Recruited Globally, Neglected Locally

International Medical Graduates' experiences in Aotearoa New Zealand

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Key findings

5.3

per cent of New Zealand Medical Graduates and

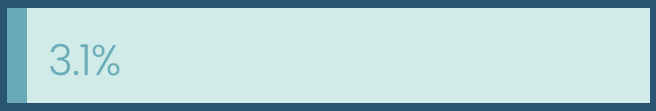
17.1

per cent of International Medical Graduates are likely to **go abroad to work** and settle permanently overseas.

International Medical Graduates long-term intentions to remain in Aotearoa New Zealand are shaped by **Remuneration (32.2 per cent), workload issues (21.5 per cent), and quality of managerial relationships (17.9 per cent).**

Upon moving to Aotearoa New Zealand, IMGs are faced with the challenges of: **distance from family/ friends (52.2 per cent), New Zealand health system differences (37.6 per cent), and cost of living (29.9 per cent).**

Only **3.1 per cent** of IMGs received an **orientation to the New Zealand health system upon arrival** in Aotearoa New Zealand.



Only **24.7 per cent** of IMGs received **cultural competency/cultural safety training**.

Only **50.9 per cent** of IMGs received a **formal induction process**, including job expectations, IT systems, and explanations of electronic records.

Introduction

Aotearoa New Zealand's health system could not function without overseas-trained doctors. This is not unusual. Health systems globally rely on the experience, knowledge and skills that international medical graduates (IMGs) bring to operating theatres, wards and clinics to deliver health services. This is because, like many other advanced economies, Aotearoa has not trained enough medical students domestically to meet population health needs over many decades.[1]

The Organisation for Economic Co-operation and Development's (OECD) data shows that 42.1 per cent of Aotearoa New Zealand's medical workforce gained their undergraduate medical degree overseas. This puts Aotearoa New Zealand second equal with Norway (42.1 per cent) and behind Israel (57.8 per cent) in terms of the highest proportion of IMGs in their health systems.[2] However, a large proportion of IMGs in Israel and Norway were born locally but went abroad to study before returning home.[3]

Recent reporting by Te Kaunihera Rata o Aotearoa Medical Council of New Zealand (MCNZ) shows that 43.3 per cent of our current medical workforce are IMGs. Between 1st July 2024 and 30th June 2025, 1,266 IMGs were registered, down 3.7 per cent from the previous year, and 558 New Zealand Medical Graduates (NZMGs) were registered, up 4.3 per cent.[4]

Internationally, health systems continue to face significant pressure, including unmet need, workforce recruitment and retention, and meeting the health needs of a growing and ageing population, particularly since the onset of the COVID-19 pandemic.[5,6] The challenges of health worker migration to Aotearoa New Zealand were highlighted during the emergency phase of the pandemic, notably difficulties with Immigration New Zealand, residency insecurity, and pathways to qualification recognition and medical practice.[7,8] Given the original distribution timing of the current survey (August 2022) and the public discourse surrounding healthcare worker migration, many of these factors were still fresh in the minds of respondents.

In OECD countries, IMGs comprise an average of 18.6 per cent of the medical workforce (ranging from 0.6 per cent in Lithuania to 57.8 per cent in Israel).[9] This demonstrates how health systems globally rely

1 OECD, *Recent Trends in International Migration of Doctors, Nurses and Medical Students* (OECD, 2019), https://doi.org/10.1787/5571ef48-en.

2 OECD, *Health at a Glance 2023: OECD Indicators*, Health at a Glance (OECD, 2023), https://doi.org/10.1787/7a7afb35-en.

3 OECD, *Health at a Glance 2023*.

4 *He Kete Whakamārama Insights Pack 1 July 2024 - 31 June 2025* (Te Kaunihera Rata o Aotearoa Medical Council of New Zealand, 2025).

5 Alessandro Stievano et al., 'Navigating the Health Professional Migration Tsunami in the Era of COVID-19 and Globalization: A Call to Action for a Collective and Coordinated Response from Government and Non-Government Organizations', Healthcare 11, no. 7 (2023): 931, https://doi.org/10.3390/healthcare11070931.

6 A. Šavrova et al., 'Factors Associated with Advanced-Stage Diagnosis of Cervical Cancer in Estonia: A Population-Based Study', Public Health 225 (December 2023): 369–75, https://doi.org/10.1016/j.puhe.2023.10.025.

7 Changes to Aotearoa's immigration settings for health workers included the 'green list' which offered a straight-to-residency pathway, as well as increased support for IMGs working in other fields due to difficulties in acquiring hospital-based training posts once they have passed the NZREX (clinical exam administered by the Medical Council of New Zealand).

8 Johanna Thomas-Maude and Sharon McLennan, 'Critically Understaffed and with Omicron Looming, Why Isn't NZ Employing More of Its Foreign-Trained Doctors?', The Conversation, 3 February 2022, http://theconversation.com/critically-understaffed-and-with-omicron-looming-why-isnt-nz-employing-more-of-its-foreign-trained-doctors-175914.

9 OECD, *Health at a Glance 2023*.

on IMGs to keep services running. Understanding the motivations, challenges, and experiences in moving to practice in Aotearoa New Zealand is essential if the public health system is to maintain services. This is especially important, as initiatives to boost the domestic supply of medical graduates, such as establishing a third medical school, will take some years to produce new graduates. The success of increasing trainees domestically is also dependent on our ability to recruit and retain sufficient senior doctors to supervise and train the increased number of junior doctors coming through the pipeline.

In November 2024, the MCNZ introduced fast-track registration for specialist IMGs. The changes made it "easier and quicker for doctors from overseas to gain specialist registration in the following areas of medicine: general practice, psychiatry, dermatology, emergency medicine, anaesthesia, internal medicine, and pathology (anatomical)."[10] Under this, eligible doctors from the United Kingdom, Ireland, and Australia "will have their applications assessed against a set of core requirements without needing advice from the specialist medical colleges"[11] speeding up approvals. Alongside this, in early 2025, the MCNZ increased registration exam places from 60 to 180, and the government announced the expansion of the pilot placement, whereby ten overseas-trained doctors got clinical placements in general practice to meet registration requirements, up to 100 places. Although the details are not yet clear, the initiative is expected to cost $23.94 million over four years and involve a two-year pre-vocational medical training programme during which "IMGs will be placed in a hospital setting for the first 3 months, with one further 3-month placement in a hospital setting sometime over the remainder of the two years."[12,13]

While increasing the number of places for sitting the NZREX and increasing clinical placements in general practice for IMGs may be positive steps, the changes leave some issues unaddressed. Yhere are often challenges for NZREX candidates in securing first-year supervised House Officer positions. Thomas-Maude notes that "first-year supervised House Officer positions are rarely offered to NZREX candidates because the limited number of PGY1 [House Officer positions] places roughly corresponds with the medical students graduating from local universities, and NZMGs are given priority."[14] This priority stems from NZMG's greater likelihood of remaining in Aotearoa New Zealand.[15] PGY1 positions are limited by supervision capacity, owing to an already overstretched SMO workforce.

This research builds on the Association of Salaried Medical Specialists Toi Mata Hauora's (ASMS) 2017 study into international medical migration. It showed increasing competition to attract IMGs, an ageing medical workforce, and continued poor retention rates of IMGs in Aotearoa New Zealand.[16]

10 *New Fast-Track Registration for Specialist International Medical Graduates to Start in November* (Te Kaunihera Rata o Aotearoa Medical Council of New Zealand, 2024).

11 *New Fast-Track Registration for Specialist International Medical Graduates to Start in November.*

12 Janine Rankin, 'Faster Track for Overseas-Trained Doctors a "Band-Aid on Broken System"', The Post, 19 January 2025, https://www.thepost.co.nz/nz-news/360548199/faster-track-overseas-trained-doctors-work-nz-band-aid-broken-system-phd-graduate.

13 'Unwrapping Package: Details on Tenfold Increase in Overseas-Doctor Places in General Practices Still to Come | New Zealand Doctor', 5 June 2025, https://www.nzdoctor.co.nz/article/news/unwrapping-package-details-tenfold-increase-overseas-doctor-places-general-practices.

14 Johanna Thomas-Maude, '"Broken" Pathways: Understanding the Licensing Experiences of Overseas-Trained Medical Doctors in Aotearoa New Zealand' (Massey University Te Kunenga Ki Pūrehuroa, 2024).

15 Just over 40 percent of IMGs leave after one year, 60 percent after two years, and 75 percent after 10 years. In comparison, one average only 1 percent of NZMGs leave after one year, 6 percent after two years, and 27 percent after 10 years.

16 *International Medical Migration: How Can New Zealand Compete as Specialist Shortages Intensify?* (Association of Salaried Medical Specialists Toi Mata Hauora, 2017), https://asms.org.nz/wp-content/uploads/2022/05/IMG-Research-Brief_167359.5.pdf.

Definitions

Doctor

It should be assumed, unless otherwise stated, that doctor refers to a medical doctor. In this paper, this term refers to doctors who trained in Aotearoa New Zealand (NZMGs) and those who trained overseas (IMGs).[17]

International medical graduate (IMG)

A doctor who obtained their primary medical qualification in a country other than New Zealand. For the purposes of this work, this includes doctors and dentists.[18]

Medical Officer

A doctor working in a general scope of practice and registered with the Medical Council of New Zealand. They are not participating in a vocational training programme or under supervision, but may not have met the requirements for a vocational scope of practice.

New Zealand Medical Graduate (NZMG)

NZMGs are doctors who obtained their primary medical qualification in Aotearoa New Zealand. For the purposes of this work, this includes doctors and dentists.

Resident Medical Officer (RMO)

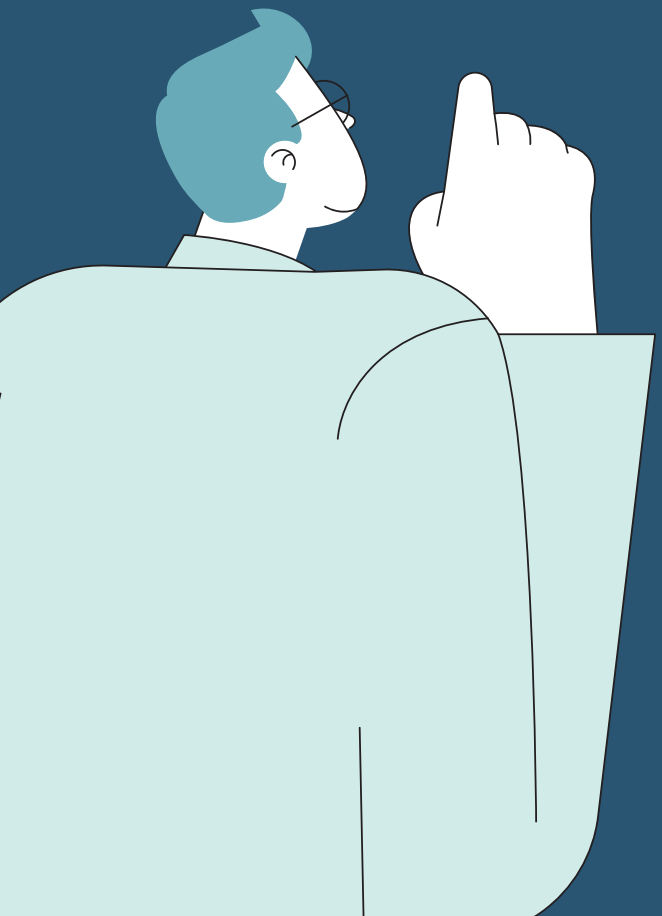
A medical doctor working under the supervision of a senior medical officer. Most RMOs working in Aotearoa New Zealand are training for a specialist vocational qualification through a medical college.

Senior medical officer (SMO)

A medical doctor with a postgraduate specialist qualification in a particular field over and above their primary medical qualification. In the Aotearoa New Zealand context, they are vocationally registered with the Medical Council of New Zealand.

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand (MCNZ)

MCNZ is the responsible authority for medical standards, accreditation of institutions, and registration of doctors in Aotearoa New Zealand.



17 Thomas-Maude, "'Broken" Pathways: Understanding the Licensing Experiences of Overseas-Trained Medical Doctors in Aotearoa New Zealand'.

18 'Glossary', New Zealand Medical Council, 21 May 2019, https://www.mcnz.org.nz/about-us/glossary/.

Methodology

The survey was designed with dual aims: to investigate the experiences of IMGs in moving to and practising in Aotearoa New Zealand, and to gather data on the job satisfaction and future intentions of senior doctors and dentists. The survey was sent to all current members of Toi Mata Hauora ASMS (n = 5,560) in August and September 2022. The survey was open for a period of four weeks. Participation was voluntary, and no incentives were provided in exchange.

The job satisfaction and future intentions results were published previously in *Over the Edge: Future Intentions of the Senior Medical Workforce*.[19] The current paper analyses the demographic characteristics of IMG doctors and dentists living and working in Aotearoa. It examines responses to questions regarding the experience of relocating and acclimatising. These questions cover professional and personal/whānau perspectives.

This report uses Te Kaunihera Rata o Aotearoa Medical Council of New Zealand (MCNZ) definition for IMGs: "a doctor who obtained their primary medical qualification in a country other than New Zealand."[20] This definition is based on the country where a doctor undertook their undergraduate medical qualification, rather than any postgraduate vocational training. Therefore, a doctor who gained their medical undergraduate degree outside of Aotearoa New Zealand is technically an IMG, even if they complete their vocational training in Aotearoa.

In addition to the MCNZ IMG definition, the report uses demographic results to examine primary and secondary medical qualifications, as well as the number of IMGs who have gained specialist and vocational qualifications in Aotearoa New Zealand.

Response rate

The survey invitation was sent to all ASMS members (n = 5,560) on August 4, 2022, and remained open until August 31, 2022. 1,639 responses were received, an overall response rate of 29.5 per cent.

Of the total respondents, 1,560 responded to the question about where they received their primary medical qualification. 50.9 per cent (n = 794) received their primary medical qualification in Aotearoa New Zealand, and 49.1 per cent (n = 766) received it internationally. This is a higher proportion than statistics provided by MCNZ, which in 2024 reported 11,809 doctors who received their primary medical qualification in Aotearoa New Zealand (55.6 per cent) and 9,436 who received it overseas (44.4 per cent). This overrepresentation is likely due to the explicit call for IMGs to participate, as well as the second half of the survey, which included questions about their experience in Aotearoa New Zealand.

19 *Over the Edge: Findings of the 2022 Survey of the Future Intentions of Senior Doctors and Dentists* (Association of Salaried Medical Specialists Toi Mata Hauora, 2022).

20 *Over the Edge: Findings of the 2022 Survey of the Future Intentions of Senior Doctors and Dentists.*

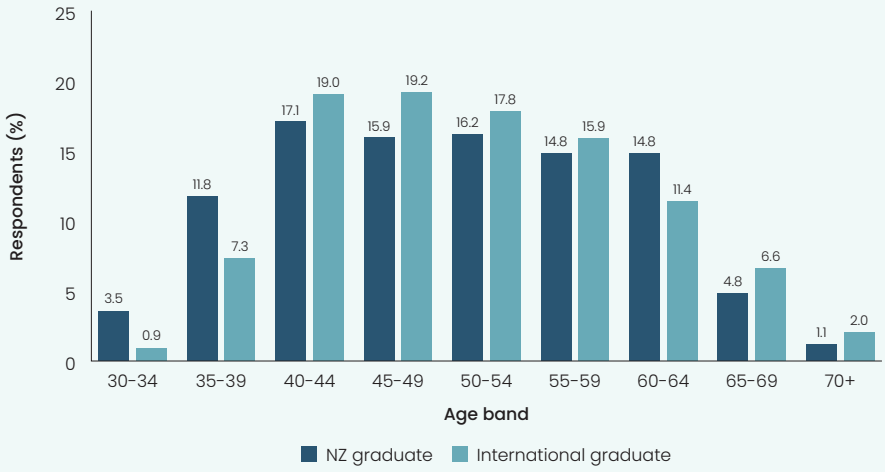
Results: Demographics

Age

The majority of IMG SMOs were clustered in the 40-54 age bands, with 56 per cent of respondents falling into these groupings.

The median age of IMG SMOs in the survey cohort was 51.2, which is consistent with the median age reported in the *Future Intentions* survey.[21] This median is older than the 45.3 year mean age calculated by the MCNZ as part of its annual workforce survey. This may be explainable by different average calculations or that the MCNZ data includes all post-graduate doctors working in Aotearoa, not just SMOs.

Figure 1: IMG and NZMG respondents by age band



IMG and NZMGs by age band

When examining the results by age, IMG SMOs represented a greater proportion in each age band, except for the 30-34, 35-39, and 60-64 age bands, where a higher frequency of NZMGs was observed.

In the overall survey cohort (comprising both IMGs and NZ graduates), 35.5 per cent of the survey respondents are aged between 40 and 49 years. For NZMGs alone, the proportion in the 40-44 and 45-49 age group bands was 32.9 per cent.

Gender

Within the IMG cohort, of the 756 people who responded to the question, 44.2 per cent of respondents identified as female (n = 334), and 55.5 per cent as male (n = 420). Just over 1 per cent stated that they preferred not to state a gender. Respondents of other genders, including non-binary and transgender individuals, were small in number and did not meet the threshold for inclusion in the analysis.

21 *Over the Edge: Findings of the 2022 Survey of the Future Intentions of Senior Doctors and Dentists.*

Within the NZMG cohort, 787 people responded to the question. 46.1 per cent (n =3 63) identifying as female, 53.7 per cent (n = 423) identifying as male, and slightly less than 1 per cent preferring not to state a gender. Like the IMG cohort, respondents of other genders did not meet the threshold for reporting.

MCNZ reports that the proportion of female doctors is 49.6 per cent, or 10,177 of the 20,530 registered doctors.[22]

Dependents – children and other dependents

Within the IMG population who answered the questions (n = 757), 474 (62.6 per cent) respondents reported having dependent children, and 203 (26.8 per cent) respondents reported supporting other dependents, e.g. older people. Some respondents (in both the IMG and NZMG populations) interpreted this question to include older children and spouses who were not employed. The question did not assess whether dependents were living domestically or internationally.

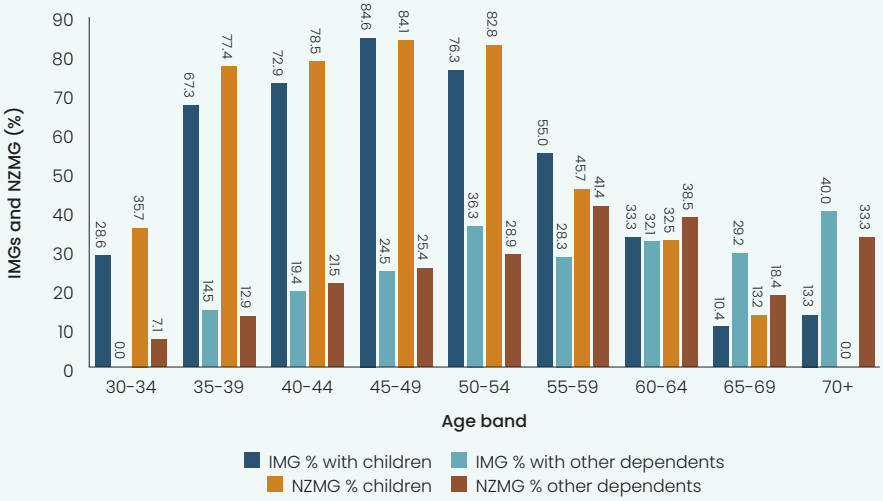
IMG respondents aged between 40 and 54 years were more likely to report dependent children. Respondents in the age band 45-49 had dependent children in 84.6 per cent of cases. Within the 35-39 age band, 67.3 per cent reported dependent children and 14.5 per cent reported other dependents (e.g older people).

Several IMGs left comments about their individual circumstances, including supporting increasingly frail parents and grandparents overseas in their countries of origin. Some commented on the restrictions on family reunification visas, the impact of the Covid-19 pandemic and the emotional toll of separated parents and grandchildren.

> “Old parents of us IMGs, that serve this country immensely, are on no one’s agenda. I accept that, but it still makes me sad.”

In comparison, of the NZMGs who answered the question (n = 791), 497 (62.8 per cent) respondents reported having dependent children, and 216 (27.3 per cent) respondents reported supporting other dependents. NZMGs aged between 35 and 54 years were more likely to report dependent children. Respondents in the age band 45-49 had dependent children in 84.1 per cent of cases. Within the 35-39 age band, 77.4 per cent reported dependent children and 12.9 per cent reported other dependents (e.g older people).

Figure 2: IMG and NZMGs supporting dependent children and other dependents, by age group



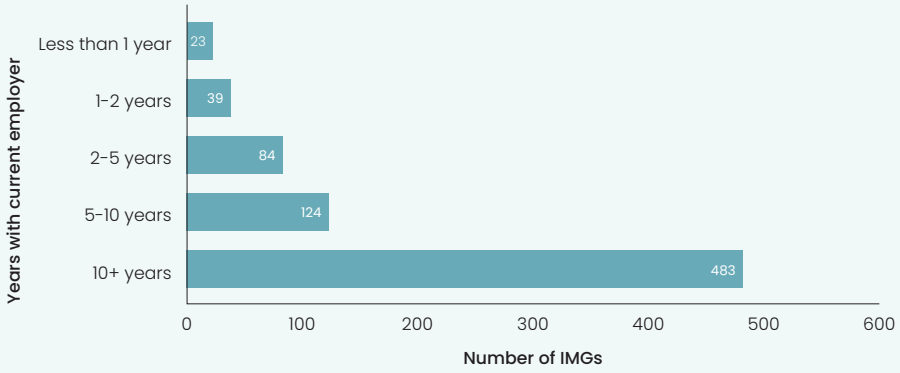
22 *He Kete Whakamārama Insights Pack 1 July 2024 - 31 June 2025.*

Results: Employment demographics

Years employed in Aotearoa New Zealand and time with current employer

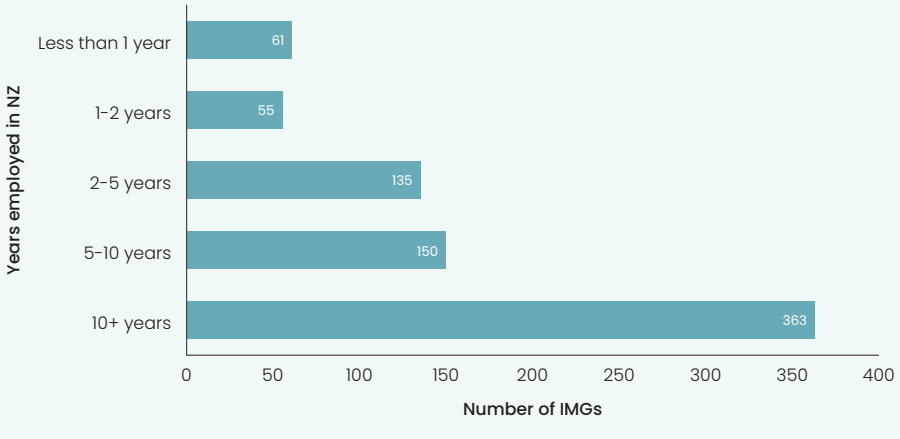
Of the IMGs who answered the question (n = 753), nearly two-thirds of IMG respondents (483, 64.1 per cent) had been employed in Aotearoa New Zealand for more than 10 years.

Figure 3: How many years have international medical graduates been employed in New Zealand?



This data can be read alongside the length of service of IMGs with their current employer. Of the IMGs who answered the question (n = 764), nearly half (n = 363, 47.5 per cent) had been with their current employer for over ten years.

Figure 4: How long have international medical graduates been with their current employer?



Our data also revealed that among the IMGs who had been in Aotearoa New Zealand for over 10 years (n = 481), 351 (73 per cent) had been with the same employer for at least 10 years. The reasons for long tenure and reduced turnover are likely multifactorial and highly contextual. However, some previous studies have suggested that increased age, working years, and level of expertise were all positively correlated with increased tenure.[23, 24, 25] Additionally, the emergency phase of the COVID-19 pandemic likely impacted SMO decision-making around these career intentions. Over The Edge found that, while the overall intention to leave medicine or dentistry in the next 5 years has moved marginally (18 per cent in 2022 compared to 16 per cent in 2017), the likelihood for SMOs (regardless of IMG/NZMG classification) to continue in public hospital employment dropped sharply from 83 per cent in 2017 to 62 per cent in 2022.[26]

23 Pål E. Martinussen et al., 'Should I Stay or Should I Go? The Role of Leadership and Organisational Context for Hospital Physicians' Intention to Leave Their Current Job', *BMC Health Services Research* 20, no. 1 (2020): 400, https://doi.org/10.1186/s12913-020-05285-4.

24 Suhyun Oh and Hyeongsu Kim, 'Turnover Intention and Its Related Factors of Employed Doctors in Korea', *International Journal of Environmental Research and Public Health* 16, no. 14 (2019), https://doi.org/10.3390/ijerph16142509.

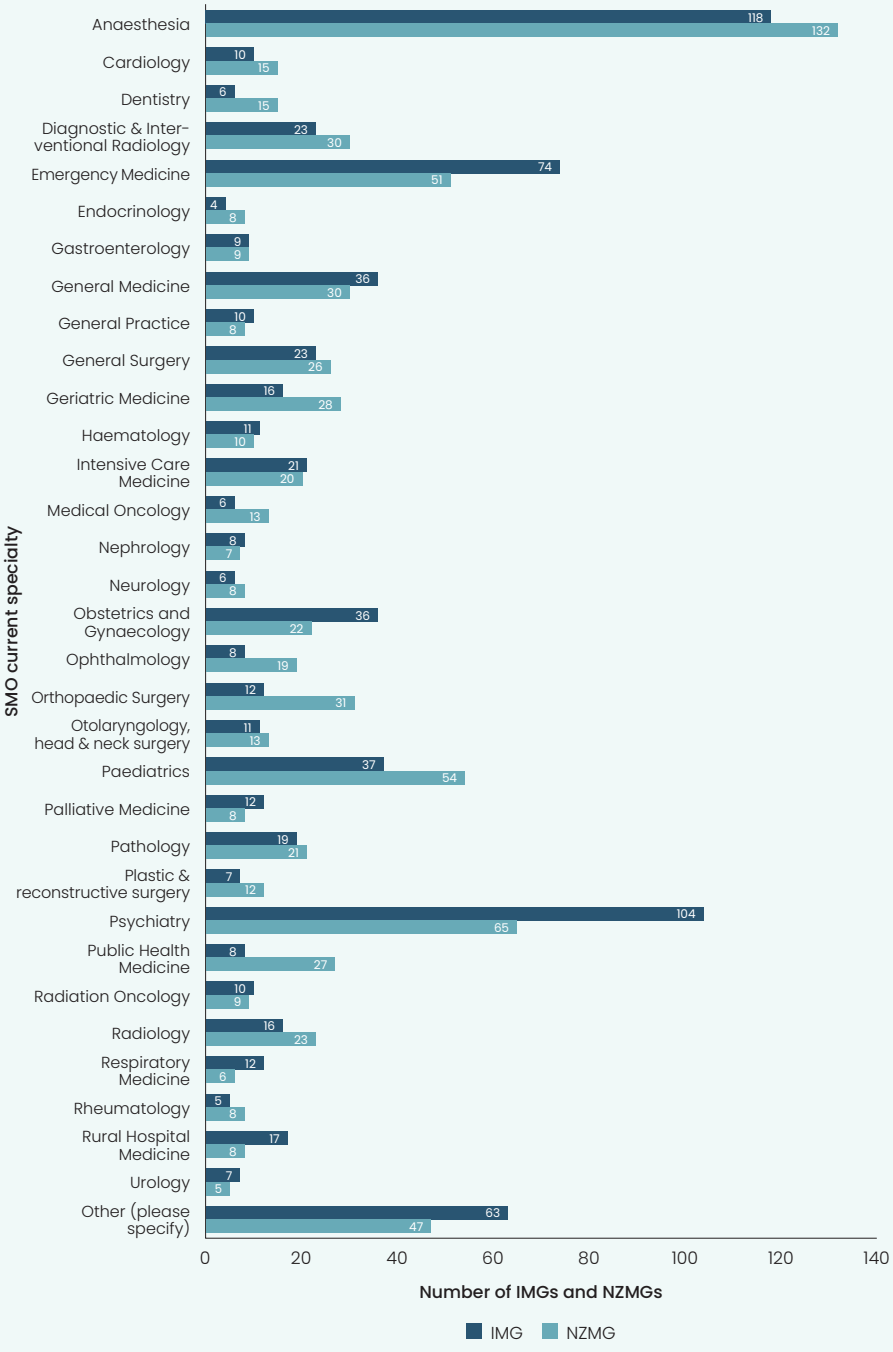
25 Neeltje De Vries et al., 'The Race to Retain Healthcare Workers: A Systematic Review on Factors That Impact Retention of Nurses and Physicians in Hospitals', INQUIRY: *The Journal of Health Care Organization, Provision, and Financing* 60 (January 2023): 00469580231159318, https://doi.org/10.1177/00469580231159318.

26 *Over the Edge: Findings of the 2022 Survey of the Future Intentions of Senior Doctors and Dentists.*

Employment specialty

SMOs were asked about their current speciality. To prevent the disclosure of identifiable data, to improve the readability of the figures below, and to prevent misrepresentative small samples, specialities with fewer than ten combined IMGs and NZMGs were grouped under "other". Of the 1553 SMOs who answered the question, 765 (49.3 per cent) were IMGs and 788 (50.7 per cent) were NZMGs. Additionally, as this is a self-selecting sample, rather than a random sample, there are differences with the more comprehensive MCNZ data.[27]

Figure 5: What speciality area are you currently working in? (IMG vs. NZMG)



27 *The New Zealand Medical Workforce in 2024* (Te Kaunihera Rata o Aotearoa Medical Council of New Zealand, 2024).

Figure 6: What speciality area are you currently working in? (IMG vs. NZMG, %)

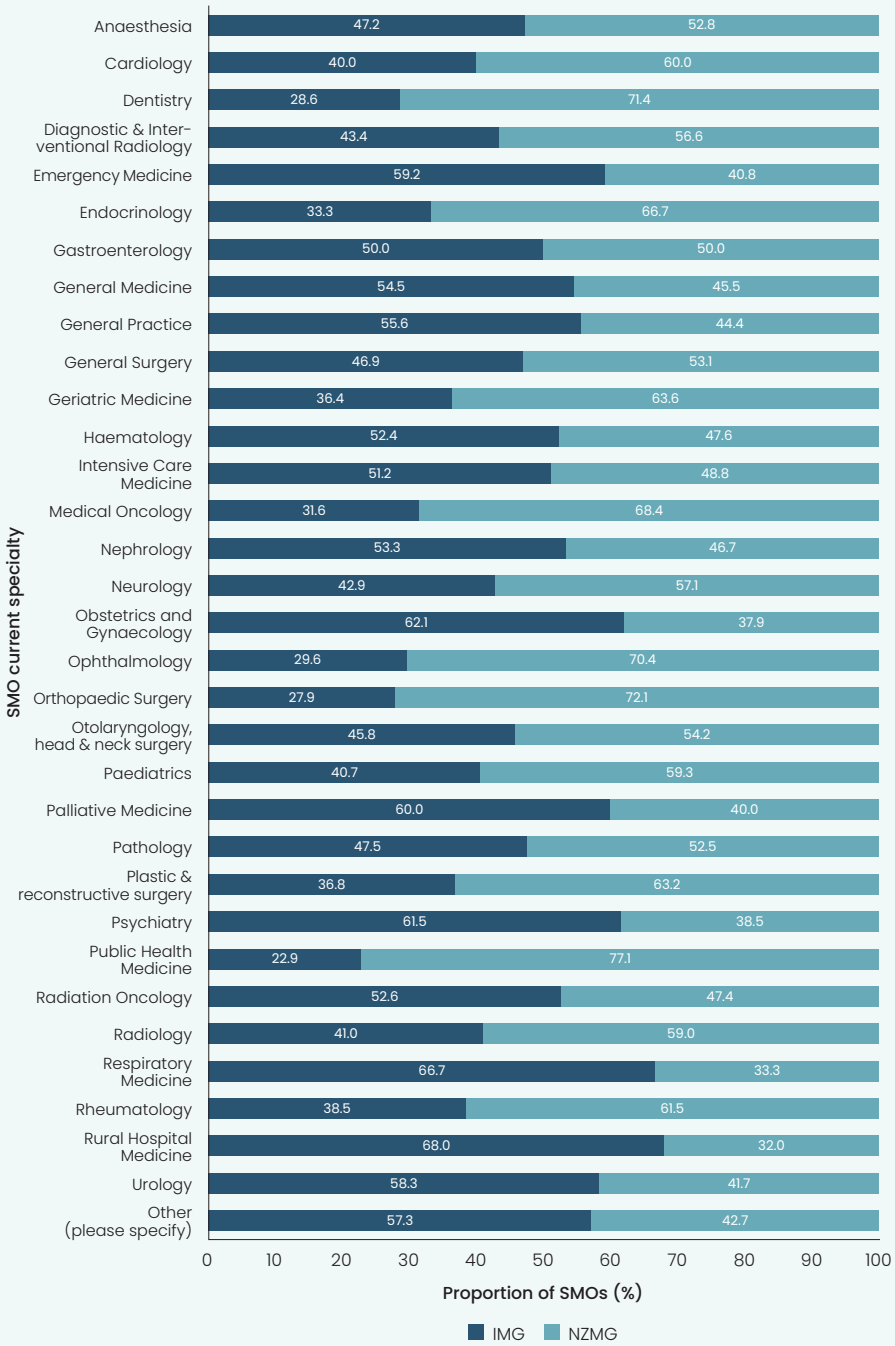


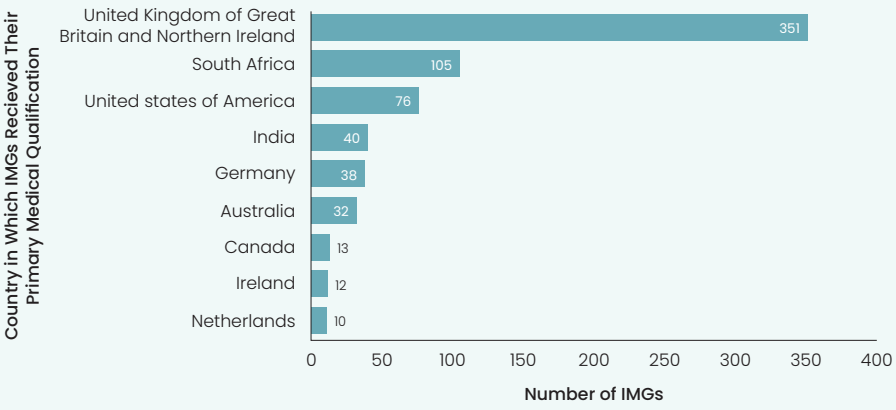
Figure 5 and Figure 6 present data on IMGs and NZMGs by speciality. Figure 5 presents the raw numbers, while Figure 6 shows the proportion. Only specialty with greater than 10 participants are reported. IMGs made up a significant proportion of the rural medicine (68 per cent, 12 total SMOs), respiratory medicine (66.7 per cent, 18 total SMOs), obstetrics and gynaecology (62.1 per cent, 58 total SMOs), psychiatry (61.5 per cent, 169 total SMOs), palliative medicine (60 per cent, 20 total SMOs, and emergency medicine (59.2 per cent, 125 total SMOs).

Primary and specialist medical qualifications

IMG Primary medical qualifications country

IMGs are defined by where their primary (i.e. undergraduate medical qualification) was gained. This survey yielded over 50 different countries where IMGs had gained their primary medical degree, with the most likely countries detailed in Figure 7 below. If all 54 countries were grouped by geographic region, Europe continues to dominate, with 59 per cent of Aotearoa's IMG workforce having gained their primary medical qualification in a European country.

Figure 7: Most common countries/regions for primary medical qualification for international medical graduates

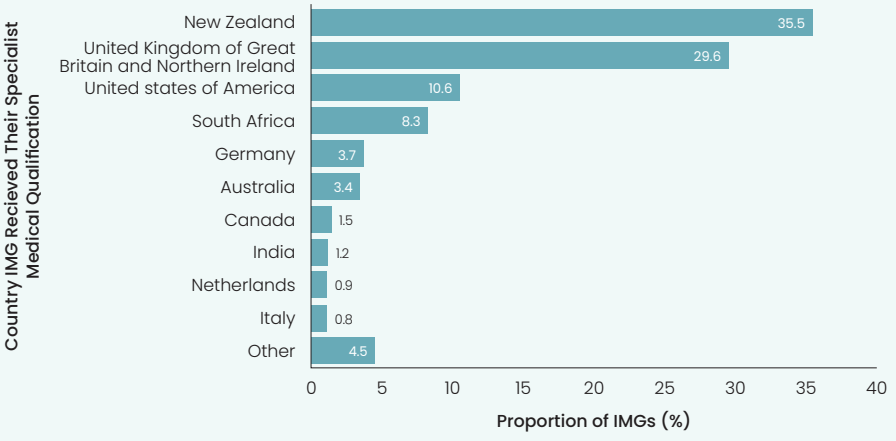


IMG Specialist medical qualifications country

Specialist medical qualifications are administered and awarded by vocational medical training bodies (medical colleges). IMGs applying to work in Aotearoa New Zealand will have their specialist qualifications assessed by the relevant specialist medical college, which makes a recommendation to MCNZ on the equivalency of education, training, and experience compared to the Aotearoa New Zealand pathway for that medical speciality.

From the total number of responses to the question "in which country did you gain your specialist medical qualification?" (n = 748), around one-third of IMGs (35.1 per cent) stated they gained their specialist qualification in Aotearoa New Zealand, followed by the United Kingdom (29.7 per cent) and the United States (10.7 per cent). It is important to note, however, that the comments show that many respondents hold multiple specialist qualifications, such as their initial Fellowship and the equivalent in Aotearoa New Zealand.

Figure 8: Most common countries/regions for specialist medical qualifications for international medical graduates



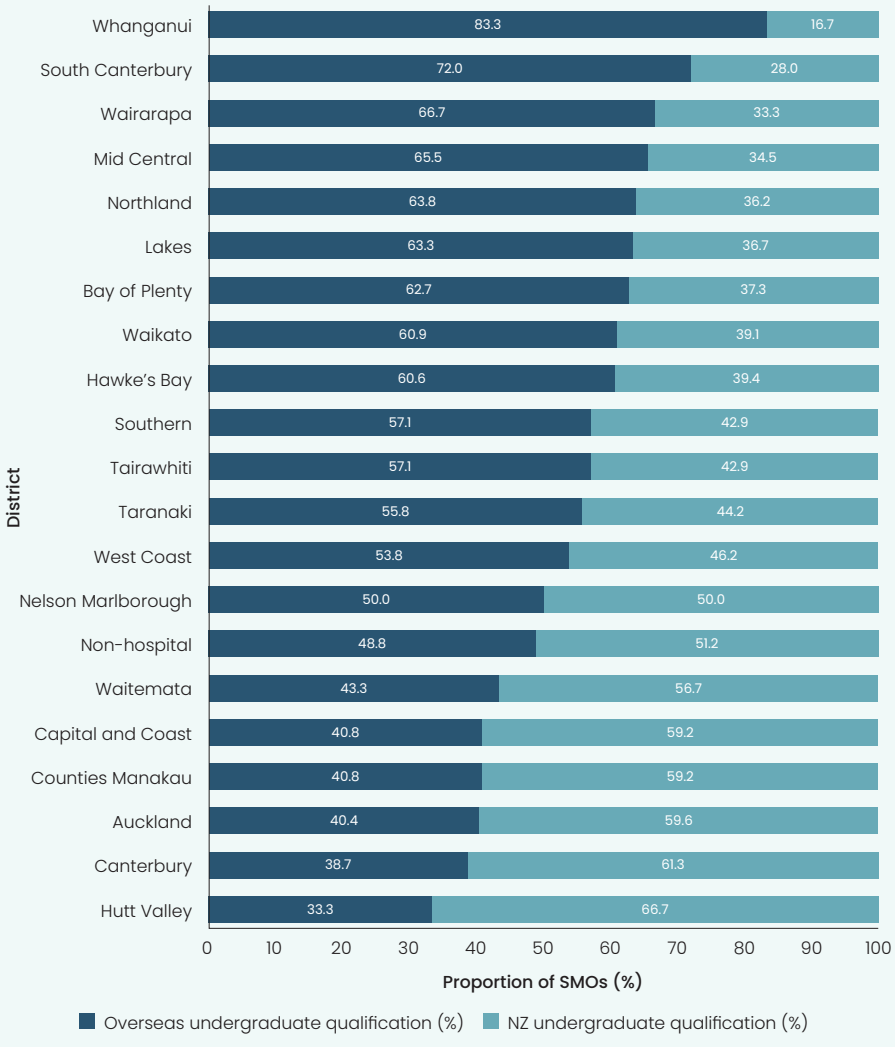
Place of work by primary medical qualification

In 2025, 43.3 per cent of doctors on the medical register are IMGs. IMGs are most represented among Medical Officers (59 per cent) and Specialists (41.2 per cent).[28]

At the individual District level, our survey results (n = 1557) indicate that nearly three-quarters of all Te Whatu Ora Districts have an IMG workforce of at least 43.3 per cent. The five Districts with an IMG workforce at or below this proportion are all in metropolitan centres (Auckland, Wellington and Christchurch), and range from 33.3 per cent IMG at Hutt Hospital (the lowest proportion of IMGs) to 40.8 per cent at Waitematā.

The three Districts with the greatest proportion of IMGs are all secondary-level hospitals in regional centres: Whanganui (83.3 per cent), South Canterbury (72 per cent), and Wairarapa (66.7 per cent). Districts with growing populations, such as Bay of Plenty, Lakes, Hawkes Bay, and Waikato, all report over 60 per cent IMGs in their workforces. Where the site of work is a non-hospital setting, such as general practice, hospice, or a national service such as the Ministry of Health, the proportion of IMGs to NZMGs is almost 50:50 (51.5 per cent IMG).

Figure 9: Place of work by primary medical qualification, IMG and NZMGs (per cent)



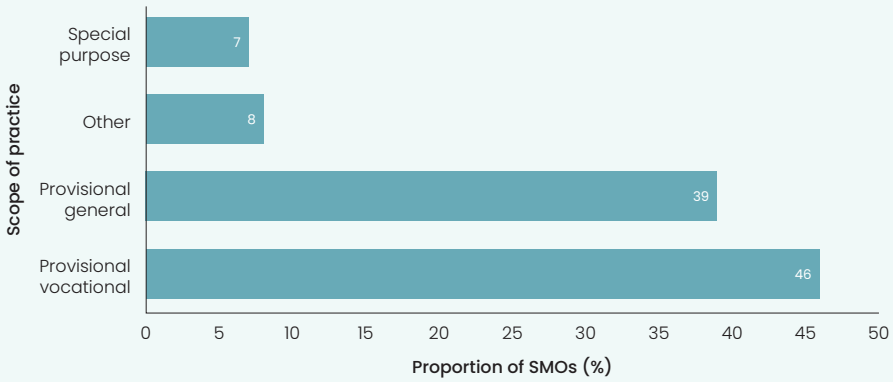
28 *He Kete Whakamārama Insights Pack 1 July 2024 - 31 June 2025.*

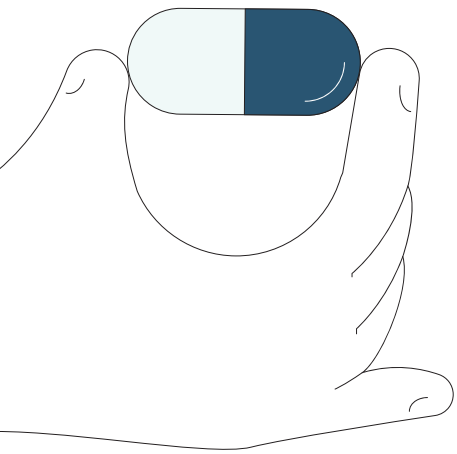
Scope of practice upon entering Aotearoa New Zealand

Of the IMGs who responded to the question (n = 757), the majority (n = 349, 46 per cent) were registered in a provisional vocational scope of practice when entering Aotearoa, with a further 39 per cent (n = 296) arriving with a provisional general scope.

The remainder arrived as 'special purpose' (7 per cent) or stated 'other' (8 per cent). Some in the 'other' category noted in the free text box that, as they arrived long ago, they had forgotten. A few noted that they had entered Aotearoa New Zealand as an IMG before the development of the existing scope of practice policy with "full registration", the equivalent of vocational registration in 2024.

Figure 10: IMG scope of practice upon entering Aotearoa New Zealand (%)





Results: Job satisfaction and career intentions

Job satisfaction

Findings on job satisfaction and career intentions have been reported previously in *Over the Edge*. For this paper, the data has been analysed to compare the job satisfaction scores between IMG and NZMG respondents.

The job satisfaction question assesses nine different aspects of work using a five-point Likert scale, as per the Warr-Cook-Wall questionnaire.[29] Participants scored their responses on a five-point Likert scale, with 1 indicating "extremely dissatisfied" and 5 indicating "extremely satisfied." Scores were reported on a three-point Likert scale broken into dissatisfied, neutral and satisfied.

While there were slight differences due to the varying total number of respondents across each of the nine indicators, resulting from incomplete responses, the two cohorts were broadly equal in proportion (average 49 per cent IMG and 51 per cent NZMG) when considering the number of responses for each indicator.

29 Peter Warr et al., 'Scales for the Measurement of Some Work Attitudes and Aspects of Psychological Well-being', *Journal of Occupational Psychology* 52, no. 2 (1979): 129–48, https://doi.org/10.1111/j.2044-8325.1979.tb00448.x.

Table 1: Job satisfaction, New Zealand medical graduates in comparison to international medical graduates. "Satisfied" combines the categories of "Extremely Satisfied" and "Satisfied". "Dissatisfied" combines the categories of "Extremely Dissatisfied" and "Dissatisfied"

Job satisfaction variable	Satisfied		Neutral		Dissatisfied		P-value
	NZMG N (%)	IMG N (%)	NZMG N (%)	IMG N (%)	NZMG N (%)	IMG N (%)	
Your physical working conditions	342 (43.1)	365 (47.7)	167 (21)	149 (19.5)	285 (35.9)	252 (32.9)	**0.046**
Your ability to choose your way and method of working	417 (52.8)	414 (54.2)	205 (25.9)	186 (24.3)	168 (21.3)	164 (21.5)	0.548
Your interactions with colleagues and fellow workers	650 (82)	598 (78.4)	88 (11.1)	95 (12.5)	55 (6.9)	70 (9.2)	0.777
The level of recognition you get for good work	317 (40)	313 (40.9)	235 (29.6)	217 (28.4)	241 (30.4)	235 (30.7)	0.340
The amount of responsibility you have	518 (65.4)	507 (66.4)	166 (21)	140 (18.3)	108 (13.6)	117 (15.3)	0.332
Your remuneration	327 (41.3)	298 (39)	174 (22)	184 (24.1)	291 (36.7)	283 (37)	0.944
The level of opportunity you have to use your skills and abilities	481 (61)	455 (59.5)	138 (17.5)	143 (18.7)	170 (21.5)	167 (21.8)	0.898
Your hours of work	395 (49.7)	448 (58.6)	202 (25.4)	153 (20)	197 (24.8)	163 (21.3)	**<0.001**
The amount of variety in your work	589 (74.2)	538 (70.4)	129 (16.2)	148 (19.4)	76 (9.6)	78 (10.2)	0.403

There was no statistically significant difference between NZMGs and IMG respondents for seven out of nine variables related to job satisfaction. For both cohorts, the level of recognition received for good work and remuneration had the highest proportion of respondents who indicated they were dissatisfied (60 per cent for NZMGs versus 59.1 per cent for IMGs; and 58.7 per cent for NZ trained versus 61.1 per cent for IMGs, respectively).

Statistically significant differences between NZMG and IMGs were evident on two variables, physical working conditions and hours of work. Here, NZMG SMOs were more likely to signal dissatisfaction than their IMG colleagues ($P = 0.046$ and <0.001 respectively, 95 per cent CI).

The greater dissatisfaction among NZMG SMOs may reflect a number of contributing factors, including the impact of after-hours on call work on rates of fatigue and burnout when already covering for a lack of colleagues due to chronic workforce vacancies.[30, 31] In *Over the Edge*, ASMS' previous report on the future intentions of the senior medical workforce, rates of satisfaction for hours of work and physical working conditions had the greatest decrease of 14 percentage points (surpassed only by remuneration at 17 percentage points) between the two iterations of the survey in 2016 and 2022.[32]

The evidence as to whether aspects of work confer some protection against job dissatisfaction is mixed. A cross-sectional study of doctors from the United Kingdom working in Aotearoa New Zealand found that they had higher job satisfaction compared to those who remained working in the United Kingdom. Additionally, it found that many intended to remain due to a preference for the lifestyle in Aotearoa New Zealand.[33] More recently, a paper examining burnout among psychiatrists working in Aotearoa New Zealand found that NZ-trained psychiatrists perceived their workplace demands to be greater than those of their IMG psychiatrist colleagues.[34] Conversely, a 2023 scoping review of 31 studies found that IMGs were subjected to greater workplace inequities, including salary inequities, marginalisation, little autonomy and control, racism, and harsher sanctions.[35] It is also possible that actively deciding to live and work in Aotearoa New Zealand (at least for the time being) is a motivating factor for some and helps protect against job dissatisfaction. Given the proportion of IMGs who have committed to the public health service in Aotearoa New Zealand for more than 10 years (64.1 per cent in this survey), it is likely that they are well-established in their careers, whānau and communities.

Job satisfaction questionnaire: qualitative analysis

Many respondents also left comments (n = 126) to further illustrate their experiences or provide specific examples of how particular variables affected their work.

Most comments (69.8 per cent) reflected an overall emotional response of dissatisfaction, while 11.9 per cent of comments expressed satisfaction. The remainder (18.3 per cent) contained references to positive and negative aspects of job satisfaction and were coded as neutral.

Qualitative themes aligned strongly with the job satisfaction indicators. "Hours of work" was the most frequently cited by respondents, reflecting the greatest difference in job satisfaction in the quantitative analysis.

Many reflected on the arduousness of on-call work, made more acute by the frequency of after-hours call. Strong secondary themes emerging from the "hours of work" coded comments related to workload, namely, the volume and complexity of work, could not be contained within available hours.

Here, understaffing was a key determinant of workload. As the number of vacancies increases at the RMO and SMO levels, the workload burden on the remaining SMOs in the public hospital sector also increases. This has the potential for negative health and well-being outcomes, including burnout.

As noted above, SMO remuneration saw the greatest drop in satisfaction between the 2016 and 2022 iterations of the survey, from 57 per cent satisfied or very satisfied to 40 per cent. Several comments left by IMGs reflected on whether they felt valued by hospital management or the system in general and linked this to remuneration.

Others linked feelings of value to the recognition they received for good work. Some respondents felt they experienced recognition from their departmental colleagues, while recognition from management and the wider organisation was lacking. One respondent made a point of detailing other aspects of their career, such as "teaching, collegial relationships", which they actively pursued to support their sense of feeling valued.

30 C. P. West et al., 'Physician Burnout: Contributors, Consequences and Solutions', *Journal of Internal Medicine* 283, no. 6 (2018): 516–29, https://doi.org/10.1111/joim.12752.

31 Ruth Hill, 'Senior Doctors "routinely Pressured" to Take on Junior Doctor Shifts', RNZ, 28 November 2023, https://www.rnz.co.nz/news/national/503399/senior-doctors-routinely-pressured-to-take-on-junior-doctor-shifts.

32 *Over the Edge: Findings of the 2022 Survey of the Future Intentions of Senior Doctors and Dentists.*

33 Avinash Sharma et al., 'Why UK-Trained Doctors Leave the UK: Cross-Sectional Survey of Doctors in New Zealand', *Journal of the Royal Society of Medicine* 105, no. 1 (2012): 25–34, https://doi.org/10.1258/jrsm.2011.110146.

34 Charlotte N. L. Chambers and Christopher M. A. Frampton, 'Burnout, Stress and Intentions to Leave Work in New Zealand Psychiatrists; a Mixed Methods Cross Sectional Study', *BMC Psychiatry* 22, no. 1 (2022), https://doi.org/10.1186/s12888-022-03980-6.

35 Sunita Joann Rebecca Healey et al., 'Inequitable Treatment as Perceived by International Medical Graduates (IMGs): A Scoping Review', *BMJ Open* 13, no. 7 (2023): e071992, https://doi.org/10.1136/bmjopen-2023-071992.

Perceptions of being valued were also reflected in comments on the level of responsibility. Several respondents noted that responsibility ultimately lay with them as SMOs, but they had no ability to influence the safety and sustainability of the workloads they were expected to meet. Extremes of vocational scope were noted. A respondent working in acute mental health services described being forced to work outside of their scope (which was not in psychiatry). Another noted that, as the sole SMO, everything fell to them to manage across existing and upcoming medical vacancies at registrar and consultant levels. Furthermore, another respondent described being unable to work at the top of their scope due to the time required to manage complex patients on the ward, a consequence of chronic registrar shortages.

Tokens of organisational appreciation, such as food or coffee vouchers, were mentioned in several comments. However, the inadequacy of these actions was contrasted with references to periods of significant stress and heavy workloads, such as during the COVID-19 pandemic. Respondents linked shifts in recognition for good work and a sense of value to tangible actions that could make a difference to workload, namely, increases in medical staffing.

Comments on physical working conditions revealed a variety of hospital infrastructure and resourcing concerns, but also offered insights into SMO perspectives on bed block/access block impacting patient flow, lack of theatre capacity, theatre size and inpatient beds, and supply shortages (including common medicines and devices). Several commenters linked substandard physical working conditions to an inability to provide safe, high-quality service to meet unrelenting demand for treatment.

Others noted the substandard office facilities, lack of space for private meetings with patients and whānau, and poor IT infrastructure, all of which hindered SMOs' abilities to ensure best practice was met.

Feedback on collegial interactions and relationships frequently expressed a duality whereby positive working relationships were often eroded by staff shortages and workload, impacting both individual satisfaction and departmental collegiality. Several comments specifically mentioned Clinical Directors as supportive advocates, while interactions with management were more strained.

Table 3 contains themes and illustrative comments. It is available in the appendix.

Career Intentions

Survey respondents were asked to rate the likelihood of their career movements against several scenarios, including practising internationally, leaving medicine or dentistry entirely, or starting or increasing private practice. Responses to each scenario were divided by undergraduate qualification to compare responses from IMGs and NZ-trained SMOs.

Table 2: Career intentions of International Medical Graduates and New Zealand Medical Graduate populations

Scenario	Unlikely		Neither likely nor unlikely		Likely		Mean (SD)*		P-value
	NZMG N (%)	IMG N (%)	NZMG N (%)	IMG N (%)	NZMG N (%)	IMG N (%)	NZMG	IMG	
How likely are you to continue in your current employment?	186 (23.5)	202 (26.4)	77 (9.7)	114 (14.9)	530 (66.8)	450 (58.7)	**3.68 (1.35)**	**3.47 (1.33)**	**<0.001**
Go abroad to work, but with the plan to eventually return and work in New Zealand?	617 (77.8)	506 (66.2)	87 (11)	147 (19.2)	89 (11.2)	111 (14.5)	**1.91 (1.1)**	**2.16 (1.12)**	**<0.001**
Go abroad to work and settle permanently overseas?	685 (86.6)	507 (66.4)	64 (8.1)	126 (16.5)	42 (5.3)	131 (17.1)	**1.55 (0.91)**	**2.16 (1.23)**	**<0.001**
Leave medicine/ dentistry altogether?	542 (68.3)	540 (70.6)	96 (12.1)	106 (13.9)	155 (19.5)	119 (15.6)	2.19 (1.31)	2.13 (1.2)	0.787
Reduce the amount of public work you do, and start or increase private work?	316 (40.1)	318 (41.8)	127 (16.1)	138 (18.2)	346 (43.9)	304 (40)	3.04 (1.48)	2.94 (1.41)	0.211
Total (n)	**793**	**766**	**793**	**764**	**793**	**765**			

* Possible score for each item between 1 (very unlikely) and 5 (very likely).
\# Statistical significance p < 0.05
SD standard deviation

When compared to job satisfaction results (nine indicators), the career intentions responses showed greater variance between IMGs and NZ-trained doctors. Three scenarios produced significant differences (p = <0.001, 95 per cent CI):

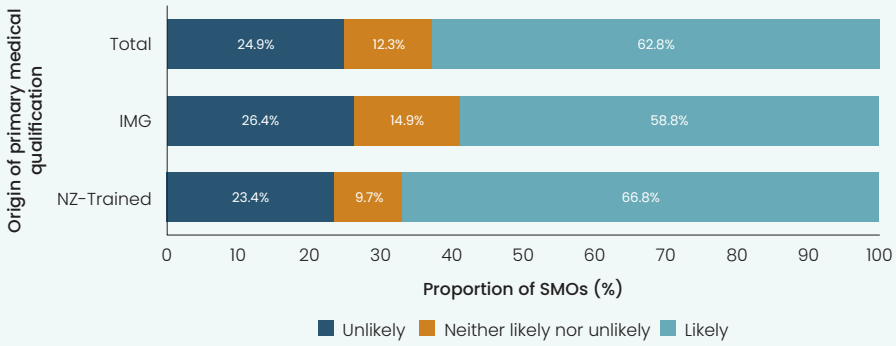
- How likely are you to continue in your current employment?
- How likely are you to go abroad to work, but with the plan to eventually return to and work in New Zealand?
- How likely are you to go abroad to work and settle permanently overseas?

The scenarios "How likely are you to leave medicine/dentistry permanently?" and "How likely are you to start/increase private practice?" did not produce significant results (p = 0.787 and 0.211, respectively, 95 per cent CI).

Considering the three significant results in greater detail suggests that broadly, IMG respondents consider their career intentions with greater fluidity and mobility than their NZ-trained colleagues.

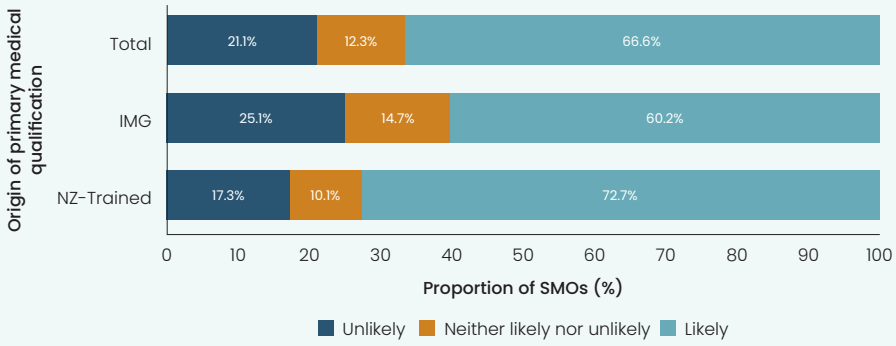
This was most pronounced in intentions to leave current employment in the next five years, and options for overseas relocation.

Figure 11: How likely are you to remain in your current employment? (IMG and NZMG, %)



The scenario "How likely are you to remain in your current employment?" will reflect both internal (within Aotearoa New Zealand) and external (internationally) movements within medicine, as well as beyond the public health care system. SMOs tend to remain with their employer longer than other health sector professions, with the most recent Te Whatu Ora Health Workforce publication stating average length of service was 10.1 years (8.8 years for women and 11.1 years for men).[36] Te Kawa Mataaho, the Public Service Commission's 2022/23 Wellbeing at Work survey, found that the average length of service for public employees (including SMOs) is 7.9 years, down from 9.5 years in 2016.[37]

Figure 12: How likely are you to remain in your current employment? (IMG and NZMG, %) Removing 60-64, 65-69, and 70+ age cohorts



When the 60-64, 65-69, and 70+ age cohorts are removed from the scenario "How likely are you to remain in your current employment?", to account for the externality of retirement, those likely to remain with their current employer increases by 3.8 percentage points for the total population, 1.4 percentage points for the IMG population, and 5.9 percentage points for the NZ-trained population.

36 *Districts Employed Workforce Quarterly Report: 1 July to 30 September 2023* (Te Whatu Ora, 2023).

37 'Workforce Data - Wellbeing at Work', Te Kawa Mataaho Public Service Commission, accessed 13 May 2025, https://www.publicservice.govt.nz/research-and-data/workforce-data-working-in-the-public-service/workforce-data-wellbeing-at-work.

Practising overseas

One in three (33.7 per cent) of IMG respondents were actively considering or wouldn't rule out practising overseas, compared to one in five (22.2 per cent) NZMGs. Similar trends can be observed across both temporary relocation and permanent resettlement, though the differences are even more pronounced when analysing intentions to leave Aotearoa permanently. Intentions of permanent relocation were more prevalent among IMGs than NZMGs: 17.1 per cent compared to 5.3 per cent.

The differences likely reflect the age groupings of survey respondents: NZMG SMOs were a smaller proportion of every age group in the survey, except for those aged 30-34, 35-39, and 60-64 years. The higher numbers of IMGs in the 40-54 age group (around 50 per cent of all IMG respondents) may reflect a greater propensity to consider temporary and/or permanent relocation overseas than older cohorts. However, many within this cohort would have school-aged children, potentially making them more likely to remain in Aotearoa. This was reflected in comments:

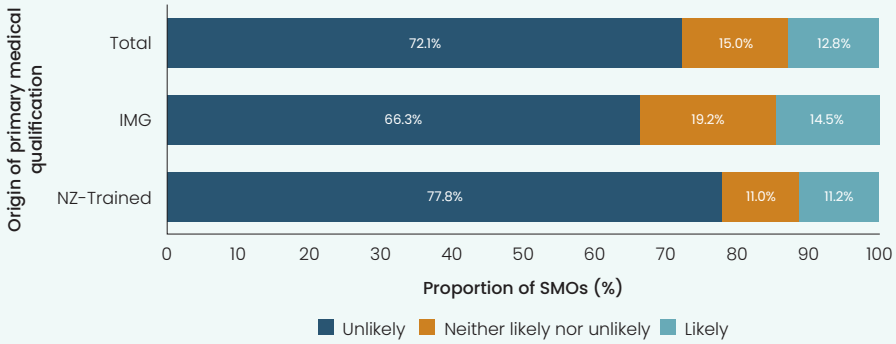
> "I have family and that's why I can't move to another country easily. If conditions don't improve, then I have to move."

> "Family circumstances trap me here at present, otherwise I would be looking seriously at what my options were for the next 20 years or so. I used to think this was my long-term post but having serious doubts."

> "Plan to leave NZ once children finished school."

> "My family are in the UK and this has become increasingly hard over the last few years. I've managed to take some time out of work to see them and look at opportunities in the UK but I'll be back in NZ for the next 3-4 years at least."

Figure 13: How likely are you to go abroad to work but eventually return to work in New Zealand?



Several comments also pointed to SMOs setting timeframes to decide on staying in Aotearoa or leaving (either for their country of origin or a third location):

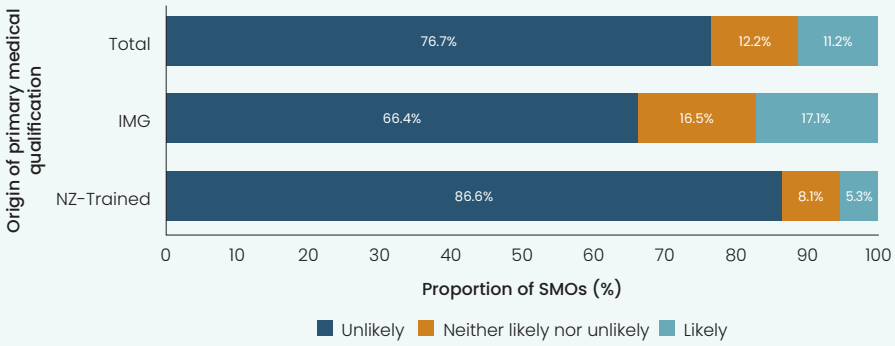
"We have for now decided to stay another 2 years and then reassess if we want to return to Germany or stay here."

"I am planning to return home if things do not improve in 6 months."

"Actively looking for jobs overseas; without NZ permanent residency or citizenship, would not have any legal status return, even though we would consider it if our status in this country were better."

"I recently explored the option of moving overseas for a better remunerated job closer to family in Europe. The hours of work in the alternative role (only ascertained during a visit and not made explicit in the [job description]) led me to retract my application as I intend to reduce hours as I get older not increase them. I do look at employment in Canada from time to time being 8-12 hours from Europe rather than 24-35 hours."

Figure 14: How likely are you to settle permanently overseas? (IMG and NZMG, %)

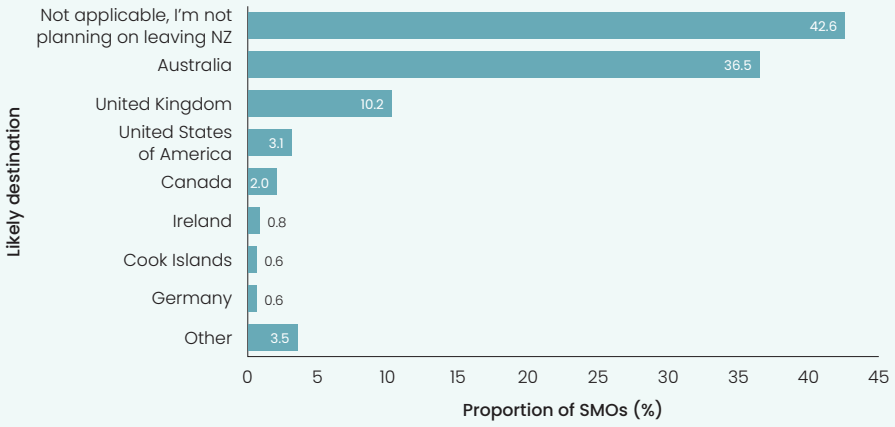


A desire for permanent overseas relocation was more pronounced among IMG SMOs than temporary relocation. 17.1 per cent agreed that they would likely leave Aotearoa permanently in the next five years, with one in four undecided. In contrast, 5.3 per cent of NZMG SMOs considered permanent overseas relocation likely.

For IMGs, as with the survey respondents as a whole, Australia was the preferred destination indicated by those who left a comment. This is lower than the preference (62 per cent) reported for Australia in *Over the Edge*.[38] However, this may reflect a greater interest among IMGs in returning to their country of origin or a third country rather than relocating to the other side of the Tasman Sea.

Several comments in this section mentioned their Fellowship post-nominals, such as The Royal Australian and New Zealand College of Psychiatrists (RANZCP) or the Royal Australian and New Zealand College of Radiologists (RANZCR), and how their vocational training was recognised in Australia through the bi-national medical college structures. Having recognised qualifications was viewed favourably by IMGs considering relocation.

Figure 15: If you did relocate overseas (temporarily or permanently), what is your intended destination? (IMG and NZMG Combined, %)

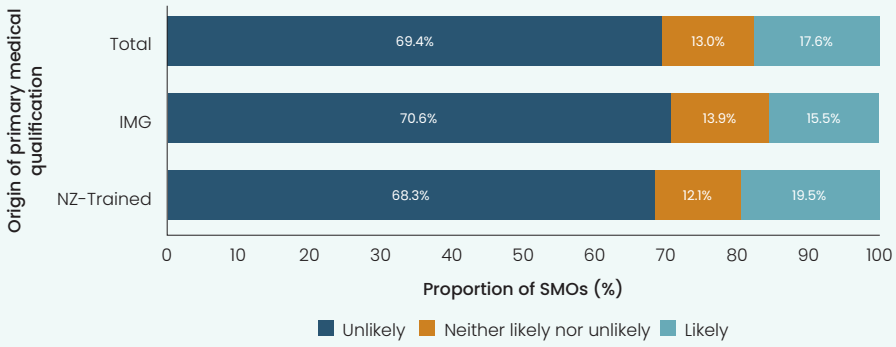


38 *Over the Edge: Findings of the 2022 Survey of the Future Intentions of Senior Doctors and Dentists.*

Leaving medicine/dentistry altogether

IMGs were less likely than NZMGs to report an intention to leave medicine or dentistry entirely in the next five years, although the differences were not statistically significant (p = 0.787). As noted elsewhere in this paper, the age grouping of NZ-trained respondents tended to skew older, meaning that this cohort was more likely to consider retirement in their career intentions responses.

Figure 16: How likely are you to leave medicine/dentistry entirely in the next 5 years?



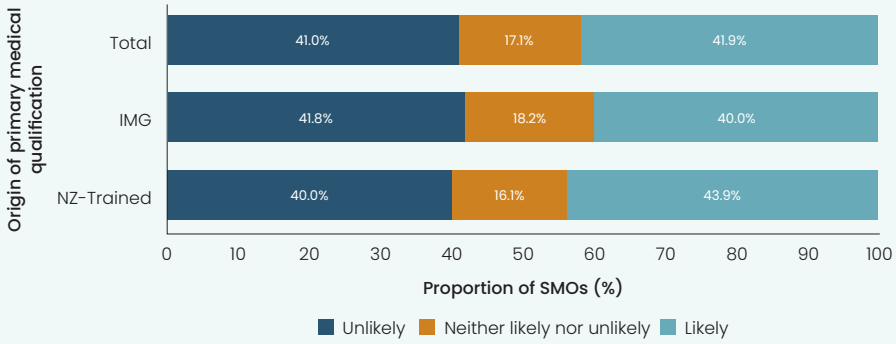
More than 760 IMGs responded to the career intentions questions, and 98 left comments that illuminated their choices and offered further insights. The majority of these comments (45) mentioned retirement, with some signalling an exit strategy in place, noting the number of years they intended to remain in the public system, or any alternative arrangements they were considering:

> “Thinking of full retirement in 5 years when I will be 70. Would do locum work, most likely in NZ but still an option to do so in the US, if I was discontented enough locally.”
>
> “I hope to retire by 5 years at the latest.”
>
> “Age 78 will work approximately 2 years more.”

Aotearoa's ageing medical workforce has been well recognised, especially among general practitioners, with the RNZCGP reporting that 37 per cent of GPs intend to retire by 2027.[39] For hospital-based doctors, certain specialities and clinical areas are more vulnerable to an ageing workforce, including psychiatry, where the proportion of SMOs over 65 years of age is anticipated to increase from 18 per cent to 19 per cent in 2033.[40] However, few strategies are in place to mitigate the longer-term consequences of failing to attract, train, and retain NZMGs and IMGs to bolster the workforce. This is in terms of FTE per capita and accounting for the growing and ageing population, as well as the healthcare resources required to support it.

Reduce hours and then start or increase private practice

Figure 17: How likely are you to reduce your public FTE, and start and/or increase private practice?



Statistically significant differences were not found between IMGs and NZMGs when asked about the reduction of public FTE and the increase in private practice. However, the high extent to which SMOs were considering options available to them is signalled in the more than 40 per cent likely to shift some of their work and clinical practice to the private sector.

These trends, namely, greater provision of health care through the private sector and increasing numbers of SMOs to consider private practice, are traversed in the ASMS publications *Creeping Privatisation: An analysis of trends in planned care provision in Aotearoa New Zealand, A Less Public Place: A survey of ASMS members on reasons for working outside the public health system,* and *A spreading problem: Changes in the distribution of medical specialists between public and private work - 2022-2024.*[41, 42, 43] Many of the comments in the current survey address similar themes to those presented in these publications.

Thirty-two respondents stated an intention to reduce their hours, but not necessarily to increase their private FTE. As explored in *Over the Edge* and the papers on privatisation, this tactic is one way to build in greater recovery time from unsustainable work patterns, arduous on-call rosters, and high work intensity.[44] Others explicitly stated they intended to reduce their public hospital hours to increase their leisure time and as a transition to retirement.

39 *Workforce Survey Covering Paper* (The Royal New Zealand College of General Practitioners Te Whare Tohu Rata o Aotearoa, 2022).

40 *OIA Request HNZ00033193: Technical Notes on 2023 Medical Workforce Forecasts* (Te Whatu Ora, 2023).

41 Lyndon Keene, *Creeping Privatisation: Analysis of Trends in Planned Care Provision in Aotearoa New Zealand* (Association of Salaried Medical Specialists Toi Mata Hauora, 2023).

42 Association of Salaried Medical Specialists, *A Less Public Place* (Association of Salaried Medical Specialists, 2023), https://asms.org.nz/wp-content/uploads/2023/08/A-Less-Public-Place-FINAL-1.0.pdf.

43 Lyndon Keene, *A Spreading Problem: Changes in the Distribution of Medical Specialists between Public and Private Work - 2022 to 2024* (Association of Salaried Medical Specialists Toi Mata Hauora, 2025).

44 *Over the Edge: Findings of the 2022 Survey of the Future Intentions of Senior Doctors and Dentists.*

"I will look to reduce my workload over the next 5 years, especially in the public system. I doubt I will move overseas or leave medicine, but I will be looking to retire earlier than I would have envisaged a few years ago. Much of the joy has gone out of my clinical role in recent years."

"May drop more public time to achieve more time off. It's not great to work there now."

"Likely to cut down my hours for leisure rather than private work in order to prepare for retirement and to better cope with the day-to-day pressures of the job."

Results: IMGs' experience of living and working in Aotearoa New Zealand

This section explores the survey's second research question: "What factors have influenced IMGs in choosing to live and practice in New Zealand, and what has impacted on their experience?" Although medicine is an increasingly globalised profession, with many doctors and dentists undertaking education, training, and clinical practice in various countries, emigrating to any country will present specific and unforeseen challenges. Previous research by Gauld and Horsburgh has explored "push factors" among UK-trained doctors who have emigrated to Aotearoa. Additionally, a report from the General Medical Council considered doctors' motivations and intentions to leave in relation to their current working conditions and career stage.[45, 46]

Coming to Aotearoa: Information before departure

Figure 18 below illustrates the forms of support provided to IMGs prior to or around their departure to Aotearoa New Zealand. The most frequently reported form of emigration support was a relocation allowance, which could cover airfares and household relocation costs for emigrating SMOs and their families.

However, 71 per cent of IMGs reported receiving no information regarding living in Aotearoa New Zealand. As many IMGS will relocate with a spouse/partner and potentially children, information on accessing services, including enrolling with a general practitioner, the school system, banking, renting a house, and immigration, is important to ensure their transition is well-supported.

Furthermore, 70 per cent of IMGs reported receiving no information on cultural differences. This includes Aotearoa's Indigenous Māori population, its bi-cultural history, the settler-colonial foundation, and the country's current multicultural societal context. Information on health inequities for many populations in Aotearoa, including Māori, Pasifika, LGBTQIA+, and disabled people, and the increased acknowledgement of the importance of intersectional cultural safety should be provided and then reiterated on arrival through employer orientation programmes, CPD, and Medical Council and College workshops.

Similarly, 71 per cent were not provided with information about Aotearoa's health system. Aotearoa New Zealand's health system has unique characteristics, including a largely privatised primary care system and a free public secondary care and hospital system. Information from both the service user and health worker perspectives provides context for IMGs, which could then be followed up with workplace orientations and informal advice from colleagues.

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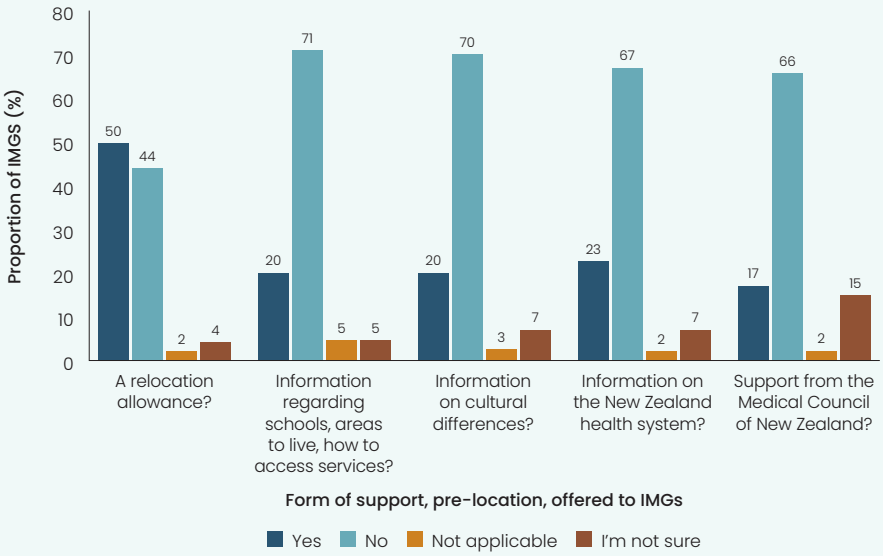
45 Robin Gauld and Simon Horsburgh, 'Does a Host Country Capture Knowledge of Migrant Doctors and How Might It? A Study of UK Doctors in New Zealand', *International Journal of Public Health* 61, no. 1 (2016): 1–8, https://doi.org/10.1007/s00038-015-0770-z.

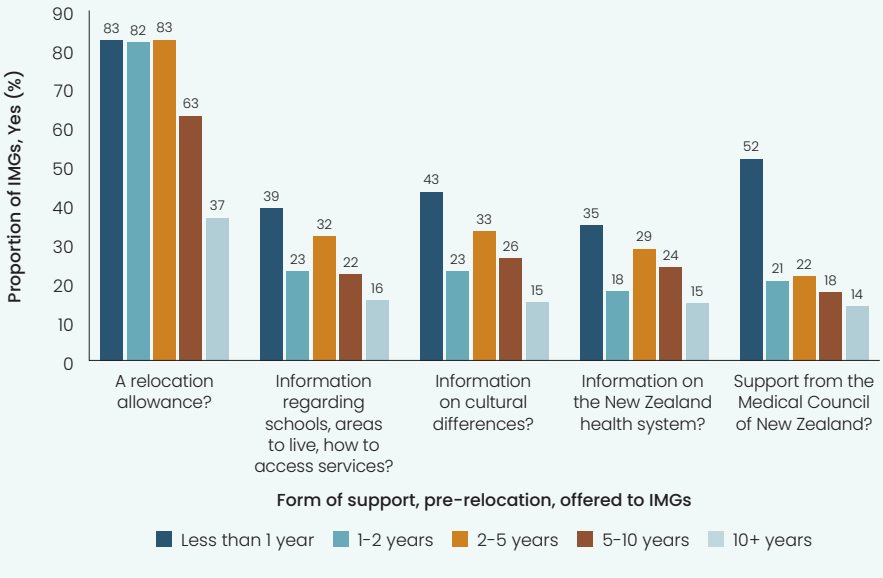
46 *Identifying Groups of Migrating Doctors Research* (IFF Research, 2023).

Figure 18: Were you provided with any of the following before arriving in New Zealand?



As most respondents reported having lived and worked in New Zealand for more than 10 years, the provision of pre-departure information by tenure was explored. IMGs who had emigrated to New Zealand in the previous five years (since 2018) were more likely to have received a relocation allowance (the most common form of support). Additionally, while there were positive shifts in the proportion of respondents who received information on other aspects of life and work in Aotearoa New Zealand, and support from the Medical Council, the majority of respondents did not receive information that would help them integrate into work and life in New Zealand, regardless of when they had arrived.

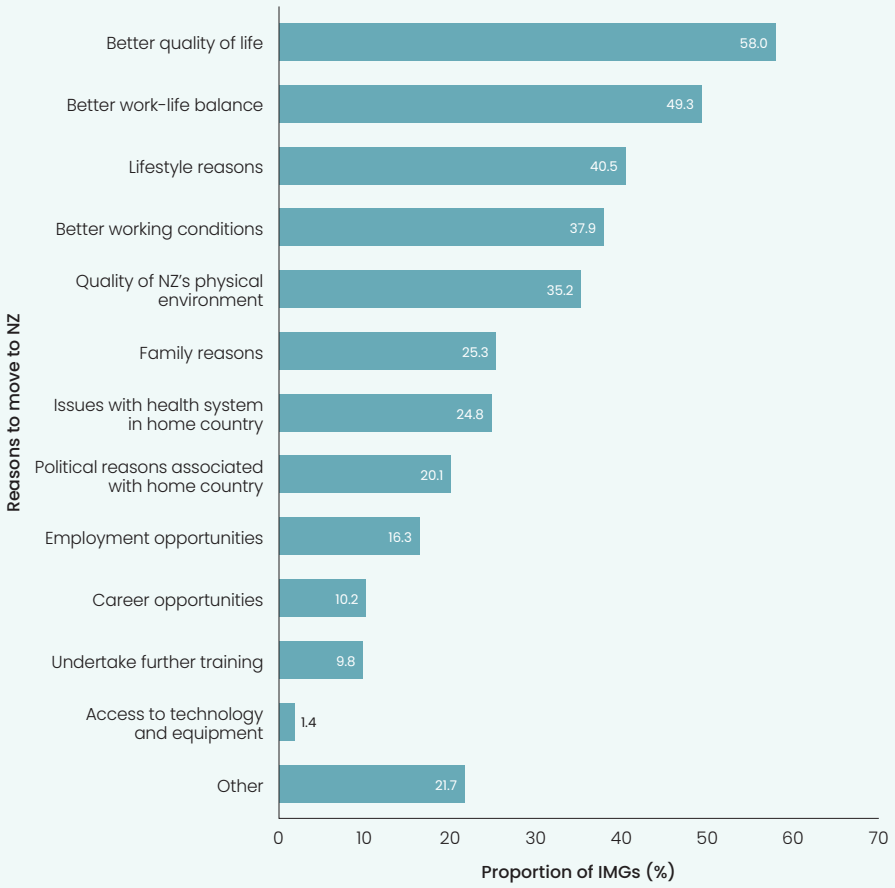
Figure 19: Forms of support offered to IMGs prior to relocation, percentage responding 'yes' by tenure in Aotearoa New Zealand



Reasons why IMGs choose Aotearoa New Zealand

The survey included a question about the factors that influenced IMGs' decisions to relocate to Aotearoa New Zealand. Respondents could choose as many as applied to their situation. When ranked by frequency, factors associated with improved lifestyle, quality of life, and work-life balance were the most cited. More than half stated that their motivations included gaining a better quality of life and work-life balance. This is consistent with previous research, which found 96 per cent of respondents ranked a "better quality of life" as important or highly important in deciding to migrate to Aotearoa.[47]

Figure 20: What were the main reasons you chose to move to New Zealand?



Although this could suggest that training and career progression opportunities are less likely to be a decisive factor in relocation, the factors that emerged as dominant have a greater impact on work, well-being, and lifestyle more generally. This was especially evident in relation to family units, where a partner/spouse, and potentially children, are also considered.

The 'Other' category was also frequently used to go into further detail, particularly where respondents wanted to note a variety of reasons for relocation, including being in a long-term relationship with a New Zealander, a desire for change, travel and adventure, an overseas experience/OE, and, for one respondent, trout fishing.

47 Robin Gauld and Simon Horsburgh, '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, no. 1 (2015): 75, https://doi.org/10.1186/s12960-015-0069-4.

Systemic issues also emerged as a motivator. One in five respondents cited political reasons, with their home country being a factor, and several noted in the comments section that authoritarian political regimes and civil unrest influenced their decision. One in four stated issues with health systems at home, again following up with more detail in the comments, especially regarding the UK's National Health Service (NHS).

Some comments reflected on the state of health systems they left, the ones they arrived at to work in, and how they saw things change over time:

"The better working conditions and work-life balance aspirations were in part illusory but the economics of life in NZ versus the UK favour the former. Nonetheless, working for the [Southern District] has unquestionably been more stressful and a greater challenge to both physical and mental well-being than working for the NHS. It is unlikely that many of the challenges experienced were unique to [Southern District] within the NZ Health system and both the Ministry of Health and their political masters almost certainly contribute to challenges that emerge at local levels."

"The health system in NZ at that time was of incredible quality by all world [sic] I felt extremely privileged to be a part of it - unlike today."

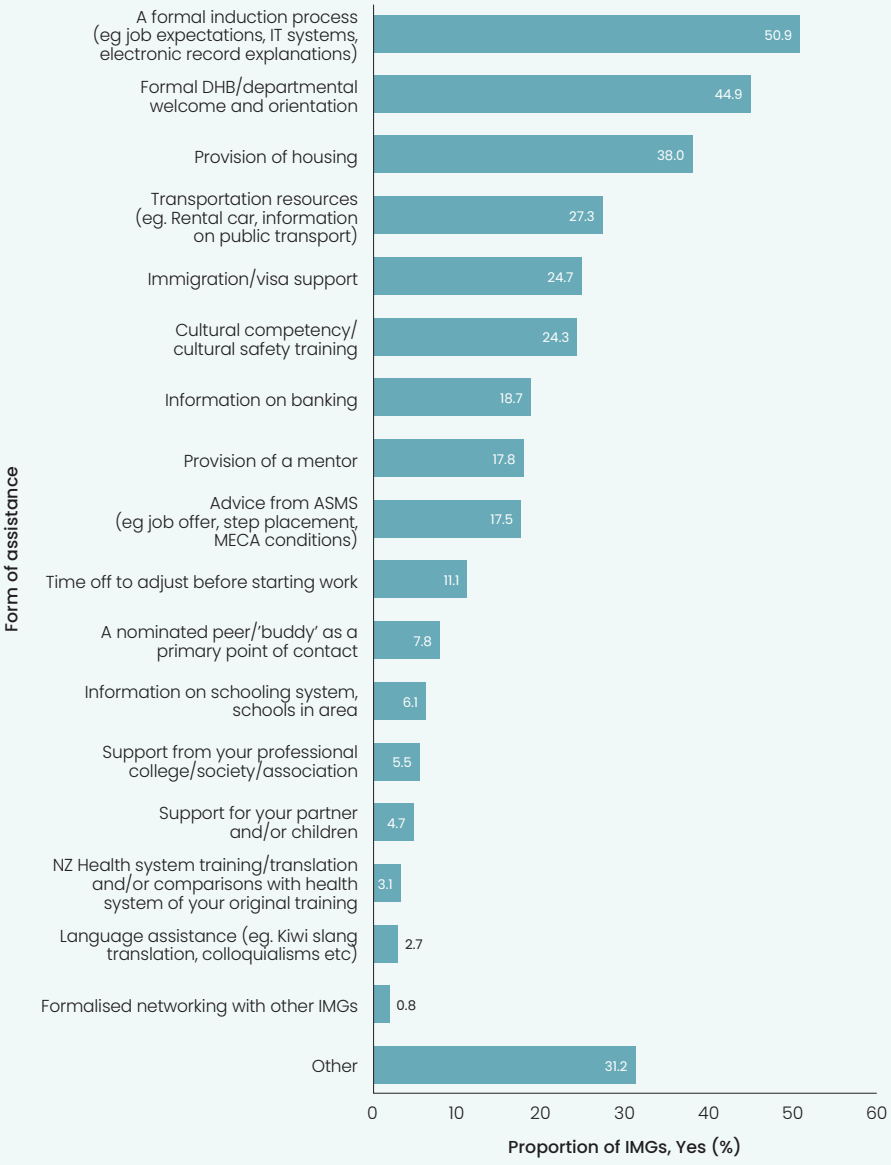
"Was totally disillusioned with life in the NHS so came to NZ for a year to consider my options. Fell in love with the country and never went home. The current feeling of despair and low morale feels like the NHS felt when I left."

What support do IMGs receive on arrival in Aotearoa?

Respondents could select as many forms of support as they received upon arrival in Aotearoa New Zealand, as with other questions in this section. Supports included aspects related to an IMG's workplace (such as orientation and training) and those considering wider family and community integration (such as schools, housing, banking, and transportation).

The most frequently cited form of support provided was a formal induction process (50.9 per cent), followed by departmental/district welcome and orientation, noted by 44.9 per cent.

Figure 21: On arrival in New Zealand, were you provided with any of the following?



Notably, the 'Other – please specify' category was ranked fourth overall by respondents, with 31.2 per cent of all comments stating in free-text fields that they received no support. Statements were often qualified with an acknowledgement that they had arrived in New Zealand several decades previously. They reflected that this would have been useful at the time, and/or it was long ago and not an expectation:

"None of the above but this was 22 years ago!"

"Nil of the above (it was 1994). However, I was very welcomed by HR and the staff of the cardiology department at Wellington Hospital, for which I was very grateful. I found New Zealand a very warm and welcoming country, and loved it."

"Gosh any of those would have been lovely!!"

Others expressed feelings of overwhelm and frustration at bureaucratic processes:

"No support whatsoever when I got the job. In fact, the hospital botched the registration application. MCNZ wouldn't communicate clearly either. I was off work for nearly 6 months and then had to work for less hours and less pay due to the medical council not allowing me to do on calls. Very traumatic. Didn't know where I could get help."

"None of the above. In fact I was told quite early on that as I was a foreigner, the training (I arrived in NZ as a registrar and promptly joined the college to continue my paediatric training) of my Kiwi colleagues took priority over mine. This was repeated several times at the time of job allocations as some of my positions were not recognised by the college as training jobs..."

Results over time have likely been influenced by changes such as, the increasing emphasis on cultural safety, Te Tiriti o Waitangi and Hauora Māori from the Health Practitioner's Competence Assurance Act 2003, and the Medical Council's first statement on cultural competence published in 2005.

Just 3.1 per cent of respondents (n = 24) reported receiving an orientation on Aotearoa New Zealand's health system. Like any large public service, the healthcare system is complex and has many idiosyncrasies that would be unexpected for IMGs without information and explanation. This includes Aotearoa New Zealand's largely privatised primary care system, the function of Pharmac, and the no-fault Accident Compensation Corporation.

There is a demonstrable need for additional resources to support IMGs transitioning to work in the Aotearoa New Zealand health system. In 2022, MCNZ piloted a workshop series for IMGs concentrating on its professional standards for good medical practice, including cultural safety, safe prescribing practices, informed consent, and professionalism in Aotearoa New Zealand.[48] Although 93 per cent of attendees reported it mostly or fully met their objectives, particularly the session on cultural safety and health equity, its future as a permanent offering to IMGs was not assured. The report stated that the resource intensity of such a course meant that alternative structures and providers would be necessary to continue.

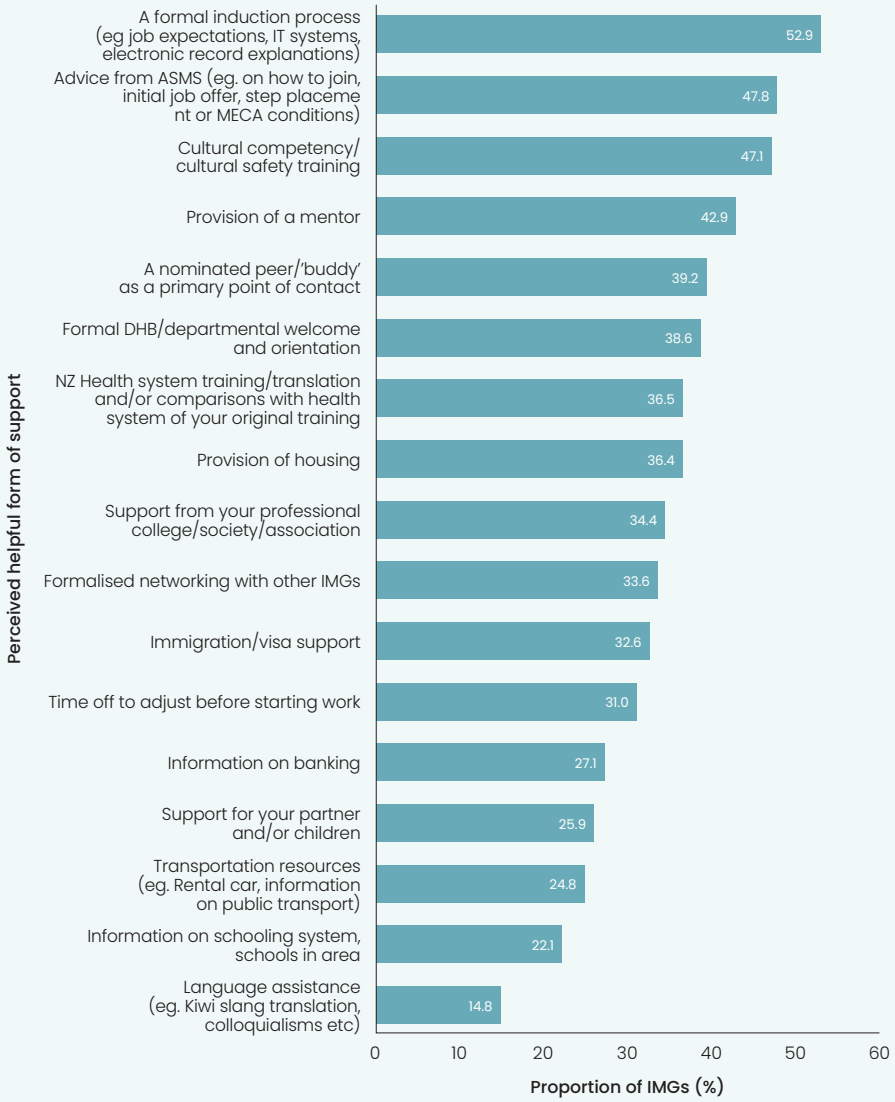
A recent paper examining the psychological challenges of cross-cultural code-switching for IMGs found that the greater the cultural differences for the IMG (compared to NZMGs), the greater the intensity of cultural code-switching.[49] Furthermore, IMGs experienced challenges arising from cross-cultural code-switching regardless of the length of their tenure in Aotearoa New Zealand. This suggests that assumptions around successful integration being linked to longer residence may be unfounded. The authors note that, although cross-cultural code-switching is an aspect of the IMGs' 'journey', NZMG colleagues, professional bodies, and medical educators need to understand the impact of the psychological challenges that may arise from code-switching and establish supports, including cultural mentors.

Figure 22 illustrates the data after adjusting for those who received a specific form of support. This provides insight into what the remaining IMG population would have liked to receive. Across all areas except three ("provision of housing", "transport resources", and "Formal DHB/departmental welcome and orientation"), there was a greater demand for support than what was provided. The most significant differences between what IMGs would have found helpful and what was provided were in having "A nominated peer/'buddy' as a primary point of contact", "formalised networking was other IMGs", "NZ Health system training/translation and/or comparisons with health system of your original training", "support from your professional college/society/association", and "advice from ASMS (eg job offer, step placement, MECA conditions)."

48 *Evaluation Report: 'Welcome to Practice in Aotearoa New Zealand' Workshops for International Medical Graduates* (Te Kaunihera Rata o Aotearoa Medical Council of New Zealand, 2022).

49 Cross-cultural code switching is defined as "the conscious act of switching from one's native, default cultural code of interaction in order to meet or match expectations for behaviours in a foreign cultural setting." Mariska M. Mannes et al., 'Cross-Cultural Code-Switching – the Impact on International Medical Graduates in New Zealand', *BMC Medical Education* 23, no. 1 (2023): 920, https://doi.org/10.1186/s12909-023-04900-2.

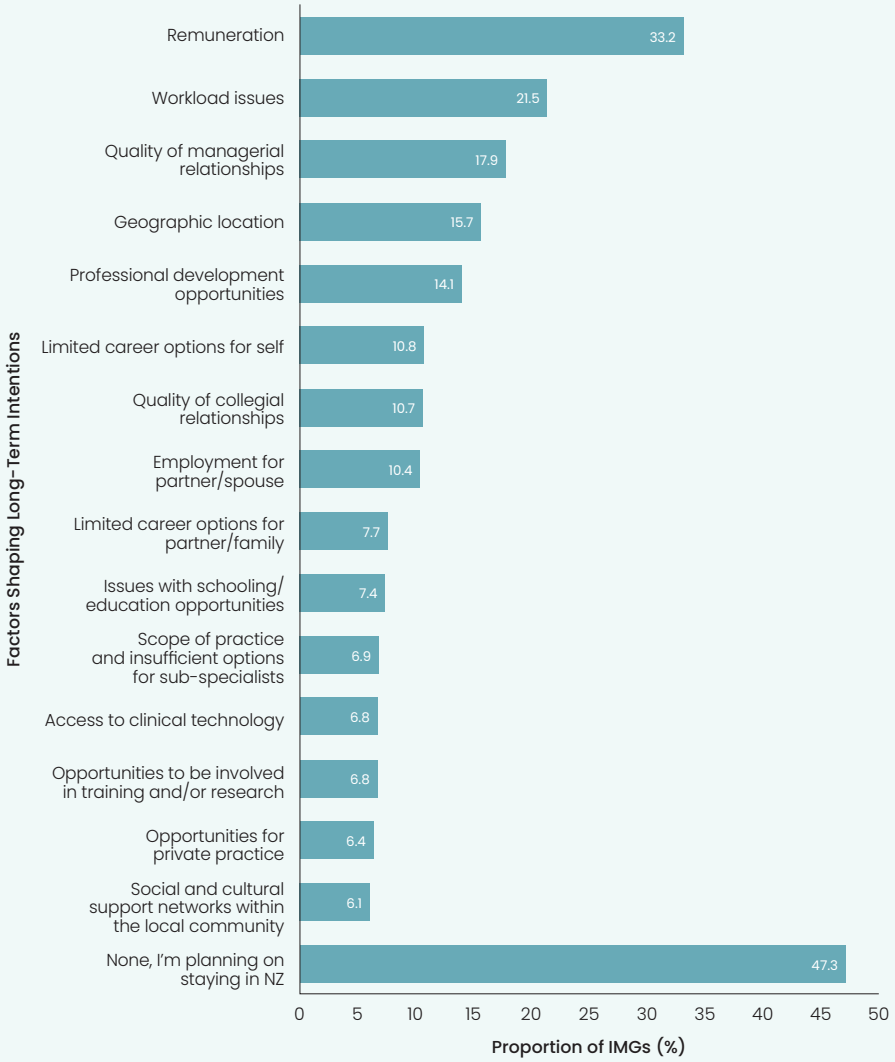
Figure 22: What, if any of the following, would you have found helpful upon your arrival to New Zealand? Adjusted to remove those who received a given support



What is shaping the long-term intentions of IMGs to remain in Aotearoa New Zealand?

IMG participants were asked to select as many factors as possible that shape their long-term intentions to remain in Aotearoa New Zealand. These factors encompassed remuneration, broader workplace factors, and lifestyle and living conditions.

Figure 23: What, if any of the following factors, are likely to shape your long-term intentions to remain in New Zealand? (IMGs, %)



The most selected answer, "none, I'm planning on staying in New Zealand permanently", was selected 47.3 per cent of the time. However, this presents a different result to the similar questions, such as "How likely are you to go abroad to work but eventually return to work in New Zealand?", where 66.3 per cent of participants indicated unlikely, and "How likely are you to settle permanently overseas?", where 66.4 per cent of participants indicated unlikely. It is unclear if this variation occurred due to the language of the question, survey fatigue, its framing as an 'N/A' option, or other compounding reasons.

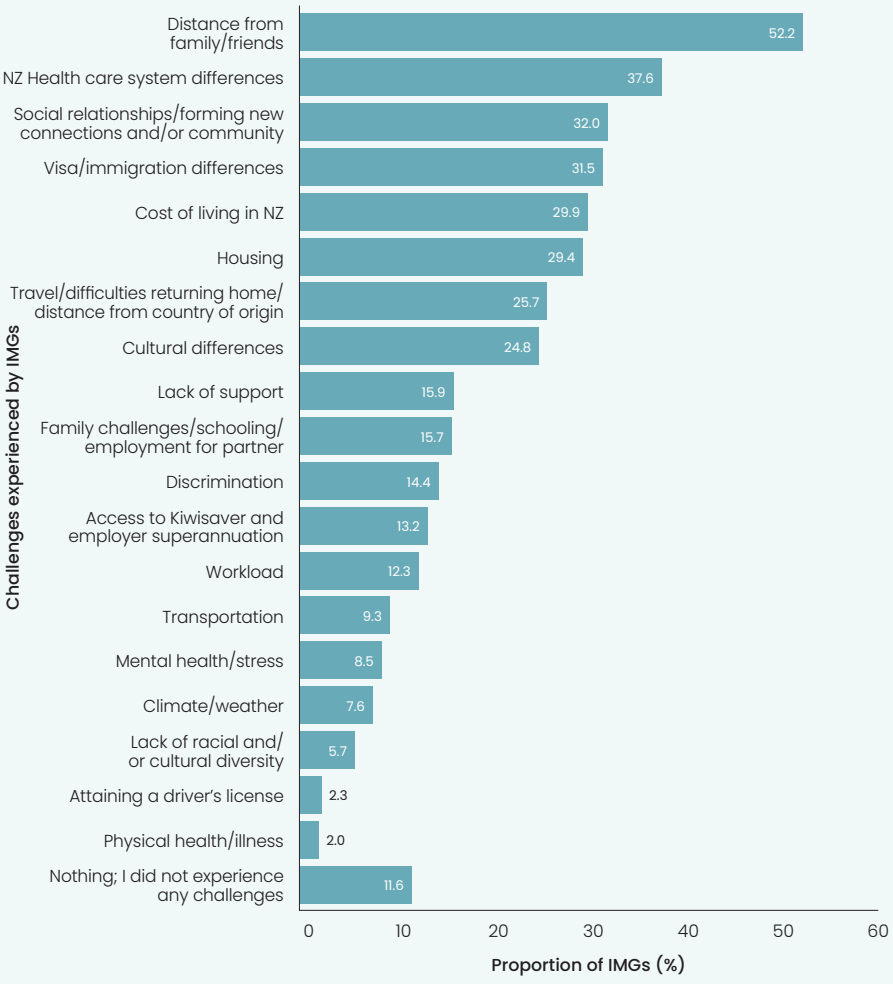
From this data, we can infer that remuneration is the most important factor to IMG SMOs by a substantial margin (11.7 percentage points). Participants could interpret the question in two ways. Namely, "what factors are keeping you here?" and "what factors, if addressed, would keep you here?" Regardless, the data show that the most important factors influencing intentions to remain.

Results: Challenges experienced by IMGs

IMGs experience various challenges upon arrival in a new country, including those related to belonging and society, cultural differences, professional and health system differences.[50, 51] Survey respondents could select as many variables that aligned with their experience and elaborate through comments as necessary. Variables were deliberately inclusive of factors beyond the health system and professional domains, such as housing, transportation, cost of living, and challenges that would impact partners and children.

The results are explored in the subsections below.

Figure 24: What challenges, if any, did you experience on arrival in Aotearoa NZ?



50 Mo Al-Haddad et al., 'International Medical Graduates' Experiences before and after Migration: A Meta-Ethnography of Qualitative Studies', *Medical Education* 56, no. 5 (2022): 504–15, https://doi.org/10.1111/medu.14708.

51 N. Brennan et al., 'Drivers and Barriers of International Migration of Doctors to and from the United Kingdom: A Scoping Review', *Human Resources for Health* 21, no. 1 (2023): 11, https://doi.org/10.1186/s12960-022-00789-y.

Social connection

More than half of all respondents (52.2 per cent) included "distance from family and friends" as a challenge upon arrival in Aotearoa. This is an anticipated finding, considering both the demographic characteristics of the survey cohort and the impact of the COVID-19 pandemic. The United Kingdom, Ireland, and the United States are the top three countries reported to hold undergraduate medical qualifications. Each requires long-haul flights to reach.

Additionally, the COVID-19 border restrictions limited travel to and from Aotearoa for more than two years. Some noted this through comments:

> "Most of the challenges were brought on by the occurrence of the COVID pandemic."
>
> "Covid limitations on seeing family (no travel x2 years)."
>
> "COVID lockdown upon arrival. Colleagues regularly calling in sick or taking time off."

Nearly one-third of respondents (32 per cent) found social relationships, forming new connections, and developing community a challenge in Aotearoa. Free-text comments indicate the COVID-19 pandemic exacerbated this for some, with lockdowns and requirements for children to be home-schooled posing challenges to forming relationships and settling into a community.

Discrimination was experienced by 14.4 per cent of respondents, with free-text comments providing examples of discrimination based on race, gender, and sexual orientation. Some respondents reported being discriminated against as a doctor who had trained overseas.

15.7 per cent of respondents noted wider family challenges regarding employment and schooling options for partners and children, and 15.9 per cent of respondents noted the lack of support upon arriving in New Zealand as a challenge.

NZ health care system differences – employment and registration

Differences in the New Zealand health system were cited as a challenge by 37.6 per cent of respondents. As illustrated in Figure 21, only 3.1 per cent of IMGs reported receiving any training on the New Zealand health system. Given that Aotearoa New Zealand has significant structural differences in its health system, even when compared to similar health systems, there is a clear need for accessible and consistent documentation that can provide orientation. This is compounded by the health reforms, with Te Whatu Ora formally launching weeks before the survey.

As well as structural differences, day-to-day aspects of health system management, clinical leadership, and governance were evidenced in the comments left:

> “The then senior management of the DHB were extremely reluctant to accept the validity of both clinical governance and workforce challenges faced within the service. There appeared to be great reluctance to either accept or hear of service-level challenges and a model of crisis response rather than strategic service planning.”

> “The almost complete lack of day-to-day administrative support this is number one two and three this is a major contributing factor in my decision making to cut down/retire from the health service.”

> “NZ is resistant to change especially if it comes from someone who is coming from another country.”

The registration process has been identified as a particular challenge for IMGs.[52, 53] Difficulties with the processes used by the Medical Council of New Zealand and the Colleges featured prominently in the free-text comments section.

Delays can be costly for individual IMGs, creating additional uncertainty during periods of acute stress when relocating to a new country. Several respondents reflected on their circumstances in their pathway to vocational registration, perceiving MCNZ and medical colleges as unsupportive, difficult to navigate, and in some cases, negatively affecting career progression. It is important to note that these comments reflect the experiences of IMGs over several decades, and in recent years the Medical Council of New Zealand has been working to improve the registration process. Recent changes are also included in the discussion section.

> “The process with MCNZ was horrific.”
>
> “Specialist registration was complicated as… [the college] were in the process of changes and took some time to decide what to do with me - I was initially told UK [qualification] would be accepted, but this decision was reversed and I had to do NZ exams and 2 years post-exam as a registrar. This was not made clear before coming to NZ.”
>
> “The immigration and New Zealand Medical Council processes were ridiculously difficult to navigate. Unless you are extremely motivated to come to NZ, this process will, and does, discourage other highly qualified, much needed docs to immigrate here.”

52 Pam McGrath et al., ‘Integration into the Australian Health Care System: Insights from International Medical Graduates’, *Australian Family Physician* 38, no. 10 (2009), world, https://search.informit.org/doi/abs/10.3316/informit.246260015952526.

53 Brennan et al., ‘Drivers and Barriers of International Migration of Doctors to and from the United Kingdom’.

"Ground reality was very different from what was agreed to verbally at my interview. I was used to fill in gaps in the acute roster and I had an unpredictable roster. I was not allowed equitable access to operating Theatres and very little opportunity to maintain my skills, let alone develop further skills. It was all about me meeting the service needs. My learning and growth needs were not met, there was no designated supervisor or mentor for me. As a new SMO under supervision and provisional vocational registration support could have been more equitable and better. This has gradually changed over the years. There remains room for improvement."

"The approach of ...[the college]as branch advisory body and the attitude of the assessors was of appalling arrogance and condescension towards me. Having done all my... training in tertiary level hospitals they treated me like I've never seen the inside of an operating theatre. Only after massive intervention from local colleagues did the MCNZ show mercy and after a further year of supervised practice granted vocational registration."

"Vocational registration was an issue for me. The current system is a great improvement and appears to work well. I had been a specialist anaesthetist for 12 years before coming to NZ, working in a well-resourced, technically supported health system, providing anaesthesia for both the usual secondary services, but also for tertiary services such as cardiothoracic surgery, neurosurgery and complex paediatric and neonatal surgery. Initially I was expected to pass the FANZCA Part 2 exam. It was very difficult to find the time needed with a young family, and heavy workload including 3 after hours rosters"

Superannuation

Access to KiwiSaver and superannuation was found challenging by 13.2 per cent of respondents, as well as appearing as an issue in the free text section. Twelve respondents commented that their employer provided no information or poor/incorrect information about KiwiSaver or alternative superannuation options. Six of these respondents indicated they had missed several years' worth of contributions as a result.

> "My employer did not mention KiwiSaver / superannuation at all. I only found out through a friend. I lost out on about 12 months of possible savings."

> "I was wrongly advised by payroll in the DHB that I couldn't do kiwisaver so missed 5 years of this."

> "I was not informed about superannuation benefits for 3 years after arrival, then 2 years passed before I was enrolled after repeated request ("the system is down"). They would not compensate for any of that time."

> "I was not made aware of employer superannuation plan initially and the personal liability insurance until I found out about it and asked almost 2 years later."

Immigration

Visa and immigration issues were cited as a challenge by about one-third of respondents (31.5 per cent). The free text comments section included several comments highlighting delays and difficulties in obtaining permanent residency visas. In some cases, these delays had significant impacts, such as respondents being unable to purchase a home. Respondents describe immigration processes as being stressful, expensive, and time-consuming, with little access to support. Some respondents commented that challenges with their visas were still ongoing.

> “Immigration posed a HUGE issue and it took 2 years to get our residency visas so we could buy a house. I considered moving back multiple times due to the ongoing issues.”

> “Visa and immigration process still remains problematic. We have had to apply three separate times for entry into the country, then to work visa, now for residency, with still no end in sight to this process.”

> “We considered leaving over the huge confusion and delays in obtaining a permanent resident visa.”

> “The immigration was the most stressful event of my career and my family life.”

> “Husband is an engineer, the company he was employed by assisted with relocation costs, initial accommodation, collected us from the airport, arranged for a loan vehicle and assisted with visa applications and practical advice on arranging further accommodation. The transition would have been much harder if we had not had this support, there was no support from the hospital who initially employed me.”

Cost-of-living and housing

Almost a third of respondents indicated that cost-of-living and housing were challenges in Aotearoa New Zealand (29.9 per cent and 29.4 per cent respectively). Free text comments indicated a range of problems concerning housing, including the inability to purchase a home while awaiting permanent residency status, the high cost of housing in New Zealand, and the lack of availability of warm, dry, and healthy housing. Several respondents noted their surprise at the poor standard of housing in New Zealand.

> “The cost of living and the paucity of good quality housing was a shock. I would never have believed that houses in a modern country could be of such low standard while costing so much.”

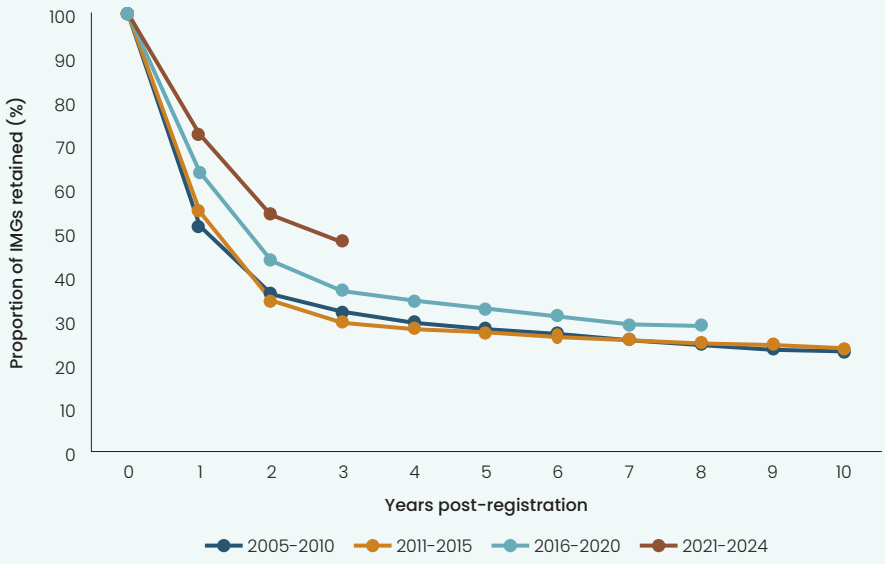
Cultural differences

Just under one quarter of respondents (24.8 per cent) noted that cultural differences were a challenge in Aotearoa New Zealand. Cultural differences highlighted in free-text comments ranged from accent and communication styles to adjusting to different transportation, shopping hours, and socialising options. Some comments indicated a difficulty in understanding New Zealand’s bicultural context. This may be related to a lack of support in cultural orientation, illustrated in Figure 21.

Discussion

In 2024, IMGs comprised 43.3 per cent of all doctors (including RMOs) and 42.5 per cent of all SMOs registered in New Zealand.[54] This proportion has persisted, with IMGs comprising 43 per cent of the SMO workforce in ASMS' prior survey of August 2016. Similarly, 2021 OECD data placed Aotearoa New Zealand's percentage of foreign-trained doctors at 42.1 per cent, tied for the second-highest with Norway behind Israel at 57.8 per cent. This put Aotearoa New Zealand 23.2 percentage points higher than the 28-country average of 18.9 per cent.[55] MCNZ medical workforce data indicate that most IMGs who register in Aotearoa New Zealand do not stay long. "Just over 40 per cent leave after one year, 60 per cent after two years, and 75 per cent after 10 years",[56] although there have been retention improvements over time.

Figure 25: Retention rate for IMGs (2005-2024)[57]



Despite some improvements in retention of Aotearoa New Zealand's heavily IMG-reliant healthcare workforce, this survey suggests that measures to support IMGs once they are in New Zealand are lacking. This is demonstrated by the data in Figure 21 and Figure 22. New Zealand is sometimes referred to as having a "revolving door" of IMGs that costs the country in terms of recruitment and turnover.[58] Research by Gauld and Horsburgh found that UK-trained doctors leave Aotearoa New Zealand due to a desire to return home.

54 *Whārangi Mōhio Fact Sheet* (Te Kaunihera Rata o Aotearoa Medical Council of New Zealand, 2025).

55 Health Workforce', OECD, accessed 11 March 2025, https://www.oecd.org/en/topics/health-workforce.html.

56 *The New Zealand Medical Workforce in 2024.*

57 *The New Zealand Medical Workforce in 2024.*

58 John Gibb, 'High Turnover Rate of Foreign Doctors Probed', Otago Daily Times Online News, 16 June 2015, https://www.odt.co.nz/news/dunedin/high-turnover-rate-foreign-doctors-probed.

In these cases, policy options may be limited to address this flow.[59] Nevertheless, our survey indicates that there are areas for improvement to support retention. The support provisions identified in Figure 21 and Figure 22 could be grouped as workplace orientation (a formal induction process, departmental welcome, cultural competency training, New Zealand health system training), networking (formalised networking with our IMGs, provision of a mentor, a nominated peer or buddy), and wider social supports (provision of housing, transportation resources, immigration/visa support, information on schooling system, language assistance). Addressing these deeply and widely felt gaps presents easy and significant opportunities for improvement.

Base salary and working conditions remain core retention strategies, regardless of whether respondents were IMGs or NZMGs.[60] It is worth noting that Gauld et al. found that UK-trained graduates reported high levels of satisfaction with aspects of working in Aotearoa New Zealand in 2015, with 94 per cent feeling valued for the work they do and 91 per cent being satisfied with their work hours. This is significantly different to what we found in this survey. Caution is necessary when comparing these results due to the differences in survey questions and variables used. However, it could indicate salary degradation over time, increased workforce stress and pressure, and the COVID-19 pandemic contributing to Aotearoa New Zealand being a less satisfying place to live and work.

IMGs are a significant part of Aotearoa New Zealand's medical workforce, making up 44.4 per cent of doctors on the Medical Council's register in 2025, up from 43.7 per cent in 2023.[61] According to NZMC data, IMGs make up 63 per cent of Aotearoa New Zealand's Psychiatry workforce, and over 50 per cent of the workforces for Emergency Medicine, Obstetrics and Gynaecology, Palliative Care, and Rural Hospital Medicine.[62] Aotearoa New Zealand also relies heavily on IMGs to fill hard-to-staff areas, with medical workforces in regional areas such as the West Coast, Whanganui and the Wairarapa composed of over 60 per cent IMGs.[63] Given that, IMGs make up a significant portion of these particular workforces and Aotearoa New Zealand's overall Medical workforce, retention rates are lower than NZMGs, and IMG mobility is higher, investment in retention supports is critical. Now that Aotearoa New Zealand has a national employer, there is a significant opportunity for a planned and coordinated approach to IMG retention. To this point, MCNZ data indicates that after five years, only 28.9 per cent of IMGs remain in the country, compared to 84.9 per cent of locally trained doctors.[64]

Our findings emphasise the need for the employer to retain IMGs as well as SMOs more broadly. As detailed in Figure 23, IMGs are likely to have their remaining in Aotearoa New Zealand influenced by remuneration (33.2 per cent), workload issues (21.5 per cent), the quality of managerial relationships (17.9 per cent), professional development opportunities (14.1 per cent), and limited career opportunities (10.8 per cent). As shown in Figure 21 and Figure 22, there are low-hanging support provisions, including workplace orientation, networking, and wider social supports, which the government and the employer could provide.

Strengths and limitations

The survey has both strengths and limitations. Its strengths include a good sample size of both NZMG and IMG cohorts, allowing for comparison between the groups. Participants also provided rich qualitative information through free-text comments on many survey questions. This gave depth to the survey's breadth.

However, the survey did have some limitations. Firstly, the initial survey had a dual aim of informing ASMS' *Future Intentions of Senior Doctors and Dentists*[65] research and this paper on the IMG experience. Due to this, IMG respondents required a considerable time commitment. During the design and development phase, the number of possible responses was weighed against the number of questions and subsequent survey length.

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59 Gauld and Horsburgh, 'Does a Host Country Capture Knowledge of Migrant Doctors and How Might It?'

60 Table 1.

61 'International Medical Graduates', Medical Council, 2025, https://www.mcnz.org.nz/about-us/our-data/international-medical-graduates/.

62 *The New Zealand Medical Workforce in 2024.*

63 Figure 9.

64 *Whārangi Mōhio Fact Sheet.*

65 *Over the Edge: Findings of the 2022 Survey of the Future Intentions of Senior Doctors and Dentists.*

In terms of sampling, the survey was limited by a likely response bias. The survey was opt-in and sent to existing union members. Respondents with existing concerns may have been more motivated to participate. Also, as ASMS membership predominantly comprises hospital-based doctors, this research cannot draw conclusions about the experience of IMGs working in other areas, such as primary care. Potential participants who recently left either Aotearoa New Zealand, the profession, or ASMS were unable to be captured by the methodology.

A question on ethnicity involved a drop-down list whereby participants could select one option or "Other (please specify)". Due to the complexity and self-identification of ethnicity, many participants used the "Other (please specify)" option to express multiple distinct or overlapping ethnicities. To amend this, a "select all that apply to you" style question, similar to the 2023 Aotearoa New Zealand Census, would render more usable and accurate data.

Additionally, as mentioned explicitly in the section, "'Looking to retire here': What is shaping the long-term intentions of IMGs to remain in Aotearoa New Zealand?" some of the questions had multiple possible interpretations. These issues, which limited analysis, could be easily amended in future research.

Future Research

Further research is needed to add a longitudinal view to the data, particularly changes in the qualitative data gathered. This would allow researchers to track the effect of: major health reforms (such as shifts in health policy or major changes to remuneration), changes to worksite policies (including onboarding or support), interrelated societal changes (such as shifts to visa or residency settings), and career intentions and job satisfaction of IMG and Aotearoa New Zealand cohorts over time.

The survey was circulated to current ASMS members in 2022 who were, in turn, currently employed as doctors in New Zealand. This means the experiences of IMGs who had already left New Zealand are not captured in the data. It is possible that seeking feedback from IMGs who worked in New Zealand but decided to leave would provide more insight into the push-and-pull factors that influence IMG retention in Aotearoa New Zealand.

Conclusion

Aotearoa New Zealand's health system could not function without the IMGs who have chosen to live, work, and contribute to our hospitals and communities. The proportion of IMGs in our health workforce is increasing, and the results of this paper show that numerous low-hanging recruitment and retention strategies could be implemented for IMGs prior to departure, upon arrival, and throughout their time here. By providing orientation, networking, and wider social supports alongside addressing remuneration, professional and career development, managerial, and workload issues, there is not only the potential to improve the working lives of IMGs, but to improve the quality of Aotearoa New Zealand's healthcare system generally.

In 2022, when this survey was conducted, Aotearoa New Zealand had just experienced a winter of chronic staff shortages and surging cases of Covid-19 and influenza. In 2025, as this report was written, the healthcare system is experiencing job cuts, faltering collective agreement negotiations, understaffing, and eroding physical infrastructure, to name a few. Decades of underinvestment in health, falling levels of self-reported health, and a cost-of-living crisis are increasing the gap between Aotearoa's health needs and healthcare system capacity. These gaps amplify the stress on an already overstretched IMG and NZMG health workforce.[66]

66 'Annual Update of Key Results 2023/24: New Zealand Health Survey', Ministry of Health NZ, 18 November 2024, https://www.health.govt.nz/publications/annual-update-of-key-results-202324-new-zealand-health-survey.

Recommendations

Toi Mata Hauora recommends employers of IMGs:

- Establish a consistent welcome and induction package for overseas doctors prior to departure, and upon arrival in Aotearoa New Zealand. This includes information on employment conditions and superannuation, support with visas and Medical Council registration, orientation to the health system, cultural orientation, and peer support and mentoring.
- Establish a cultural orientation for IMGs similar to the training Aotearoa New Zealand medical students receive. This needs to include Hauora Māori, cultural competence, and cultural safety. We recommend that the employer draw on the program run and evaluated by MCNZ.
- Undertake changes to increase the retention and recruitment of IMGs. This includes addressing remuneration, workload issues, the quality of managerial relationships, professional development opportunities, and limited career opportunities.
- Undertake changes to address job dissatisfaction in both IMGs and NZMGs. This includes dissatisfaction with recognition, remuneration, physical working conditions, and hours of work.
- Embed clinical leadership and address the marginalisation of clinical voice. Safe staffing and provision of care for patients are issues for IMGs and NZMGs alike. Remedying this is an important retention strategy as well as a critical part of staff and patient safety.
- Must undertake meaningful action on unsafe staffing, poor facilities, SMOs being forced to work outside of scope, excessive hours for SMOs in covering shortages, and SMOs not being provided adequate tools for the job.
- Must analyse and release the number of SMO fixed-term contracts being filled by IMGs, as well as the effects of fixed-term contracts generally.

Appendix

Job satisfaction questionnaire qualitative analysis: Table of themes and illustrative comments.[67]

Table 3: Job satisfaction questionnaire, participant comments

Primary theme	Comment
Hours of work	"The work just can't be done in the hours available. I know this is a job sizing issue, but there is always more work to be done, including supervising trainees. I have resigned myself to the fact that, to do the work to the standard that I am happy with, that I have to spend my own time to complete the work."
	"Currently working 1.0 FTE and covering job size 2.6 FTE after SMO resigned 2 months ago and no applicants for the position. My contract is for 0.8 FTE and I would like to return to those hours."
	"The workload has got increasingly onerous. We do a 7 day stretch on call, which is 12 days in a row for full timers (4 days clinic, then 7 days on call). We (the SMOs) are the only continuity on the wards given the RMOs have [rostered days off] etc. The amount of complexity has increased significantly. I am regularly doing a 60-70 week on site when I am on call. I then get two days off to recover and am back to clinic as well as other responsibilities."
	"At present we are routinely doing RMO work including out of hours work. This is highly unsatisfying as well as dangerous in terms of patient safety and our own safety. While this work has been acknowledged by our hospital there has been no meaningful offer of any solution. To add insult to injury we have to argue about remuneration for this. Highly unsatisfactory."
	"The daytime hours of work are fine, but the after-hours on-call are becoming increasingly exhausting and hard to recover from. Many times up all night, supporting very junior RMO staff with sick neonates/children. There is no stand-down after on-call nights, so then have to do my clinic or other day-work the following day. This is unsustainable and will be the reason I end this job much earlier than retirement age."

67 Acronyms used in comments have been noted in full, and any emphasis used was present in the original.

Primary theme	Comment
Remuneration	"Very disappointed with salary compared to amount of work required. Having done fellowships in Australia, and knowing how much they get paid, will very seriously consider moving and encouraging others to move as well. Sick of being undervalued with no progress. Seems like this has been ongoing for decades when talking to more senior SMOs as well. Slap in the face for all healthcare workers when we've been told we're 'essential' and 'thank you for your work' but then told to work harder for less pay."
	"I work far in excess of my paid tenths and the DHB refuses to look at appropriate job sizing! I am tired of being undervalued, overworked and being told that it is acceptable to be expected to work excessive regular unpaid overtime."
	"Frequently asked to cover for sickness without renumeration, which is only way we are recognised for helping out even though renumeration is modest."
	"I would chose to work less but the remuneration for public hospital doctors especially the remuneration for high acuity acute and after-hours work is poor given current cost of living."
Physical working conditions	"Under-resourced bed blocked department unable to deliver care to patients in timely manner."
	"Cancellations in elective surgery obviously reduce work satisfaction. Main complaint with physical conditions is cramped, overcrowded theatre environment that is not big enough for the amount of work that needs doing."
	"Department too small. Shortages essential supplies. Unrelenting nursing shortages and constant sick calls."
	"The only private spaces on the wards for important conversations are tiny and difficult to access, hard to fit in any whānau. Nowhere to speak privately on a ward to a patient who can't get out of bed unless they are in a side room - not many of those. Multiple small clinic rooms with no space for a support person unless they sit on the examination bed."
	"My department and office is in a "temporary" prefab building that has been here for nearly 20 years. It is freezing in winter and unbearably hot in summer. There is no good aircon and in summer I find it difficult to work due to heat and headache. After new aircon units were finally approved for funding, they have been declined by Facilities because the building is UNCONSENTED (still, after 20 years). No solution still and I can see this coming summer I will be in the same position."
	"The biggest problem with my job is a lack of physical infrastructure and associated staff to do operating lists. The operating theatres need expansion as well as the associated wards etc."
	"I work in an office where the computer drops off the internet at alarmingly regular intervals - like when I am in the middle of checking my letters or triaging referrals. I have complained to my clinical director and manager, and no one sees this as a priority. I work WAY more hours than I am paid for, and I still cannot achieve even a baseline of feeling on top of my priority list. I have almost no time to engage in actual non-clinical work. It is demoralising to say the least."

Primary theme	Comment
Recognition for good work	"I do not always feel there is recognition for my work from my organisation but there is at a department level. I accept that my work will not give me "gold stars" for doing my work well, so I look for other ways to feel valued - patient interactions, collegial relationships, teaching. I see my future being more in the private sector - not because of financial reward - but the benefits that come with working in smaller organisations."
	"I am part of a very good multiprofessional team which is supportive and has a tradition of a caring culture.
	"We really need more SMOs, but all we get is a 'thank you for your mahi and here's a coffee voucher to make you feel better'. I feel that we will lose our accreditation for training from the college given our inability to provide the required teaching given the clinical requirements."
	"I no longer wish to work in public hospital settings, either on call due to lack of support, resources, recognition and RMO shortfall (during work hours and on call). I have part-time commitment increasingly difficult to sustain due to increased burden due to older age patient bed block, mental health inpatient and rehab resources unattainable apart from MHA and latter usually has wait list, reduced collegiality from other disciplines general hospital setting and mental health silos of care etc. etc."
	"[Nelson Marlborough] Health turns a career into a job! I feel undervalued & neglected by my managerial colleagues."
Level of responsibility	"I am forced - without consent - to admit and manage severe, acute, psychiatric admissions outside of my job description and scope. We have no resources to manage these patients which has resulted in assaults on our staff and compromised care (with potential for physical harm). We have not been asked for permission or thanked for this role. We are not recognised or remunerated for the additional workload ... It's not fair or tenable, there is no plan, and it impacts recruitment, retention, and morale. I am not a psychiatrist, yet I am being forced to manage the most extreme cases with no resources and all the responsibility."
	"[With regard to] 'responsibility', for the last 12 months I have been covering the 0.7 FTE SMO vacancy, and in 2 weeks will no-longer have any registrar support (loss of 0.5 FTE) and will be the only doctor within the area I work in and thus much more responsibility and less opportunity to use "non-doctor" skill set."
	"It feel like we specialists have all the clinical responsibility and yet no power to dictate any type of workload appropriateness. The stress of the pandemic has caused most people's behaviour to understandably deteriorate. There is no acknowledgment of this currently. We got some food boxes some months back during delta which although I was cynical at the time actually made me realise somebody thought the team was worth the effort."
Opportunities to use skills and abilities	"I find that increasingly management undervalues specialist expertise in my field and treats us as assembly-line workers. There is little power to make meaningful improvements in a system that is repeatedly missing such opportunities, instead being focused on 'rearranging the deck chairs'. Consequently, staff turnover is escalating."
	"Feel underutilized for my skills in some areas"
	"Some of my skills are not used or recognised to their potential. I have issues containing my workload within the hours I'm contracted for."
	"I would like to have a component of my job working in ICU (I have a dual specialist qualification). I would also like to be using my ECMO skills in my place of work."
	"Our inpatient wards are completely outdated and not fit for purpose. We are not working at top of scope by being stuck on wards managing complex patients that are often very difficult to discharge - we would value add more being more community front facing and intervening earlier in frail and pre frail states."

Primary theme	Comment
Variety in work	"Although the work is demanding it is extremely rewarding working in South Auckland where I feel can make a measurable difference in patient outcomes in a multicultural environment"
	"We are so stretched for staff that although "the work" is good, the interruptions engendered by not having enough others to spread the load makes the job less satisfactory."
	"Would like more variety in work however not possible at the moment due to staff shortages."
	"I am dissatisfied in the variety of work that we do, in as much as we hardly ever do elective surgery anymore, only acutes and cancers, due to lack of resources in my hospital."
	"Limited variety at the moment because of bed-block - limited elective work, just cancer and trauma stuff."
Interactions with colleagues	"I have wonderful colleagues and an amazing clinical director. Under-staffing is an issue as it is everywhere, but I still consider myself very fortunate to do the work that I do."
	"I feel I get paid well and am fortunate to work in dept (Wellington) that is collegial and supportive. Our clinical directors advocate for our well-being and our hours are good."
	"Everyone tired, so collegial interactions becoming tense."
	"Dept colleagues are great but toxic environment in wider hospital with bullying & inequitable treatment of different craft groups; rooted in [fee for service/point of care/eat, sleep, console] model of care & remuneration which has festered for years and now coming to a head with planned care catch-up again favouring surgeons."
	"Interactions with management difficult [at the moment]"
	"I have left my most recent job because of bullying and poor oversight from management."

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