

**Human Resource Development (HRD) related issues amongst Migrant Nurses
living and working in the Republic of Ireland**

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Introduction

Despite the advances in medical research the depletion of the nursing workforce has the potential to jeopardise the provision of professional health care in many countries (Smith et al. 2011). Smith et al (2011) have discussed the persistent shortage and ‘depletion’ of nursing staff in many industrialised countries and the threat this poses to the delivery of healthcare. Given that the nursing workforce as a whole is aging (Nursing and Midwifery Council, 2008) and as the demand for healthcare rises it is likely that healthcare providers will continue to recruit from overseas (Nichols and Campbell, 2010). Over the past decade numerous countries including the United Kingdom (UK) and Ireland have recruited nurses from overseas to address shortages of qualified nursing staff in their own health services (Buchan 2006). Since the creation of the British National Health Service in 1948, it has depended on a steady stream of imported, trained health professionals (Batnitzky and McDowell, 2011). Migrant nurses have historically played a major role in the expansion of the British NHS (Smith and Mackintosh, 2007), leading some to describe them as the ‘saviours of British nursing’ (Buchan, 2003). In order to sustain its growing healthcare system, Ireland also heavily relies on nurses who have completed their professional education in other countries (Cummins, 2009).

Freeman et al (2011) discuss nursing migration as a 'human right', characterised by dynamic movement and free choice, one that is not only guided by individual motivation and decision-making, but is also influenced by 'external barriers' and 'facilitators'. While many commentators suggest that the motive for nurses to migrate is primarily economic (Kingma, 2006), with a strong commitment to supporting their families, others have also highlighted the importance of other professional factors such as career development opportunities unavailable in their home countries (Allen and Larsen, 2003; Buchan et al, 2005; Daniel et al 2001; Withers and Snowball, 2003). Nichols and Campbell (2010, p. 35) discuss the many advantages offered through 'international recruitment' of overseas nurses. They suggest that senior nurses who are willing to invest and embrace the diversity of overseas nurses can greatly benefit from their experience, insight and motivation.

While Freeman et al (2011) suggest that nurse migration is on the rise, and that the consequence of this movement will affect nursing practice and health care throughout the world, they also say that there is little primary research and evidence to guide practice, policy or research on this phenomena (Haour-Knipe & Davies 2008, McGillis Hall et al. 2009). While Batnitzky and McDowell (2011, p. 197) discuss the long history of recruiting nurses overseas to meet shortages of qualified nurses within the UK, they also discuss the perceived disadvantaged position of migrant nurses. During the 1990's rather than training nursing staff directly for their own health service, migrant nurses were recruited to address nursing shortages within the UK. This creates a potential tension between "native" nurses, who quite legitimately would expect more training and "imported" – migrant – nurses, who may fulfil training gaps

that may exist among within “native” nurses, at least in the short-run. It may also reflect a simple supply and demand imbalance, with little, or no, quality dimension.

Studies suggest that despite their skills and experience migrant nurses were employed in lower grades of nursing (Ball and Pike, 2005; Beishon, Virdee and Hagell, 1995; Carter, 2003; Henry 2007; O’Brien, 2007). Batnitzky and McDowell (2011) have highlighted a combination of ‘institutional discrimination’ in recruitment, progression, daily interactions and workplace ‘cultural practices’, which reinforce the perception of migrant nurses as less skilled, with limited career prospects as a consequence.

Literature Review

Migrant Nurses Experiences

The theory frequently used to describe nurse migration patterns is the ‘push pull theory’ (Meija et al. 1979, Kline 2003, Kingma 2006, Bach 2007). This theory focuses on the micro level as to why nurses migrate, but it does not explore individual decision making in relation to migration and decisions as to why people decide to migrate (Arango, 2000; De Jong & Fawcett, 1981). Freeman et al. (2011) found that whether or not the consequences of nursing migration were discussed in positive or negative terms depended on a number of factors. These included the perspective of the individual and other stakeholders such as the ‘source country, destination country, healthcare systems and the nursing profession’.

A recurring theme amongst migrant nurses concerned differences in nursing practice as well as the work environment, patients, doctors and colleagues who were overwhelming different to that of their home country (Smith et al, 2011). Smith et al (2011) have discussed the positive and negative experiences of migrant nurses in trying to integrate into a Western Australian metropolitan hospital setting. They attributed the major differences experienced by migrant nurses to clinical skills, holistic care, interpersonal dynamics between doctors and patients, and the societal status of the nursing profession. They found that the majority of migrant nurses adjusted their work practices to conform to their new work environment. They found that migrant nurses were also surprised at the need for skills of communication, problem solving, documentation, patient education, patient case management, administration, liaising with other professionals and agencies in relation to the patient (Gerrish & Griffith, 2003). A major theme in their study concerned holistic patient care. Participants had previously not attended to basic nursing care in their previous practice and subsequently felt belittled in their professional practice. Despite the perceived better terms and conditions offered by the host country, many felt dissatisfied by the lack of recognition of nursing as a profession by governments and policy-makers (Allan et al., 2008).

Smith et al (2011) also suggest that nursing as a profession is shaped by the power structures in which it exists, and discovered that many nurses felt disempowered and felt that they had to adjust their nursing practice to fit in with the Western Australia healthcare setting. Filipino migrant nurses found that their social status was lower in Australia than in their home country. They felt that Australian nurses regarded nursing more as a livelihood rather than a profession (Teschendorff, 1994). They felt

that their professional status had been belittled as they could not use their full range of clinical knowledge and skills. Hoare et al (2012) also discovered that overseas trained nurses (OTN), much to the detriment of the health services as well as the nurses themselves were prevented from using the full technical skills they acquired in their own countries or origin. They found that regardless of their advanced skills and experience, overseas trained nurses were expected to occupy a subordinate position. These findings have potentially profound implications for the performance of the health care providers where these nurses are employed.

Other difficulties experienced by overseas trained nurses, included gaining registration to practice autonomously, cultural and language differences and barriers, often leading to a loss of self-confidence, self-esteem and in severe cases psychological breakdown and depression (Ok Ohr et al., 2010). O'Brien (2007) found that while migrant IRN's were usually highly trained and proficient in technical skills, the system in which they are recruited tends to place them in a 'subordinate position' incompatible with the expression of their advanced clinical skills, were they are recruited on lower nursing grades and deskilling often occurs. In their research Ball and Pike (2005, 2007) also discovered that more migrant IRNs worked at band 5 or equivalent. They found that they were promoted more slowly, than their UK-born counterparts, and that the qualifications, knowledge, skills and experiences of migrant nurses largely went unacknowledged by their UK employers. This is further supported in other studies (Allen and Larsen, 2003; Withers and Snowball, 2003; Gerrish and Griffith, 2004, Matiti and Taylor, 2005; O'Brien, 2007). Such perceived inequity can lead to feelings of unfairness and dissatisfaction, resulting in anger and resentment. Many migrant nurses felt aggrieved that they had to take up roles more junior than

nurses with fewer qualifications (Smith et al, 2006). Some IRNs have been known to go so far as to disguise their experience from colleagues so they don't appear 'arrogant' - a process which they describe as 'learning to be humble' (Smith et al 2006).

Cummins, (2009) has discussed the challenges faced by migrant nurses, which include feeling like an outsider and the need for being trusted and valued by host nurses (Magnusdottir, 2005). Cummins' (2009) study on migrant nurses in Ireland found that 49% of migrant nurses felt that their new work practices were different from their home countries. Cultural differences such as communication issues, understanding the host culture, its traditions and different accents, were all challenges for migrant nurses. The main difficulties facing migrant nurses concerned communication in terms of language, local dialects and colloquialisms, which caused frustration for both migrant and host nurses, staff and patients (Alan & Larson 2003, Sparacio 2005). The preoperative environment has been highlighted as a particularly stressful area to work in, which requires nurses to be assertive but also to work well in a multidisciplinary team (Cummins, 2009). Cummins (2009) found that migrant nurses had difficulties with being assertive and in delegating. Nichols and Campbell (2010), suggest that the cultural differences of migrant nurses can place them at a professional disadvantage. Parry and Lipp (2006) observed Filipino nurses who were content to display cultural behaviours such as deference of women to men, to authority and avoidance of conflict, experienced difficulties in being both assertive in their nursing practice and in challenging poor care practices. Some internationally recruited nurses described poor working relationships and lack of respect from HCAs. They identified cross-cultural training and understanding as an appropriate area to

address this. They found that Nigerian IRN nurses expected HCA's to carry out specific tasks, follow instructions without question, and have no involvement in decisions about care. Some migrant nurses felt humiliated and degraded by HCA's attitudes towards them (Smith et al, 2006; Aboderin, 2007). Smith and Mercer (2011) discuss the issue of 'patient empowerment' where nurses are obliged to involve patients and discuss with them decisions in relation to their treatment. In Yi's (2000) study participating nurses found that patients were demanding and self-centered, reflecting the high value Americans place on individualism.

HRD

Cummins (2009) found that migrant nurses working in Ireland experienced less difficulties in communicating with other professionals than with non-professional staff. She highlighted a lack of awareness and respect for other cultures from non-professional staff as a possible contributing factor. Migrant nurses found communicating with ancillary staff challenging. The potential risk to patient safety through communication barriers has also been previously highlighted (Flynn & Aiken 2002). Cummins found that the orientation, induction programmes and support received were reported to be beneficial, and that generally migrant nurses required six weeks adaption. She discussed the need for greater cultural awareness, education and understanding for both migrants and host staff to ensure a harmonious work environment (Cummins 2009). On the whole she found that migrant nurses benefited from orientation, induction and workshops in service education programmes, and discussed the benefit of additional supports for skills in delegation and confidence building - particularly amongst migrant nurses not accustomed to delegating and asserting themselves. The orientation and induction programmes and supports from

the preceptors were reported to be beneficial. This was in addition to the buddy system, which was viewed as particularly valuable to helping migrant nurses integrate (Ryan 2003, Parry & Lipp 2006). There is wider evidence of successful orientation programs for new overseas staff, including support groups that meet to review and discuss language, cultural and nursing issues (Witchell Ouch, 2002), which can also include the appointment of buddies and mentors. Migrant nurses who received support from their managers found integration less challenging (Withers and Snowball, 2003).

Within the UK the need for cultural education has focused on the demands of a multi-cultural society (Duffy 2001, Button et al. 2005) while in Ireland the focus of cultural education has been to ensure harmony and respect between nurses with different cultural practices (McAdam et al. 2004). Nichols and Campbell (2010) suggest the need to better manage the expectations of migrant nurses working in the UK, many of whom do so with a view to sending money home. Managing the expectations of migrant nurses was considered particularly important in relation to the cost of living and other costs. O'Brien (2007) also claims that there is an arrogant assumption in the UK nursing profession that 'our way is the only way'. This should be challenged through a 'culture of openness' to new ideas, exchange of knowledge and approaches to new practices. Nichols and Campbell (2010) suggest greater acknowledgement and awareness of migrant nurses' knowledge, attributes and experience, linked to timely professional development.

Kingma (2006, p. 70) identified racism and discrimination as the most serious problems encountered by migrant nurses, and described the sad reality where they are

bullied, their professional skills are undermined and they are discriminated against in promotion and educational opportunities. Allen and Larsen, (2003) and Smith et al (2003) also identified racial discrimination amongst migrant nurses. Nichols and Campbell (2010) recommend greater managerial involvement in managing racism through a zero tolerance approach, diversity awareness training amongst staff and commitment to good practice.

Research Questions

Our study seeks to explore and examine HRD related phenomena amongst migrant nurses living and working in Ireland. We look at issues of perceived racism and bullying amongst migrant nurses, and what implications if any these have for organisational performance and productivity, and other related factors such as workplace absenteeism and turnover. We also look at the impact on mediated variables such as commitment and stress. The study will initially examine HRD related phenomena through the eyes of migrant nurses, exploring their meanings and interpretations in order to clarify and develop frameworks for greater understanding of the phenomenon under investigation (Burrell and Morgan, 1979; Daft & Weick, 1984). The study will seek to examine the relationship between perceptions of workplace bullying and discrimination with workplace absenteeism, turnover and productivity, and other mediated variables such as commitment and stress.

Methodology

We initially intend to explore the experiences of migrant nurses living and working in the Republic of Ireland through an interpretivist methodology. This will involve the use of semi-structured interviews to explore and capture the experiences of migrant nurses working in the Irish health service. The purpose of the interviews will be to learn as much as possible about the experiences of migrant nurses working and living in Ireland. By examining phenomena through the eyes of the participants, exploring their meanings and interpretations, we seek to clarify and develop frameworks for understanding the references used (Burrell and Morgan, 1979; Daft & Weick, 1984). This study seeks to provide a contextually relevant understanding of the experience of migrant nurses (O'Neill, 1995). The interview schedule will be informed by the literature review and piloted with a small number of migrant nurses. The interview schedule will consist of a detailed set of open-ended questions: (1) The factors/forces influencing nurses migrate; (2) Positive and negative experiences of living and working in Ireland; (3) The workplace challenges they face; (4) An assessment of the HRD challenges and proposed solutions.

It is hoped that our findings will inform the construction of a conceptual model illustrating the various HRD challenges drawn from the experiences of migrant nurses working in the Irish health service. We then hope to consider the use of a survey to measure the extent of the phenomena identified through our interpretivist study. We will then seek to measure the phenomena, captured through our qualitative study through a survey methodology. Our survey will examine the relationships of any perceived workplace bullying and discrimination, with workplace absenteeism, turnover and productivity as well as mediated variables such as commitment and stress. The study population will involve participants working in acute and

community health care organisations. They will be selected through a process of purposive sampling, reflecting variations in terms of country of origin, age, grade, ward and tenure. We will then explore how best to address the HRD challenges faced by migrant nurses working in Ireland based on the findings of our study.

Initial Findings

The following summarises the main points taken from an unstructured interview relating to migrant nurses living and working in a large and busy acute sector hospital in Dublin, Ireland. The interview was conducted with the head of HR operations within the hospital's nursing division.

The interviewee had been in his current role for seven years. Upon joining the hospital he said that he was surprised to discover that nurses were categorised as follows; 'nurses', 'non-Irish nurses' and 'managers'. Upon arrival he re-categorised the three groups of nurses into one single group running in alphabetical order, A – Z. In discussing the issues of equity and fairness relating to the treatment of migrant and national nurses, he discussed a 'perceptual barrier' amongst staff that migrant nurses were working in Ireland and in the hospital on a 'temporary basis'. He said that the hospital had gone some way to address and challenge this perception by encouraging migrant nurses to apply for promotion and more senior nursing positions. He highlighted three examples where migrant nurses had been promoted to more senior nursing roles within the hospital. The holders of these positions were in his view key in championing and 'selling the message' in relation to the value and status of overseas trained nurses.

The interviewee highlighted and discussed the issue of absenteeism amongst nursing staff within the hospital. Data on the absence figures, and 'performance meetings'

with Clinical Nurse Managers and nursing staff within the hospital had previously been collected and analysed. It was discovered that the rate of absence amongst national nurses was significantly higher compared to non-national nursing staff. On further analysis of the data it emerged that the number of 'performance meetings' in relation to the (lower) level of absence amongst non-national nursing staff was considerably higher compared with their national counterparts.

Subsequently the data on absenteeism and performance meetings was discussed at a meeting with the Clinical Nurse (Ward) Managers. This involved an 'open' and 'frank' discussion with the Clinical Nurse Management team in relation to their attitudes towards non-national nurses and their subsequent handling and management of absenteeism amongst nursing staff. The Clinical Nurse Management Team said that they were more comfortable, and found it easier to discuss performance issues with non-national nurses in relation to absence than they did with national nurses. They said that they found it harder to conduct performance meetings with nurses they had known a long time. The outcome from the discussions with the Clinical Nurse Management team resulted in greater awareness and the evolution of a much more even handed approach in managing absenteeism amongst nursing staff – for both migrant and national nurses.

In relation to the issue of discrimination and bullying, the interviewee discussed and highlighted the issue of discrimination and bullying amongst migrant nurses themselves. He went on to discuss two examples amongst Indian migrant nurses, were as a result of the conservative social norms and customs of their home countries, found that there were occasions when they were isolated by their Indian colleagues. One incident related to the second marriage of an Indian nurse in which her husband

tragically died. Her first husband had also previously died of natural causes. The newly widowed Indian nurse was also expecting a child. She received little or no support from her Indian colleagues. Those Indian nurses who did support her, did so only through phone calls. The other example involved the ‘caste system’ within India, where following a road traffic accident one Indian nurse did not receive any Indian nurse visitors whilst in hospital. The reason for this was because she was from a higher caste. The interviewee also discussed tensions and clashes amongst Indian and Filipino nurses, which he said presented challenges for both hospital management as well as the nurses themselves.

In sum, the initial review of the literature and findings from the pilot interviews demonstrate how complex notions of workplace harassment and bullying can be. This is especially so when the analysis is conducted with a migrant population – so important not only in the context of nursing but also in an ever increasingly diverse global work force. Specifically, it raises the question of how “imported” relationships, whether by gender, race, caste, religion – are managed by recipient organisations – in this case the health care system in Ireland.

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