual reports between 1987 and 2014, and the NZREX status updates posted online by MCNZ from 2020 onwards, including the online database available from 2023 (MCNZ, 2024l).

Table 14

Pass Rates for PRENZ and NZREX Clinical Examinations Between 1984 and 2023

Year	Attempts	Passes	Pass rate	Examination Format
1984	2	2	100%	PRENZ Clinical
1985	5	5	100%	PRENZ Clinical
1986	2	2	100%	PRENZ Clinical
1987	6	5	83%	PRENZ Clinical
1988	32	12	38%	PRENZ Clinical
1989	23	13	57%	PRENZ Clinical
1990	31	13	42%	NZREX Clinical (Part IV)
1991	49	18	37%	NZREX Clinical (Part IV)
1992	65	24	37%	NZREX Clinical (Part IV)
1993	81	36	44%	NZREX Clinical (Part IV)
1994	95	42	44%	NZREX Clinical (Part IV/Part 3)
1995	91	44	48%	NZREX Clinical (Part 3)
1996	214	118	55%	NZREX Clinical (Part 3)
1997	325	154	47%	NZREX Clinical (Part 3)
1998 ⁵⁴	428	210	49%	NZREX Clinical (Standalone)
1999	238	110	46%	NZREX Clinical (Standalone)
2000	167	78	47%	NZREX Clinical (Standalone)
2001	83	48	58%	NZREX Clinical (Standalone)
2002	167	101	60%	NZREX Clinical (Standalone)
2003	229	104	45%	NZREX Clinical (Standalone)
2004 ⁵⁵	145	68	47%	NZREX Clinical (Standalone)
2005	41	22	54%	NZREX Clinical (Standalone)
2006	52	31	60%	NZREX Clinical (Standalone)
2007	56	35	63%	NZREX Clinical (Standalone)
2008	73	48	66%	NZREX Clinical (Standalone)
2009	108	57	53%	NZREX Clinical (Standalone)
2010	114	72	63%	NZREX Clinical (Standalone)
2011	111	73	66%	NZREX Clinical (Standalone)
2012	137	81	59%	NZREX Clinical (Standalone)
2013 ⁵⁶	53	27	51%	NZREX Clinical (Standalone)
2014 ⁵⁷	72	34	47%	NZREX Clinical (Standalone)

⁵⁴ Between 1998 and 2004, the data are collated from 1st April of that year to 31st March of the next year. Earlier years are from January to December.

⁵⁵ Between 2004 and 2013, the data are compiled from 1st July of that year to 30th June of the following year.

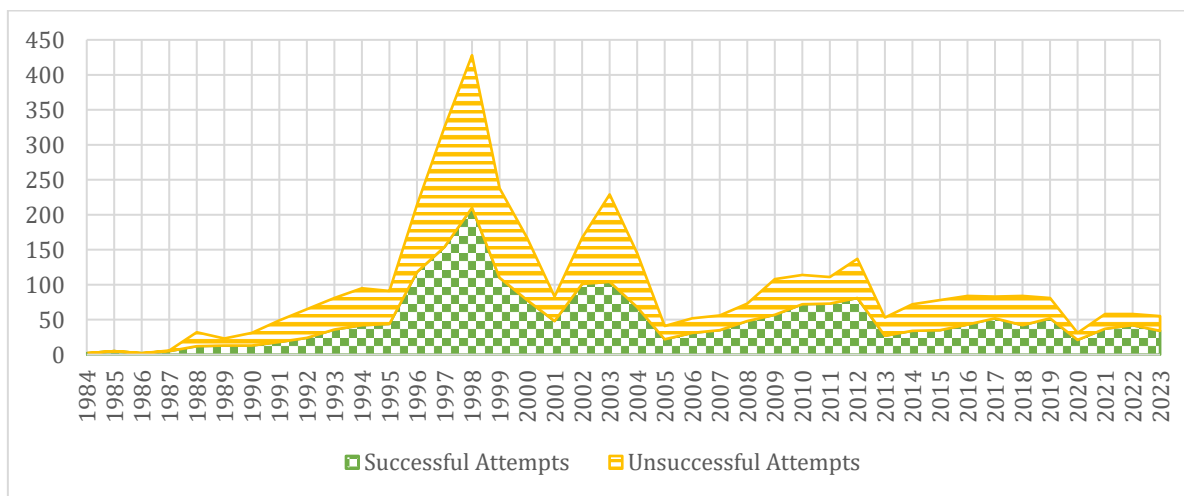
⁵⁶ The 2013 dataset only includes examinations between July and December 2013, due to the transition in reporting from 2014.

⁵⁷ From 2014, data resumes being reported from January to December of each year.

Year	Attempts	Passes	Pass rate	Examination Format
2015	78	35	45%	NZREX Clinical (Standalone)
2016	84	43	51%	NZREX Clinical (Standalone)
2017	83	52	63%	NZREX Clinical (Standalone)
2018	84	42	50%	NZREX Clinical (Standalone)
2019	81	52	64%	NZREX Clinical (Standalone)
2020	31	21	68%	NZREX Clinical (Standalone)
2021	58	37	64%	NZREX Clinical (Standalone)
2022	58	42	72%	NZREX Clinical (Standalone)
2023	55	34	62%	NZREX Clinical (Standalone)
TOTAL	3852	2011	58% (average)	

Figure 52

IMG Clinical Examination Attempts Between 1984 and 2023 (PRENZ and NZREX)



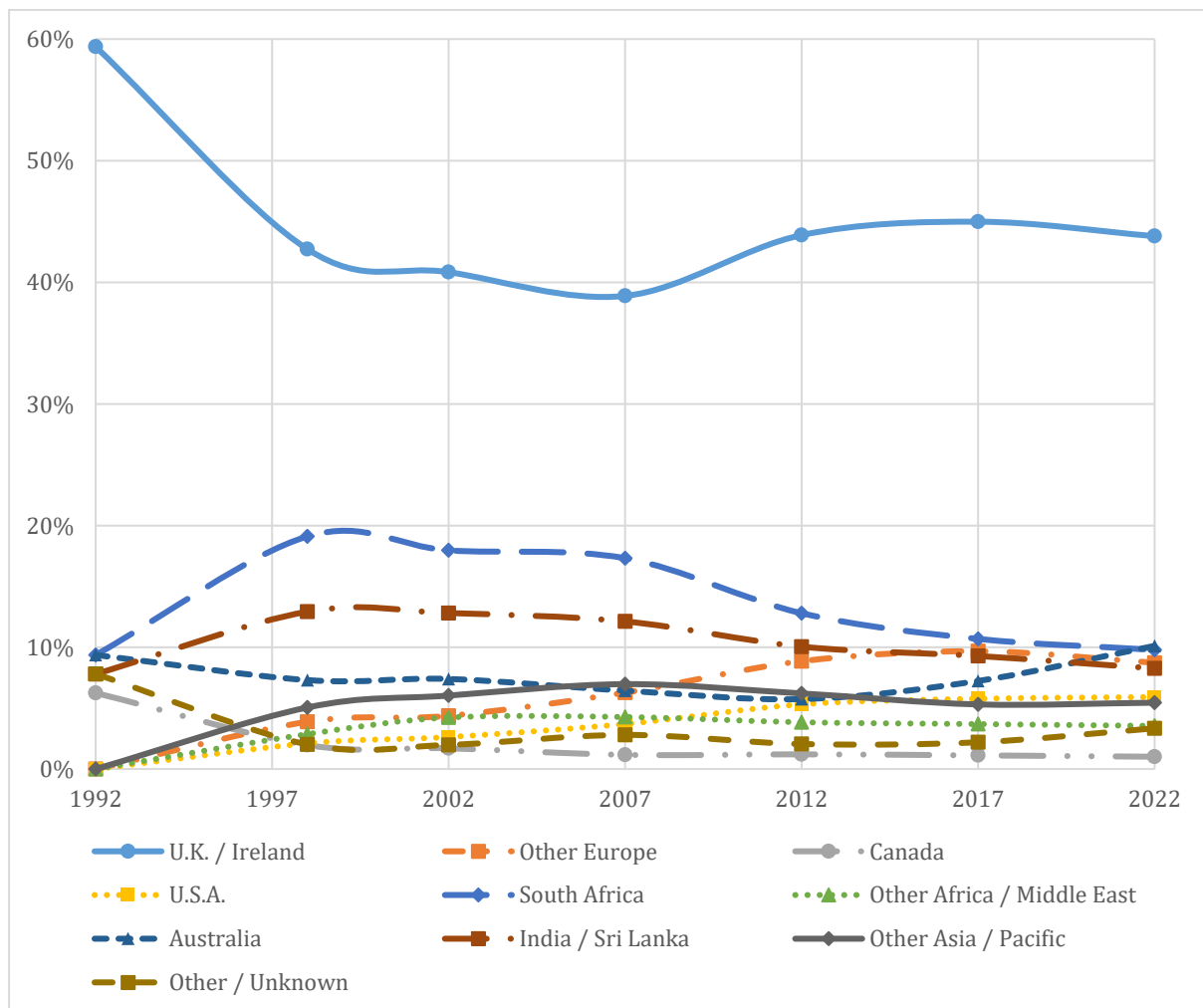
There is a noticeable increase in total attempts and successful passes when NZREX became briefly compulsory for all IMGs hoping to gain probationary registration (not just temporary registration) from July 1996. Similarly, there is a marked decrease when the CA and CHS pathways were introduced from 2004 and NZREX was required by a much smaller portion of IMGs. There is also a visible reduction in examination offerings since 2013. Similarly, the effect of the cancellation of examinations during COVID-19 lockdowns in 2020 and 2021 is visible in Figure 52.

12.4 APPENDIX D: COUNTRY OF PRIMARY QUALIFICATION OF IMG WORKFORCE

The countries from which IMGs have tended to receive their primary qualifications have fluctuated over the decades, alongside these overall increases in IMG representation in the workforce. Trends in the country of primary qualification of IMGs are captured in Figure 53, Figure 54, and Figure 55, which have been created by the author based on data from MCNZ annual reports (MCNZ, 1983, 1987, 1992, 1997, 1998a, 2002a, 2007b, 2012a, 2017a, 2022a).

Figure 53

Proportion of Registered IMG Workforce by Country or Region of Primary Qualification, 1992-2022⁵⁸



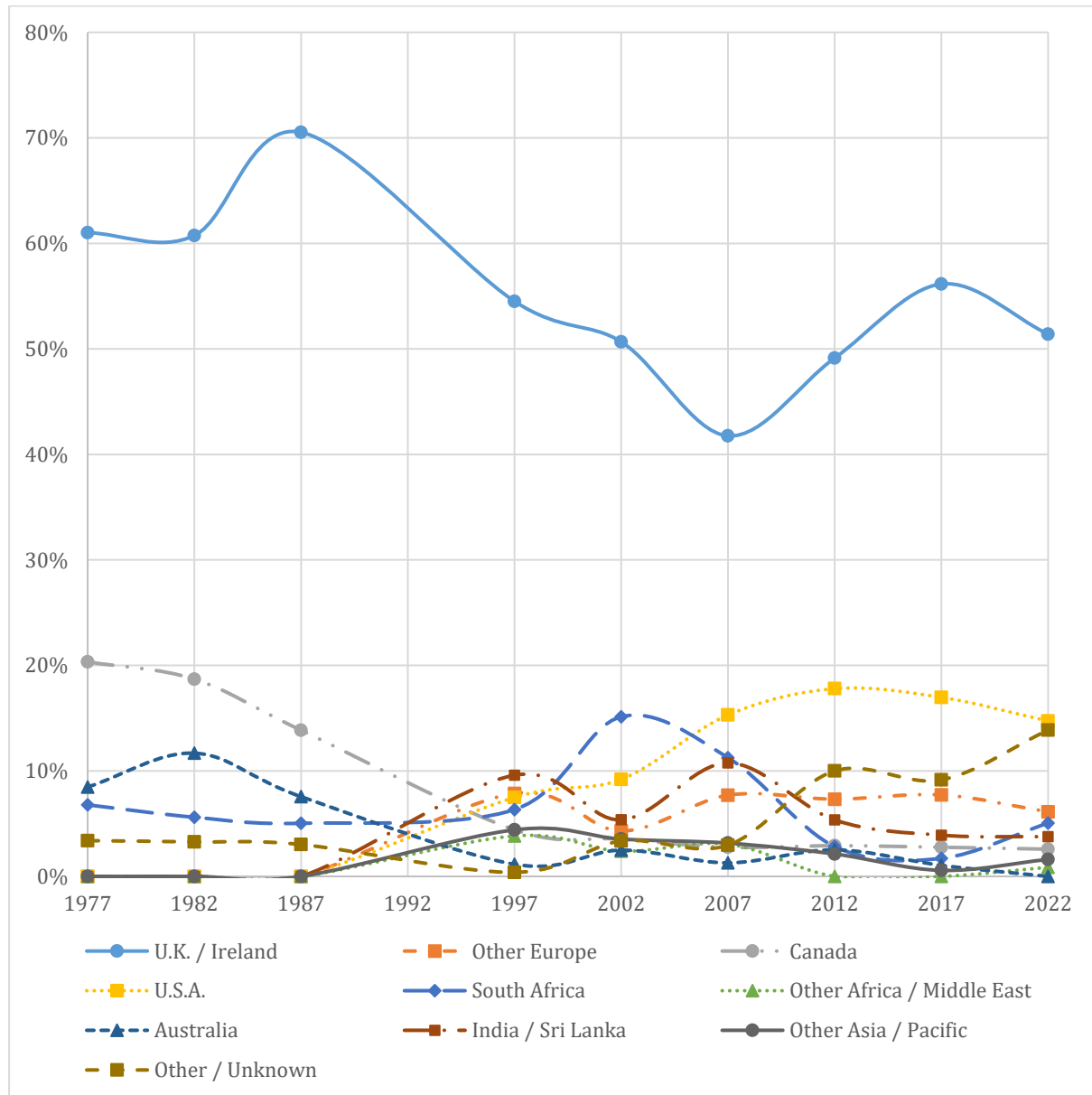
While medical doctors who trained in the U.K. and Ireland continue to make up the largest proportion of IMGs in the workforce, Figure 53 highlights the significant increase in other European doctors between 2002 and 2007, and onwards. This is likely to correspond with the

⁵⁸ The goal was to provide a data snapshot in five-year intervals – however, the lack of availability for data from 1997 meant that data from 1998 were used instead.

introduction of the CHS pathway, which was favourable to many Europeans, particularly those from Germany and the Netherlands, who make up the largest proportion of this group. Since the inclusion of American-trained doctors for temporary registration in the late 1990s, the number of doctors with a primary qualification from the U.S.A. has increased from virtually 0 to 6%, while the representation of Canadian doctors has dwindled from 6% to just 1%. The proportion of South African trained doctors has varied through the decades but appears to be decreasing overall since the majority of South African doctors were diverted by the NZREX pathway and were no longer automatically eligible for general registration, as they were prior to 2004. There is also an overall increase in IMGs contributing to the workforce from other Asian, African, and Pacific countries, with the highest representation within these regions coming from Iraq, Egypt, Zimbabwe, Bangladesh, Hong Kong and China, Pakistan, Fiji, and the Philippines.

Data relating to new annual registrations also supports these observations of the makeup of the medical workforce over time. Figure 54 highlights the growth in registration of European and American doctors, alongside reduced registrations for South African, Canadian, and Australian doctors overall⁵⁹.

⁵⁹ Between 1971 and 1982 there were also 187 successful Probationary Registrants, including 57 from India or Sri Lanka, 51 from Europe, 29 from Scandinavia, 33 from the U.S.A., 6 from the Middle East and 11 from the Philippines and “other” countries. These doctors were required to work for one year in a New Zealand hospital before they could apply for full registration (MCNZ, 1983).

Figure 54*New IMG Registrants by Country of Primary Qualification, 1977-2022⁶⁰*

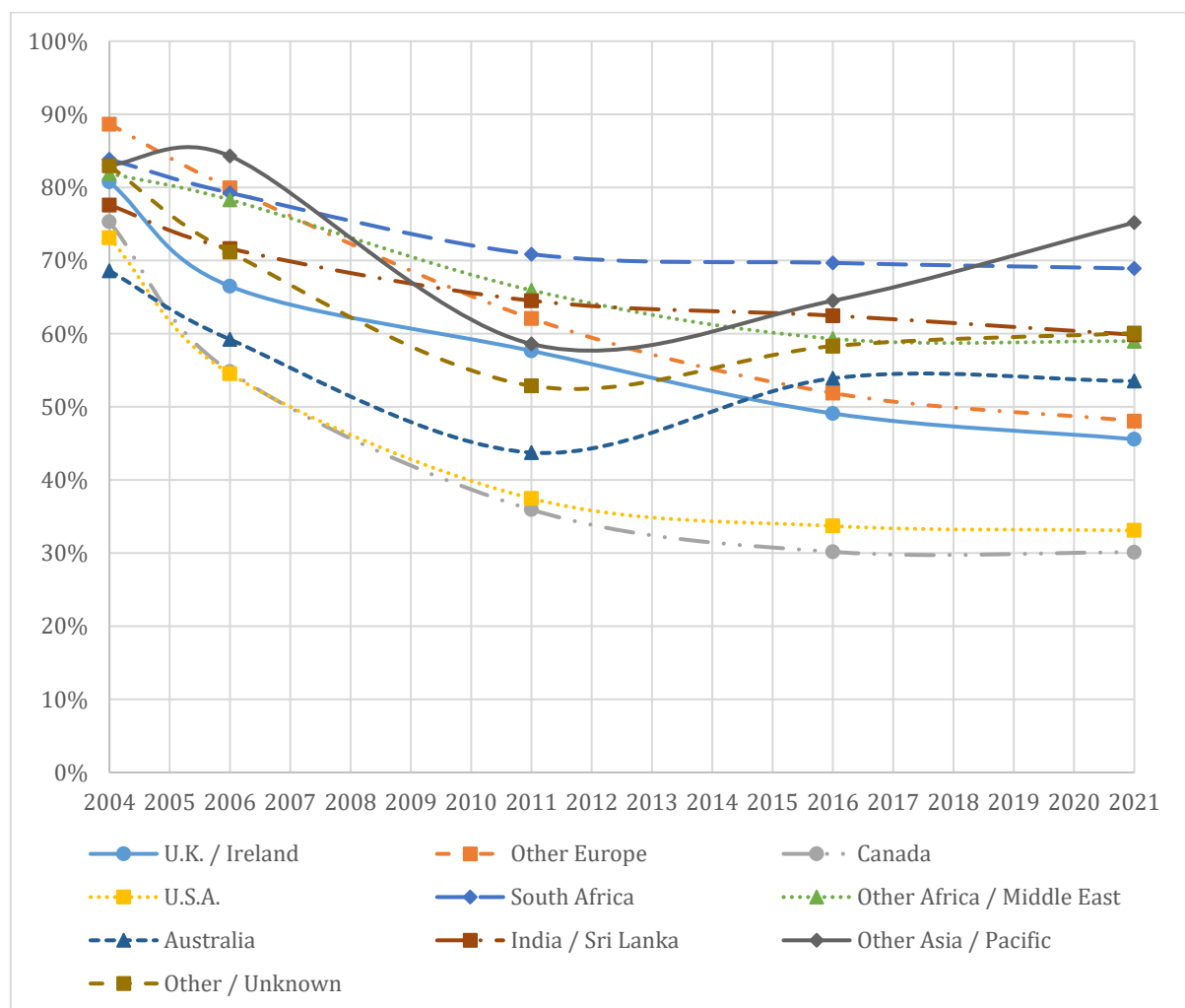
The way dynamics of brain drain, gain and waste play out in relation to the differential licensing pathways for IMGs in Aotearoa New Zealand can also be seen in data relating to the country of primary qualification of the active medical workforce. Between 2004 and 2021, MCNZ reported on the number of IMGs on the register by primary qualification, compared to the number of individuals with current annual practising certificates (APCs). Not all doctors are removed from the register immediately upon leaving the country, and so the proportion of registered individuals with APCs can be an indication of how many from that region were

⁶⁰ While the aim was to present data in five-year intervals, there were no data available for 1992 or any of the early-mid 1990s that could be drawn on.

actively working and therefore still residing in Aotearoa New Zealand. Doctors on the register from Canada, the U.S.A., the U.K., Ireland, and other European countries are least likely to have a current APC. This supports earlier studies (Morton et al., 2008) and data provided by MCNZ (2022c) indicating that doctors from Africa, the Middle East and Asia (those generally eligible to register via the NZREX pathway) are most likely to stay long-term. Figure 55 provides a snapshot of the data relating to proportion of IMGs on the register with current APCs from each region (MCNZ, 2004a, 2006a, 2011a, 2016, 2021a).

Figure 55

Proportion of IMGs With Current Annual Practising Certificates (APCs) in 2004, 2006, 2011, 2016 and 2021, by Region of Primary Qualification



12.5 APPENDIX E: MIXED METHODS RATIONALES FOR THIS RESEARCH

The various rationales for drawing on mixed methods approaches have been formalised in the literature over the past three to four decades, with specific terminology being advanced for researchers to draw on in describing their methodological choices (Plano Clark & Ivankova, 2016). Initially, Greene et al. (1989) identified five main purposes for mixing methods (*triangulation, complementarity, development, initiation and expansion*). Bryman (2006) expanded this list to include eighteen options, while Doyle et al. (2019) refined and simplified it to seven key rationales. Table 15 details the justifications for using a mixed methods approach according to the language mixed methods literature, by providing a snapshot of the most relevant aspects in relation to this research. Unless cited otherwise, the list and definitions are adapted from Greene et al. (1989), Bryman (2006) and Doyle et al. (2019).

Table 15

Mixed Methods Rationales for This Research

Term	Definition	How this is relevant to this research
Exploration / development	An initial phase is required to develop an instrument, identify variables to study, or develop a hypothesis to test	There is limited research on the experiences of IMGs in this context, and so qualitative exploration of these experiences was required to ensure the correct questions would be asked in a questionnaire with a wider reach. Furthermore, a sequential mixed methods approach lent itself to the concurrent development and refinement of the evolving theoretical framework this research contributes to.
Completeness / complementarity	Provides a more comprehensive account of phenomena under study	The questionnaire component provided the opportunity for a more complete understanding of the experiences of IMGs in Aotearoa New Zealand than a purely qualitative approach. The methods complemented each other to provide a more comprehensive understanding of the phenomenon.
Offset	Ensures that the weaknesses of each method are minimised (Creswell, 2015), although methods should be rigorous in their own right (O'Cathain, 2010)	Qualitative research tends to provide confidentiality but not anonymity to participants, which is addressed by the questionnaire component of the research design. On the other hand, quantitative data tends to be more impersonal and may provide limited understanding of the context of participants, which is explored in the qualitative component of the study (Creswell, 2015). Quantitative methods

Term	Definition	How this is relevant to this research
		can also play a role in helping to avoid “elite bias” (talking only to high-status individuals) that may be more prevalent in qualitative approaches, to thus better understand the way these themes are experienced (Johnson et al., 2007).
Utility / credibility	Improving usefulness of findings – combining approaches would be more useful for some practitioners and may be perceived as more legitimate	Combining the approaches may make this research of interest to a wider range of audiences, particularly those who tend to respond more favourably to quantitative data, such as policymakers. Overall, this research approach may also be considered ‘practical’ because individuals tend to solve problems more naturally using both numbers and words, not by separating them (Creswell & Plano Clark, 2018).
Enhancement / expansion	Building upon qualitative findings and augmenting the findings	The usefulness of qualitative findings is enhanced by exploring these among a wider pool of participants from the same population group. This broadens the range of enquiry and also supports the development of the theoretical framework alongside data analysis and integration.
Initiation / diversity of views	Combining researchers’ and participants’ perspectives through the qualitative research process, and exploring unexpected or contradictory relationships between data sets, allows room for new ideas and perspectives to emerge	There was a similar relationship between licensing pathway and the overall sense of an IMG’s experience in Aotearoa New Zealand in both the qualitative and quantitative phases of this research. Nevertheless, the anonymity of the questionnaire did afford the opportunity for a broader range of IMGs to participate, with individuals most likely to be female and on the NZREX licensing pathway. As I did not directly engage with participants in Phase 2, as I did in Phase 1, it was also helpful to see how they responded to my interpretation of the themes of IMG licensing experiences from Phase 1 that I included in the questionnaire.

12.6 APPENDIX F: PHASE 1: SOCIAL MEDIA ADVERTISEMENT

Kia ora koutou, I am conducting interviews as part of PhD research on the experiences of foreign-trained physicians. This includes both practising and non-practising doctors living in Aotearoa New Zealand, including those who are undertaking or have undertaken the NZREX or Comparable Health System pathway. All participants will receive a \$50 voucher as compensation for their time.

Please contact J.Thomas-Maude@massey.ac.nz if you would like to contribute. I look forward to hearing from you!



Are you a foreign-trained doctor?

**Would you like to share your story of
medical licensing in Aotearoa New Zealand?**

Please contact Johanna:
J.Thomas-Maude@massey.ac.nz
021 081 08462



MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

12.7 APPENDIX G: PHASE 1: PARTICIPANT INFORMATION SHEET (IMGs)

Development Studies
School of People, Environment and Planning
Massey University
Private Bag 11 222
Palmerston North 4442
NEW ZEALAND



Understanding the experiences of overseas-trained doctors in Aotearoa New Zealand

Information sheet – Overseas-trained doctor interview

Researcher introduction

My name is Johanna Thomas-Maude, and I am completing a PhD in Development Studies at Massey University. I have a background in teaching English as a Foreign Language and healthcare consulting. The aim of this research is to understand the experiences of foreign-trained medical doctors from different backgrounds in Aotearoa New Zealand.

Project description and invitation

The purpose of this research is to explore and understand the different experiences of foreign-trained medical doctors residing in Aotearoa New Zealand. In the first phase of the research I am interviewing around twenty doctors and ten local experts. Themes from these interviews will then be used to develop a wider reaching survey for foreign-trained doctors. Because this project focuses on the experiences of a range of individuals, every perspective is important, valid and valuable for this research. As such, your contribution would be greatly appreciated, should you choose to accept this invitation.

Participant identification and recruitment

To gain a broad picture of experiences, I am inviting the following kinds of participants:

- Practising and non-practising foreign-trained medical doctors in Aotearoa New Zealand
- Foreign-trained medical doctors who trained in comparable health systems
- Foreign-trained doctors required to undertake the New Zealand Registration Examination (NZREX)
- Employers, experts and/or policymakers with relevant background knowledge

I will be recruiting participants both through personal contacts and through posts on forums and groups on social media such as Facebook. Local expert participants will be approached directly.

An aim of the interviews is to hear a diverse range of perspectives. This means I may not be able to interview everyone who would like to participate if they share similar professional backgrounds. The survey component of this research will, however, provide an opportunity for a much larger group to share their experiences if they choose.

Project Procedures

You are invited to participate in a one-on-one interview with the researcher, consisting of a series of open-ended questions and a general discussion about your experiences as a foreign-trained medical doctor in Aotearoa New Zealand. The interview will take around 45-60 minutes at a location and time that is convenient for you, and can be ended at any time.

Development Studies
School of People, Environment and Planning
Massey University
Private Bag 11 222
Palmerston North 4442
NEW ZEALAND



The main themes of this discussion will include:

- Your background as a doctor
- Your journey to licensing in Aotearoa New Zealand
- Your sense of preparedness and that your skills are being utilised
- What an ideal pathway to licensing would look like for you

Please contact the researcher if you wish to receive a copy of the interview schedule in advance.

With your consent, the interview will be recorded so that it can be transcribed and analysed later. You are welcome to request a copy of the transcript within three weeks of the interview, and may review and edit this if you wish, for up to three weeks of receiving it.

Data management

Your interview transcript and consent will be stored digitally, on a password protected computer. At the end of the study, a summary of the overall research findings will be available to participants.

In any dissemination of the research findings, I will make every effort to keep your identity confidential by not reporting on any personal information that could make you easily identifiable.

Participant's rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right:

- To decline to answer any particular question;
- To withdraw from the study, up until the completion of the interview;
- To ask any questions about the study at any time during the interview;
- To provide information on the understanding that your name will not be used;
- To be given access to a summary of the project findings when it is concluded; and
- To ask for the recorder to be turned off at any time during the interview.

Project contacts

If you have any questions about the project, please do not hesitate to contact:

Researcher:

Johanna Thomas-Maude: J.Thomas-Maude@massey.ac.nz or [REDACTED]

Doctoral Supervisor:

Dr Sharon McLennan: S.McLennan@massey.ac.nz

Other supervisors include Dr Vicky Walters and Professor Bethan Greener.

Ethics

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 22/19. If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63363, email humanethicsoutha@massey.ac.nz.

12.8 APPENDIX H: PHASE 1: PARTICIPANT INFORMATION SHEET (LOCAL EXPERTS)

Development Studies
School of People, Environment and Planning
Massey University
Private Bag 11 222
Palmerston North 4442
NEW ZEALAND



Understanding the experiences of foreign-trained medical doctors (IMGs) in Aotearoa New Zealand

Information sheet – Local expert interview

Researcher introduction

My name is Johanna Thomas-Maude, and I am completing a PhD in Development Studies at Massey University. I have a background in teaching English as a Foreign Language and healthcare consulting. The aim of this research is to understand the experiences of foreign-trained doctors from different backgrounds in Aotearoa New Zealand.

Project description and invitation

The purpose of this research is to explore and understand the different experiences of foreign-trained doctors (IMGs) residing in Aotearoa New Zealand. In the first phase of the research I am interviewing around twenty IMGs and ten local experts. Themes from these interviews will then be used to develop a wider reaching survey for IMGs. Because this project focuses on the experiences of a range of individuals, every perspective is important, valid and valuable for this research. As such, your contribution would be greatly appreciated, should you choose to accept this invitation.

Participant identification and recruitment

To gain a broad picture of IMG experiences, I am inviting the following kinds of participants:

- Practising and non-practising IMGs in Aotearoa New Zealand
- IMGs who trained in comparable health systems
- IMGs required to undertake the New Zealand Registration Examination (NZREX)
- Employers, experts and/or policymakers with relevant background knowledge

I will be recruiting participants both through personal contacts and through posts on forums and groups on social media such as Facebook. Local expert participants will be approached directly.

Project Procedures

'Expert' participants include those with professional experience with IMGs, an understanding of the pathways IMGs undergo in order to practise and/or in-depth background knowledge of the health system and medical workforce in Aotearoa. As a local expert, you are invited to participate in a one-on-one interview with the researcher, consisting of a series of open-ended questions and a general discussion about your experiences with medical licensing for IMGs in Aotearoa New Zealand. The interview will take around 45-60 minutes at a time that is convenient for you, and can be ended at any time.

The main themes of this discussion will include:

- Your current role and/or professional background in relation to the health sector; and
- The health workforce of Aotearoa New Zealand and the role of foreign-trained doctors.

Please contact the researcher if you wish to receive a copy of the interview schedule in advance.

Development Studies
 School of People, Environment and Planning
 Massey University
 Private Bag 11 222
 Palmerston North 4442
 NEW ZEALAND



With your consent, the interview will be recorded so that it can be transcribed and analysed later. You are welcome to request a copy of the transcript within three weeks of the interview, and may review and edit this if you wish, for up to three weeks of receiving it.

Data management

Your interview transcript and consent will be stored digitally, on a password protected computer. At the end of the study, a summary of the overall research findings will be available to participants.

In any dissemination of the research findings, I will make every effort to keep findings confidential, without reporting your name, unless you wish for this to be included.

Participant's rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right:

- To decline to answer any particular question;
- To withdraw from the study, up until the completion of the interview;
- To ask any questions about the study at any time during the interview;
- To provide information on the understanding that your name will not be used;
- To be given access to a summary of the project findings when it is concluded; and
- To ask for the recorder to be turned off at any time during the interview.

Project contacts

If you have any questions about the project, please do not hesitate to contact:

Researcher:

Johanna Thomas-Maude: J.Thomas-Maude@massey.ac.nz or [REDACTED]

Doctoral Supervisor:

Dr Sharon McLennan: S.McLennan@massey.ac.nz

Other supervisors include Dr Vicky Walters and Professor Bethan Greener.

Ethics

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 22/19. If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63363, email humanethicsoutha@massey.ac.nz.

12.9 APPENDIX I: PHASE 1: PARTICIPANT CONSENT FORM (ONLINE INTERVIEW)

Development Studies
School of People, Environment and Planning
Massey University
Private Bag 11 222
Palmerston North 4442
NEW ZEALAND



MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Understanding the experiences of overseas-trained doctors (IMGs) in Aotearoa New Zealand

Participant consent form – Individual interview

I have read and I understand the Information Sheet. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study before the end of the interview.

1. I agree to the online interview being sound recorded.
2. I agree to the online interview being image recorded.
3. I agree to participate in this study under the conditions set out in the Information Sheet.

Declaration by Participant

I, _____, consent to take part in this study.

Signature: _____ Date: _____

12.10 APPENDIX J: PHASE 1: PARTICIPANT CONSENT FORM (IN-PERSON INTERVIEW)

Development Studies
School of People, Environment and Planning
Massey University
Private Bag 11 222
Palmerston North 4442
NEW ZEALAND



Understanding the experiences of overseas-trained doctors (IMGs) in Aotearoa New Zealand

Participant consent form – Individual interview

I have read and I understand the Information Sheet. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study before the end of this interview.

1. I agree to the interview being sound recorded.
2. I agree to participate in this study under the conditions set out in the Information Sheet.

Declaration by Participant

I, _____, consent to take part in this study.

Signature: _____ Date: _____

12.11 APPENDIX K: PHASE 1: FINAL INTERVIEW SCHEDULES

The following tables lay out the final interview schedules among each participant type.

Table 16

Interview Schedule for International Medical Graduates (IMGs)

Key Question	Follow-up Questions (if Needed)
Why did you choose to come to Aotearoa New Zealand?	↳ Did you come here with the intention of practising medicine? ↳ How long have you been here? ↳ Do you intend to stay in Aotearoa?
What is your professional background?	↳ Where and when did you receive your medical qualifications? ↳ What medical experience did you have before coming to Aotearoa?
Are you licensed to practise medicine in Aotearoa New Zealand?	↳ If not yet licensed, do you hope to become registered to practise? ↳ Which stage are you at on your pathway to licensing? ↳ Which pathway to licensing applies to you? ↳ What has worked well on your journey to licensing? ↳ What kinds of challenges have you experienced? ↳ Are there any important relationships or contacts that have guided you professionally on your licensing journey?
Do you feel like you are fully utilising your skills and potential?	↳ Why/why not? ↳ Has Aotearoa met your expectations professionally? ↳ How prepared did you feel to practise medicine here when you first arrived/began? How prepared do you feel now? ↳ What kinds of similarities/differences have you noticed between the health system and medical training in Aotearoa, compared to the country where you trained? ↳ What preparation have you completed in relation to providing culturally appropriate care to Māori and Pasifika peoples? ↳ What has been the impact of COVID-19 on your licensing/professional experiences in Aotearoa New Zealand?
What would an ideal pathway to licensing look like for you?	↳ What knowledge or expertise should a foreign-trained doctor be required to demonstrate to work as a physician in Aotearoa? ↳ Should all foreign-trained physicians be required to demonstrate the same knowledge and expertise to achieve licensing?

Key Question	Follow-up Questions (if Needed)
	☞ If you think change is necessary, is there anything you have taken part in to help achieve this, that you would like to share?
Is there anything else you would like to comment on with respect to medical licensing for FTPs in Aotearoa?	☞ Do you have any questions for me?

Table 17

Interview Schedule for Local Experts Group 1: Policymakers and/or Policy Advisors

Key Question	Follow-up Questions (if Needed)
What is your role and/or professional background?	☞ What is your role/background in relation to the health system and health workforce in Aotearoa New Zealand? ☞ Do you have experience working directly with foreign-trained physicians and/or their pathways to licensing?
How do foreign-trained doctors get licensed in Aotearoa?	☞ What works well with the current medical licensing pathways in place for foreign-trained physicians? ☞ What kinds of challenges do you often see or hear about in relation to foreign-trained physicians and their medical licensing? ☞ What knowledge or expertise should a foreign-trained doctor be required to demonstrate to work as a physician in Aotearoa? ☞ Should all foreign-trained physicians be required to demonstrate the same knowledge and expertise to achieve licensing?
Does Aotearoa New Zealand have enough doctors?	☞ What are the impacts of this on the local and migrant health workforce? ☞ What kind of a role do/should foreign-trained physicians play in addressing workforce challenges? ☞ How can we ensure migrant physicians provide culturally appropriate care, particularly for Māori and Pasifika peoples? ☞ What has been the impact of COVID-19 on the health workforce, foreign-trained physicians and/or medical licensing processes?
Is there anything else you would like to comment on with respect to medical	☞ Do you have any questions for me?

Key Question	Follow-up Questions (if Needed)
licensing for FTPs in Aotearoa?	

Table 18*Interview Schedule for Local Experts Group 2: Employer*

Key Question	Follow-up Questions (if needed)
What is your role and/or professional background?	➤ What is your role/background with the health system and health workforce in Aotearoa New Zealand? ➤ Do you have experience working directly with foreign-trained physicians and/or their pathways to licensing?
How do foreign-trained doctors get licensed in Aotearoa?	➤ Do you currently employ foreign-trained physicians? ➤ What works well when recruiting foreign-trained physicians and navigating the medical licensing pathways in place? ➤ What kinds of challenges do you experience or hear about in relation to foreign-trained physicians and their medical licensing? ➤ What knowledge or expertise should a foreign-trained doctor be required to demonstrate to work as a physician in Aotearoa? ➤ Should all foreign-trained physicians be required to demonstrate the same knowledge and expertise to achieve licensing? ➤ If you think change is necessary, is there anything you have taken part in to help achieve this, that you would like to share?
Does Aotearoa New Zealand have enough doctors?	➤ What are the impacts of this in your professional context? ➤ What kind of a role do/should foreign-trained physicians play in addressing workforce challenges? ➤ How can we ensure migrant physicians provide culturally appropriate care, particularly for Māori and Pasifika peoples? ➤ What has been the impact of COVID-19 on recruiting foreign-trained physicians who can achieve registration?
Is there anything else you would like to comment on with respect to medical licensing for FTPs in Aotearoa?	➤ Do you have any questions for me?

Table 19

Interview Schedule for Local Experts Group 3: Other Expert (Such as Māori Health Expert, Politician, Commentator)

Key Question	Follow-up Questions (if Needed)
What is your professional background?	✎ What is your experience with the health system and health workforce in Aotearoa New Zealand? ✎ Do you have experience working directly with foreign-trained physicians and/or their pathways to licensing?
Does Aotearoa New Zealand have enough doctors?	✎ What are the impacts of this on Aotearoa and tangata whenua? ✎ What kind of a role do/should foreign-trained physicians play in addressing workforce challenges? ✎ How can we ensure migrant physicians provide culturally appropriate care, particularly for Māori and Pasifika peoples? ✎ How has COVID-19 affected the health workforce in Aotearoa New Zealand and how has this impacted our population, including tangata whenua?
How do foreign-trained doctors get licensed in Aotearoa?	✎ What knowledge or expertise should a foreign-trained doctor be required to demonstrate to work as a physician in Aotearoa? ✎ Should all foreign-trained physicians be required to demonstrate the same knowledge and expertise to achieve licensing? ✎ If you think change is necessary, is there anything you have taken part in to help achieve this, that you would like to share?
Is there anything else you would like to comment on with respect to FTPs and/or medical licensing in Aotearoa?	✎ Do you have any questions for me?

12.12 APPENDIX L: PHASE 2: SOCIAL MEDIA ADVERTISEMENT FOR ONLINE QUESTIONNAIRE

Kia ora koutou, as part of my doctoral research, I am carrying out a national level survey to understand the experiences of foreign-trained physicians in Aotearoa New Zealand. I invite you to participate in my research by completing the attached survey and enter the draw for one of three \$100 vouchers. Your contribution would be greatly appreciated, should you be willing to take 10 minutes out of your day.

This survey is open for both practising and non-practising doctors living in Aotearoa New Zealand, including those who are undertaking or have undertaken the NZREX or Comparable Health System pathway.

Please contact Johanna at J.Thomas-Maude@massey.ac.nz if you have any questions.



Are you a foreign-trained doctor?

**Do you have something to say about
medical licensing in Aotearoa New
Zealand?**

Survey: [SURVEY LINK](#)



MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

12.13 APPENDIX M: PHASE 2: ONLINE QUESTIONNAIRE

Start of Block: Questionnaire eligibility 1

1 Are you a medical doctor (MBChB/MBBS/MD or equivalent) who completed your primary medical qualification outside of New Zealand?

For example, a medical doctor is awarded a Bachelor of Medicine and Bachelor of Surgery (MBChB) on graduation in New Zealand. In other countries this may be known as Bachelor of Medicine and Bachelor of Surgery (MBBS) or Doctor of Medicine (MD), among others.

☐ Yes (1)

☐ No (2)

End of Block: Questionnaire eligibility 1

Start of Block: Questionnaire eligibility 2

Display This Question:

If 1 = Yes



1a Where did you complete your primary medical qualification (MBChB/MBBS/MD or equivalent)?

▼ New Zealand (1) ... Zimbabwe (1357)

End of Block: Questionnaire eligibility 2

Start of Block: Questionnaire eligibility 3

2 Do you currently live in New Zealand?

☐ Yes (1)

☐ No (2)

Display This Question:

If 2 = No

2a Have you ever lived in New Zealand?

☐ Yes (1)

☐ No (2)

End of Block: Questionnaire eligibility 3

Start of Block: Questionnaire eligibility 4

3 Have you ever achieved provisional or full registration to work as a medical doctor in New Zealand?

☐ Yes (1)

☐ No (2)

Display This Question:

If 3 = Yes

3a When did you first gain provisional or full medical registration in New Zealand?

Please enter a year.

Display This Question:

If 3 = No

3b Have you ever had an interest in registering to practise as a medical doctor in New Zealand?

☐ Yes (1)

☐ No (2)

End of Block: Questionnaire eligibility 4

Start of Block: Background and experience 1

4 What is your gender?

☐ Male (1)

☐ Female (2)

☐ I'd prefer not to say (3)

☐ I'd prefer to self-describe: (4) _____

Page Break

5 How long did you work as a registered medical doctor before moving to New Zealand?

▼ I didn't work as a registered medical doctor before moving to New Zealand (1) ... More than 20 years (23)

Display This Question:

If 5 != I didn't work as a registered medical doctor before moving to New Zealand

X→

5a What country did you primarily work in as a doctor before moving to New Zealand?
This should be the country where you have the most work experience as a medical doctor outside of New Zealand.

▼ Afghanistan (1) ... Zimbabwe (1357)

Display This Question:

If 5 != I didn't work as a registered medical doctor before moving to New Zealand

And 5 != Less than 1 year

And 5 != 1 year

And 5 != 2 years

5b In the four years before you moved to New Zealand with the intention of registering as a doctor, did you work as a licensed medical doctor in this country for at least 20 hours per week, for at least 33 months?

☐ Yes (1)

☐ No (2)

Display This Question:

If 5 != I didn't work as a registered medical doctor before moving to New Zealand

5c If you worked in more than one country before moving to New Zealand, you may indicate the other countries here.

End of Block: Background and experience 1

Start of Block: Background and experience 2

6 What is your current stage of medical licensing registration?

If you are no longer pursuing medical licensing in New Zealand, please indicate the stage at which you decided not to go any further.

Please select all options that apply.

- ☐ Working as a licensed medical doctor in New Zealand (1)
- ☐ Provisionally or fully registered but not currently working as a doctor in New Zealand (3)
- ☐ Fully registered as a medical doctor in New Zealand (2)
- ☐ Provisionally registered as a medical doctor in New Zealand (15)
- ☐ Completing PGY2 (second year House Officer position) in New Zealand (4)
- ☐ Completing PGY1 (first year House Officer position) in New Zealand (14)
- ☐ Completing a bridging programme in New Zealand (5)
- ☐ Working as a Physician's/Medical/Healthcare Assistant in New Zealand (6)
- ☐ Waiting for Medical Council of New Zealand (MCNZ) approval (7)
- ☐ Passed NZREX exam (8)
- ☐ Waiting to take the NZREX exam (9)
- ☐ Preparing for a medical knowledge exam (e.g., PLAB, AMC MCQ, USMLE) (10)
- ☐ Preparing for an English language test (11)
- ☐ Registration not attempted (12)
- ☐ Other (please specify) (13) _____

Page Break

Display This Question:

If 6 != Registration not attempted

6a When did you first start the process of becoming a registered doctor in New Zealand?

▼ Before 2000 (1) ... 2023 (25)

7 Have you ever completed training and become qualified in a specialist area?

For example, Family Medicine, Surgery, Paediatrics, Cardiology, Obstetrics, and so on.

☐ Yes (1)

☐ No (2)

Display This Question:

If 7 = Yes



7a Where did you first become qualified as a specialist?

▼ Afghanistan (1) ... Zimbabwe (1357)

Display This Question:

If 7a != New Zealand

And 7 = Yes

7b Is this specialist training recognised in New Zealand?

For example, you may have registered as a medical doctor in New Zealand via the vocational pathway.

- ☐ Yes (1)
- ☐ No (2)
- ☐ I don't know (3)

End of Block: Background and experience 2

Start of Block: Your experiences 1

8 The next part of the questionnaire will ask you to consider several statements relating to your New Zealand medical licensing experiences, as a doctor who trained overseas.

To what extent would you agree with each of the following statements?

Statement	Likert Scale
The time it takes to register as a medical doctor in New Zealand is reasonable. (1)	Strongly disagree
The cost of New Zealand medical licensing for doctors who trained overseas is reasonable. (2)	Disagree
In terms of immigration processes, it was easy to move/migrate to New Zealand. (3)	Somewhat disagree
Immigration New Zealand and Medical Council of New Zealand processes work together to make medical licensing easier. (4)	Neither agree nor disagree
Medical licensing processes in New Zealand are clear and easy to follow. (5)	Somewhat agree
All necessary resources and materials are readily available for overseas-trained doctors to navigate the medical licensing process in New Zealand. (6)	Agree
Networking with potential employers has been important to my licensing process in New Zealand. (7)	Strongly agree
Networking with <u>other doctors who trained overseas</u> has been important to my licensing process in New Zealand. (8)	
<u>COVID-19</u> has made it more difficult to register as a doctor in New Zealand. (9)	
My <u>gender</u> has played a role in my medical licensing experiences in New Zealand. (10)	
My overseas <u>training and qualifications</u> are valued in New Zealand. (11)	
My overseas <u>clinical experience</u> is valued in New Zealand. (12)	
As a medical professional, I feel <u>welcome</u> in New Zealand. (13)	
I am able to utilise my <u>full potential</u> as a medical professional in New Zealand. (14)	
I would <u>recommend</u> that other doctors, with a similar background to me, migrate to New Zealand. (15)	
My <u>overall experience</u> of registering as a doctor in New Zealand has been positive. (16)	

9 Is there anything else you'd like to share regarding your experience of medical licensing in New Zealand?

End of Block: Your experiences 1

Start of Block: An ideal future

10 Have you ever been involved in advocating for changes to New Zealand medical licensing for doctors who trained overseas?

For example, taking legal action, writing or signing a petition, contacting Members of Parliament, or talking to the media.

- ☐ Yes (1)
- ☐ No (2)
- ☐ Prefer not to say (3)

Display This Question:

If 10 = Yes

10a What forms of advocacy have you been involved with?

Please tick as many as apply.

- ☐ Prefer not to say (1)
- ☐ Signing a petition (2)
- ☐ Legal action (3)
- ☐ Contacting Members of Parliament (4)
- ☐ Contacting the Ministry of Health (5)
- ☐ Talking to the media (e.g., for newspaper articles, radio, TV) (6)
- ☐ Other (specify if you choose) (7) _____

11 The final part of the questionnaire will ask you to consider several potential changes that might have a positive impact on the experiences of overseas-trained doctors in New Zealand. ***To what extent would you agree with each of the following suggestions for change?***

Statement	Likert Scale
<u>Reduced English</u> language requirements. (1)	Strongly disagree
<u>Compulsory induction course/bridging programme</u> on the New Zealand health system and cultural safety for <u>all</u> migrant doctors. (2)	Disagree
Stronger <u>peer support networks</u> with other doctors who trained overseas. (3)	Somewhat disagree
Increased support with <u>immigration processes</u> . (4)	Neither agree nor disagree
Recognition of prior <u>clinical experience</u> from an increased range of time periods. (5)	Somewhat agree
Recognition of prior <u>clinical experience</u> from an increased range of countries. (6)	Agree
<u>Loans</u> to cover the costs of licensing exams for overseas-trained doctors. (7)	Strongly agree
Licensing pathways based on an <u>individual's medical school</u> , rather than country of training. (8)	
All overseas-trained doctors follow the <u>same pathway</u> to licensing. (9)	
Stronger emphasis on New Zealand <u>cultural competency</u> and safety during the medical licensing process. (10)	
NZREX exam should be <u>offered more</u> than three times per year. (11)	
NZREX exam results should include a grade (<u>not just pass/fail</u>). (12)	
More opportunities to complete the alternative first-year house officer (<u>PGY1</u>) <u>pathway in GP clinics</u> instead of hospitals. (13)	
<u>Guaranteed first-year house officer (PGY1)</u> placements available after passing the NZREX exam. (14)	
NZREX should not be required for overseas-trained doctors who have passed an <u>alternative clinical skills exam</u> from Australia, U.K., U.S., or Canada (e.g., PLAB 2, AMC Part 2 or USMLE Step 2 CS). (15)	
First-year house officer training (<u>PGY1</u>) <u>should not be compulsory</u> for NZREX graduates who completed a full internship year in an overseas country. (16)	
The NZREX pathway should be <u>discontinued</u> altogether. (17)	

12 Do you have any other suggestions about New Zealand medical licensing for overseas-trained doctors?

End of Block: An ideal future

12.14 APPENDIX N: PHASE 2: INFORMATION BLURB FOR ONLINE

QUESTIONNAIRE

Understanding the experiences of medical doctors in Aotearoa New Zealand who trained overseas

Kia ora, my name is Johanna Thomas-Maude, and I am a doctoral candidate in Development Studies at Massey University. As part of my doctoral research, I am exploring the medical licensing experiences of doctors who trained outside of Aotearoa New Zealand.

If you are a **medical doctor** who completed your primary medical qualification **overseas**, currently live or have previously lived in **Aotearoa New Zealand**, and have ever had an **interest in registering** as a doctor here, I invite you to participate in my research by completing this short, 10-minute questionnaire.

This questionnaire is anonymous, and you are under no obligation to accept this invitation. Although there are three compulsory questions at the start to establish eligibility for this questionnaire, **you can choose not to answer** any other question. If you decide to complete the questionnaire, completion implies consent. On completion, your responses will be stored securely and will not be distributed to third parties.

You will see an option at the end to provide your email address, if you wish to receive a summary of the overall research – this is completely optional and will not be linked to questionnaire responses.

If you have any questions about the project, you are welcome to contact me (J.Thomas-Maude@massey.ac.nz), or my research supervisor, Dr Sharon McLennan (S.McLennan@massey.ac.nz). If you feel you need to access further support and are currently working, Employee Assistance (EAP) can be found [here](#). The [Mental Health Foundation of New Zealand](#) also has many helpful resources regarding wellbeing and managing distress.

This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika 1, Application OM1 23/03. If you have any concerns about the conduct of this research, please contact A/Prof Louise Brough, Chair, Massey University Human Ethics Ohu Matatika 1, telephone 06 356 9099 x 84575, email humanethics1@massey.ac.nz.

Do you wish to participate in this questionnaire?

- ✓ Yes – let me in!
- ✗ No – I've changed my mind.

12.15 APPENDIX O: SUMMARY OF QUESTIONNAIRE FINDINGS ACCORDING TO LICENSING PATHWAY

Table 21 and Figure 56 analyse the relationship between IMG experiences and their licensing pathway by grouping questionnaire respondents according to those eligible for the Specialist pathways (VOC), those eligible for Competent/Comparable general pathways (AUS, CA, CHS or GR), and those only eligible for the NZREX licensing pathway. For each statement, a brief interpretation of these measures of central tendency, Standard Deviation (SD), and the effect size, is provided in the final column of the table. The mean values of the table are depicted in the first chart to provide a visual representation of the trends described.

Inferential statistics such as the t-test and p-value are not included here, as this questionnaire does not claim to be statistically representative of the overall population. Instead, effect size is given as a descriptive measure of association between different sets of respondents in this particular group. As there were three groups to compare, Cohen's *f* (Cohen, 1988) was used as a measure of association. Although this is often used to complement the ANOVA test, an inferential statistic, it is also useful as an independent measure of association in this context. A larger effect size indicates that at least one group's responses tended to be higher than the other groups' responses. Table 20 summarises the conventional effect sizes proposed by Cohen (1988).

Table 20

Cohen's f Effect Sizes

Cohen's <i>f</i> value	Interpretation
0.4 or larger	Large effect
0.25 or larger (but less than 0.4)	Medium effect
0.1 or larger (but less than 0.25)	Small effect
Less than 0.1	Trivial or no effect

A response with a large Cohen's *f* effect size will clearly show one group having much higher measures of central tendency than the other. The Likert scale responses to the statements were classified according to a points-based system where:

- 1 = Strongly disagree
- 2 = Disagree
- 3 = Somewhat disagree
- 4 = Neither agree nor disagree

5 = Somewhat agree

6 = Agree

7 = Strongly agree

The measures of central tendency produced can therefore be interpreted in relation to this scale. For example, a mean of 2.3 indicates the average respondent in that group tended to disagree with the statement.

Measures of central tendency (mean, median and mode) are also included to interpret the impact of the Cohen's *f* effect size, along with the Standard Deviation (SD) is also included in the following table. SD is used in the calculation of Cohen's *f*, and measures how much the members of each licensing pathway group differ from the mean value for the group (Reid, 2014). A smaller SD indicates that participants in that group tended to respond very similarly to each other while a larger SD indicates more diversity in responses. For example, a mean of 4.1 indicates the average respondent tended to neither agree nor disagree. However, if there is a large SD (such as greater than 2), this suggests that there were a number of respondents who both agreed and disagreed with the statement, and this average reflects the diversity in response as the middle point.

Table 21

Extent of Agreement From Respondents According to Three Licensing Pathway Groupings (Where 1 = Strongly Disagree; 2 = Disagree; 3 = Somewhat Disagree; 4 = Neither Agree nor Disagree; 5 = Somewhat Agree; 6 = Agree; 7 = Strongly Agree)

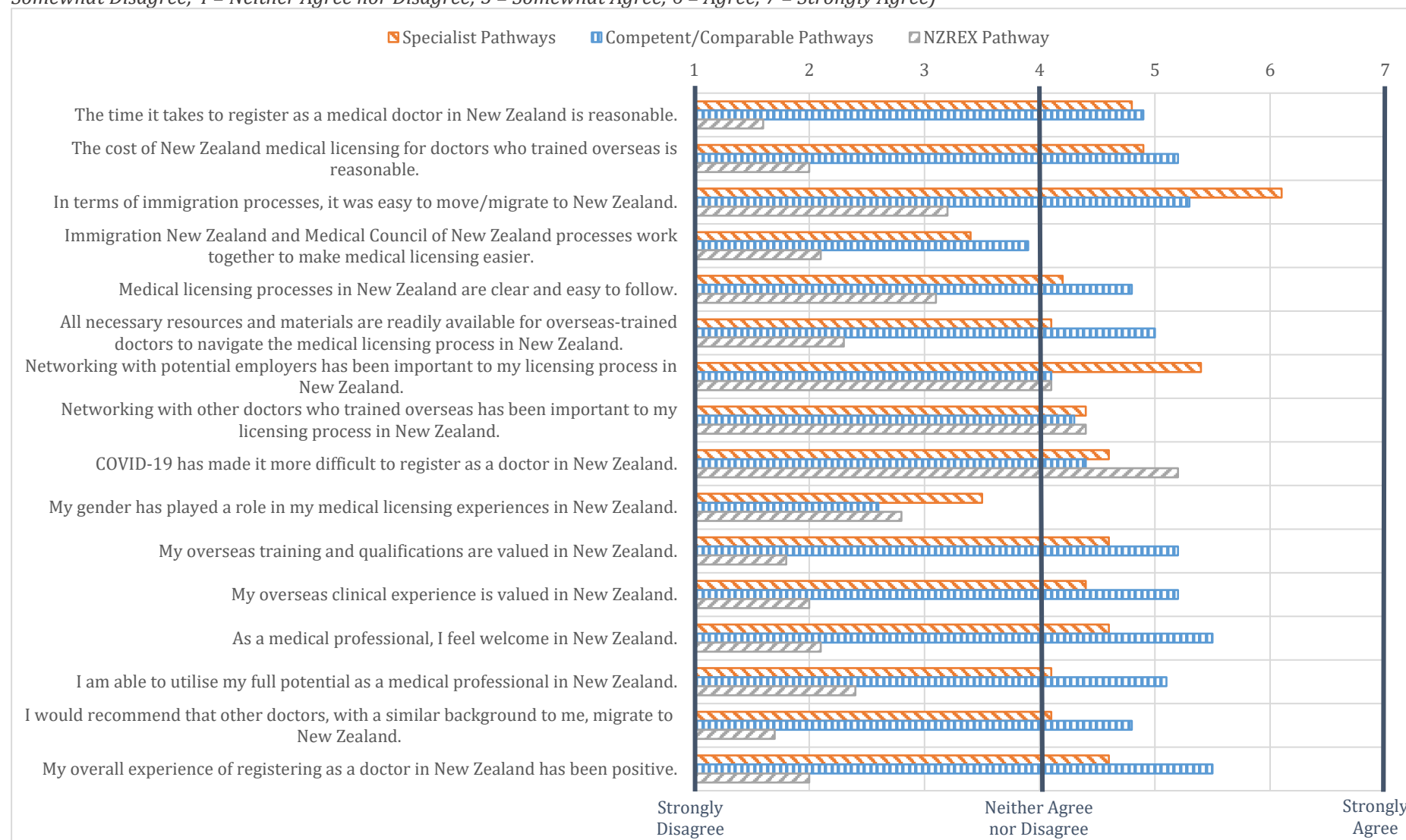
Statement	Specialist Pathways (8-9 responses)				Competent/Comparable Pathways (12-13 responses)				NZREX Pathway (44-46 responses)				Effect / Interpretation	
	Mean	Median	Mode	SD	Mean	Median	Mode	SD	Mean	Median	Mode	SD	Cohen's f	Conclusion
To what extent do you agree?														
The time it takes to register as a medical doctor in New Zealand is reasonable.	4.8	5.0	4.0, 6.0	1.8	4.9	6.0	6.0	1.9	1.6	1.0	1.0	0.93	0.95 (large)	Both VOC, and AUS, CA, CHS and GR, respondents tended to somewhat agree, while NZREX respondents tended to strongly disagree.
The cost of New Zealand medical licensing for doctors who trained overseas is reasonable.	4.9	5.0	6.0	1.5	5.2	5.0	5.0, 6.0	1.5	2.0	2.0	1.0	1.4	0.98 (large)	Both VOC, and AUS, CA, CHS and GR, respondents tended to somewhat agree, while NZREX respondents tended to disagree.
In terms of immigration processes, it was easy to move/migrate to New Zealand.	6.1	6.0	7.0	1.1	5.3	5.0	5.0	1.4	3.2	3.0	1.0	1.8	0.72 (large)	NZREX respondents tended to somewhat disagree, while AUS, CA, CHS and GR respondents tended to agree, and VOC respondents tended to agree more strongly.
Immigration New Zealand and Medical Council of New Zealand processes work together to make medical licensing easier.	3.4	4.0	4.0	2.1	3.9	4.0	4.0	1.6	2.1	2.0	1.0	1.4	0.49 (large)	NZREX respondents tended to disagree, while both VOC, and AUS, CA, CHS and GR, respondents tended to neither agree nor disagree.
Medical licensing processes in New Zealand are clear and easy to follow.	4.2	5.0	5.0, 6.0	2.2	4.8	5.0	5.0, 6.0	1.6	3.1	3.0	1.0, 2.0, 3.0	1.7	0.41 (large)	NZREX respondents tended to somewhat disagree, while VOC, and AUS, CA, CHS and GR respondents tended to somewhat agree.

Statement	Specialist Pathways <i>(8-9 responses)</i>				Competent/Comparable Pathways <i>(12-13 responses)</i>				NZREX Pathway <i>(44-46 responses)</i>				Effect / Interpretation	
All necessary resources and materials are readily available for overseas-trained doctors to navigate the medical licensing process in New Zealand.	4.1	4.0	3.0	1.9	5.0	5.0	5.0	0.82	2.3	2.0	1.0	1.6	0.76 (large)	AUS, CA, CHS and GR respondents tended to somewhat agree, while NZREX respondents tended to disagree. VOC respondents tended to neither agree nor disagree.
Networking with potential employers has been important to my licensing process in New Zealand.	5.4	6.0	6.0	1.7	4.1	4.0	4.0	1.6	4.1	4.0	4.0	2.0	0.22 (small)	Both AUS, CA, CHS and GR, and NZREX, respondents tended to neither agree nor disagree, while VOC respondents tended to agree.
Networking with other doctors who trained overseas has been important to my licensing process in New Zealand.	4.4	4.5	4.0, 5.0	1.2	4.3	4.0	4.0	1.3	4.4	5.0	5.0	1.8	0.02 (no effect)	All groups tended to neither agree nor disagree.
COVID-19 has made it more difficult to register as a doctor in New Zealand.	4.6	4.0	4.0	2.0	4.4	4.0	4.0	1.1	5.2	6.0	7.0	1.8	0.22 (small)	NZREX respondents tended to somewhat agree while VOC, and AUS, CA, CHS and GR, respondents tended to neither agree nor disagree.
My gender has played a role in my medical licensing experiences in New Zealand.	3.5	4.0	4.0	1.7	2.6	2.0	4.0	1.4	2.8	2.0	2.0, 4.0	1.2	0.19 (small)	All groups tended to disagree.
My overseas training and qualifications are valued in New Zealand.	4.6	5.0	7.0	2.4	5.2	5.0	5.0	0.90	1.8	1.0	1.0	1.28	0.97 (large)	Both VOC, and AUS, CA, CHS and GR, respondents tended to agree, while NZREX respondents tended to strongly disagree.

Statement	Specialist Pathways (8-9 responses)				Competent/Comparable Pathways (12-13 responses)				NZREX Pathway (44-46 responses)				Effect / Interpretation	
My overseas clinical experience is valued in New Zealand.	4.4	5.0	7.0	2.4	5.2	5.0	6.0	1.1	2.0	2.0	1.0	1.3	0.89 (large)	Both VOC, and AUS, CA, CHS and GR, respondents tended to agree, while NZREX respondents tended to disagree.
As a medical professional, I feel welcome in New Zealand.	4.6	5.0	2.0, 7.0	2.4	5.5	6.0	6.0	0.97	2.1	1.0	1.0	1.5	0.98 (large)	AUS, CA, CHS and GR respondents tended to agree more than VOC respondents, although VOC respondents also tended to somewhat agree. NZREX respondents tended to disagree.
I am able to utilise my full potential as a medical professional in New Zealand.	4.1	4.0	1.0, 3.0, 7.0	2.5	5.1	6.0	6.0	2.0	2.4	1.5	1.0	1.8	0.56 (large)	AUS, CA, CHS and GR respondents tended to agree, while VOC respondents tended to neither agree nor disagree. NZREX respondents tended to disagree.
I would recommend that other doctors, with a similar background to me, migrate to New Zealand.	4.1	5.0	5.0	2.0	4.8	5.0	6.0	1.7	1.7	1.0	1.0	1.4	0.88 (large)	AUS, CA, CHS and GR tended to agree more strongly than VOC, although VOC respondents tended to somewhat agree. NZREX respondents tended to strongly disagree.
My overall experience of registering as a doctor in New Zealand has been positive.	4.6	5.0	5.0	1.9	5.5	6.0	6.0	1.3	2.0	1.0	1.0	1.5	0.98 (large)	AUS, CA, CHS and GR respondents tended to agree more than VOC respondents, although VOC respondents also tended to somewhat agree. NZREX respondents tended to disagree.

Figure 56

Mean Agreement of Questionnaire Respondents on Different Licensing Pathways With a Series of Statements (Where 1 = Strongly Disagree; 2 = Disagree; 3 = Somewhat Disagree; 4 = Neither Agree nor Disagree; 5 = Somewhat Agree; 6 = Agree; 7 = Strongly Agree)



12.16 APPENDIX P: SUMMARY OF QUESTIONNAIRE FINDINGS ACCORDING TO GENDER

There was a correlation between gender and many of the other statements regarding ease of immigration processes, and time and cost of registration, the role of networking, feeling welcome as a medical professional, clarity of licensing processes, perceptions of clinical experience and qualifications being valued in Aotearoa, and whether they would recommend other doctors with a similar background to theirs immigrate to Aotearoa New Zealand. In all cases, males were more likely to agree with these statements than females. Table 22 and Figure 57 highlight this relationship in more detail. Cohen's f is used to measure effect size, as there are three groups ("Female", "Male" and "I'd prefer not to say"). As there were only two or three responses for "I'd prefer not to say", it is not possible to draw conclusions from these, although these responses are still included for reference.

Table 22

Extent of Agreement From Respondents According to Gender (Where 1 = Strongly Disagree; 2 = Disagree; 3 = Somewhat Disagree; 4 = Neither Agree nor Disagree; 5 = Somewhat Agree; 6 = Agree; 7 = Strongly Agree)

Statement	Female (44-45 responses)				Male (20 responses)				I'd Prefer not to say (2-3 responses)				Effect / Interpretation	
	Mean	Median	Mode	SD	Mean	Median	Mode	SD	Mean	Median	Mode	SD	Cohen's f	Conclusion
To what extent do you agree?														
The time it takes to register as a medical doctor in New Zealand is reasonable.	2.0	1.0	1.0	1.6	3.9	4.0	1.0, 6.0	2.3	4.0	5.0	5.0	1.7	0.51 (large)	Male respondents tended to neither agree nor disagree while female respondents tended to disagree.
The cost of New Zealand medical licensing for doctors who trained overseas is reasonable.	2.3	2.0	1.0	1.7	4.4	4.5	6.0	2.0	4.0	5.0	5.0	1.7	0.56 (large)	Male respondents tended to agree while female respondents tended to disagree.
In terms of immigration processes, it was easy to move/migrate to New Zealand.	3.2	3.0	1.0, 2.0	1.8	5.6	6.0	6.0, 7.0	1.5	3.7	4.0	2.0, 4.0, 5.0	1.5	0.66 (large)	Male respondents tended to agree while female respondents tended to disagree.
Immigration New Zealand and Medical Council of New Zealand	2.1	2.0	1.0	1.3	3.7	4.0	1.0, 4.0	2.0	3.3	4.0	1.0, 4.0, 5.0	2.1	0.49 (large)	Male respondents tended to neither agree nor disagree while

Statement	Female (44-45 responses)				Male (20 responses)				I'd Prefer not to say (2-3 responses)				Effect / Interpretation	
processes work together to make medical licensing easier.														female respondents tended to disagree.
Medical licensing processes in New Zealand are clear and easy to follow.	3.1	3.0	1.0	1.8	4.5	5.0	6.0	1.8	3.7	4.0	2.0, 4.0, 5.0	1.5	0.36 (medium)	Male respondents tended somewhat agree, while female respondents tended to disagree.
All necessary resources and materials are readily available for overseas-trained doctors to navigate the medical licensing process in New Zealand.	2.6	2.0	1.0	1.7	4.2	4.0	3.0, 4.0, 5.0	1.8	3.0	3.0	2.0, 3.0, 4.0	1.0	0.41 (large)	Male respondents tended to neither agree nor disagree, while female respondents tended to disagree.
Networking with potential employers has been important to my licensing process in New Zealand.	4.2	4.0	4.0	2.0	4.6	4.0	4.0	1.7	3.5	3.5	2.0, 5.0	2.1	0.13 (small)	All groups tended to neither agree nor disagree.
Networking with other doctors who trained overseas has been important to my licensing process in New Zealand.	4.5	5.0	5.0	1.7	4.1	4.0	4.0	1.5	5.0	5.0	4.0, 6.0	1.4	0.13 (small)	Female respondents tended to somewhat agree, while male respondents tended to neither agree nor disagree.
COVID-19 has made it more difficult to register as a doctor in New Zealand.	5.0	5.0	6.0, 6.0	1.8	5.0	5.0	4.0	1.7	5.5	5.5	4.0, 6.0	2.1	0.053 (no effect)	All groups tended to somewhat agree.
My gender has played a role in my medical licensing experiences in New Zealand.	2.6	2.0	2.0	1.2	3.2	4.0	4.0	1.5	4.0	4.0	4.0	0.0	0.25 (medium)	Male respondents tended to somewhat disagree, while female respondents tended to disagree.
My overseas training and qualifications are valued in New Zealand.	2.4	2.0	1.0	1.8	3.8	4.0	1.0	2.3	3.3	4.0	1.0, 4.0, 5.0	2.1	0.34 (medium)	Male respondents tended to neither agree nor disagree, while

Statement	Female (44-45 responses)				Male (20 responses)				I'd Prefer not to say (2-3 responses)				Effect / Interpretation	
														female respondents tended to disagree.
My overseas clinical experience is valued in New Zealand.	2.5	2.0	1.0	1.8	3.9	4.0	1.0	2.2	3.3	4.0	1.0, 4.0, 5.0	2.1	0.34 (medium)	Male respondents tended to neither agree nor disagree while female respondents tended to disagree.
As a medical professional, I feel welcome in New Zealand.	2.6	1.0	1.0	1.9	4.3	4.5	4.0, 6.0	2.1	3.0	3.0	1.0, 5.0	2.8	0.40 (large)	Male respondents tended somewhat agree, while female respondents tended to disagree.
I am able to utilise my full potential as a medical professional in New Zealand.	2.7	2.0	1.0	2.1	4.1	4.5	1.0, 6.0	2.8	3.0	3.0	1.0, 5.0	2.2	0.27 (medium)	Male respondents tended to neither agree nor disagree, while female respondents tended to disagree.
I would recommend that other doctors, with a similar background to me, migrate to New Zealand.	2.1	1.0	1.0	1.8	3.7	4.0	1.0	2.2	3.7	5.0	5.0	2.3	0.39 (medium)	Male respondents tended to neither agree nor disagree, while female respondents tended to disagree.
My overall experience of registering as a doctor in New Zealand has been positive.	2.5	1.0	1.0	1.8	4.1	5.0	1.0, 6.0	2.3	3.7	5.0	5.0	2.3	0.38 (medium)	Male respondents tended to neither agree nor disagree, while female respondents tended to disagree.

Figure 57

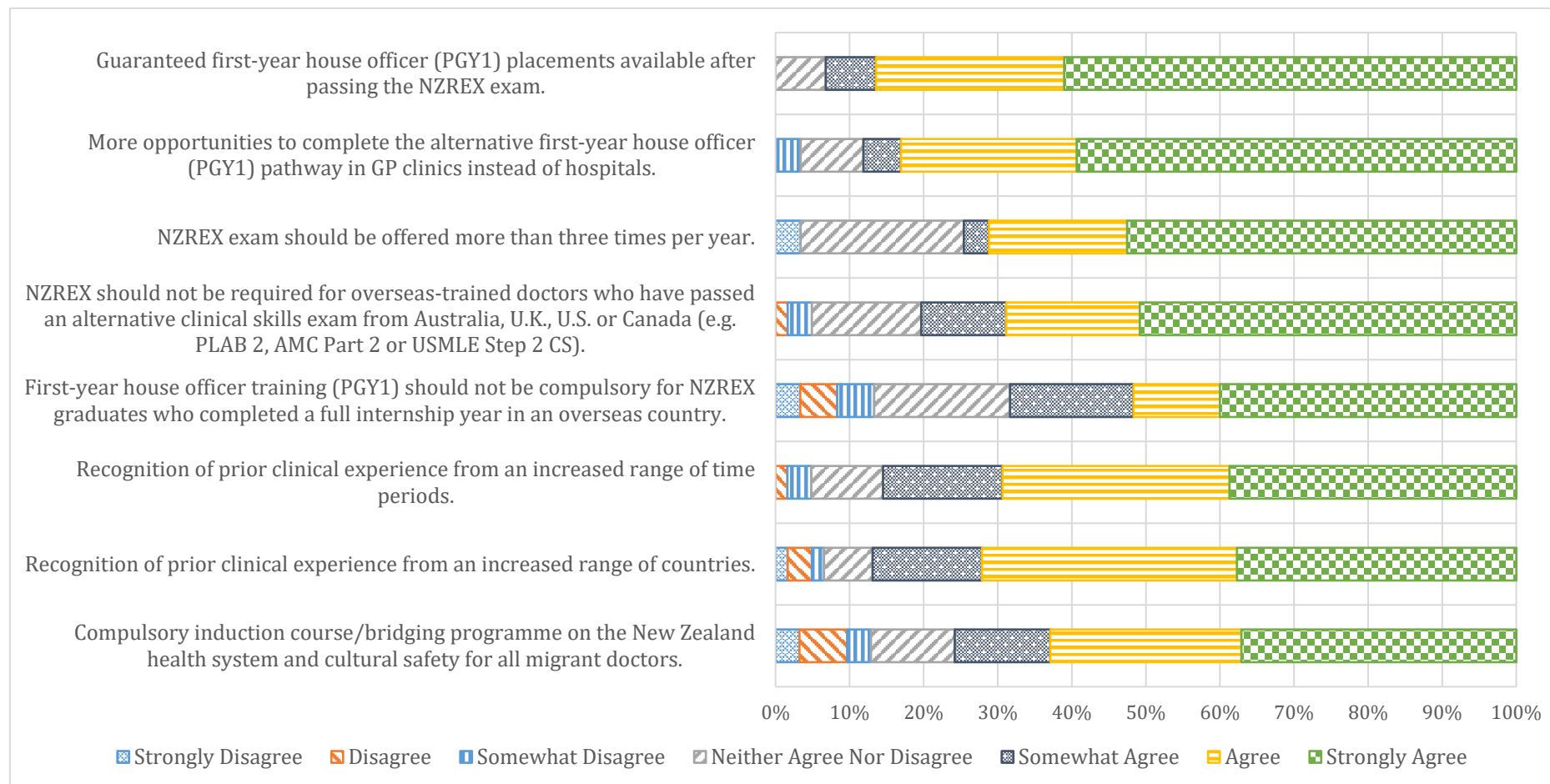
Mean Agreement of Doctors of Different Genders With a Series of Statements (Where 1 = Strongly Disagree; 2 = Disagree; 3 = Somewhat Disagree; 4 = Neither Agree nor Disagree; 5 = Somewhat Agree; 6 = Agree; 7 = Strongly Agree)

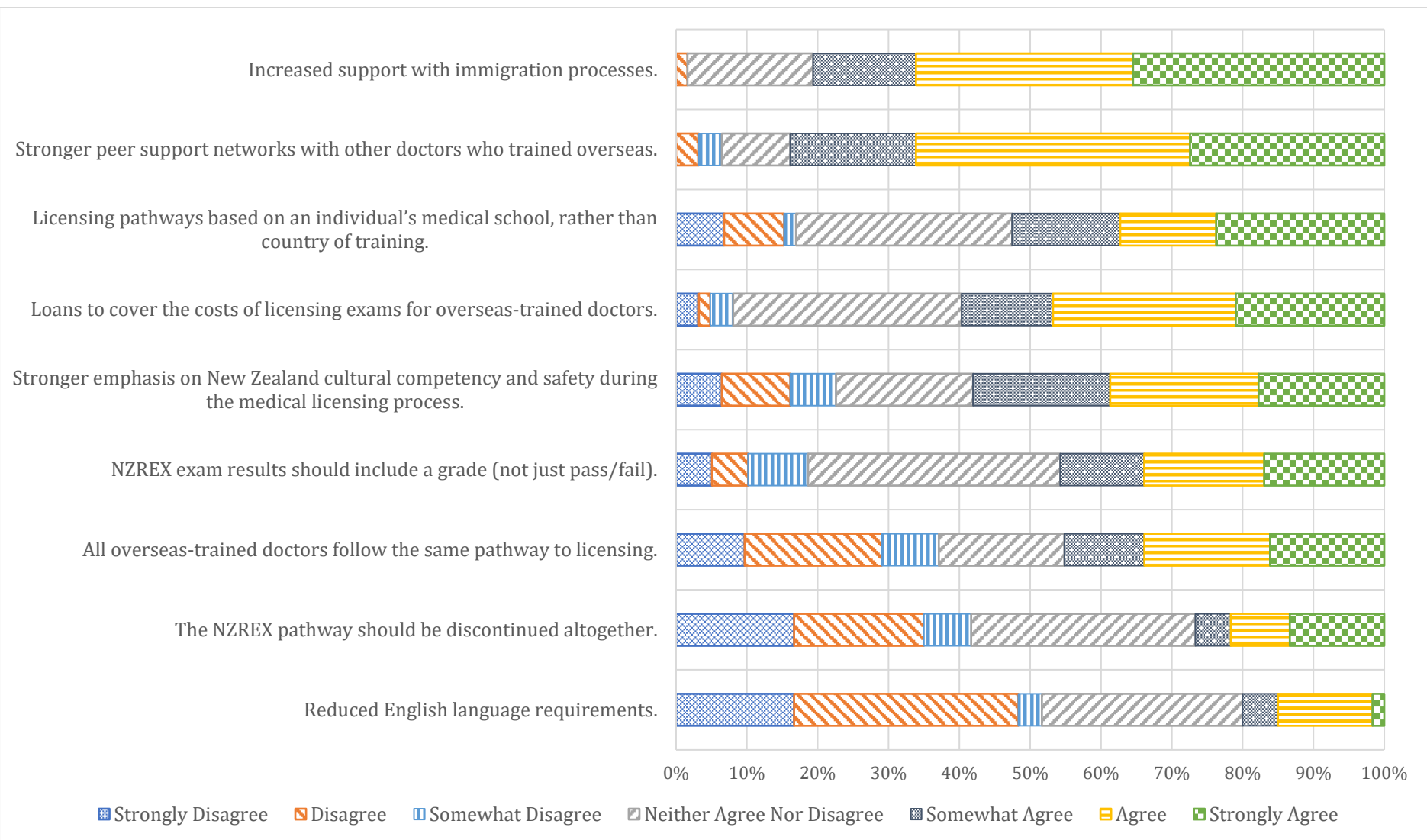


12.17 APPENDIX Q: FULL SPECTRUM OF AGREEMENT WITH SUGGESTIONS FOR CHANGE AMONG QUESTIONNAIRE PARTICIPANTS

Figure 58

Suggestions for Change According to the Extent of Agreement of Questionnaire Respondents (N ≈ 59 to 62)





12.18 APPENDIX R: SUMMARY OF QUESTIONNAIRE FINDINGS ACCORDING TO INCOME LEVEL OF COUNTRY OF PRIMARY QUALIFICATION

As there is a relationship between the income status of the country of primary medical qualification, the respondent's medical licensing pathway, and whether they had achieved medical registration in Aotearoa New Zealand, it was helpful to directly explore how income status of country of primary medical qualification may relate to an IMG's experiences (refer to Table 24 and Figure 59). As this analysis had only two groups – high-income countries and middle-income countries – Cohen's *d* was used to measure effect size (Cohen, 1988). While often used with the inferential *t*-test, it is also useful as an independent measure. A larger effect size indicates that one group's responses tended to be higher than the other group's responses. Table 23 summarises the conventional effect sizes proposed by Cohen (1988).

Table 23

Cohen's d Effect Sizes

Cohen's <i>d</i> value	Interpretation
0.8 or larger	Large effect
0.5 or larger (but less than 0.8)	Medium effect
0.2 or larger (but less than 0.5)	Small effect
Less than 0.2	Trivial or no effect

A response with a large Cohen's *d* effect size will clearly show one group having much higher measures of central tendency than the other. Other statistical measures are described in more detail above in [Appendix Q](#).

Table 24

Extent of Agreement From Respondents According to Income Level of Country of Primary Qualification (Where 1 = Strongly Disagree; 2 = Disagree; 3 = Somewhat Disagree; 4 = Neither Agree nor Disagree; 5 = Somewhat Agree; 6 = Agree; 7 = Strongly Agree)

Statement	High-income countries (23-24 responses)				Middle-income countries (43-44 responses)				Effect / Interpretation	
To what extent do you agree?	Mean	Median	Mode	SD	Mean	Median	Mode	SD	Cohen's d	Conclusion
The time it takes to register as a medical doctor in New Zealand is reasonable.	4.2	5.0	6.0	2.1	1.8	1.0	1.0	1.4	1.4 (large)	Respondents from high-income countries tended to somewhat agree, while those from middle-income countries tended to disagree.
The cost of New Zealand medical licensing for doctors who trained overseas is reasonable.	4.4	5.0	6.0	1.8	2.2	2.0	1.0	1.7	1.30 (large)	Respondents from high-income countries tended to somewhat agree, while those from middle-income countries tended to disagree.
In terms of immigration processes, it was easy to move/migrate to New Zealand.	4.8	5.0	7.0	2.1	3.5	4.0	2.0, 6.0	1.8	0.68 (medium)	Respondents from high-income countries tended to agree, while those from middle-income countries tended to disagree.
Immigration New Zealand and Medical Council of New Zealand processes work together to make medical licensing easier.	3.2	4.0	4.0	1.7	2.3	2.0	1.0	1.6	0.55 (medium)	Respondents from high-income countries tended to somewhat disagree, while those from middle-income countries tended to disagree.
Medical licensing processes in New Zealand are clear and easy to follow.	4.1	5.0	5.0	1.9	3.2	3.0	2.0	1.8	0.50 (medium)	Respondents from high-income countries tended to somewhat agree, while those from middle-income countries tended to somewhat disagree.

Statement	High-income countries (23-24 responses)				Middle-income countries (43-44 responses)				Effect / Interpretation	
All necessary resources and materials are readily available for overseas-trained doctors to navigate the medical licensing process in New Zealand.	3.9	4.0	5.0	1.9	2.6	2.0	1.0	1.7	0.71 (medium)	Respondents from high-income countries tended to neither agree nor disagree, while those from middle-income countries tended to disagree.
Networking with potential employers has been important to my licensing process in New Zealand.	4.4	4.0	4.0	1.8	4.2	4.0	4.0	1.9	0.14 (no effect)	Both groups tended to neither agree nor disagree.
Networking with other doctors who trained overseas has been important to my licensing process in New Zealand.	4.2	4.0	4.0	1.5	4.5	5.0	4.0, 5.0	1.7	0.15 (no effect)	Both groups tended to neither agree nor disagree.
COVID-19 has made it more difficult to register as a doctor in New Zealand.	5.0	4.0	4.0	1.5	5.0	6.0	7.0	1.9	0.039 (no effect)	Both groups tended to somewhat agree.
My gender has played a role in my medical licensing experiences in New Zealand.	2.9	4.0	4.0	1.5	2.8	2.0	4.0	1.0	0.043 (no effect)	Both groups tended to somewhat disagree.
My overseas training and qualifications are valued in New Zealand.	4.5	5.0	6.0	1.9	1.9	1.0	1.0	1.4	1.6 (large)	Respondents from high-income countries tended to somewhat agree, while those from middle-income countries tended to disagree.
My overseas clinical experience is valued in New Zealand.	4.5	5.0	5.0, 6.0	2.0	2.1	2.0	1.0	1.4	1.6 (large)	Respondents from high-income countries tended to somewhat agree, while those from middle-income countries tended to disagree.

Statement	High-income countries (23-24 responses)				Middle-income countries (43-44 responses)				Effect / Interpretation	
As a medical professional, I feel welcome in New Zealand.	4.7	5.0	6.0	2.1	2.2	1.0	1.0	1.6	1.4 (large)	Respondents from high-income countries tended to somewhat agree, while those from middle-income countries tended to disagree.
I am able to utilise my full potential as a medical professional in New Zealand.	4.3	5.0	6.0	2.4	2.6	2.0	1.0	1.9	0.84 (large)	Respondents from high-income countries tended to somewhat agree, while those from middle-income countries tended to disagree.
I would recommend that other doctors, with a similar background to me, migrate to New Zealand.	4.2	5.0	6.0	2.1	1.7	1.0	1.0	1.4	1.5 (large)	Respondents from high-income countries tended to somewhat agree, while those from middle-income countries tended to disagree.
My overall experience of registering as a doctor in New Zealand has been positive.	4.5	5.0	6.0	2.2	2.2	1.0	1.0	1.6	1.3 (large)	Respondents from high-income countries tended to agree, while those from middle-income countries tended to disagree.

Figure 59

Mean Responses to a Series of Statements in Relation to Income Level of Their Country of Primary Qualification (Where 1 = Strongly Disagree; 2 = Disagree; 3 = Somewhat Disagree; 4 = Neither Agree nor Disagree; 5 = Somewhat Agree; 6 = Agree; 7 = Strongly Agree)

