

A Psychosocial Exploration of International Medical Graduate Journeys, Perceptions, Challenges and Resulting Impacts: A Sequential Explanatory Mixed Methods Study

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Background: Several countries rely on International medical graduates (IMGs) to fill critical service gaps. IMGs experience a range of challenges related to migration, acculturation, accreditation and career.

Purpose: This study aimed to explore the journeys, perceptions and challenges of IMGs based in Australia.

Methods: We used a sequential explanatory mixed methods approach for design and analysis. An online survey was distributed Australia-wide to IMGs through various avenues (including snowballing) between 13th October 2023 and 31 December 2023. We later conducted individual interviews between February and April 2024. Quantitative data was descriptively analysed. Qualitative data from survey written responses and oral interviews were thematically analysed. Study data was triangulated and congruence assessed. Full Ethics approval was obtained.

Results: The study comprised 286 survey participants and 36 interview participants. Working conditions, location/lifestyle and personal/family opportunities were among the reasons for Australia's popularity as a host country. The most disliked aspects were system processes (eg, bureaucracy, certifications, licencing etc) (87/199; 43.7%), and discrimination, bias, racism, or prejudice (53/199; 26.6%). Two major qualitative themes identified were: (1) IMGs have a rich and diverse set of experiences and (2) IMGs encounter unexpected challenges with widespread impacts on IMGs, family and society. We found high congruency of triangulated data from the quantitative and qualitative studies supporting concepts around IMG diversity of experience and choices, life stage priorities, privilege, mismatched expectations, criticism of bureaucracy, gaps in understanding nuances of the Australian workplace, social challenges, and impact of challenges.

Conclusion: IMGs describe numerous permutations of journeys, challenges and general experiences which result from factors both inside and outside the IMG's control. Challenges, particularly those which are unexpected, may detrimentally impact IMG careers, health and desire to remain in their host country. Institutions have a role in adapting current bureaucratic processes to better support the IMG experience.

Keywords: life experiences, foreign medical graduate, workforce diversity

Introduction

International medical graduates (IMGs), also known as “foreign medical graduates” or “overseas-trained doctors” are an essential workforce in many countries. Although the term “IMG” is somewhat controversial and the definition varies

between countries,^{1,2} “IMGs” in this paper refer to doctors who have obtained their primary medical qualification (PMQ) outside the country they are now based in.

The migration of IMGs, particularly from low to high income countries, is a long-standing yet growing phenomenon due to various push and pull factors in the workforce market.³ In fact, the WHO’s Global code of Practice on the International Recruitment of Health Personnel (2010) was devised to guide ethical governance in this space.³ Despite attempts to grow the local workforce, several high-income countries, such as Australia, Canada, UK and USA continue to rely heavily on IMGs, particularly to bridge workforce shortages.⁴ In fact, IMGs collectively account for almost a fifth (19%) of doctors in OECD (Organisation for Economic Co-operation and Development) countries.⁴ Contributing factors include growing or ageing populations, increasingly part-time workforces, internationalisation of medical education (eg Ireland) and loss of local graduates to non-clinical jobs (eg Germany).^{5–7} In some countries, large numbers of doctors have moved to a foreign country to acquire their PMQ and then return to their home country to practice (eg Norway, Chile, USA)⁶– these too may be considered as a special group of IMGs in their own right.

There remains a general dearth of exploration in the literature of the IMG population group, despite their importance to healthcare systems at an international level. Motala’s 2019 scoping review analysed 20 articles for IMG experiences and identified several common challenges.⁸ Challenges included personal stressors, lack of country-specific knowledge, and professional barriers, including bureaucracy and certification, mismatched clinical experience, limited career progression and workplace discrimination.⁸ Al-Haddad’s meta-ethnography of 46 qualitative studies exploring IMG experiences before and after migration provided insight into shared experiences and stressors common to the IMG journey, including aspects of migration and issues related to language, culture, medical education and belonging.⁹ Several studies identify challenges of IMGs and clinical training programs.^{10–12} Also, there are multi-levelled criticisms that IMGs face unnecessary hurdles and unfair treatment.^{13,14} Importantly, there is a gap in understanding the experiences of those IMGs who did not progress to working in their host country, nor those in non-clinical fields.

Australia is an attractive destination for migrants, and IMGs are no exception. In fact, almost a third (30.7%) of Australia’s population were born overseas, the largest groups from England, India and China.¹⁵ IMGs based in Australia are most prominently drawn from current or former Commonwealth countries such as United Kingdom (UK), India, New Zealand (NZ), South Africa and Sri Lanka; in addition to China.¹⁶

The Australian Health Practitioner Regulation Agency (AHPRA) Medical Board permits graduates from UK, USA, NZ, Canada and Ireland, with sufficiently deemed experience to by-pass standard assessment processes to obtain provisional and general registration in Australia– a process called the “competent authority pathway” (CAP).¹⁷ All other IMGs seeking non-temporary registration must present themselves for assessment through another pathway accredited by the Australian Medical Council (AMC) – the “standard pathway” (for most candidates) or the “specialist pathway” (for those with international specialist qualifications).¹⁸ The standard pathway is a two-stage assessment process comprising a multiple-choice exam (AMC-1) and a clinical examination (AMC-2). The AMC-2 may be substituted for the “Workplace Based Assessment” (WBA) program, a series of short clinical exams, discussions and assessment reports offered at limited hospital locations around Australia.¹⁹ Assessment of specialty qualifications for those seeking registration via the Specialty pathway are conducted by individual specialist colleges.²⁰ General registration gives wider freedom to IMGs for job and career opportunities and is therefore sought after by many IMGs. Australian medical graduates are granted general registration following completion of their internship.²¹

There are several gaps in the current literature. Firstly, there is a general dearth of studies exploring the general experiences of IMG populations globally. Many tend to focus on training and acculturation yet there is a gap in understanding other general experiences and motivations. With very few exceptions,²² the majority of studies exploring IMG experiences in Australia are typically over a decade old.^{23–25}

Therefore, the purpose of this study was to better understand current experiences and perceptions of IMGs living in Australia. We were particularly interested in what choices were made around migration and career, what challenges IMGs faced, and how these impacted employment success in Australia. By gathering such insights, we seek to provide evidence for institutions to consider when modifying policies and tailoring support for this integral workforce.

Materials and Methods

Aim

The aim of this study was to explore the journeys, perceptions and challenges of IMGs based in Australia. The study formed part of a larger PhD body of work, exploring IMG experiences in Australia. To date, one other publication related to the larger research project (exploring reports of inequitable experiences) has been published.²²

Study Design and Setting

We undertook this study using the sequential explanatory mixed methods (SEMM) study design, where the quantitative study is completed first, subsequently informing the direction of the qualitative study.²⁶ This design allowed us to identify broad concepts of IMG experiences through a cross-sectional (quantitative) survey of non-random participants, and then deeply explore underlying reasons to explain those concepts through semi-structured individual interviews (qualitative study). Hosted by Hunter Medical Research Institute, we used REDCap (Research Electronic Data Capture) – an online, secure data capture platform to create the survey and manage the data.^{27,28} An online format was chosen to ensure data integrity and access by participants Australia-wide. The survey was open from 13th October 2023 to 31 December 2023 (11 weeks) and interviews were conducted by phone, teleconference or in-person over a three-month period: February to April 2024. The study was approved as low risk research by the Human Ethics Advisory Panel at the University of Newcastle H2022-0392 with Access Request approved through Hunter New England Health Human Research Ethics Committee (HREC): AR20230405_Nair and Central Coast Health HREC: 0323–024C. Informed consent procedures were undertaken in accordance with approved Ethics stipulations – implied consent for survey participants, and written consent for interview participants; and included publication of anonymous responses and direct quotes.

Participants, Recruitment and Sample Size

Survey participants were invited to participate through several avenues across Australia, including community and social media groups, government healthcare workplaces, and training groups. Snowballing was also used to increase response rate. Recruitment avenues are deliberately kept anonymous here to protect participants. Participants were eligible if they held a PMQ from a country outside Australia and were living in Australia at the time of survey completion, irrespective of employment status. Excluded were casual holiday visitors, or those who had come to Australia without intention to work. The interview sample was drawn from interested survey participants and snowballing. Without the availability of a database of IMG numbers in Australia, a conservative sample size of 200 participants was estimated to achieve precision of $\pm 4.7\%$ (95% confidence intervals) to report the proportion of participants reporting experiences. We aimed for 15–20 participants for the interview sample, with intent to terminate at data saturation or cessation of received consent forms.

Data Collection

The *survey instrument* was deliberately developed by the researchers to explore IMG experiences detected in the literature including a recent scoping review undertaken by the research team.¹³ The survey instrument underwent several iterations by the research team (comprising experts in methodology, behavioral research, content and lived experience) and was trialed on ten IMGs prior to finalization, ensuring usability and face and content validity for our population. The survey questions broadly explored IMG experiences eg decision to migrate, enjoyed and disliked factors of working in Australia and experiences with registration and assessments, with free text open ended response options available. The semi-structured *interview questions* were guided by the findings from the survey, as per SEMM approach²⁶ and collectively approved by the research team (see [Supplementary material 1](#)). The survey completion time was estimated at 20 minutes and interviews at 30–60 minutes; forewarned on the participant information statement.

Survey data was collected via REDCap^{27,28} tool and transferred to Stata²⁹ for data analysis. Data was cleaned before analysis, removing missing data and combining categories for small data sets, or if more appropriate categories were identified. Open answer responses were transferred to NVivo,³⁰ a qualitative analysis software program.

Interview data: All interview data plus field notes were transcribed by the primary researcher within 48 hours, ensuring accuracy of transcription, especially for heavily accented participants, familiarization with the data and as a cost-saving exercise. Interview data was also transferred to NVivo for analysis.

Reflexivity and Stance

The primary researcher conducting this study is an international medical graduate, who has worked as a clinical doctor in Australia for over twenty years, across several states and territories. To maximize research integrity and minimize the impact of implicit biases, several processes were conducted throughout the study, eg, note-taking, member checking, and regular review of methods and results with non-medical members of the research team. We used a pragmatic stance in conducting this study, using data from survey and interviews to inform practical solutions.³¹ We used phenomenological inquiry methods for the qualitative component, which was valuable for exploring participant perceptions and feelings in relation to personal experiences described.³²

Data Analysis

We undertook descriptive analysis of all survey quantitative data provided, using Stata²⁹ specifically describing frequencies N (%) for the categorical variables. Thematic analysis was conducted separately on both qualitative components of the study ie, the survey open-ended responses and the interview data, guided by Clarke and Braun's data analysis process.³³ SJRH and KF familiarized themselves with the data, created visual mind maps and co-constructed coding trees for both qualitative study components. Thematic analysis was undertaken primarily by SJRH with oversight, discussion and review by KF, including dual coding of 10% (four) transcripts to support coding standardization. A third researcher with expertise in research methodology (BMA) was assigned to confirm identified themes. Themes from the survey open responses and the interviews were compared, merged and refined due to the high congruence found during analysis. Two major themes and six sub-themes were identified from the qualitative data: (1) IMGs have a rich and diverse set of experiences: 1a) Intentions to migrate vary; 1b) Life stages and competing priorities impact employment, training and career; 1c) Challenges and privileges vary; and (2) IMGs encounter unexpected challenges with widespread impacts on IMGs, family and society: 2a) Mismatched expectations have deleterious effects; 2b) IMGs identify gaps in understanding systems, culture, skills and workplace etiquette; 2c) Social challenges of settlement compound IMG challenges. Further, we reviewed the quantitative and qualitative results together, triangulating findings to search for areas of congruence and difference. We used the Good Reporting of a Mixed Methods Study (GRAMMS) checklist³⁴ to ensure thorough report of our study [see [Supplementary material 2](#)].

Results

Participant Details

Survey

A wide range of IMGs participated in the survey from across Australia. Participant demographic details are reported in detail elsewhere.²² Of the 304 participants who consented to the study, 286 were eligible after completing screening. Therefore, 286 is used as the total denominator (n) for study reporting. However, due to the optional nature of the survey items, variable response rates are seen throughout the survey and therefore participant numbers for each section vary accordingly. Sixty-eight percent [195/286 (68.2%)] of the surveys commenced were fully completed.

Participants came to Australia with PMQs from a total of 46 countries. We calculated that most participants (76.5%) graduated outside an AMC-defined "competent authority pathway" (CAP) country. Sample participants reported 44 native languages. Over half (147/228, 64.4%) of the participants had migrated to Australia within the last 10 years (since 2014); and the majority (82%; 187/228) migrated to Australia within the last 15 years (since 2009). The average time from migration to work was 1.61 years; SD 3.34; (range 0–32). Most participants (190/213; 89.2%) reported working in clinical/specialty domains and 17 specialties were reported by participants. Twenty-four (24/213; 11.3%) reported working non-clinically, and a smaller number (11/213; 5.2%) reported working in fields unrelated to Medicine. Of those, 11 participants worked across a combination of work-types. Twenty-two [22/234 (9.4%)] survey participants

reported not working at the time of survey completion; not in paid employment (15/234), on extended leave (5/234), retired (1/234) or on a disability pension (1/234). Every Australian state and territory had at least three IMGs participating in the survey; 10 participants worked across 2 or more states or territories. Most (152/213; 71.4%) participants reported living or working in metropolitan locations, with the remainder in rural [65/213 (30.5%)] or remote [7/213 (3.3%)] locations. Eleven (11) participants reported living/working across two or more location categories.

Interviews

Qualitative participant demographics were broadly similar to the quantitative participants, as the majority were drawn from the survey participant pool.²² Five interview participants external to the survey were recruited by snowballing. The 36 interview participants came to Australia with PMQs from a total of 16 countries. Interview participants had lived in Australia for a duration range of 5 months to 25 years; lived or worked across six of Australia's eight states or territories at the time of interview; the majority in metropolitan regions (22/36; 61.1%). The majority were clinicians; two participants held additional non-clinical roles. One participant was unemployed at the time of interview. Individual participant details have been deliberately withheld to protect identities within this small cohort.

Quantitative Survey results

General Experiences in Australia

Three single-response questions were posed to explore general experiences of IMGs (see Table 1). From the ten provided options, the singular top reason chosen by survey participants for moving to Australia was “better working conditions than my home country” (40/207; 19.3%); followed by “reunion/links with family in Australia including, accompanying a spouse” (36/207; 17.4%). Participants reported that they most enjoyed location and lifestyle in Australia (65/207; 31.4%) followed by personal opportunities for family (25/207; 12.1%), and opportunities for career progression (23/207; 11.1%). The most disliked factor about working in Australia was system processes, eg, bureaucracy, certifications, licensing etc. (87/199; 43.7%), followed by discrimination, bias, racism, or prejudice (53/199; 26.6%).

Table 1 General Experiences of Survey Participants

Question 1) What was your primary reason for choosing to move to Australia?		
Primary reason for choosing to move to Australia	Fraction of total responses in this section (/207)	Percentage of total responses in this section (%)
Better working conditions than my home country	40	19.3
Reunion/ links with family in Australia, including accompanying spouse	36	17.4
Improved opportunities for children/family	30	14.5
Improved lifestyle	29	14
Further qualifications/ post-graduate studies	20	9.7
Career opportunity and training	20	9.7
Security/Safety in Australia	10	4.8
Better pay than my home country	9	4.3
Travel/adventure	8	3.9
Other	5	2.4
TOTAL	207	100

(Continued)

Table 1 (Continued).

Question 2: What do you ENJOY most about working in Australia?		
Most enjoyed factor about working in Australia	Fraction of total responses in this section (/207)	Percentage of total responses in this section (%)
Location and lifestyle	65	31.4
Personal opportunities for family/ partner	25	12.1
Opportunities for career progression	23	11.1
Working conditions, rostering etc	21	10.1
Upskilling and training exposure	18	8.7
Pay	16	7.7
Improving patients' lives	14	6.8
Challenging and interesting work	14	6.8
Workplace culture	11	5.3
TOTAL	207	100
Question 3: What do you DISLIKE most about working in Australia?		
Most disliked factor about working in Australia	Fraction of total responses in this section (/199)	Percentage of total responses in this section (%)
System processes eg bureaucracy, certifications, licencing etc	87	43.7
Discrimination, bias, racism or prejudice	53	26.6
Workplace culture	12	6.0
Career options	11	5.5
Negative impact on family/partner/children	10	5.0
Working conditions	9	4.5
Rostering	9	4.5
Location	5	2.5
Pay	3	1.5
Lifestyle	0	0
TOTAL	199	100

Experiences with Registration and Assessment Processes

Registration type: Over half the survey participants reported holding full or unconditional medical registration (125/221; 56.6%). About a quarter (56/221; 25.3%) reported holding limited registration and a smaller number reported holding provisional registration (9/221; 4.1%). Twenty-seven participants (27/221; 12.2%) did not hold medical registration in Australia. Four participants were unsure what type of registration they held.

The most common reasons for not completing the registration processes were difficulties with bureaucratic processes (8/27; 29.6%), followed by failed attempts (7/27; 25.9%) and other reasons such as ineligibility including awaiting

examination processes (7/27; 25.9%), financial reasons and child caring. Of those unregistered, most (24/26; 92.3%) reported that being unregistered in Australia had negatively impacted their career choice/s in a significant way.

Pathways to registration: The most common pathway sought by survey participants was through the standard AMC pathway (87/220, 39.6%), followed by the WBA program (41/220; 18.6%), Specialist pathway (40/220; 18.2%), and the competent authority pathway (33/220; 15%). Unlisted pathways were reported by eleven participants (11/220). Two or more pathways were sought by 33/220 participants. Of those who had passed both parts of the AMC examination, participants reported that the process mostly took 1–5 years to complete (40/49; 81.7%) – almost half within the 3–5-year bracket (22/49; 44.9%). 7/49 (14%) participants reported the process taking under one year, and 2/49 participants taking over 6 years to pass the AMC examination process.

Satisfaction with registration pathways: Almost equal proportions of IMGs reported satisfaction (Very or somewhat) [39/114 (34.2%)] with the AMC pathway, as those who reported dissatisfaction [38/114 (33.3%)] (very or somewhat); 37/114 were neutral. A higher proportion of IMGs [33/43 (76.7%)] reported satisfaction with the WBA pathway, compared to 5/43 reporting dissatisfaction (very or somewhat); [5/43 were neutral]. More than half of the participants on the specialist pathway (25/40, 62.5%) reported satisfaction [10/40 were dissatisfied and 5/40 were neutral], as did those who used the competent authority pathway (28/39, 71.8%) [4/39 were dissatisfied and 7/39 were neutral].

Qualitative results

Theme 1: IMGs Have a Rich and Diverse Set of Experiences

IMGs described a broad and diverse range of clinical, academic and research training and work experiences prior to arrival in Australia. From newly graduated IMGs to those with decades of specialist experience, IMGs shared their PMQ country's unique methods and standards for assessing graduate and post-graduate competency. Some had worked in two or three countries before coming to Australia or had returned to Australia after an earlier stint in life.

Intentions to Migrate Vary

Various personal and political factors drove IMG choices around migration. Some (especially UK) IMGs, came as junior doctors, intending a temporary stay in Australia with goals for training, adventure and to experience a new healthcare system. Some came partially trained, with intention to return to their home-country with their newfound international skills from Australia. On occasion, this original intention changed over time as IMGs spent longer in Australia and became more established. On the other hand, many IMGs had firm plans to emigrate to Australia long-term, citing geopolitical safety and stability, favorable salary and better opportunities for their children. Other positives reported by IMGs about Australia included the weather, lifestyle, scenery, opportunities for training and contribution to society and access to healthcare.

IMGs intending permanent migration tended to arrive with dependents (spouse and/or young family) and commonly originated from Asian/African/Middle Eastern background. These IMGs had often undertaken some/full training or post-graduate qualifications overseas; therefore, generally older in age and sporting several years of clinical and/or academic experience. Some IMGs came as “medical spouses”, who were accompanying their IMG partner who had already secured a job in Australia. Often women from developing nations, these IMGs came with intention to initially support their spouse and growing family, then later join the medical workforce.

Life Stages and Competing Priorities Impact Employment, Training and Career

“IMGs not only have to think about work, but they also have to be mindful about their visa status, work rights, so there are many things IMGs face” [survey participant open response].

Interviewed IMGs reported that choices around employment and training in Australia were often made around other priorities in their life, particularly for those seeking permanent migration. Primary goals for these IMGs were reported to be maintenance of a constant income and securing permanent residency [PR] for their family, including any steps which might aid these processes, eg, gaining general registration. Permanent residency was also highly sought after as it permitted access to training positions and better billing opportunities, by acquiring a provider number. Visa incentives encouraged IMGs to settle in non-metropolitan regions, sometimes impacting opportunities to access training and thereby

stagnating careers. AMC examinations were also seen as a priority for IMGs entering Australia through the “non-competent authority pathway”, as this facilitated access to general registration, which was often needed for specialty training. IMG spouses reported the need to delay AMC examinations to care for their young family.

Some IMGs reported a training change to General Practice (GP) or Career Medical Officer (CMO) as a suitable career option over their original specialty, due to shorter training periods, geographic stability and consistency of income. Also, older IMGs with family reported that the demands and commitments of shift work and on-calls were difficult, thereby choosing less strenuous training pathways.

Challenges and Privileges Vary

IMGs reported varying combinations of challenge and privilege in the workplace across a range of aspects, such as interpersonal interactions with staff, patients, and institutions. Mixed reviews were given when asked specifically about non-metropolitan (rural) placements. Some found comradery and support at rural locations due to higher numbers of IMGs employed in certain hospitals. One IMG said:

From a town perspective, from a community perspective, people are very welcoming... people are quite appreciative of doctors who actually stay back and don't leave. [Interviewee #28; PMQ: Egypt]

Others found rural locations to be isolating and unsuitable for growing families. Some reported that challenges were location specific and that resolution occurred after moving institutions, or state. Even the COVID-19 pandemic played a role for some IMG careers, eg timing of exit from own country, extending stay in Australia, or compromising exam opportunities.

Recruiting methods impacted the ease of migration for IMGs. Several IMGs reported recruiting agencies were helpful for organizing visas and jobs. Those IMGs who came to Australia without already having a job lined up tended to struggle, often needing to complete the AMC assessment process, and gaining registration before being eligible for a job. A minority of open-ended respondents reported the registration or assessment process as being uncomplicated and a few reported the first part (MCQ) AMC exam as satisfactory. Importantly, these responses came from participants who had PMQs mainly from UK and New Zealand.

Some interviewed IMGs reported that working in another developed country beforehand gave them a sense of health service familiarity which was transferrable to the Australian workplace. Some IMGs did not identify any challenges with either the workplace, staff and/or patients. However, this was often supported by an acknowledgement of privilege on behalf of the IMG. Native English speakers and those of Caucasian appearance commonly reported observing system and interpersonal biases and mistreatment of non-English/non-Caucasian IMG colleagues. Accent was identified as playing a notable role in how colleagues and patients treated IMGs, particularly those from developing nations. IMGs with British or Australian accents were viewed by other IMGs to be more accepted and favored in the workplace. One IMG said:

I can honestly say, I don't think I have felt any prejudice, being an IMG, but I think it helps that I've got a British accent, went to a good Uni, [and] look pretty Caucasian. [Interviewee #21; PMQ: UK]

These IMGs also acknowledged privilege in career path as entry via the competent authority pathway [CAP] exempted them from AMC exam requirements to gain general registration and subsequent privilege in joining training schemes. Some IMGs told of the inert stigma associated with the term “IMG” in society. “And I think that ‘IMG’...that term...I feel is negative...carries a negative meaning like labelling. Like negative label. I don't like ‘IMG’, that term, at all” [Interviewee #25; PMQ: China]. Some IMGs from UK and South Africa reported being treated favorably by senior staff due to preconceived ideas about their clinical competence in acute care settings, although occasionally this impression led to falsely elevated expectations. The “benefit of the doubt” attributed to UK IMGs was: “not the case for many [other] IMGs...They are considered inferior to the average, and they have to prove themselves” [Interviewee #21; PMQ: UK].

Some IMGs reported that certain aspects of living in Australia made for a more positive experience. For example, sharing culture and language with patients helped gain rapport and trust with multicultural patients. On occasion, sharing a native language was helpful in clinical situations, particularly communication with elderly confused patients. Some IMGs reported

that social privileges facilitated their integration at work, eg, being single, young or from a major ethnic group. Some IMGs reported that personal attributes related to resilience provided them with a positive outlook on challenges, minimizing negative perceptions of challenge. “I think adversities are stepping stones to your success. So, it depends on how you view it, it changes your perspective” [Interviewee #11; PMQ: India].

Several IMGs reported a general sense of gratefulness for the opportunity to live in Australia and experience a new life, particularly older IMGs who immigrated to Australia with intention to settle their family/dependents. IMGs who came with temporary intentions were grateful for the chance to travel and adventure/exploration of the country and the opportunity to supplement their “work holiday” with good income as junior doctors. Migration to Australia was described by one IMG as the “Best thing that ever happened to me” [Interviewee #02; PMQ: UK].

Theme 2: IMGs Encounter Unexpected Challenges with Widespread Impacts on IMGs, Family and Society

Although IMGs accepted that some challenge was part of the immigrant experience, many IMGs reported several challenges as unexpected, thereby resulting in unanticipated impacts.

Mismatched Expectations Have Deleterious Effects

Frankly, to be honest... I didn't think that it was [going to be] this hard. I never thought that I would be spending nine years without working. I didn't have any expectations like that when I came. [Interviewee #18; PMQ: India]

Institutions and bureaucracy were major sources of unexpected problems for many IMGs, particularly those from non-CAP countries. Registration and assessment processes were described as “long”, “tedious”, “expensive” and “arduous”. IMGs reported poor communication from institutions such as AMC, AHPRA and workplace institutions (eg hospital Human Resources departments) and disjointed processes resulted in unexpected delays and outcomes for visas, work contracts, exam progress and job acquisition. IMGs reported unnecessary barriers to onboarding eg A UK IMG reported that her evidence of schooling in English language was rejected by AHPRA for being on paper that was “too light weight”. Another IMG had been asked by the Medical Board to enroll in a course which she was also appointed to teach on. IMGs reported that unclear offshore information and complex, outdated websites lacked transparency, impacting their ability to plan adequately for arrival in Australia. One doctor reported a ten month wait for registration, despite only intending to work in Australia for one year. Some doctors reported inconsistent advice from AHPRA staff, and unhelpful responses when seeking advice.

Furthermore, some interviewed IMGs reported being verbally offered jobs during interviews, together with promises of assistance in securing permanent residency, but this was not followed through upon arrival in Australia. IMGs reported that such misleading information compromised their choices surrounding migration. One IMG was contracted to work in the Emergency Department, but instead upon arrival spent the first four months doing ward night shifts. Another IMG reported how they had relocated their whole family on the promise of income, car, and support for permanent residency, none of which materialized. Uncertainty and unpredictability about their future was a commonly reported dilemma faced by interviewed IMGs. IMGs reported feeling devalued when treated poorly by the system. One IMG reported that “bureaucratic hoops were a trigger for depression and anxiety” [Interviewee #36, PMQ: South Africa]. IMGs reported that bureaucratic delays contributed to lost clinical work time. One IMG spoke about the need for their hospital to remove them from the work roster, due to delays in extending their AHPRA registration, thereby jeopardising patient care. IMGs reported that the unexpected burden of bureaucratic processes impacted their desire to remain in Australia: “The whole system is so fixed and rigid that it does more to put off IMGs from coming here to work rather than encouraging them” [survey participant open response]. Furthermore, several IMGs described the unexpected “catch-22” relationship between registration and job offers.

For me it was quite a surprise when I realized that to get registered in Australia you need a job offer but to get a job offer you need to be registered. Very few hospitals consider employing doctors without registration making the whole process almost impossible. It's frustrating and leads to clinical gap which make the whole process even harder. [survey participant open response]

There was a general acceptance by IMGs for the need for formal evaluation of international experiences and programs, however, the current format of the AMC examination was commonly seen as unfit for purpose. Furthermore, low pass-rates and performance requirements of the AMC assessment process were reportedly unknown to many IMGs beforehand. This was again attributed to complex and outdated website information, and a lack of up-to-date resources available for effective study. Undue pressure of passing exams took a toll on the mental and physical health of many of our interviewed IMGs. The AMC exam process was reported as perpetuating stress for IMGs, particularly in relation to financial and time costs, coupled with the pressure of passing to secure career progression and establishing permanent residency status: “I actually know [IMGs who are taking] antidepressant treatment, just because of the amount of ... pressure this exam gives them...like in terms of passing” [Interviewee #09; PMQ: Italy]. IMGs reported effects on mood, motivation, confidence, with a sense of despair and failure, hopelessness, vulnerability and uncertainty for future. Physical effects included sleep difficulties, fatigue, palpitations and panic attacks. One IMG reported overwhelming mental exhaustion from repeating AMC exams.

Many IMGs were unaware of the registration requirement of “recency of practice”, and inadvertently resulted with a three year plus gap in clinical practice. This was often due to a combination of social situations (eg, parental leave) and lengthy attempts at the AMC examination. One IMG said:

And I thought, ok, cool, I’m going to have a job now, I’ve passed the AMC part two...and then people ... were telling me, ‘look, you have a gap, and you’re not going to have [get] a job...’ But I explain I’ve been spending this time trying to get this [AMC] exam!. [Interviewee #19; PMQ: Italy]

The unexpected high costs of daycare and lack of extended family nearby meant that some IMGs chose to delay AMC examinations to care for their young families. Unbeknownst to some of our participants, such delays added to further problems with recency of practice requirements, therefore limiting their registration prospects. Furthermore, one participant reported leaving their family in Australia and returned to their home country to work temporarily in order to fulfil the AHPRA recency requirements. The difficulty of not being able to find a job added to the financial and social strain the IMGs were already experiencing. Delays in entering the workforce were stressful for IMGs, and impacted them financially, affecting their mortgages overseas, and their ability to pay rent in Australia. Some IMGs worked in non-medical jobs for income whilst waiting for medical employment, eg, gardening, restaurant work, delivery drivers, phlebotomists, and store workers. IMGs reported the uncertainty around employment, registration, financial security, and visa status as being destabilizing and contributing to mental strain and stress on themselves and their families.

The financial burden of migration, paperwork certification and assessments were often underestimated by IMGs. One IMG reported a workplace day-long observership assessment costing AUD\$8000. Another IMG reported the costs of relocation to be upward of AUD\$100,000. One IMG explained:

It’s not really clear. I think, if they [institutions] were clear, people wouldn’t come. If I knew that I would spend all my life savings, maybe I wouldn’t have come. But now it’s too late. [Interviewee #23; PMQ: Brazil]

Frequent relocations to extend visa coverage, participate in training schemes and programs such as the workplace-based assessment added to costs for IMGs and “interfere[d] with your choices in both training and work” [Interviewee #20; PMQ: Egypt].

With the exception of UK IMGs who had “travelled a well-trodden path” [Interviewee #01; PMQ: UK], many interviewed IMGs did not have access to contacts inside Australia to help advise and plan a “roadmap” to guide their employment and career. In fact, some IMGs were unaware of requirements, completion times and the importance of gaining general registration (by completing AMC assessments) to be eligible for training positions in certain specialties and support for permanent residency. Location-dependent variability of this requirement further confused IMGs. Several IMGs reported being unaware of the geographical restrictions and limitations on work freedoms which came with being tied to employer sponsored visas.

Some IMGs were surprised that their background experience and skill level were not considered in job allocations or training applications. Unexpected career changes were demoralizing and perceived as a waste of skills. IMGs described feeling humiliated in being allocated positions below their experience level. Participants used words like “discouraging”,

“stressful”, “dishearten”, “suffer”, “fearful”, “hopeless”, “isolated”, “devalued”, “depressing” and “demotivating”, “humiliating” when describing the registration and assessment processes. One IMG described the unexpected sacrifice of their career for geographical freedom as “traumatic”:

Always I wanted to be a surgeon... That was my vision, dream, ... So, coming here and giving up all... I didn't think I have to give up... [but]... if I had to move rural again, it's going to compromise my [child's] life. So I chose what I chose. [Interviewee #34; PMQ: India]

Sometimes, system issues were perceived as a manifestation of discrimination against IMGs. In response to the open response question exploring the registration process, one IMG simply wrote: “Unfair, biased and dishonest” [survey participant open response]. Geographical restrictions, limited job options and career progression due to IMG status, were also reported as unfair. The regulatory arrangement known as the “10-year Moratorium”, (or “Section 19AB”) which restricts IMGs to work in locations of need for a period of up to ten years, was reported to be “based on pure discrimination without consideration of your family and where they have kids in schools” [survey participant open response]. Lack of professional recognition was reported as a form of exploitation. Inequitable treatment was described as a catalyst for IMGs to leave Australia. One IMG wrote: “[I]...have friends who have experienced direct racism resulting in returning to home country” [survey participant open response].

IMGs Identify Gaps in Understanding Systems, Culture, Skills and Workplace Etiquette

Several interviewed IMGs self-identified various gaps in their knowledge of Australia's healthcare system and culture when they first arrived. Concepts such as social support, allied health, LGBTQI (Lesbian, gay, bisexual, transgender, queer and intersex) health, clinical governance, preventative care, and palliative care were new to many IMGs, as were workplace practices such as clinical handover, shared decision making, rapid response processes and where to access protocols. Many IMGs reported unfamiliarity with government schemes such as Medicare, Pharmaceutical Benefits Scheme (PBS), and the National Disability Insurance Scheme (NDIS), sometimes resulting in inadequate or inappropriate billing.

Some IMGs had differences in skill attainment due to different roles of nurses and doctors in their home country. Unfamiliarity with “fancy” Australian equipment posed technical difficulties for new IMGs. Ceilings of care, resources and investigations were sometimes markedly different in Australia, particularly for those coming from developing nations. One older IMG reported struggling initially with using computers for documentation on ward rounds. Differences in disease prevalence and timing of presentations were different for many IMGs from developing nations. Some IMGs reported initial uncertainty about workplace expectations, roles and responsibilities and socio-cultural norms. One Indian IMG identified their deficit in “soft skills” training, such as communication, critical thinking and team dynamics. Some IMGs unintentionally offended others by their manner of communication, which was misinterpreted in the Australian context.

IMGs reported lacking the performance skills and techniques (rather than content gaps) needed to succeed in Australian examinations. Curriculum vitae presentation skills suitable to an Australian market were also identified as a gap. IMGs reported that specific feedback helped them learn such skills and better present themselves in examination and interview settings.

IMGs reported that gaps between staff expectations and IMG performance sometimes led to misunderstandings, conflicts and assumptions made about competencies. Several IMGs reported their frustration that their mistakes or cultural missteps were not addressed early in a constructive way. As a result, IMGs unknowingly continued in their errors, leading to longer term problems and impacting the way others perceived them. “Because when I had a problem, I didn't know whom to ask... Nobody tell me, ‘You are doing wrong thing’. There was no insight, and this is big problem” [Interviewee #20; PMQ: Egypt]. Furthermore, some IMGs reported not being aware of their work rights, such as entitlements to lunch breaks and leave. IMGs reported that these deficits left them at risk of exploitation by employers.

Social Challenges of Settlement compound IMG challenges

Most interviewed IMGs expected to miss friends and family when coming to Australia. They also anticipated limited social support, although costs of childcare were generally not accounted for. Pressures of financially supporting extended

family overseas whilst navigating work and life in Australia was also noted by some IMGs. A few IMGs expressed emotional guilt and failed responsibility for ageing parents overseas, or for abandoning clinical contribution to their homeland.

IMGs also mentioned the ordinary private life adjustments which came with moving to a new country; from learning the road rules and obtaining a driver's license to learning how to use a petrol pump or self-checkout at grocery stores. For some IMGs, there were additional hardships in rural areas where they felt more isolated and less culturally and religiously supported. IMGs reported that one of their biggest stressors was gaining permanent residency. Although some delay in career was anticipated, several interviewed IMGs reported grieving for their previous specialty, previous position in the workplace and material belongings since moving to Australia. IMGs spoke about the struggle of balancing work, family and study, with effect on exam success.

Especially early on, some IMGs reported feeling an inhibition to socially integrate with Australian workplace colleagues, as they did not share common customs such as afterwork drinks, barbecues or cultural banter. Some IMGs reported the difficulty of making friends in the hospital setting, due to age differences and different life stages with peers. Some IMGs reported difficulties breaking into social circles as an adult as locals already had established friendship groups. One IMG expressed that absence of social support in Australia stunted their motivation to pursue specialty training. Character development and resilience were seen as positive outcomes of IMG challenges. Some IMGs explained that adversity in Australia grew their courage, bravery and perseverance to "soldier on". One IMG said: "Maybe it has made me better because I haven't been given everything for free" [Interviewee #31; PMQ: Germany].

Triangulation of Results

Overall, we found strong congruency between the quantitative and qualitative findings (see [Supplementary material 3](#)). For example, the richness and diversity of journeys and experiences of IMGs were evident in both the broad demographics (17 specialties and 58.8% completed or partially completed post-graduate training overseas) and description of training backgrounds reported by both survey and interviewee participants. The spread of responses provided by survey respondents regarding the primary reasons for migration and most enjoyed factors of working in Australia were explained in the interview data by the differing priorities of participants in their life stages at the time of migration.

Survey data criticizing system processes (bureaucracy) as the most unfavorable factor (43.7%) of working in Australia was strongly supported by qualitative data which revealed that the lack of transparency, unexpected and perceived unfair bureaucratic hurdles or delays contributed to IMG dissatisfaction. Despite the quantitative data showing almost equal proportion of IMGs reporting satisfaction (34.2%) and dissatisfaction (33.3%) with AMC pathway for registration, this was incongruent with the heavy scrutiny reported in the qualitative data, which provided very little positive commentary, possibly a reflection of participant bias.

Interview data highlighted unforeseen challenges, mismatched expectations and unexpected impacts of certain challenges experienced by IMGs, which were unable to be explored in the quantitative study. The high ranking of discrimination as a disliked factor (26.6%) channeled exploration in the qualitative data, pointing to descriptions of perceived challenge and privilege which logically accompany the demographically diverse population (46 PMQs).

Discussion

This study provides new and updated evidence about the experiences and challenges perceived by IMGs based in Australia. The SEMM approach provided meaningful explanations of IMG choices around migration and career and explained the widespread impacts on IMGs and their families due to unexpected hurdles and mismatched expectations. Our study is novel in that it surveyed a wide range of IMGs with diverse demographic and training backgrounds and included participants working in non-clinical field. Our study provided a voice for those IMGs who are not currently employed, and new insights into the barriers for successful registration.

We found a significant proportion of participants spent several years completing AMC assessment processes in order to gain general registration and that such delays impacted on IMG access to training schemes and ultimately career progression. Therefore, the privilege afforded to IMGs accessing registration through the CAP included not only waiving of examination fees and requirements but also benefits to professional freedoms. Importantly, although there are sporadic

and incidental reports of inequitable treatment in IMG studies internationally, lack of direct exploration may result in underreporting.¹³ The complexities of disadvantage and discrimination impacting this study group are discussed in our related study.²²

Our findings highlight the unexpectedness of challenges, and the role institutions play in perpetuating that unexpectedness for IMGs. Regarding factors for choices to migrate to Australia, we found that our sample responded similarly to data reported from studies almost 20 years ago,^{23,24} indicating stability of Australia as a choice for prospective IMGs. However, the discovery of IMGs working in non-medical roles to financially support unexpected expenses such as examination costs in Australia is confronting, as are insights into the desire for some IMGs to leave Australia due to dissatisfaction with current bureaucratic processes. The rich diversity of IMGs in our study highlights a need to better match past experience, skill set, career and migration intentions, to existing opportunities in the Australian labor market. Recently, an Australian national independent review of health practitioner regulatory settings recommended the improvement of internationally qualified health practitioner experiences, increased flexibility and expanding of fast-track registration pathways as priority areas for reform.¹⁴ Such changes proposed reduced fiscal and time barriers for IMGs and accelerated workforce mobilization.¹⁴

We identified that some challenges experienced by IMGs may stem from mismatched expectations and gaps in understanding nuances of a new workplace system and culture. Our study supports other findings of IMG challenges identified in the international literature, such as difficulties with communication and language proficiency, intercultural problems (eg, patient-centered care, hierarchical structure in the healthcare system) and different focuses in medical education.^{11,35–37} Indeed, differences in PMQ teaching styles, curricula and pre-migration training may impact how IMGs transition to their host country and subsequently affect career progression.¹¹

The value of sustaining the IMG workforce has become increasingly topical as various institutions explore and advocate for bettering the support of IMGs in host countries.^{14,38} Proposed recommendations include institutional changes to address system processes and improvements of workplace support eg, tailored education, orientation and mentoring.^{14,35}

Implications for Practice

Our study highlights the unexpectedness of certain challenges faced by IMGs upon arrival and early transition in Australia. By being aware of such challenges, IMGs have an opportunity to be better prepared and make more informed decisions about migration to Australia. Our findings also give institutions some direction to improve processes and identify system gaps and faults which need addressing.

Strengths and Limitations

This study provides a deep understanding of IMG experiences in Australia, benefited by the SEMM approach. However, the focus on one country may limit generalisation to other contexts. The non-random sampling lends propensity to participant bias, and the relatively small study numbers may not reflect the experiences of the larger IMG population in Australia. Furthermore, the experiences are limited to IMGs who are still living in Australia and therefore challenges may be underreported. Despite our attempts to recruit broadly across the country, we resulted in only a small number of non-clinical and non-employed IMGs. The importance of gathering information from this cohort should not be underestimated, and we recommend future studies seek their stories. Although the survey instrument was specifically developed for the purpose of this study, we recommend further psychometric testing of the instrument for future research.

Conclusion

IMGs are a diverse workforce with rich background and training experiences, deserving of individual attention to their career and social needs. IMGs may experience a range of unexpected social and work-related challenges after arrival in Australia which can affect their career choices and trajectory. Bureaucratic challenges, such as those related to registration, AMC examination processes and job allocations, may contribute to IMG stressors. IMGs are subject to a range of social and financial pressures, particularly for those IMGs with dependents. Furthermore, mismatched expectations and gaps in workplace understandings can detrimentally impact IMG careers, health, and security of the

workforce. Institutions have the potential to address problematic bureaucratic processes and other work-related factors. Further exploration into the individual needs and IMG-acceptable support is warranted.

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