

NEW NORMALISING: A GROUNDED THEORY OF THE TRANSITION FOR MIGRANT HEALTHCARE PROFESSIONALS

A thesis presented to Dublin City University for the Degree of
Doctor in Philosophy

By

John Collins
RPN, RN, DPSN, BA (Hons), Dip. Ed., MA

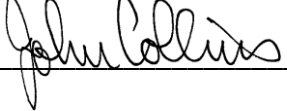
School of Education Studies, Dublin City University

Supervisor: Dr. Carmel Mulcahy

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DECLARATION

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of PhD is entirely my own work, that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

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TITLE: New Normalising: a grounded theory of the transition for migrant healthcare professionals

John Collins

ABSTRACT

Canada has long been a country of immigration, witnessing a large increase in the years between 1998 and 2008 (Bourgeault 2007, Kelley and Trebilcock 2010). Ireland, which was always considered a country of emigration, saw an influx of immigrants during a similar period (Office of the Minister for Integration 2008). Nowhere was this more evident than in the health care industries of both countries, where severe manpower shortages prompted the recruitment of skilled healthcare professionals from abroad.

Estimates suggest that about one third of all healthcare professional immigrants never take up a position in the health care system of the new country. (Jeans et al. 2005, Blythe et al. 2006) In addition, attrition rates among those who do pursue their career in the host country are at about 25%. (Blythe et al. 2006) The remainder recount multiple barriers and delays in obtaining full registration and employment. With this degree of loss and delay to the professional workforce, it is critical to discover what the transition experience is for these migrant healthcare professionals and how they might resolve their concerns. (Jeans et al. 2005, Szekely 2007, Humphries, Brugha and McGee 2009a)

In this grounded theory study (Glaser and Strauss 1967, Glaser 1978, Glaser 1998) the transition experience of the migrant healthcare professionals (nurses and doctors) is conceptualised in the grounded theory of *New Normalising*. *New Normalising* occurs through the stages of *transplanting, regressing and adapting*. It is through *New Normalising* that participants resolve their main concerns of transition. The potential applications and implications of this research are discussed, as well as directions for further development of the theory.

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Writing conventions used in this study:

Throughout this thesis, though the male pronoun is used for ease of reading, it should be understood that it refers to both the male and female gender in all instances, other than where a particular individual is referred to.

CHAPTER 1: Introduction to *New Normalising*

Other than a few exceptions, healthcare systems around the world have experienced, and are continuing to experience, shortages in all of their professional disciplines (Blythe et al. 2006, Bach 2003, Joyce 2011, CIHI 2010b, Connell 2009). Underlying this development are political, economic, social, demographic and technological changes and decisions (to mention just some of the complex variables) since the late 1980s and early 1990s. Furthermore, the trend towards Globalization is evident in the progress of the European Union, Free Trade agreements on different continents, international economic cooperation and interdependency, and the trillions of dollars exchanged on the world's stock markets every day. Travel between one part of the world and another can be achieved in shorter time frames than ever before. At an individual level, the ability, freedom and desire to grow and develop personally and professionally, as well as economically, has led to significant increases in travel and migration (Szekely 2007, Statistics Canada, OECD 2010a). In sum, opportunities to travel and relocate, the quest for a better quality of life, together with the need for their professional expertise and services, have resulted in a willingness on the part of health professionals to migrate. There have also been heavy financial incentives for them to do so, as employers desperately seek their skills. (Kelley and Trebilcock 2010)

Nevertheless, moving to a new location on the planet is not without its problems for the migrant healthcare professional, the employer who would hire him/her, and the recipient of his/her services. Issues of culture, culture shock and related stressors, language, communication, education requirements and adaptation to the new practice environment, as well as attitudes of the indigenous population, pose a number of barriers to success for all concerned. (Szekely 2007, Pearson-Evans et al. 2007, Jeans 2005)

The years before the current economic decline saw a significant increase in migration worldwide. (Kelley and Trebilcock 2010, OECD 2011, IOM 2010) Among these migrants were healthcare professionals, who were in big demand in a number of developed countries. (OECD 2010b) Canada and Ireland were two such countries which saw massive influxes of workers, including healthcare professionals, in these years of economic growth. (Kelley and Trebilcock 2010, CIHI 2010b, International Centre on Nurse Migration 2010) Two groups of healthcare professionals within these workers were the focus of this study – doctors and nurses.

Problems arose for the migrant healthcare professionals in the host countries, and not all were successful in making the transition to practicing their profession in the new country. Others seemed to be struggling with the process. Since critical shortages of healthcare professionals were the focus of recruitment drives, the media in both countries began to uncover significant concerns with the transition. (Gol 2006, O'Meara 2006) These issues became the focus of research studies in Canada and Ireland, in order to develop policy positions for the respective governments. There were also reports of significant attrition among migrant healthcare professionals applying for licensure and long delays in navigating the system. (Jeans et al. 2005, Humphries, Brugha and McGee 2008b)

As I had been involved in developing and providing education programs for migrant nurses in Canada, I was interested in exploring the transition experiences of migrant healthcare professionals, to try to understand it and to enable me to be more responsive to their needs. As a migrant healthcare professional myself, the matter was of some importance to me. I, therefore, decided to focus my research in this area.

In the study, I focused on the issues of transition and I asked two main questions: what are the main concerns of the migrant healthcare professionals? And what accounts for most of the variation in their resolution? I used a Classic Grounded Theory method to study these

questions and to generate a theory which would explain the resolution of the main concern for migrant healthcare professionals. (Glaser and Strauss 1967, Glaser 1978, 1998, 1992) Employing iterative data collection and analysis, guided by theoretical sampling and constant comparison of data with emerging conceptual categories, the research undertaken has generated a grounded theory of *New Normalising*.

Grounded theory was developed in the 1960s and is used extensively in research studies. It is a general method of analysis linked with data collection and uses a very specific set of procedures to induce a theory about a substantive area (Glaser 1992). Grounded theory utilises the interchangeability of indicators through a process of constant comparison to enable the emergence of conceptual theory that is empirically grounded in data.

The methodology is emergent, so the researcher must enter the field, suspend his knowing, and remain open to exploring a substantive area and allowing the chief concerns of those actively engaged therein to guide the emergence of a core issue or problem to be resolved. The conceptualisation of the core problem becomes the basis for the presentation of a grounded theory that explains the problem and its resolution. (Holton 2006)

The Emergent Theory

To resolve their main problem in the variety of contexts of transition, the migrant healthcare professionals in this study describe a basic social process which I have conceptualised as *New Normalising*. Migration to a new country results in the loss of almost everything that was familiar to the migrant healthcare professional. The rules of everything change, as does technology, techniques, communication, environment and a multiplicity of other factors. This is true in every aspect of their lives and, consequently, produces a 'destabilization of living', not just of professional practice. *New Normalising* is a process that involves the resolution of these problems and the re-establishment of order or personal and professional stability, through rebuilding social and psychological structures that allow the migrant healthcare professional to function effectively in his new personal and professional life.

The Thesis

In this thesis I present the background to the study, a detailed account of the grounded theory method and then the theory itself, in some detail. The order of chapters is as follows:

Chapter 1 is this introduction and overview of the study.

Chapter 2 provides historical background from each of the countries in the study; Ireland and Canada. This history is not just an “interesting read”, but it provides a very informative account, which helps to clarify some of the issues which individuals tend to attribute to today, yet they have their roots in a previous time. This is true of some of the issues of transition encountered by the migrant healthcare professionals in this study.

In Chapter 3, I bring us up to date with the general data on migration in Ireland and Canada, and then focus on doctor and nurse migration. In this, the trends and extent of movement of healthcare professionals across borders is drawn out and presented for the reader.

In Chapter 4, I provide an explanation of the Classic Grounded Theory methodology described by Glaser and Strauss in 1967, and further elaborated on in numerous publications by Glaser since.

In Chapter 5, I add to the explanation and understanding of the Classic Grounded Theory research method, by discussing the application of the procedures during this study. I add further documents in the appendices to demonstrate some of these procedures and their outputs as the study progressed.

In Chapter 6, I provide an explanation of *New Normalising* in some detail. In this chapter I provide some diagrammatic representation of the core category and its sub-categories. The chapter starts with an overview of *New Normalising* and is followed by a detailed account of the categories and subcategories in the theory.

In Chapter 7, I compare the extant literature in the field with the theory of *New Normalising*, as well as drawing comparisons with the theory of transitions from the field of nursing. (Im 2009, Meleis 2000)

Finally, in Chapter 8, I make some further and final comments on *New Normalising*. In the process, I discuss the evaluation of the research and its product, the theory of *New Normalising*, using the evaluative criteria from Grounded Theory. I also make some suggestions for the usefulness of *New Normalising* to migrant healthcare professionals, other healthcare professionals and to policy-makers. I then make some remarks about the limitations of the study, my own reflections as a novice grounded theorist and some possible directions for future research. I complete the thesis with some concluding remarks about the theory and its modifiability.

Chapter 2: A History of Migration in Canada and Ireland

Setting the Scene for this Research

This research studies the transition for migrant healthcare professionals, as they move from positions of practice in their home country to similar positions in the host country. In doing so they are following in the footsteps of millions of migrants before them who have made the same or similar journeys. The migration story is as old as people and its recorded history helps set the stage onto which this study is released. It is important to place this study in the migration context, as the study of migration is not new, and it is vital to the theory of *New Normalising*, which is new. Of special significance to this study is the historical context of migration in Ireland and Canada, and, in particular, the migration of healthcare professionals in both of these countries. The historical records that follow, fashion the ultimate context of migration which each individual migrant healthcare professional encounters in his own time period.

As Castles and Miller state, "International migration is a constant, not an aberration, in human history". (Castles and Miller 2008, pp.299) The fact that people inhabit almost every corner of our planet is a testimony to the human spirit and drive for exploring new territories, lands and experiences, and surviving in the most challenging of conditions. Conversely, it is also a reminder of all that is not good about people, as they deal badly with conflicts and disagreements, abuse each other, war with each other, and drive each from the other's company and location – forced migration is a well known phenomenon producing refugees and reluctant migrants. (pp.80) Forced migration is also to be found among migrant healthcare professionals, even those in this study!

Some of the migrant 'pioneers' were people who travelled to locations for a short duration and then returned to their home country. Others moved to find resources and 'treasures' to bring back home to share with their families, friends and fellow-countrymen, or give to their monarch, emperor or rulers in exchange for favours, titles and land. Yet others

moved for a “better way of life” and, having found what they were looking for, settled in the new location. Many of these migrants were escaping severe conditions in their homeland, such as poverty, draconian poor laws and workhouses. (Castles and Miller 2008, Purcell 1995) Some individuals found ‘love’ in their new location and stayed in the host country to be with their spouse, while others under similar circumstances brought their new spouses back home with them, making migrants of their new spouses. Given human’s propensity as a group for violence, it is not surprising to know that some individuals, families and groups, fled their countries to avoid conflicts, wars or death. (Zolberg and Benda 2001) In situations of famine or natural disasters, massive numbers of people became refugees from their homeland and took up residence elsewhere. (Zolberg and Benda 2001, Moses 2006) At one time, rulers of countries shipped people abroad who were no longer wanted in their own country – undesirables, the mentally ill, and criminals (Cockerham 1989). In modern times, economic circumstances and political pressures led to the creation of immigration policies and, ironically, these same policies motivated people to emigrate (Moses 2006). New developments and technologies create new reasons for leaving or staying in one’s home location, but also create the means to travel between countries within a much shorter time frame, and in far more comfort than previously. In sum, there are almost as many situations and motivations for migration as there are people. Migration is a complex business and all of it applies to the participants in this study, from whose experiences this theory of *New Normalisation* is induced!

In this chapter, then, I start from a broad world perspective on migration, based predominantly on the European and North American experience, since these are the continents on which this particular research was conducted. From there, I discuss Ireland and Canada as two countries (one on each continent) with long histories and experience with the issues of migration, though perhaps from opposite perspectives. After describing these historical contexts, I draw the discussion into the events of recent years in health care and, finally, to the particulars of the participant healthcare professionals in this study.

Consequently, I set the scene into which I (the researcher) entered to meet the migrant healthcare professionals who agreed to participate in this study and discuss their transition experiences with me. The theory of *New Normalising* presented in this thesis, and conceptualized from these experiences, relates to this substantive area of migrant healthcare professionals.

A Brief History of Migration: Europe and North America

Historically, the numbers of migrants across the globe have waxed and waned through various time periods and to and from various countries. According to Purcell the first migrants may have been the aboriginal peoples of North America, some 40,000 years ago. (Purcell 1995) They are believed to have travelled on foot from Asia, across what was then a “land bridge”, to Alaska. Kelley and Trebilcock suggest the timing of this event is unclear and may have been much sooner. (Kelley and Trebilcock 2010) Nevertheless, from Alaska they made their way south and east over a long number of years, spreading across what is now the Americas. By the time Columbus arrived millions of Indians (as the native people have become known, due to the Spanish believing they had arrived in India when they first landed on the continent) now lived in North and South America. It is believed that during the time since their arrival they had formed many tribes with their own customs and languages, with each occupying its own territory (Purcell 1995, pp.ix; Walker 2008). As time passed, the ice melted and the continents were split by the sea encroaching, these people became cut off from the land of their origin. As far as we know, there were no serious further migrations to North America until the Europeans discovered that it existed in the fifteenth century.

According to Purcell, “it wasn’t till nearly a century after Columbus made his landfall in the Caribbean in 1492 that Europeans began to actually colonize” North America. (Purcell 1995, pp.1) Initially, they came from England, France, Holland and Spain, but only to exploit the continent, not to emigrate there. The primary motivation at that time was

greed. Following from these exploits, these same countries started to send “settlers” to where they had staked their land claims, to work the territory and extract what resources they could for sale on home markets. These settlements were small and not well supported. Some vanished quickly as they were not prepared for conditions in the new territory. “Starvation”, “social disorientation” and “conflict with the natives”, as well as harsh conditions posed continual threats to life. “Though about 8000 men and women came across the Atlantic to Virginia between 1607 and 1624, only about 1300 survived.” (Purcell 1995, pp.3) It seemed that the lesson from this was to understand that there would be no get-rich quick scheme on these lands, but they could gain ample benefit from establishing stronger well-supported settlements and from working hard. The land was highly arable, as was proven through the mass production of tobacco, which, as a “New World” crop, sold extremely well in European markets. The production of this crop, and others, required many labourers and this spurred an influx of employer-sponsored immigration.

Most came to the English southern colonies as indentured servants. In exchange for passage to Virginia or Maryland and the promise of land at the end of their service, they contracted to give up temporarily most of their economic and legal rights and work for the landowners under terms of a contract (called an indenture) for between four and seven years. These people were eager to escape from England, where economic changes had driven many workers into poverty and where decades of political unrest and revolution had created social chaos. (Purcell 1995, pp.3)

The recruitment of healthcare professionals in present times occurs in a not dissimilar employment environment, with some employment conditions similar in intent!

During this same period, and for the next two hundred years, forced immigration saw the arrival of Black African slaves into North America. These slaves were sold to landowners and traders, and were put to work on farms, mines and plantations. They lived under harsh conditions of control and were treated cruelly by their owners. According to Castles and Miller an estimated 15 million slaves were forcibly taken to the Americas by 1850. (Castles and Miller 2008)

Another tragic effect of the European migration into North America was its impact on native people. Their populations were decimated by disease and wars. They did not have the immunity to survive European diseases and their weapons were primitive in comparison to the immigrants and colonizers.

While the European immigrants were arriving for the reasons already discussed, further north in the colony immigrants were arriving to escape religious and political restrictions. These were 'the Pilgrims' who had been harassed in their native England. This group came in small numbers. They were followed by 'the Puritans', whose motives were different and they arrived in large numbers with the aim of establishing and spreading a model community, built on their religious beliefs.

During the 16th and 17th centuries the preponderance of migrants arriving in America was of British origin. These groups established the systems and language which have pervaded American culture ever since. However, migrants arrived from other European countries too, and settled in small numbers in various locations on the east coast of America. These groups included the Dutch and Swedes who held small colonies for a short duration during the first half of the 17th century. The Dutch, in fact, started a new colony in what is now recognised as New York City ("New Amsterdam"). However, due to conflicts among themselves and their leaders the Dutch were easily ousted from the area by an incoming British fleet in 1664. Prior to that, the Dutch themselves had managed to oust the Swedes who attempted to set up a colony of their own. The Swedish enterprise was small in comparison and did not encourage Swedish people to leave their home country, where economic and life circumstances at the time were prospering. (Kelley and Trebilcock 2010)

The roots of American culture and society were laid down further by the mass immigration of Scots-Irish during the 18th century. These immigrants were neither the Scots nor the Irish who came to America in large numbers during the 19th century. These Scotch-Irish were “Protestant Presbyterian Scots, Lowlanders who had been transplanted by the British government to the northern counties of Ireland during the early 1600s to form a barrier against the unruly Irish Catholics to the south” (Purcell 1995, pp.13). As with other immigrants at various points in time, they were motivated to come to America due to economic pressures and religious persecution by the English government. Throughout the 17th, 18th, and 19th centuries British migrants were invariably compelled to leave the land of their birth due to landlords increasing rents, or laws of the land forbidding the practice of their religion or participation in various sections of society if they did not practice the religion of the day, or due to famine. The distinct culture of these and other British immigrants has been since submerged into the broader American culture that we know today. However, the largest group of immigrants to America were of German ancestry. Like many other groups of migrants they were motivated by wars in central Europe, poor living conditions, and oppressive circumstances in their homeland. Like many migrants before them they financed their passage to North America by indenturing themselves to shipping and other companies. As before, this led to many abuses of immigrants after their arrival in the New World.

International migration is portrayed as a market in which workers make the free choice to move to the area where they will receive the highest income. But this harmonious picture often fails to match reality.... Labour migrants have frequently been unfree workers either because they are taken by force to the place where their labour is needed, or because they are denied rights enjoyed by other workers, and cannot therefore compete under equal conditions. Even where migration is voluntary and unregulated, institutional and informal discrimination may limit the real freedom and equality of the workers concerned. (Castles & Miller 2008 pp.79-80)

This is not dissimilar to the experiences of migrant healthcare professionals in this study, as they go through the stage of *adapting*, during *New Normalising*.

The number of immigrants to the colonies in the eastern seaboard of North America had swelled since the early 17th Century and, by the time the American War of Independence broke out in 1775, there were two and a half to three million living in the colonies. (Purcell 1995)

The British colonies experience(d) enormous population growth: the mainland colonies have about 400,000 residents in 1720 and nearly 2 million by 1765. A population explosion in Europe brings new waves of white migrants while the continued importation of enslaved Africans increases the number of blacks.

The war of revolution resulted from a series of taxes imposed on the colonies by the British to pay for a permanent garrison there.

The British realized that they needed a permanent garrison in the colonies to protect their interests; to finance this endeavor; they imposed new trade laws and taxes on the colonists. The Sugar Act, the Stamp Act, and the Townshend Acts were all enforced between 1764 and 1767. Eager to trade freely as before, the colonists deeply resented the various taxes: if they paid taxes to Britain, they should have representatives in Parliament. The rallying cry "no taxation without representation" mobilized demonstrations, bloodshed, and finally total revolution...In 1775, the first battles of the Revolutionary War were fought at Lexington and Concord, Massachusetts. (The Metropolitan Museum of Art 2000)

While many English immigrants returned home after the war (1781), others moved north to Canada, while non-English immigrants preferred to stay in their new homeland. As discussed later in this thesis, the revolution had an impact on Canadian migration – first immigration then emigration. The years after the war saw a trend towards unity in North America. English was the main language of communication, and Protestantism the main religion, and each of the colonies had similar forms of government. The same years also saw reduced numbers of immigrants due to continuing wars in Europe (1812). This trend has continued across time. During periods of war, nations forbid people to leave and travel is dangerous. Indeed, the Atlantic, in particular, was impossible to cross at various times, due to the presence of warships and blockades at various ports. In addition, the British government enacted legislation which set conditions on ships as to the reduced number of passengers they could carry and the necessary onboard facilities for those passengers.

Nevertheless, the end of the war in Europe saw a long period with high levels of migration to North America. This is the period during which North America began to build and prosper as a nation. Employers actively recruited workers from Europe, in the main. Initially, most immigrants were British (Irish, in particular), but then migrants came from all over Europe. The biggest majority of immigrants during this period were from Germany, with only the Irish coming close to their numbers. Most of the migration that took place around this time was stimulated by the industrial revolution. Agricultural workers were hit hardest, being forced off their lands. Famine also struck in Europe in the same period. The attractiveness of migration was further underpinned by a significant reduction in the cost of the voyage across the Atlantic. (Castles and Miller 2008, Purcell 1995, Moses 2006, The Metropolitan Museum of Art 2000)

Immigrants played a major role in the American civil war of 1861. As mostly northern and eastern dwellers, they joined the Union in large numbers. After the war, they started to move out west, developing railroads and prosperous cities. More immigrants came from more countries, making the country more powerful and wealthy. At the same time, 'nativism' was evident in American society at various junctures. Purcell suggests that nativism, while prevalent across society, was more prominent in the same cultural group as the immigrants under criticism.

“There is also a deeply rooted trend for Americans to blame the most recent immigration group for problems, probably because the immigrants seem too foreign or strange. When a particular immigrant group feels it has established itself, it considers the next group as less worthy. This cycle, too, goes back to the earliest days of the American experience, and we can trace the change in many immigrant groups from despised newcomers to becoming smug nativists, people who attack immigrants or “foreigners”. (Purcell 1995, pp. xii)

Immigrants from two countries were discriminated against and finally barred from entry to the US; the Chinese and the Japanese. Despite this, significant numbers had already arrived in the country. They were treated badly and were disallowed under naturalisation

legislation from becoming American citizens. If they left the USA to visit home, they were not allowed back into the country.

Politicians in the developing USA also used immigration laws to deport individuals or groups of immigrants who they deemed dissident, undesirable or a threat to security. Nevertheless, immigration continued in large numbers throughout the 19th century and into the 20th century, interrupted only by the two world wars. After the Second World War, immigration slowed somewhat and, with various legislative measures in one direction or another, the numbers and original locations of immigrants has been more controlled. Regardless, the USA continues to be the number one country for immigration in the world.

Canada and Migration

The first migrants to land in Canada were the Aboriginal people, previously mentioned with respect to the USA. However, some of these First Nations Peoples believe that humanity was created in Canada and, therefore, they do not recognise themselves as immigrants. (Kelley and Trebilcock 2010) Nevertheless, archaeologists continue to suggest that these people came from Asia, spreading across North and South America. Each nation adapted to the territory where they settled, developing rich cultures and ways of life. Walker describes their status at the time of their first encounters with the colonists from Europe.

“...each had their own language, history, culture, mores and traditions. A rich array of nations had taken root in this part of the world, and this would change when the French and English newcomers, both of whom needed to make allies of the First Peoples, slowly imposed a new order and a new reality upon the region.” (Walker 2008)

It is estimated that about 500,000 First Nations people lived across Canada at the time that the first Europeans arrived on the continent. Unconfirmed reports suggest that Irish monks came to Newfoundland before any other Europeans. (Knowles 2007) While Christopher Columbus stumbled upon North America around 1492, there is evidence that

Vikings (led by Leif Ericson) arrived in Canada around the year 1000 AD, and created a settlement in a place he later named Vinland (on the northern tip of Newfoundland). It seems that their ships were blown off course and they ended up in Labrador. From there they made their way to Newfoundland, where the settlements in the northern part of the province have been uncovered by archaeologists. It appears, though, that the Norse settlers did not remain in Canada for long. "The Greenland colony died out during the 14th and 15th centuries, and the Norse adventures in Canada must have come to an end well before that time." (linksnorth.com 2011)

The first European to make contact with Canada was John Cabot in 1497, who was looking for the treasures of Asia at the time. Although he was an Italian, he arrived in Canada under the auspices of King Henry VII of Great Britain. He landed on the Grand Banks off Newfoundland and claimed the island for England. In 1534, Jaques Cartier arrived on the Gulf of St Lawrence at the entrance to Gaspé Harbour and claimed this newly discovered territory for the King of France, Francis I, by planting a thirty foot cross. Over the next almost 300 years the British and French competed over control of Canada. (Kelley and Trebilcock 2010, linksnorth.com 2011, Access History Web Company 2011) For the most part, both countries made half-hearted attempts at establishing settlements but never provided adequate numbers of people or resources to support them. In addition, they were susceptible to the severe conditions and scurvy, which took many lives. New France, as the French settlement in Quebec was called by Samuel Champlain in 1608 when he founded it, received more concerted input than the small British outposts in various parts of eastern Canada (Nova Scotia) and Hudson's Bay. There is also some evidence that French, Basque, Portuguese and British fisherman came to the Grand Banks for the cod fishery, perhaps on an annual basis. (Kelley and Trebilcock 2010, Powell 2005) After establishing various settlements at what are now Quebec City, Montreal and Port Royal the French explorers invariably returned home for years at a time. Thus the territory survived on a lucrative fur trade conducted by the small number of settlers who stayed. Efforts to

increase the number of immigrants were encouraged by the French government. A group of some 6000 immigrants were provided with passage to Quebec from France. Further, fathers were paid an allowance for each child that they produced. They were also fined if their children did not marry at an early age. All of these efforts at increasing the population were only minimally effective. In total, the population grew to 12,000 people under French rule. The French ceded their territory in North America to the British in the Treaty of Paris (1763). (Access History Web Company 2011) The efforts to maintain immigration in Canada today have a similar goal in seeking to increase the population of the country.

In the period between 1763 and 1812, Canada received a large influx of loyalist British immigrants from the home countries, as well as refugees from the colonies to the south. Much of this migration was spurred by the war of American Independence. According to Barrington, some of these refugees reintroduced slavery into Canada, bringing their black slaves with them into the British territory. (Walker 2008) However, not all blacks who came to Canada were slaves. Many had fled their masters in the south and joined the black British loyalist movement in the north, at the instigation of the British. They were evacuated mostly from New York to Nova Scotia, along with the white refugees from the 13 colonies. Barrington states that there is some question as to whether their loyalty to Britain was real or part of the freedom movement. (Walker 2008) If they could obtain the land they had been promised and were able to be subjects of Britain, then they would surely be free and protected. Nevertheless, they formed a large movement (3000) and had received promises from the British government of land in Nova Scotia for their loyalty. However, these promises were not fulfilled, an issue which was contested for many years afterwards by their descendents. (Kelley and Trebilcock 2010, Walker 2008)

In the earlier part of this period, Nova Scotia was also the destination for many Scots highland immigrants. For the most part they were dispossessed crofters or those caught

up in the upheaval since the defeat of the Jacobites in 1745. From this point on Nova Scotia became a significant area for Scottish immigrants to Canada. (Knowles 2007)

At the same time as the refugees (mentioned above) were entering Nova Scotia, some 10,000 entered Canada through the St. Lawrence and arrived in Quebec and Montreal. Though most of these were British soldiers and their families who intended to recapture and return to their homes, after the war they remained in Canada. Moreover, many others were encouraged to follow them from the United States into the Upper Canada (or West Canada as it became after the treaty of union in 1841) on the promise of free land. This helped to populate the area and at the same time provide a workforce to develop the roads and settlements.

With the increase in British immigrants to the territory, Britain appointed a Chief Emigration Agent (A.C. Buchanan) and, subsequently, many other Emigration Agents. The emphasis was on facilitating migration to Canada from the British Isles.

In 1828, A.C. Buchanan was appointed by Britain as Upper Canada's first Chief Agent for Emigration. The fact that he was an emigration agent, not an immigration officer, speaks volumes about the role Canada played in establishing its own immigration policies during this period. During the first half of the 19th century, immigration to Upper Canada and Lower Canada (named Canada West and Canada East in 1841) largely came from, and was directed by, the British Isles. In fact, Buchanan himself had advised the British authorities to appoint Canadians only as emigration agents, not as immigration officers, to ensure that the administration of immigration to the colony from the mother country was "free from local prejudice." (Library and Archives Canada 2011)

In the same year the British Government passed, "*An Act to Regulate the Carrying of Passengers in Merchant Vessels, 1828*", which regulated the numbers of people who could travel on a ship and the conditions of their passage; including space allocated and the provision of food and water. While some authors suggest that this Act evidences the British recognition of its responsibility for the safety of those leaving the country (Library and Archives Canada 2011), others state that the Act was designed to stem the flow of

emigration by making it more difficult for the ships and their owners (whose reputations were not the best) to accommodate passengers and by making the costs of the passage prohibitive for some. (Kelley and Trebilcock 2010) The former perspective is supported by the fact that this Act was a revision of a previous Act of 1803, designed to provide some protection for emigrants from unscrupulous ship owners and fraudulent ticket sellers.

Emigration from Britain and Ireland increased markedly after 1815, the end of the wars in Europe. The seas were now safe for travel and conditions at home were not good due to industrial revolution, famine and the Scottish Highland "Clearances"¹. Large scale poverty and unemployment led many to make the journey to the 'new world'. Even orphaned children were shipped from Poor Houses, on the belief that they might have a better chance in life by emigrating. While the government saw emigration as a partial solution to the tension and unrest caused by these conditions (especially in Scotland and Ireland), it was wary of sending too many emigrants to the United States, only to increase its population and strength. Hence, the British Government encouraged emigrants to go to Canada.

In addition to the government's motivation for sending people to Canada, trades unions were also motivated to provide financial support to individuals and groups due to the high levels of unemployment in the country. Unions wanted to maintain their wage rates and conditions of service and hoped to do so by reducing the pool of available labour. (Kelley and Trebilcock 2010)

The migration of the British and Irish to Canada continued and increased throughout the 19th Century.

In the 1820s British immigration reached such proportions that it began to transform the face of British North America. Throughout its vast territory,

¹ Landlords discovered that the rewards of sheep farming were more lucrative than the rents paid by the Crofters.

newcomers from England, Ireland and Scotland filled in the settled areas, pushed back the frontiers and introduced welcome funds into cash-starved economies. With their skills and Capital the expatriate British built new Canadian businesses and institutions. But more importantly, they reinforced British customs and values.

Thanks principally to the immigrant tide from Britain the population of the northern provinces grew from less than 500,000 people in 1812 to approximately 2.4 million in 1850. By 1867, the year of confederation, two thirds of British North America's population was British in origin. (Knowles 2007)

The population of British North America of European origin grew from little more than 250,000 in 1791 to 1.6 million in 1845, and to more than 3 million in 1871 (the year of the first census taken after Confederation). Between 1790 and 1845, probably more than 750,000 Britons settled in British North America. About one half of the emigrants were Irish, one third English and one-quarter Scottish. (Kelley and Trebilcock 2010)

When Britain gained control over the territory of 'New France' after 1763, its rule of the territories in the North was not without problem. British law did not allow the participation of Roman Catholics in society, and most of the inhabitants of 'New France' were Roman Catholic. In 1774, the British tried to ameliorate the problem by passing the Quebec Act. This allowed for Roman Catholic participation in daily affairs and maintained much of the French laws and ways of life. It also expanded the territory of Quebec as far east as Labrador and as far south as some lands in Mississippi and Ohio. This Act was partly responsible for some of the irritations of people in the 13 British North American Colonies which led to the American war of Revolution. In 1791 The Constitution Act divided Quebec into Upper and Lower Canada. (The Colonies in the Maritimes - New Brunswick and Cape Breton - already had individual governments.)

This Act was intended to standardize British Parliamentary traditions and systems and to ensure that the individual rights and liberties were maintained through all of the colonies. It was also a different way to handle the delicate question of taxation in the colonies. Rather than impose taxes and levies from England, the Governor of the colony was responsible for imposing revenue generating policies in the colony in conjunction with his appointed council. This increased the real power of the Governor and removed Parliament in London from any blame concerning fiscal and taxation issues in the Canadas. (Access History Web Company 2011)

The ruling councils in both Lower and Upper Canada were composed of individuals with vested interests in their own businesses and politics. Lower classes' and immigrants' interests were not served by them. In Upper Canada the council progressed the interests of wealthy merchants and businessmen, while in Lower Canada they appointed 'Anglophones' to the council and they served the interests of the English-speaking minority. They pressed for unity between Upper and Lower Canada. In 1841 this union was formed when Canada East and Canada West were created as one Canada. Each part of Canada was to have 42 representatives in the new legislature, "even though the predominantly French speaking Canada East had 200,000 more people." (Access History Web Company 2011) Legislative business was conducted in English. Upper Canada, who were carrying a major debt from infrastructure develops (which served the businessmen on council), were able to reconcile some of that debt by putting it on the books of Canada. Lower Canada had no debt and was financially sound. Upper Canada, then, was highly motivated to increase immigration on two counts: to outnumber the 'Francophones' in Quebec and to rapidly increase economic growth. (Access History Web Company 2011)

In 1864, the Maritime colonies planned to meet to discuss a Union among them – New Brunswick, Prince Edward Island, Nova Scotia. However, unknown to them at the time, eight Canadians (from East and West Canada) were on their way to propose a federal union among the colonies. From this conference the idea of a federal government for all of Canada, with each province having its own legislative assembly and prime minister, and both levels of government overseen by the British Parliament, was developed. A second conference to iron out details and prepare a proposal to send to London was arranged, to take place in Quebec in October of the same year. The two Canadas, Nova Scotia and New Brunswick all agreed to join and the proposal was put to the British in a London conference in December 1866. It was passed by the British Parliament in March of 1867 and on July 1, 1867 the Dominion of Canada was officially declared by Royal Statute. The

other provinces joined at various times, with Newfoundland being the last to join as late as 1949. (Kelley and Trebilcock 2010, Knowles 2007, Access History Web Company 2011)

Settlement in the west occurred much later than in the east of Canada. The Hudson Bay Company (HBC), which had been formed by a charter from King Charles II in 1670, operated trading posts and forts in the West and North West, and owned large amounts of land. The two companies came into conflict over trading routes and after a massacre at Seven Oaks resulted in the deaths of 21 men from Northwest Company, and an invasion from the south destroyed their trading post in Sault Ste. Marie, they were forced into a merger with HBC. (Access History Web Company 2011)

In the years immediately before Confederation, explorers were sent out to present a picture of the potential of the west, with a particular focus on its agricultural possibilities. Writers, reporters and orators recreated the image of the territory in the minds of their audiences, as a spectacular garden, ripe for farming activity.

According to Owram, between 1856 and 1869 the image of the west was transformed in Canadian writings and political and public discourse, from a semi-arctic wilderness to a fertile garden well adapted to agricultural pursuits. This newly discovered potential allowed the west to be seen as the means by which Canada would be lifted from colony to nation. (Kelley and Trebilcock 2010)

In the initial period of Confederation the need for emphasis on uniting east and west was proffered by the first Prime Minister, John A. MacDonald and his colleagues. They pursued the idea of a railway linking Canada from sea to sea. The recent invention of the steam engine made this a possibility. They also wanted to open up the lands to the west for farming and to create a market for products manufactured in the east. However, to achieve this aim required that more immigrants (farm workers) be brought into Canada. In 1859 Canada sent recruiters to Britain (Liverpool) and to Germany, to find suitable agricultural workers. This foreshadowed the immigration agents who were appointed to the Dominion

of Canada at the end of the 19th Century, and recruited from Britain and all over Europe with great success.

Following Confederation, the newly formed country of Canada began to develop its own national immigration policies. Seeking rapid population growth and economic expansion, the country was more interested in enticing than it was in restricting immigration. Its open-door policy helped attract a more diverse group of arrivals than ever before, but not all the new immigrants were welcomed with open arms. (Library and Archives Canada 2011)

Initially, these immigrants were located in the Prairie Provinces – Manitoba for the most part. By the 1880s immigration had been reduced to a trickle. High tariffs between Canada and the United States interfered with the goals of the Federal government, as the immigrants encountered hardship because they could not sell their excess produce. Many didn't stay and left their farms to head south into the US. MacDonald's policy of relying on the British for trade and immigration was no longer working. Immigration did not pick up again until a new liberal government campaigned across Europe for farmers to fill the Prairie Provinces in the last few years of the century.

While Britain had been involved in British Columbia (BC) since Cook landed on Vancouver Island (around 1776), it only declared BC a colony in 1858, shortly after the "Fraser Gold rush", which saw some 25,000 immigrants move into the province. (Kelley and Trebilcock 2010) British Columbia threatened to become a state of the USA right up to the time it joined Confederation in 1871. With the US having purchased Alaska from the Russians, and having taken over and developed the west coast states of Oregon and Washington, there was a belief in North America that it was inevitable that all of the northern continent would become part of the United States. In addition, the American army was strong following the civil war. When BC joined confederation, Canada finally was a nation from sea-to-sea and coast-to-coast.

As stated above, immigration had slowed in the early 1880s. In fact, “The number of immigrants between 1881 and 1896 who had applied for their free land was only 56,520 and of these only 40,194 had come west.” (Access History Web Company 2011) The MP from Manitoba, Sifton, was made Minister of the Interior in the Laurier Government and, as such, was responsible for immigration. He understood what was required on the Prairies. In the same time period a new type of wheat had been developed in Glasgow, Scotland which was fast growing and could be grown and harvested before the bad weather arrived in the fall. It was also a hardier type of wheat and could be grown even further north. Sifton understood that one of the things that held back immigrants was their inability to obtain their free 160 acres because the Railway Company CPR had been promised massive amounts of land in exchange for building the railway. They had not yet selected their land and this was holding up everything else. Sifton forced the issue with CPR and made them “choose or lose” their land. This cleared the way for immigrants to take possession of their 160 acres of free land as soon as they arrived in Canada. Further, Sifton sent out agents across Britain and Europe to recruit farmers to come to the Prairies. He also mounted a recruitment campaign in the US. This produced remarkable results!

In 1897, the number of immigrants had increased to 32,000 from 16,835 two years earlier and from 1896 to 1911 over 2,000,000 immigrants arrived in Canada which in the 1901 census had only 5,371,315 people but by 1911 was up to 7,206,643 people. Of the arrivals 38% were from Great Britain, 34% were from the US and 26% from the rest of Europe. During the same period Manitoba’s population swelled from 255,211 to 455,625 and Saskatchewan and Alberta went from 164,281 to 867,095. (Access History Web Company 2011)

While these figures tell one half of the story of the success of Sifton’s policies, Hawkins completes the picture by demonstrating the success of the advertising and recruitment campaigns.

Some two and a half million immigrants came to Canada between 1896 and 1914. Of these, it is estimated that close to a million came from Britain; more than three quarters of a million came from the United States, many of them returning Canadians; and more than half a million came from continental Europe...more than a million settlers from all three groups arrived on the Prairies and in British Columbia during the peak period of immigration

between 1901 and 1911. While the majority were English speaking, there were considerable numbers from Germany, Scandinavia, the Netherlands, Russia (including many from the Ukraine), Austria, Hungary, Italy and what is now Poland, as well as a large Jewish group. It was the beginning of diversification of Canada's population and the point of origin of some of her largest, present-day ethnic communities. (Hawkins 1991)

Despite the success of this recruitment drive and the desire to attract as many immigrants as possible, the policies of the Laurier government were such that a significant number of applicants were denied entry. These policies were presented in various formats including claims to be protecting the people who were refused entry because Canada's harsh climate posed a serious threat to their survival. In truth, the determinations of who was accepted and refused were more varied and sinister.

Popular pseudo-scientific race theories concerning the perceived ability of certain ethnic groups to 'conform' to the Anglo-Canadian identity resulted in many potential immigrants barred from entering Canada. Sifton, and particularly his successors, believed some groups to be inferior and unable to assimilate. Calculating immigrants' 'foreignness' took into consideration the hue of the foreigner's skin; the darker the skin, the more 'foreign' the immigrant was supposed to be. Also important in determining 'foreignness' was the extent to which the immigrant's religious, political and social institutions differed from those of the British. A type of racial hierarchy based on these 'standards' emerged. The British headed the list as the most desired settlers, followed by Americans and northern and western Europeans. Less desired settlers included central and eastern Europeans; who, in turn, were followed by southern Europeans. The least desired settlers included Asiatics and Blacks.

Climate was often cited as the reason for the preference of certain ethnic groups over others in the selection of immigrants. According to social reformers climate was an important factor in the process of race selection. Many believed that Canada's hardy climate would ensure that only immigrants belonging to the 'sturdy' Northern races would flourish in Canada. Canadian agents discouraged numerous proposals made by African Americans spokespersons providing climate as the primary reason. Canadian immigration officials maintained that the Canadian climate was harsh, unforgiving, and potentially fatal to races accustomed to warmer surroundings. Between 1901 and 1911 less than 1,500 Blacks entered Canada. (Jakobsen 2011)

Other races deemed undesirable were the Chinese, Japanese and South Asians. Under public pressure, the government devised various ways to keep them out of Canada, including passing the Immigration Act of 1910 which allowed them to use these methods.

One such method, which recently came back to bite the Canadian people was the head tax on all Chinese immigrants. This tax was increased rapidly to discourage Chinese people from even considering immigration to Canada. The tax went from \$50 in 1886 to \$500.00 by 1904. Still, Chinese people immigrated to Canada, until the tax finally had its desired effect after the war of 1914-18, when Chinese immigration all but ceased. (Brune, Calverley and Sweeny 2011)

With the assistance of Britain, Japan agreed to keep Japanese immigration in check. Another strategy, aimed at preventing a specific ethnic group from entering Canada, was the "continuous journey" clause in the Immigration Act of 1908. This made it impossible for immigrants from India to land in Canada legally, because it required them to travel to Canada in an uninterrupted journey; a journey which was impossible as ocean steamers agreed not to travel directly from India to Canada. (Brune, Calverley and Sweeny 2011) These efforts signalled a change in Canadian immigration policy from the previous "open door" policies.

Immigration to Canada was vigorous throughout the 20th Century, other than during the 'depression' and the periods around the two world wars. As previously identified, countries needed their citizens to serve in armies and work in their factories, most countries had full employment during the wars, and travel on the seas was too dangerous.

A result of the high levels of immigration before the First World War was the formation, from the North West Territories, of two new provinces in 1905; Saskatchewan and Alberta. The Klondike gold rush, which started in 1896 brought miners from the United States and Russia, as well as many other countries. At the time the US had closed the frontier and no more free land was available. However, the gold rush made people aware of the extent of land available in Canada. After the gold rush was over, there was a major migration of farmers, or those seeking to be farmers, to the two areas which became the provinces of

Alberta and Saskatchewan. Adding to the attraction of these provinces were the healthy economic circumstances around the world and Canada's ability to sell wheat abroad. Further, around this same period, other minerals, ores and silver were discovered in British Columbia and Ontario, leading to a world impression of Canada "as a mineral-rich nation with great untapped potential". (linksnorth.com 2011) 1913 represents a peak in immigration to Canada. Some 400,870 people migrated from the UK and several other European countries. (Kelley and Trebilcock 2010, Library and Archives Canada 2011, Jakobsen 2011) The mass immigration during this entire period led to significant changes within Canada. First the population was no longer British Protestant in origin. White people spoke many different languages and practiced many different religions and ways of living. Secondly, the increase in numbers outside the former Upper Canada led to a need for political reform. The railways, gold rushes and free land encouraged people to move west when they landed in Canada. Thirdly, the same attractions brought many immigrants from non-white countries, which resulted in conflict and racism and the implementation of immigration laws and policies which reflected this. Not that these were not already present; as Hawkins says, white racism towards other whites was contained only by the need and desire to work and prosper together (although white English-speaking Canadians thought that the ways of central and eastern Europeans were strange). (Hawkins 1991) However, even this degree of respect was not forthcoming for migrants from Asia. It was commonly believed that these people would work for less and takeover the jobs of the whites, that their ways of life were not compatible or, indeed acceptable to Canadians, and, because of a lack of awareness and understanding of their culture, that they were evil people.

World War I created conditions where immigration to Canada was virtually brought to a halt. The war also increased racist sentiment, particularly in the aftermath when migrants from enemy countries were the focus of attention (during the war, individuals from Germany and Hungary were interned in Canada.) Additionally, Canada had suffered an

economic downturn in the run up to the war, due to shifts in the markets and the loss of foreign credit. One example was the collapse of the wheat market. This led to high rates of unemployment; another theme throughout Canadian history which prompted racist sentiment among the population. However, this economic downturn did not last long after Canada joined the war in 1914 and it seems that both situations were unexpected.

Just as the costs of the war effort were not anticipated in 1914, neither were the tremendous economic changes set in motion by Canada's involvement in the war. The war generated demand for such things as tanks, aircraft, sea vessels and explosives which stimulated existing industries in Canada and induced the development of new ones. Although the economic boom was interrupted in the recessionary years that followed the cessation of hostilities, it nevertheless revived by the mid 1920s and continued to the close of that decade. (Kelley and Trebilcock 2010)

The result of this was that Canada's economy was now much more diversified and new industries, such as the production of pulp and paper, mining of gold, silver, nickel, lead and zinc, and the generation of hydro-electric power became more significant than the iron, steel and coal industries. (Kelley and Trebilcock 2010)

As is evidenced throughout this thesis, to this point Canada had operated a more or less open policy in regard to immigration. However, from the period before the war of 1914-18 forward immigration policy was more controlled with restrictions based on the economic situation within Canada, as well as fears and racist sentiment enhanced by wars. According to Hawkins there have been six important immigration acts in Canada since Confederation – 1869, 1906, 1910, 1919, 1952 and 1976. (Hawkins 1991) These, in addition to lesser Acts, regulations and rules, have created the climate for migration to Canada throughout the twentieth century. In general, Canada has remained open to immigration with some restrictions based on the economic situation, demands for labour, intentions to bar migrants from certain countries or to prevent refugee groups from coming to Canada. The years of the depression (1929-37) and during the Second World War (1939-45) saw major alterations in immigration policy, reflective of severe economic downturn, public

suspiciousness of non-English-speaking (British) immigrants, and government fears of destabilization in Canadian society. For a long time Canada would not even accept refugees from the war based on fears of overwhelm or sedition. Immigration numbers reached the lowest recorded. Canada went from its record high of 400,870 in 1913 to a low of 7448 in 1943. Overall, between 1939 and 1945 100,000 immigrants landed in Canada. Most of these were the wives and children of individuals already resident in Canada. (Kelley and Trebilcock 2010)

Perhaps the best way to understand Canada's wartime treatment of aliens, both refugees and residents, is to acknowledge that the government's policies were motivated by an amalgam of factors, some of which, like national security, are understandable within the context of war, and others, like racism, more enduring and pervasive. What is particularly striking about Canada's wartime policies, however, with respect to prospective immigrants and resident aliens, is that they were formalized in statutes that were sweeping in scope, that sanctioned extensive delegation of authority and that were relatively free from parliamentary or judicial scrutiny. Thus, immigration policies adopted pursuant to the Immigration Act, and internal security measures effected under the War Measures Act, were subject to uneven application and abuse of authority, which caused hardship to immigrants and Canadians alike. (pp. 314-315)

After the war, the economy picked up and this played its part in a significant shift in public attitudes towards non-white and non-European Canadians and immigrants. As with previous times, economic prosperity tended to mute racial concerns and disharmony. Since many of the so called alien races had fought together with Anglo-Saxon Canadians in the armed forces there was a new respect for each other which gained momentum after the war. Over time, Canadians began to accept the concept of a multicultural society and started to move away from the predominantly Anglo-Saxon society of the pre-war years. Moreover, Hitler's policies and atrocities caused people to be more aware of where ideas of racial difference and superiority could lead. "...public expression of racial intolerance became less acceptable." (Kelley and Trebilcock 2010, pp.315)

Despite this new openness and tolerance Hawkins describes a policy of maintaining a White Canada which lasted to 1962 unopposed by any Prime Minister, political party or

politician. (Hawkins 1991) Even in 1962 she claims it was officials and not politicians who prompted the change. In the sixteen years between 1946 and 1962 over 2,150,000 immigrants entered Canada. In the same period Canada also accepted almost one quarter of a million refugees. Unlike immigration at the turn of the century, the make-up of this cohort was varied among European countries, especially eastern Europeans. Canada was now part of the world community and participated in various forums, including the United Nations, the North Atlantic Treaty Organization and various international trade agreements. This participation had its impact on Canada's growing liberal approach to immigration.

In 1967, Canada instituted a points system for immigration, with points awarded on the basis of a broad range of factors, e.g. languages spoken, education, intended location and so on. This system was perceived as being fairer though parts of it were still subject to the interpretation of individual immigration officers. Further, in 1970 Visas which allowed a person to work in Canada for one year were issued. They were granted only for specific jobs for which no Canadians were available. The visa system allowed the government to quickly fill specific vacancies without having to increase immigration.

The 1976 Immigration Act, the result of wide public consultation, represented efforts to make immigration policy and decision-making in Canada transparent and increase due process for applicants. This policy was pursued under successive governments for the next 25 years, though under some strain due to the significant increase in refugees from non-traditional countries. However, the perception that transparency was a priority changed with the events of September 11, 2001 in the U.S.A., Canada's closest neighbour, and the perceived threat from terrorism.

The government was already working on a complete revision of the immigration act, due to the fact that there had been 30 amendments or rulings since its proclamation. The

resultant Immigration and Refugee Protection Act reversed the progress that had been made and shifted power back to executive decision. It is also the Act which instituted the skilled workers class for immigration, temporary work permits, as well as, in collaboration with provincial governments, the nominee program. These are the parts of the act which have most importance for the migrant healthcare professionals in this study.

This short synopsis of Canadian immigration history points to a system founded on colonialism and exploitation of Canada by those first European migrants. It also underlines that migration in Canada has come full circle in its acceptance of the majority of its migrants from the Asian continent, if one accepts that First Nations' Peoples originated in Asia. Further, it highlights the key factors affecting immigration as economic performance, pressure from employers to increase their labour forces efficiently when needed, an underlying belief that whoever comes to Canada should integrate quickly and not cause problems for those already here, and a vacillating commitment to accept those in need of protection. Fears, first voiced by labour groups, about the impact of immigrants on the current labour force appear to be receding as their own evidence suggests that the impact is minimal. (Kelley and Trebilcock 2010, Walker 2008) Migrant healthcare professionals have been in high demand in Canada and will be again in the near future. Many of the experiences of past migrants, recorded in the documentary process above, will continue to create the context of transition for these migrant healthcare professionals.

Ireland and Migration

Though Ireland is most often referred to as a country of emigration, and though more recently it is perceived as having changed to a country of immigration during the years of the "Celtic Tiger" (c.1996-2006), there is ample evidence that Ireland has been a country of both immigration and emigration throughout its long and ancient history. The more distant history of Ireland, prior to 400 A.D., is difficult to substantiate, but most authors agree that the original inhabitants of Ireland were most likely 'hunter-gatherers' who

travelled there from the European continent at the end of the Ice Age, and probably via a land-bridge. (Moody, Martin and Radio Telefís Éireann 1994, Oppenheimer 2006) Not much is known of the history of this period and so authors assume that by around 4000BC Neolithic people inhabited the island and introduced farming. Joyce (1915) offers “legendary” evidence of the existence of five ancient colonies in Ireland between the “fanciful dates” of A.M. 2520 and A.M. 3500 (Anno Mundi):

The **Parthalonians**: ...The first man that led a colony to Ireland after the flood was a chief named Parthalon, who came hither from Greece, with his wife, his three sons, and 1,000 followers...At the end of 300 years the people of this colony were destroyed by a plague, which carried off 9,000 of them in one week on Moy-Elta.

The **Nemedians**: the second colony, A. M. 2850. After the destruction of the Parthalonians Nemed came from Scythia with his followers. These Nemedians were harassed by the Fomorian pirates, but Nemed defeated them in several battles. After some years he and 3,000 of his followers died of the plague.

The **Firbolgs**: the third colony, A. M. 3266, came from Greece under the leadership of the five sons of Dela, who led them to Ireland. These brothers partitioned the country into five provinces, Ulster, Leinster, Connaught, and the two Munsters.

The **Dedannans**: the fourth colony, A. M. 3303, also came from Greece, and were celebrated for their skill in magic. As soon as they had landed in Ireland they burned their ships; and shrouding themselves in a magic mist, so that the Firbolgs could not see them, they marched unperceived to Slieve an-Ierin mountain in the present county Leitrim. Soon afterwards a battle was fought which lasted for four days, till the Firbolgs were defeated, and the Dedannans remained masters of the island. These Dedannans were in subsequent ages deified and became *Side* [Shee] or fairies, whom the ancient Irish worshipped.

The **Milesians**: the fifth colony, A. M. 3500. From Scythia their original home they began their long pilgrimage. Their first migration was to Egypt, where they were sojourning at the time that Pharaoh and his host were drowned in the Red Sea; and after wandering through Europe for many generations they arrived in Spain. Here they abode for a long time; and at last they came to Ireland with a fleet of thirty ships under the command of the eight sons of the hero Miled or Milesius.

The Dedannans, by their magical incantations, raised a furious tempest which scattered and wrecked the fleet along the rocky coasts. Five of the eight brothers perished; and the remaining three, Eremon, Eber-Finn, and Amergin, landed with the remnant of their people. Soon afterwards two battles were fought, in which the Dedannans were defeated; and the Milesians took possession of the country. (Joyce 1915)

While many ancient historical records were either oral histories or manuscripts destroyed in later invasions and acts of aggression, O'Curry states that there are records of records, if not the original documents themselves, which allude to these events being somewhat factual. (O'Curry 1878) Whether legend or not, fanciful or not, there is little doubt that Ireland was populated during this time by migrants from various parts of the European continent. In terms of the foreground of this study of migrant healthcare professionals in Ireland and Canada, the similarities between the migration of the first settlers to Ireland and the migration of those first settlers to North America are remarkable.

There is evidence in the artefacts found by archaeologists that the peoples of Ancient Ireland progressed through the Neolithic age (8000-4000 BC), to the Bronze Age (2000 BC), and into the Iron Age (600 BC) with continued migration into the country. (Wallace and Ó Floinn 2002, Bardon and Healey 1996) Further, in the period after this it is believed that small groups of Celtic speaking people infiltrated Ireland and had an influence on the culture over time (Bardon and Healey 1996). Celtic artefacts can be traced to around 300 BC in the Northern part of the Island. (Wallace and Ó Floinn 2002). The Celtic culture, mixed with that of the indigenous people, eventually produced the Gaelic culture by around the 5th Century. These Celts were emigrants from Ireland, as well as immigrants to Ireland. According to MacNiocaill (1972) there were colonies of Celts in Wales and possibly in Cornwall, England from the third century through to the eighth century. These people apparently maintained contact with their home colony in Munster.

According to Joyce (1915) and MacNiocaill (1972), Ireland was now divided into several Kingdoms which were never truly settled and were perpetually at war with one another or with invaders over the next 500 years or more. During this time, one of these monarchs ruled all Ireland, but this constantly changed as wars were fought and monarchs died, and new ones were declared or declared themselves. Up to around the 5th Century, most of Ireland's history was an oral one. (Mac Niocaill 1972) The more accurate records of Irish

history are derived from writings of the monastic churches and secular orders of learning. (Kenney 1929) There is some evidence of Christians being in Ireland prior to the fifth century, but the uptake of Christianity in Ireland during the mission of St. Patrick (A.D. 432-465) is unrivalled in world history. (Joyce 1915, O'Curry 1878) St. Patrick was, of course, himself an immigrant (most likely from Scotland). (Joyce 1915) His fellow missionaries would have been immigrants likewise, as would many of the monks and Christian followers who came to live in Ireland around that period. Patrick came to Ireland when he was 45 years of age and died at about 78 years of age. During more than two hundred years following his death, the Christian Church flourished in Ireland. Many monasteries and convents were established and many churches built. Additionally, since these orders were also the seat of learning in Ireland, they created many schools. These schools attracted immigrants from abroad, from Britain and elsewhere – Gauls, Germans, Romans and Egyptians. Ireland gained a reputation for its teaching and learning. As a result, many of the learned migrated to other countries to teach there.

Whole crowds of ardent and learned Irishmen travelled to the Continent, spreading Christianity and secular knowledge among people ten times more rude and dangerous in those ages than the inhabitants of these islands. Irish professors and teachers were in those times held in such estimation that they were employed in most of the schools and colleges of Great Britain, France, Germany, and Italy. To this day in many towns of France, Germany, Switzerland, and Italy, Irishmen are venerated as patron saints. Nay, they found their way even to Iceland; for we have the best authority for the statement that when the Norwegians first arrived at that island, they found there Irish books, bells, croziers, and other traces of Irish missionaries. (Joyce 1915)

As we shall see in the next chapter, this Irish tradition of exporting scholarship and skilled people has continued even to today. While this is an important aspect of the Irish migration story, as background to this thesis, this study is more focused on the resultant in-migration; in particular, in-migration of healthcare professionals.

During these 200 years or more of the growth of Christianity and learning, and violent skirmishes and wars over kingdoms in Ireland, two major plagues had a profound impact.

The first is said to have been in 546 and the second, "The Great Plague" between 646 and 666. Each of these plagues accounted for the deaths of a third of the total population of the island. During the eighth Century, pestilences, diseases and famines were frequently visited upon the people of Ireland. (Mac Niocaill 1972)

The first Norsemen are acknowledged as arriving on the shores of Ireland in or around A.D. 798. (Joyce 1915, Mac Niocaill 1972, Duffy 2000)

The onslaught of the Norse sea-kings was the next great movement, after the introduction of Christianity, to affect seriously Irish life and civilisation. These freebooters began their attacks in 795, and continued to be a constant menace for more than two centuries. (Kenney 1929, pp.7)

Kenney then goes on to describe three stages of the invasion by the Vikings from Norway. The first stage lasted for most of the ninth century and involved "pillaging descents on the coast, with raids inland which penetrated deeper and deeper until all parts of the island were being harassed, but with the enemy usually sailing home before the winter storms began." (Kenney 1929, pp.7) The second stage involved the establishment of settlements at strategic locations. These then served as bases from which to foray into the neighbouring territories to plunder and subjugate them. The third stage involved invasion by amassed armies from the home nations in attempts at large scale conquest. At the famous battle of Clontarf in 1014 the invaders met with a serious defeat. According to Kenney, "Thereafter, the Northmen seem to have abandoned hope of subjugating Ireland, and their settlements tended more and more to accept the status of principalities within the Irish polity." (Kenney 1929, pp.8)

This invasion, lasting as long as it did, inevitably brought harm to the church in Ireland and, thereby, to learning. There are records of the repeated sacking of churches and monasteries, with the loss of manuscripts, records and artefacts. More significantly in this study, the aftermath caused the church to become more united with the church in Europe in general and resulted in an influx of foreign orders of monks, priests and religious to

Ireland. Nevertheless, the dominant language of ecclesiastical literature moved back towards Irish. (Kenney 1929)

These experiences of invasion also focused the country towards pursuing more joint and national interests. It created more of a move towards the re-establishment of an Irish identity. Nevertheless, by the 12th Century, Ireland continued to suffer from the continuous skirmishes between Kings and Kingdoms. As a result of an inadvertent decision by one such King, the English interest and efforts to subjugate Ireland began.

English conquest began somewhat inadvertently in 1166 when the king of Leinster, Ireland's eastern province, invited Norman lords from south Wales to assist him against his rival and nominal chief, (Rory O'Connor), the ard ri, or high king, of Ireland. (Miller 1985, pp.11)

Though this prompted the beginning of the English exploits in Ireland, according to Joyce it was a long time before the conquest was successful.

The conquest of Ireland ...might have been accomplished in a few years, if only proper measures had been adopted. Why it took so long was pointed out nearly three hundred years ago by Sir John Davies, an Englishman, who was attorney general of Ireland.

The force employed in the first instance was wholly insufficient for conquest. The king did not reside in Dublin; and there was no adequate representative of royalty with state and power to overawe the whole people both native and colonial. The great Anglo-Norman lords had too much power in their hands, and for their own selfish ends kept the country in a state of perpetual warfare. Great tracts of land belonged to absentees living in England, who merely drew their rents and did nothing for the country. But the most fatal and disastrous mistake of all was this. The native Irish, sick of anarchy, would have welcomed any strong government able and willing to maintain peace and protect them from violence. But the government, instead of treating them as subjects to be cared for, and placing them under the law that ruled the colonists, looked upon them as enemies, and refused them the protection of English law. Henry II did not conquer Ireland: it would have been better for both nations if he had. It took more than four centuries to do that—probably the longest conquest-agony recorded in history. (Joyce 1915)

As stated above, King Diarmait Mac Murchada of Leinster had been displaced from his Kingdom by the 'King of all Ireland'. He sought permission from Henry II of England to hire

Norman Knights to assist him in his effort to regain his throne. Bringing the Norman Knights, as well as an army of regular Normans, Welsh and Flemings, he took back his Kingdom and named his nephew as heir. This concerned Henry, as he did not want to have the threat of a Norman state next to his own. With papal permission, Henry invaded Ireland in 1171 and declared himself ruler of Ireland. He gave away large amounts of Irish lands and property to his the loyal barons, thus dispossessing the Irish Chiefs. He made his son Lord over Ireland, but when his son eventually became King of England the Lordship of Ireland now fell under the English Crown. Following Henry's invasion, Norman settlements were established on the east coast of Ireland. However, the English effort to limit them weakened their hold. Over the next 100 years Irish Lords regained much of the land they had lost through this in-fighting between the English and Normans, and because the English were distracted by matters elsewhere. (Miller 1985, pp.15) When another plague hit the Island in 1348 the English and Normans were worst hit since they lived in close proximity in cities, with Irish people more spread out in rural areas. As a result, after the plague, Ireland returned to speaking Gaelic and Irish customs were restored. This condition, and the in-fighting between and among Irish Kings, continued until the Tudor invasion in the early 1500s. Henry VIII declared himself King of Ireland after putting down rebellion on the Island. He decided to extend his control in an effort to prevent Ireland from ever being a base from which his enemies could invade England. He changed laws, changed land ownership and, after his break with Rome, persecuted Catholics throughout his kingdom. In Ireland, over the next 150 years, English influence led to the "Protestant Ascendancy". All power was removed from Catholics and their activities severely limited. The Protestant minority were awarded all power and rights at the expense of Catholics, who became subservient to them. These conditions were partly responsible for many Catholics migrating to countries who were enemies of England, even joining their armies to fight against the English. Others either emigrated or were sent abroad as slaves. (Joyce 1915, Miller 1985) In this same period, the English government passed laws preventing the export of Irish wool to anywhere except England and Wales. Concurrently, "rent

racking” started in Ireland; a process whereby the landlord could raise the rent whenever the lease ran out. This was in contrast to practice up to that point which allowed for 30 year renewable leases with no increase in rent. Further, the years 1714 to 1719 were years of drought in Ireland leading to hardship, the decimation of the sheep stocks and the resultant major impact, together with the previously mentioned “Woollens Act”, on the wool industry. All of these factors converged to produce a period of mass emigration from Ireland; Ulster in particular. These were the Scotch-Irish previously referred to in the section above on North American migration.

The Irish in North America

Thomas D’Arcy McGee recounts a tale that St. Brandon left Ireland for “Irland It Mikla” (Great Ireland) as early as the sixth century. (McGee 2011) However, he does recognize that the Vikings were likely the first to travel there from the west and landed on the continent some 500 years before Columbus made his voyage (Chapter I). Despite this, Columbus discovery or rediscovery of the ‘New World’ would lead to an emigration from Ireland like none ever seen before.

As previously mentioned, it was nearly a hundred years after Columbus first landed before settlers started to arrive in the new colonies. Irish migration had started before then, with mercenaries joining the French, Portuguese and Spanish armies. As a consequence of this move, they became part of expeditions to various parts of the Caribbean and North America, including Canada. (Miller 1985, McGee 2011)

After the Reformation, Irish Catholic migration was first directed to non-British jurisdictions, including Spain, France, the Low Countries, and the German principalities. Often the Irish Catholic nobility, members of defeated Irish armies, and clergy offered themselves in service to many of Europe’s Catholic monarchs. It was from these early migrants that Canada received its first Irish settlers. In the seventeenth century, Irish residents in France were among those sent to colonize the St Lawrence valley. In 1700 there were approximately one hundred Irish-born families among the 2,500 families registered in ‘New France’, along with an additional thirty families of mixed Irish and French backgrounds. (Wilson 1989)

According to Canny (1994) not many sources refer to the Irish emigration of the 17th and 18th Centuries to a variety of locations around the world. During this period Irish immigrants represented a higher proportion of total migrants within and outwith all of Europe.

The Irish Diaspora of the seventeenth and eighteenth centuries has received comparatively little attention from historians, largely because it has been overshadowed in the popular imagination by the great emigration of the nineteenth century. ...Irish men and women who crossed the North Atlantic in the nineteenth century constituted less than a quarter of the Europeans who sought North American destinations and still a smaller fraction of the total movement from Europe to America, North and South combined. By contrast, during the neglected period, the Irish constituted from mid-century the largest single flow of white immigrants to the seventeenth-century West Indies; they were the most important source of supply of mercenary soldiers in three critical decades, the 1600s, the 1650s, and the 1690s; and Ulster Scots were the most constant and at times the largest element among European migrants to mainland North America in the eighteenth century. (Canny 1994, pp.113)

These immigrants went in all directions ending up in the Amazon Basin, North America, the West Indies, and Europe, as well as with the English East India Company and the French East India Company. Further, Knowles reports that between the 1770s and 1830s, the area around Waterford in Ireland provided a steady stream of migrants to Newfoundland; some 30,000 settlers in all. However, many of them later moved south to the North American mainland at New England. (Knowles 2007, pp.31)

At home, times were relatively peaceful throughout the 18th century. Famine in 1740 and 1741 killed around 400,000 people and was part of the momentum of emigration which saw 150,000-250,000 people leave Ireland (depending on which sources you read). The behaviour of landlords in Ireland and the lack of success in getting more power and decision-making devolved to the Irish Parliament in Dublin fired the flames of republicanism. In 1791 the Society of United Irishmen was established in Belfast, encompassing all Irishmen of every persuasion. In 1798 a bloody rebellion in Ireland was put down and led to the Act of Union of 1801, when Ireland became even more tightly controlled by Britain. (Bartlett 2011)

The first impulse of anyone discussing or writing about Irish migration is to jump immediately to the nineteenth century, regardless of all of the history above (and more). Perhaps more has been written about this period in Irish history than any other, or it may have more significance for our times, but a search of the literature produces an unwieldy mass of documents on the events between the early years of the nineteenth century up to around the 1920s. Here, I will continue only to point to events related to the migration context and environment in Ireland which provides background for this study and the migration of healthcare professionals in recent times.

Firstly, Purcell exclaims the extent of Irish immigration to the USA in the years before, during and after the famine.

The history of Ireland – “that most distressful nation” – is full of drama and tragedy, but nothing rivals the astounding story of what happened to the Irish during the mid-19th century and how millions of Irish came to live in America.

Although the peak of the drama was the years of the devastating potato famine from 1845 to 1848, immigration historians point out that immigration from Ireland was significant before the famine and continued very strong until the turn of the 20th century: in the 100 years between the first recording of immigrants in 1820 and the passage of immigration restrictions in 1924, well over 4.5 million Irish immigrated to the United States. (Purcell 1995, pp.31)

With the population of Ireland reaching almost eight and a quarter million in the late 1830s, dissatisfaction with English rule, and the cheap cost of transportation across the Atlantic, some 300,000 Irish emigrants moved to North America between 1820 and 1840. (Purcell 1995, pp.32) Some of these migrants were sponsored and sent to Canada by the British Government in an effort to ‘quiet’ Ireland. There, Peter Robinson, the first commissioner of Crown Lands in Canada, was assigned to oversee the settlement of these migrants. He was successful with two groups of immigrants, 600 individuals in 1823 and another 2000 in 1825. Such was the success of these two ventures that, when the British Government cancelled the funding in 1827 it did not stop migrants from continuing to come.

In any event, the publicity surrounding the assisted immigrants spurred independent immigrants to follow, and follow they did in large numbers during the great immigration fever that gripped Britain in the 1830s and 1840s. (Knowles 2007)

Wilson (1994) provides further description of the context in Ireland prior to the mass exodus,

The Irish who crossed the Atlantic during the 19th century came from an overcrowded, overwhelmingly agricultural country. Apart from Belfast and its environs, Ireland was not directly affected by the Industrial Revolution, and farming was much the most common occupation. Irish agriculture was highly labour-intensive; farmers depended mostly on human labour, rather than on machines or animals. Most farms were small and were worked only by family members. (Wilson 1989, pp.5)

He then provides details on the extent of this migration to Canada and its effects on the population back home, over the longer term.

Between 1851 and 1921, over 4 ½ million people left Ireland for North America and Australasia. More than 80 per cent of these emigrants went to the United States; in contrast, only about 7 per cent landed in Canada. Back in Ireland, the population continued to fall steadily until 1911, when it stabilized at around 4 1/3 million. But it was not until the 1960's that the demographic curves began to turn upwards. For a brief period, there was even a net migration into Ireland. Nevertheless, with severe economic problems facing the country in the 1980's, emigration has once again become a major part of the Irish experience. (Wilson 1989, pp.6)

During the 19th Century and into the early twentieth century, Irish people continued to push for their independence from Britain. There were significant but unsuccessful rebellions in 1848 and 1867. Home Rule legislation then became an ongoing issue for the Irish parliament into the years before the First World War, finally being granted in 1921, after another failed military action of 1916. (Mabry 2011) Ireland was proclaimed a Republic in 1949.

During all of these "struggles" emigrants were involved in raising funds and support in their lands of settlement. Indeed, many joined the fight to separate Ireland from Britain in whatever form they could. This included two invasions into Canada in 1867 and 1870 by

the Fenian Brotherhood from the USA. Irish immigrants to North America have also had significant influence on the countries where they settled, given their numbers. In Canada, the numbers of immigrants of Irish origin are significant and have continued to be so up until recent times, as can be seen in the table below.

PEOPLE OF IRISH ORIGIN IN POST-CONFEDERATION CANADA

Year	Male	Female	Total Irish Population	% of Canadian Population
1871			846,414	24.3
1881			957,403	22.1
1891	Ethnicity Data not available in compatible form			
1901			988,721	18.4
1911	540,279	510,105	1,050,384	14.6
1921	565,402	542,415	1,107,817	12.6
1931	630,495	600,313	1,230,808	11.9
1941	646,823	620,879	1,267,702	11.0
1951	724,352	715,283	1,439,635	10.3
1961	881,091	872,260	1,753,351	9.6

*After 1961 the Federal Census data changed to incorporate Irish data into the data from England, Scotland, Wales, and Northern Ireland

Source: (Wilson 1989)

The data presented here evidences a long history of immigration and emigration affecting both Canada and Ireland. Migrants have been involuntarily uprooted and have voluntarily uprooted themselves from the lands of their birth and moved to these two countries for a multitude of reasons over the centuries. Some have stayed and others moved on or returned home after longer and shorter periods in the host country. The historical development of each country is both rooted in the impacts of emigration and immigration and plays a role in these very processes. Though migratory conditions were clearly rough at various points in time, it is not evident how various groups of immigrants experienced and addressed the transitions before them. Just as we see it happen now, governments provide various forms of what they perceive to be support to migrants but with what effect on the transition itself, we do not know. We know of what we might view as positive

and negative outcomes for migrants, but we know little of how they occurred for those migrants. It is to these questions that this study directs itself in the context of migrant healthcare professionals in Canada and Ireland. The next chapter lays down the recent history of migration as it relates to this specific group.

Chapter 3 Ireland and Canada: specific migration contexts

The timing of this study was both unfortunate and opportune in that it straddled the last years of economic growth and the beginning of worldwide economic decline. Ireland was hit quickly and severely by ensuing events and fell into economic recession, while Canada was able to sustain growth for a longer period and postpone going into recession; because the banking system was stable and because governments made massive investments in infrastructure projects country-wide just as the economic turmoil was unfolding in the USA.

These events had their impact on migrant healthcare professionals, prompting some to move on from the host country while others have 'sat tight' and are waiting it out. However, it should be noted here that these specific kinds of events do not influence the theory of *New Normalising*, as it continues to apply in the face of whatever conditions migrant healthcare professionals face. In fact, I believe that these unsettled times and events have contributed to the production of a stronger theory of the transition for migrant healthcare professionals in the substantive area of this study. Moreover, the World Migration Report for 2010 predicts even greater numbers of migrants in the near future and therefore the issues of transition for migrants will remain.

Over the next few decades, international migration is likely to transform in scale, reach and complexity, due to growing demographic disparities, the effects of environmental change, new global political and economic dynamics, technological revolutions and social networks. These transformations will be associated with increasing opportunities – from economic growth and poverty reduction, to social and cultural innovation. (IOM 2010, pp.3)

In the previous chapter, it was evident that, in the case of most countries, international migration was open until after the First World War. In the 20th century, and even into the 21st century, most governments developed a variety of immigration policies in an effort to try to control immigration and emigration in their jurisdictions. The priority issue for

modern economies has been the recruitment and retention of a skilled workforce, able to meet the needs of the country and its employers both now and into the future. At the same time, attempts have been made to balance those needs with maintaining the social and cultural fabric of the country. Throughout this time, Canada was viewed as being a country whose policies maintained a degree of openness in regard to immigration. Ireland continued to be seen as a country of emigration, with a stricter control on immigration. Indeed, as reported in the brief history of the previous chapter, Irish emigrants contributed much to the development of the “New Worlds”, the British Colonies and the United Kingdom itself.

The presence of so many Irish in such far-flung places from home as New Zealand, Australia, Argentina, South Africa, Canada and the United States are ample testimony to the Irish emigrant story and its resonance around the world. In the context of our nearest neighbour there has been constant movement of people in both directions for centuries. (Office of the Minister for Integration 2008, pp.7)

However, all of this changed (if only briefly) during the years of the ‘Celtic Tiger’ (1995-2007). Ireland became a country of immigration, due to changes in the European Union (EU), the European Economic Area (EEA) and the need to recruit highly skilled professionals in an effort to support and fuel its ‘roaring’ economic and population growth. (Office of the Minister for Integration 2008, Murphy 2000, Ruhs 2005) Since the effects of the world financial crisis have evolved, it is claimed that Ireland has again become a country of emigration, though this assessment is still in dispute. (Smyth 2011)

This chapter, brings us up-to-date with the state of play in worldwide migration, and presents the data on migration in Canada and Ireland. This serves as a prelude to the discussion of the particular case of migrant healthcare professionals in both countries. Migration has been increasing worldwide for some time and continues to do so despite the efforts at control and the world financial crisis mentioned above. Migrant healthcare professionals represent but a small proportion of migrants worldwide, but their case is perhaps symbolic of what happens in other similar industries. (Connell. 2010) It should,

however, be noted that comparison of migration data between and across countries is not without problems. All countries do not record data uniformly and the time frames can be different, as in the case of the two countries reported here. In addition, policy and legislation between countries is different, so that a category of immigrant which exists in one context may not exist in another. That being said, I am not attempting to compare migration data between Canada and Ireland; only to record the situation in each country at the time of this study, in order to demonstrate the contexts for healthcare professional migration in each.

In 2011 there are some 214 million migrants worldwide. In numerical terms, migration has been increasing steadily over the last ten years. However, as a percentage of world population, migrants consistently represent around 3% (one in every thirty five persons in the world is living outside his place of birth). Further, there are around 16 million refugees who currently live outside their country of birth. (Kelley and Trebilcock 2010, IOM 2010) While the growth in migration is steady from year to year, at around 2.7%, the countries migrants relocate to are changing significantly.

The distribution of migrants, however, has shifted dramatically. In 2000 migrants made up 10% of the population in seventy countries as compared to just forty-eight countries thirty years earlier. Moreover, from 1998 to 2000, the number of migrants living in the developed world more than doubled, from 48 million to 110 million, as compared to a more moderate increase from 52 million to 65 million in the developing world. Currently, some 60 percent of the world's migrants live in the developed world and account for around two thirds of the population growth in some regions. (Kelley and Trebilcock 2010, pp.3-4)

These statistics are updated in the Report of the Secretary-General of the United Nations to the sixty-fifth session of the General Assembly.

Although the economic crisis has slowed down the increase in the number of international migrants in developed countries, their overall numbers have continued to rise: by 12.8 million between 2000 and 2005 and by 10.5 million between 2005 and 2010. The reduction in the net increase in the number of international migrants in developed countries between those two periods has not been matched in developing countries, where the number of migrants rose by 4.0 million from 2000 to 2005 and by 8.2

million from 2005 to 2010. However, most of that increase can be attributed to the rising numbers of refugees. Thus, whereas the number of refugees in developing countries declined by 1.1 million from 2000 to 2005, it increased by 2.7 million from 2005 to 2010. Excluding refugees, the increases in the numbers of other types of migrants in the developing world would have been of the same order of magnitude during both periods: 5.1 million vs. 5.5 million. By 2010, the developing countries were hosting 86 million international migrants, including 14 million refugees. (Secretary-General 2010)

Most of this shift is accounted for by trends produced by globalisation and differentials in labour remuneration (and wars, natural disasters and the like, in the case of refugees). High income countries with 16% of the world's labour force account for 60% of the world's migrants. For example, in 2000 there were 52 million migrants among the 465 million workers in high income countries (12%). This contrasts with the developing world where the 32 million migrant workers represent only 1% of the 3 billion strong workforce. (Martin 2005) It should be noted, though, that the percentages in particular countries are very variable in both regards. The International Organization for Migration predicts that worldwide migration could become an even larger problem in the future. "If the migrant population continues to increase at the same pace as the last 20 years, the stock of international migrants worldwide by 2050 could be as high as 405 million." (IOM 2010, pp.3) If these predictions are only close to accurate then addressing the issues of transition for these migrants becomes even more acute.

It is against this backdrop that the current study was conducted. Ireland and Canada are two of those high income countries, which are attractive to migrants, particularly from the developing world. We now turn to the specific case of recent migration in each of these countries, where the migrant healthcare professionals in this study were located.

Canada

In 2009, Canada admitted about 252,000 permanent migrants, which represented a 2% increase over the previous year. The principal sending countries were China, the Philippines and India who accounted for 12%, 11% and 10% respectively. These numbers represent an increase from the Philippines (15%) and India (6%) and a small decrease from China (1%). In the same year Canada received 382,000 temporary immigrants, representing a decrease of 4% over the previous year. Further, Canada also received 23,000 refugees in 2009. (OECD 2011)

Among these categories, 25% of permanent migrants were “labour migrants” and 47% of temporary immigrants were “temporary foreign workers”, with the USA being the main sending country. However, the total number of temporary foreign workers entering Canada dropped for the first time since 2003 due to the economic downturn (Temporary Foreign Workers are important in this study because, in the case of healthcare professionals, many of them end up becoming permanent residents through the provincial nominee programs). Canada’s temporary foreign worker rules require employers to attempt to fill vacancies with Canadians and Permanent Residents before recruiting from outside the country. The restructuring of companies in Canada due to the economic situation created an increase in potential employees within Canada during this time. What is most notable during this period is that the majority of migrants entering Canada came for family-related reasons. Nevertheless, over the last ten years the figures for the family category have remained steady while the number of foreign workers has increased. Most figures dipped in 2009 and may do so again in 2010 data; all related to worldwide economic decline.

Organisation for Economic Co-operation and Development (OECD) population figures for Canada demonstrate a steady increase since the beginning of the 21st century. (OECD 2011) During this time, while the resident population has shown an increase, of interest in

this study is the greater population growth which is due to net migration, mostly in the foreign worker category. Again, this figure dipped in 2009. Given the Ministry of Labour's projections that Canada will rely 100% on immigration for labour market growth from 2011 forward, this decline is not expected to last.

As we saw in our review of migration history, governments react to events of their time to alter their immigration policies. Most recently, the Canadian Government has made changes in an attempt to increase flexibility and to allow immigration officials to react to changing circumstances more efficiently, with a view to increasing the pace of immigration processing.

In 2008, the Canadian government established an *Action Plan for Faster Immigration* that aims at reducing the backlog of applications from foreign workers by accelerating their processing. In order to make Canadian migration policy more flexible and responsive to changing labour demands, the plan also introduced the possibility to amend admission procedures on short notice through ministerial instructions. A first set of ministerial instructions was issued in November 2008 and defined eligibility criteria for foreign workers to have their applications considered. They either need to hold a job offer, or have been temporary residents in Canada before, or demonstrate work experience in one out of 29 shortage occupations. ...the new measure now allows Citizenship and Immigration Canada to return unprocessed applications that are not aligned with Government of Canada objectives. A second set of ministerial instructions was issued in June 2010 and limited the number of new applications to be considered under the shortage occupation scheme to 20 000 per year and 1 000 per occupation. In addition, all permanent migrants now need to prove language proficiency through an independent test. (OECD 2011, pp.268)

The OECD report continues, explaining further changes that were made to the system to improve the pace of assessment of skilled worker categories, which include migrant healthcare professionals.

Two measures were launched in 2009 that aim at facilitating the recruitment of foreign workers, as well as their integration in the Canadian labour market. The government announced the establishment of an *Employer's Roadmap to Hiring and Retaining Internationally Trained Workers* in June 2009 to provide practical advice for employers in small and medium-sized enterprises concerning the recruitment, assessment of foreign qualifications, integration and retention of internationally trained workers. Furthermore, in November 2009, federal, provincial and territorial authorities jointly established a *Pan-Canadian Framework for the*

Assessment and Recognition of Foreign Qualifications. Immigrants wanting to enter regulated occupations in Canada will receive information on assessment as early as possible in the immigration process and timely communication of recognition decisions. (OECD 2011, pp.268)

These measures, while impressive on the surface, do not tell the whole story for healthcare professionals who wish to work in Canada. The procedures referred to here represent but one stage in a complicated process of *New Normalising*.

Ireland

First, it should be noted that Irish figures are reported based on the financial year. Also, the OECD does not record migration to Ireland as “temporary migration’ in the same context as it does for Canada and other countries.

In the financial year 2010, Ireland received 31,000 migrants. This figure represents a massive reduction in immigration from the heady days up to April 2007 when this number was at 110,000 per year on average (including return migration). These recent numbers are reflective of a decline from the rate of net migration of 1.6% in 2007 to -0.8% of total population in 2010. To make matters worse, by 2009 253,000 jobs had been lost around the country, a reduction of 12% in a very short space of time. These numbers are indicative of the degree of effect of the economic crisis in Ireland. (OECD 2011, Joyce 2010) Though non-European Economic Area immigrants to Ireland were already in decline, it appears that all migrants were affected in the years to follow.

Inflows from non-EEA countries have dropped steadily since 2004. The modest decline, from 25,000 in FY 2003 to 21 000 in FY 2007, reflected Irish policy of seeking labour market needs from within the enlarged European union. The subsequent decline, to less than 5,000 in FY 2010, reflects the unfavourable labour market conditions. The decline in inflows was even more pronounced among nationals from the eight countries from Central and Eastern Europe which entered the European Union in 2004 (EU-8). Their numbers fell from 53,000 in FY 2007 to less than 6,000 in FY 2010. (OECD 2011, pp.288)

At the same time as these declines in immigration, Ireland began to shift back to some semblance of its former reputation, when it was commonly referred to as a country of emigration.

While inward migration came back to the low levels of the early 1990s, outward migration has increased to over 65,000 in both FY 2009 and 2010, leading to a net outward migration of 7,800 in FY 2009 and 34,500 in FY 2010. (OECD 2011, pp.288)

When the economy was doing well, workers flocked to Ireland, “Among the various categories of non-EU nationals coming to Ireland in the last decade, the great majority have been workers (about 280,000 work permits were issued from 1998 to 2008)...” (Ruhs and updated by Quinn 2009) With the change in economic conditions came government action which affected this group. The Irish government responded to the economic situation by making changes to the Visa system. First to be impacted were workers from outside the EEA.

In response to the difficult economic situation, the entry of new migrant workers from countries outside of the EEA was made more difficult. Since 1 June 2009, work permits for jobs paying less than EUR 30 000 per annum are only granted in “exceptional” cases and will no longer be issued for domestic workers and truck drivers. The labour market test was extended to eight weeks and now also applies to renewals and to spouses and dependants of an immigrant employee (except green card holders and researchers), these are required to apply for an employment permit in their own right according to standard eligibility criteria. Since January 2010, nationals of Mauritius, the country of origin of a substantial number of non-EEA immigrants, are required to have an entry visa before coming to Ireland. (OECD 2011, pp.288)

A month later the government instituted a fee of EUR 500 when an individual from outside the EEA is first granted long-term residency permission. They also increased the cost of renewing work permits for immigrants already living in Ireland by 50%. A month later again the government announced further measures to assist migrants who had been in Ireland for some time to continue their residence.

In August 2009, several measures were taken that facilitate migrants’ stay and economic activity. Those who stayed and worked legally in Ireland for at least five consecutive years continuously, and holders of green cards

which were due to expire no longer required a work permit. The permission is for one year and can be renewed, but the holders of the permit are expected to work and support themselves. The time to seek alternative employment for unemployed work permit holders was expanded from three to six months, and the labour market test no longer applies to them. 185 applications were received by the “Undocumented Workers” Scheme that allowed workers in the last quarter of 2009 who had become undocumented through “no fault of their own” to obtain a temporary immigration permission of four months within which they could seek legitimate employment or obtain an employment permit if they were already employed. The measure thus only concerned a small part of the estimated 30,000 undocumented migrants living in Ireland at that time. (OECD 2011, pp.288)

While Ireland’s data in family migration remains relatively stable in recent years, the data on the worker category demonstrates significant decline as a direct consequence of the factors discussed above. In fact, this category declined by 50% between 2008 and 2009. The data included in the adapted OECD table below, shows the trends in labour migration in the two countries under study between 2000 and 2009. Among these peaks and troughs in worker migration, are the international migrant healthcare professionals who participated in this study.

Annex	Table A.2.1. Inflows of foreign workers into OECD countries									
Version 1 - Last updated: 01-Jun-2011										
Table A.2.1. Inflows of foreign workers into OECD countries and the Russian Federation										
Thousands										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Canada	116.6	119.7	110.9	103.2	112.6	122.7	139.1	164.9	192.5	178.5
Ireland	18.0	36.4	40.3	47.6	34.1	27.1	24.9	23.6	13.6	8.0

Adapted from (OECD 2011)

The Migration of Healthcare professionals

To this point the discussions about migration have been general ones and have focused mostly on immigration and emigration to and from Ireland and Canada from the earliest

records of their existence. This serves to emphasise the experiences of migration throughout history and provides a context which provides compelling reasons for developing the theory of *New Normalising*, outlined in the chapters that follow. At this juncture, however, it is time to shift the focus of these discussions onto the most relevant context for this particular study; the migration of healthcare professionals – Doctors and Nurses.

Shortage of Healthcare Professionals in Canada: Doctors

The shortage of healthcare professionals had been evident in Canada for some time before the beginning of the twenty first century. Canada has depended on International Medical Graduates (IMGs) to fill its gaps and make up shortages throughout its history of organized health care. (Bourgeault 2007, Mullally and Wright 2007) Mullally and Wright report on a period of Canadian history, between 1954 and 1976, when Canada recruited significant numbers of British and Irish physicians.

In the context of a "national doctor shortage," many provinces aggressively recruited doctors from abroad, licensing over 10,000 new foreign-trained physicians, more doctors than the provinces graduated domestically during this period. By the mid-1970s many communities-particularly those in rural and or remote regions-were serviced primarily by foreign-trained doctors. (pp.67)

This recruitment achieved what appear to have been satisfactory levels of physician-to-population ratios at that time. (Esmail 2011) According to more recent data, in 1979 IMGs represented 32% of the physician workforce. However, as a result of government policies, by the early 1990s this percentage had declined to 23.4%, and remained stable until the last five or six years when it has been on the increase again. (CIHI 2010b, Esmail 2011) During the 1990s Canada experienced a period of economic decline, at the same time as implementing the policies which were (later) to impact the level of physician service. In the early years of the 21st Century, until 2009, the economy was healthy and growing. (OECD 2011) This is the period when an increase in the proportion of IMGs was noted. It is also a period when physician shortages gained more public attention.

Regardless of the above, IMGs in Canada face a tough challenge to become licensed to practice and many have given up in the face of this challenge. (Gol 2006) This, in spite of ongoing concerns about a shortage of physicians in Canada. (Joyce 2011, Chew et al. 2010, Cross 2011, Milke 2008) A recent report by the Fraser Institute, comments on this shortage.

Discussions regarding health care in Canada regularly return to the supply of medical practitioners in this country. Canadians' focus on physician supply has been driven by the publication of numerous reports and commentaries on this issue produced by research organizations, professional associations, government committees, and others. Importantly, most of these discussions and papers have generally arrived at the same conclusion: there are too few physicians practicing in Canada today (Esmail 2011, pp.12)

Esmail then proceeds to outline his basis for this claim.

That conclusion is supported by the available evidence on Canadians' unmet health care needs. For example, in 2007, almost 1.7 million Canadians (6%) aged 12 or older reported being unable to find a regular physician (Statistics Canada, 2008). More recent Statistics Canada data show that 6.6% of Canadians aged 12 or older reported being without a regular doctor and unable to find one (Statistics Canada, 2010a; calculation by author). Similarly, a research poll completed in 2007 found that 14% of Canadians (approximately 5 million) were without a family doctor, more than 41% of whom (approximately 2 million) were unsuccessful in trying to find one. (CFPC 2007) (Esmail 2011, pp.12)

Further, in comparing Canada with most other developed nations with similar healthcare funding systems, Esmail says that though higher proportions of their populations are sixty-five years or older (using more health care services), Canada's physician-to-population ratio ranks 26th out of 28 Countries. Moreover, Esmail predicts that, if nothing is done to change it, the ratio of doctors to population will decline in the coming years to 2020.

Physician Migration to Canada

Among IMGs there are two types of Doctors; those who are Canadian born and left to study medicine in another country, and are returning to Canada seeking employment, and those who are experienced doctors, nationals of other countries and have migrated to Canada. Regardless of which group a doctor belongs to he is required to complete a two year

residency in Canada. Obtaining this residency is challenging, since there are only a few residencies available and there are a significant number of applicants. For example, in British Columbia there are 18 residency places available each year and around 600 applicants for these placements. (Gol 2006) This results in IMGs working in jobs such as pizza delivery, taxi driver and as security officers in order to survive. (Gol 2006)

In the years between 1980 and 1989, 5,216 new IMGs entered Canada and the net migration for physicians was 3,778. From 1990 to 1999, 4,755 IMGs entered Canada for the first time, with net physician migration for those years at 1305. Between 2000 and 2009, Canada had a net gain of 6,322 physicians, as 7181 new IMGs entered Canada. In the 1990s, net migration was most affected by a high number of physicians emigrating from Canada; 5541 in total, as compared to around 3000 for the periods 1980-89 and 2000-09. (CIHI 2010b)

These numbers only represent the IMGs who are successful in gaining full recognition and licensure in Canada. Based on the initial comments above, there are a significant number of IMGs who are either in process or have given up trying to re-enter their profession in Canada.

Shortage of Healthcare professionals in Canada: Nurses

In a 2002 report from the Canadian Nurses Association (CNA), it was estimated that, without intervention, Canada would be short 78,000 nurses in 2011 and 113,000 by 2016. (CNA 2002) In their 2005 report of a study into the barriers to registration for “internationally educated nurses” (IENs) in Canada, Jeans et al stated, “In recent years, nursing associations, governments, employers, unions and other stakeholders have recognized that sustainability of the Canadian health care system depends on an adequate and educated workforce. Unfortunately, Canada is experiencing a nursing shortage that is projected to worsen dramatically over the next 15 to 20 years.” (Jeans et al. 2005) In this

same report, they cited studies by CIHI (2003) and the Canadian Nurses Association (CNA, 2004a), as well as a number of nursing authors in Canada, recognizing that the shortage had been in existence for some time and viewing it as a partial product of the years of economic downturn in the 1990s and the result of government policies of that period. These policies were similar to those identified for Doctors (above), in reducing education seats in basic programs and reducing the overall numbers of professionals. Since the time of these reports, governments in Canada have made major efforts to increase the nursing stock. Increases in the provision of seats in education programs together with major recruitment of IENs have had their impact, though the underlying shortage continues. According to a recent CNA report, their studies of the situation in nursing project a five-fold increase in the shortage in the next 13 years. "If the health needs of Canadians continue to change according to past trends, and if no new policies are implemented, this report shows that Canada will be short almost 60,000 FTE RNs by 2020". (CNA 2009) Since Canada has always relied on IENs to fill these gaps, quite apart from all of the other reasons that IENs immigrate, it is likely that nurse migration into Canada will continue for the foreseeable future.

Nurse Migration to Canada

Obtaining accurate numbers of Internationally Educated Nurses (IENs) in Canada is not without challenge. Immigrants enter Canada under their applicant class and one can only know that an IEN exists in Canada when they contact the relevant regulatory body and complete the requisite paperwork. Even when the information is from the databases of the regulatory bodies for nursing in Canada, it is not entirely reliable since it depends on how individuals interpret and respond to questions on their annual registration forms. Further, it is not uncommon to find questions unanswered on these forms.

That being said, CIHI reports that IENs made up 7% (24,394) of the Canadian regulated nursing workforce (348,449) in 2009 – made up of Registered Nurses (RN), Registered Psychiatric Nurses (RPN) and Licensed Practical Nurses (LPN). (CIHI 2010a) This

percentage has remained relatively stable over the last ten years, though there are differences between various locations in the country. The highest concentrations of these IENs were located in British Columbia, Ontario, and Alberta. In 2009, 8.3% of the RN workforce were IENs, 31.6% of whom were educated in the Philippines and 17.6% were educated in the United Kingdom.

Of the LPNs educated outside Canada who specified a location of graduation in 2009, 28.3% were educated in the Philippines and 21.0% were educated in the United Kingdom. A total of 2.3% of the LPN workforce in 2009 was educated outside Canada, an increase from the 2.0% observed in 2008; this represents a substantially smaller proportion than that observed for RPNs and RNs. (CIHI 2010a, pp.xii)

In the RPN group, IENs made up 7.8% of the workforce in 2009. The majority of these IENs were graduates from the UK (82.2%). Though Canada has increased its seats in basic nursing education, it is likely that both migrant nurses will continue to locate to Canada and that Canada will rely on these IENs for a proportion of its nursing workforce. (CNA 2009)

Canada Summary

Health care in Canada, due to its reliance for most of its finance on public funds, is impacted whenever the Gross Domestic Product (GDP) is in decline. The shortage of healthcare professionals may continue during these periods, but recruitment falls off as does hiring into vacant positions. As previously discussed, and evident in the historical review in Chapter 2, in general, in times of economic downturn, worker immigration slows. Canada's rules regarding the recruitment of 'foreign' workers involve Federal Human Resources assessments as to whether genuine attempts have been made by the employer to find a qualified Canadian to fill the position. Since periods of economic downturn result in "restructuring" and layoffs, the potential to find a suitable Canadian nurse or doctor to fill positions improves. However, it is anticipated that the economic recovery will ensue sooner if not later and this will result in a resumption of normal recruitment patterns. Additionally, even in the midst of the current economic downturn, nurses continue to retire

in high numbers and the population of Canada continues to grow. In the face of these conditions, it is likely that Canada will continue to seek IENs to fill the gaps.

Shortage of Healthcare professionals in Ireland: Doctors

In Ireland, the reliance on international medical graduates had been prevalent for some time, before the critical period during the “Celtic Tiger”. Aileen O’Meara, in a report in the Sunday Post Online, wrote a sensational piece on the shortage of healthcare professionals in Ireland which highlighted the situation with physicians. The following selected excerpts from that article demonstrate the issue.

Government reforms in the healthcare education sector mask serious shortages. Up to 60 per cent of staff in some major hospitals now come from abroad, writes Aileen O’Meara. The government’s commitment last week to reform the education of the country’s doctors, and expand the number of medical training places has not come a day too soon.

As serious doctor shortages loom in general practice, and more hospital consultants posts become available, the demand for doctors will increase. However, the reforms mask the serious shortage of a range of healthcare workers - from doctors and specialist nurses to general nurses and care assistants. The health service is hugely reliant on immigrant workers.

...The Department of Enterprise, Trade and Employment issued more than 2,500 work permits to medical and nursing staff in 2005 alone, and the numbers are continuing to rise.

...In the country’s regional and local hospitals in particular, the system relies heavily on overseas doctors. More than half of the 4,500 junior doctor posts in Ireland are filled by overseas doctors, mostly from Pakistan, with some from India and Egypt, working in non-accredited training posts in medical and surgical services. Most return home after gaining experience here. At the same time, their Irish counterparts, educated by the subsidised university system, leave to work in hospitals in Britain, the United States and Canada. Most never return.

...Observers believe that is unlikely to change with the education reforms. The experts recommend that the intake of non-EU students in Irish medical schools be reduced from 61 per cent at present to 25 per cent of the total intake, making more places available for Irish students at the expense of non-EU students. Neither are there plans to recruit EU or non-EU doctors to fill the gaps in family practices in the Republic. ...There is a looming manpower shortage in general practice, with 40 per cent of all GPs due to retire within the next eight to ten years. Rigid registration rules and different education systems make it more difficult for immigrant doctors to set up practices in Ireland. (O’Meara 2006)

The total number of immigrant doctors working in Ireland is unknown. This is the case because junior hospital doctors and locums can work in Ireland without a work permit, as

long as they can show their registration with the Irish Medical Council (IMC). (Joyce 2010)

Thus the medical council's records may be the most accurate record of practicing physicians in Ireland. According to the registration statistics for 2010 there were 18,770 Doctors practicing in Ireland. In the latest figures available, there were 3978 Doctors with addresses outside Ireland on the register in 2009. This number represents over 22% of the medical workforce. While the numbers of doctors registered in Ireland have increased in recent years, the proportion of non-Irish doctors has remained stable at 22-24% between 2005 and 2009. In addition to these permanent migrants, the number of temporary registrations for immigrant Doctors averaged 724 in any registration period between January 2005 and January 2009, with a range of 573 (January 2006) to 838 (July 2006). These numbers do not tell the full story as migrant doctors are identified by the address they provide at registration. It is likely that there are more migrant doctors living in Ireland and registering with their Irish address. (Irish Medical Council, 2011)

It is predicted that, in the future Ireland will need to rely more on migrant doctors as the population increases. Layte suggests that the OECD data demonstrates the extent of the shortage of GPs in Ireland and predicts that Ireland will need around 250 GPs per year to maintain adequate levels of care for the population. (Layte 2009)

Shortage of Healthcare professionals in Ireland: Nurses

Nursing, by the same token, encountered shortages which had not been witnessed before as it entered the final years of the 20th century and into the early years of the 21st century.

Although historically a net exporter of nurses to countries such as the UK and the USA, in the 1990s Ireland began to encounter nursing shortages. With a domestic nursing workforce no longer 'queuing for work' [5], employers began to look further afield and initiated international recruitment campaigns to facilitate the migration of qualified nurses to Ireland. Despite being a newcomer to overseas nurse recruitment, the rate of recruitment to Ireland in recent years has been rapid and remarkable. (Humphries, Brugha and McGee 2008b, pp.264)

Again, Aileen O'Meara, in her article in the Sunday Post Online - cited above in regard to Doctors, provides a comprehensive summary of the nursing shortage.

...The greatest demand is for nurses, due mostly to the radical changes in the education system. As a result of a change in the three-year Diploma in Nursing to a four-year bachelor of science nursing programme, there are no graduate nurses available, so the demand for overseas nurses is intense. There will be no newly qualified paediatric nurses available until 2010. Over half of all the nurses working in the intensive care unit of Our Lady's Hospital for Sick Children in Crumlin are not Irish.

"The health services would be crippled without non-nationals," said Orla O'Brien, divisional nurse manager at Crumlin. "What they contribute is immeasurable."

Most of her specialist nurses are from India and the Philippines, recruited through the Middle East, where they have gained experience working in European and American hospital services.

"We couldn't work without overseas nurses. The system would be on its knees if they were not available," said Kate Cowhig, managing director of the international recruitment agency, International Recruitment Ltd., that finds nurses for the major Dublin academic teaching hospitals.

"Up to 60 per cent of staff in some major hospitals are now from abroad. Visas for nurses coming from India, the Philippines and China can be processed in six to ten working days," she said.

In the first eight months of last year, An Bord Altranais (the Nursing Board) registered almost 3,000 non-national nursing and midwifery applicants from 49 countries, with over 1,700 coming from India alone. The board expected an even higher number for the latter four months.

The acute general hospitals, the psychiatric services and the private nursing home sector are increasingly reliant on overseas nurses, mostly Indians and Filipinos, but Polish and eastern European nurses are also being recruited.

Many of the country's private nursing homes, particularly in the cities, would have closed if Minister for Health Mary Harney had not introduced the so-called 'Harney visas' in 2002 to fast-track nursing and medical staff visas.

Her decision to give working visas to spouses of medical staff made the country a more attractive destination for many workers from the Philippines and India. (O'Meara 2006)

Humphries et al (2008) attempt to explain the complexity of factors which led to this sudden crisis in Irish healthcare and the apparent rush to recruit nurses from outside the country.

The number of nurses required by the Irish public sector health services is increasing, having risen 43% in 15 years from 24,574 full-time equivalent nurses employed in 1990 to 35,258 by December 2005 [6,7]. ... (Examples of) the demand side factors identified in the literature, e.g. the greater needs of an ageing population and increased complexity of health care. European Union policy changes are likely to further impact on demand: the

introduction of the European Working Time Directive, which will restrict the working hours of non-consultant hospital doctors, may result in the transfer of responsibility to nursing staff. A yet-to-be quantified increased demand for nurses has arisen from the rapid expansion of the private and support sectors, including private hospitals and private nursing homes [8]. Recent estimates suggest that approximately 9000 nurses are employed in the private sector [9] and the current policy emphasis in Ireland on privatising healthcare provision will undoubtedly see this figure increase further. (Humphries, Brughá and McGee 2008b)

The problem is further exacerbated by the attractiveness and availability of nursing positions abroad for new graduates in Ireland. They might also be put off choosing to work in Ireland, as will experienced nurses, by the “inefficient utilisation of nurses” in the health care system, whose time is taken up with tasks that could be completed by other workers such as healthcare assistants. (Humphries, Brughá and McGee 2008b, Barrett and Rust 2009) Job sharing is another factor, as flexible working arrangements were offered to nurses in 2001 and a quarter of all nurses accepted the offer. More nurses were needed to fill the positions which became vacant as a result. Lastly, a reduction in hours of work from 39 to 37.5, with a potential further reduction to 35 hours in the near future, creates the need for more nurses to fill the now vacant hours.

Nurse Migration to Ireland

We already have some notion of the extent of migrant nurses who entered Ireland between 1998 and 2009, from the data cited above. The data that follows is reported in the European Migration Network report by Emma Quinn. (Quinn 2010) The figures below show the numbers of Irish and non-Irish nurses practicing in Ireland between the years 2004 and 2009.

2009 Nursing and midwifery professionals	Total Irish = 47,045	83.0%	IENs = 8507	17.0%
2008 Nursing and midwifery professionals	Total Irish = 44,230	80.8%	IENs = 10476	19.2%
2007 Nursing and midwifery professionals	Total Irish = 44,169	81.8%	IENs = 9813	18.2%
2006 Nursing and midwifery professionals	Total Irish = 43,915	82.8%	IENs = 9108	17.2%
2005 Nursing and midwifery professionals	Total Irish = 45,385	89.1%	IENs = 5529	10.9%
2004 Nursing and midwifery professionals	Total Irish = 45,685	91.3%	IENs = 4347	8.7%

(Data adapted from (Quinn 2010) Calculated by Author)

This evidence clearly shows that the number of migrant nurses working in Ireland has more or less doubled since 2004. While these numbers are astounding in such a short time frame, it is even suggested that the numbers are higher.

Ireland's healthcare system is heavily dependent on non-EEA workers. Data supplied in Table 3.4 show that in 2009 18 per cent of health professionals other than nurses and 17 per cent of nursing and midwifery professionals were non Irish. Other sources suggest that this is an underestimation. For example, according to the Irish Nursing Board 21 percent of nurses are foreign (Barrett and Rust, 2009). Employment permit data indicate that just over 1,100 migrant workers took up new employment in the healthcare sector in 2009 (Expert Group on Future Skills Needs, 2010), however as discussed below some groups of healthcare workers do not require a permit so this under represents the true figure. (Joyce 2010)

Looking to the future, it is evident that Ireland will continue to depend on immigrant nurses for a proportion of its nursing workforce.

Even if there is a continuous supply of Irish born health and social care workers, Ireland will undoubtedly rely on the support of foreign-born health and social care workers in the future...Our projections suggest that there may be a need to treble the number of foreign nurses in Ireland in the period up to 2035. (Barrett and Rust 2009, pp.24)

Though current economic conditions do not encourage the migration of nurses to Ireland, it is clear that Ireland will need to continue to recruit from outside its borders. The recession has seen a return to emigration of Irish nurses, cuts to the number of nursing positions in the public sector in Ireland and non-replacement of those who retire. (International Centre on Nurse Migration 2011) Despite these circumstances, recruitment for nurses outside the country continues. (Nurses 4 London 2011) The changes that are brought about by the need to "integrate" immigrant nurses into Irish society and workplaces will remain challenges for the foreseeable future. Perhaps the theory of *New Normalising* will provide some insights to assist with this process.

Global Shortage of Healthcare professionals

If these shortages of healthcare professionals sound critical, they have to be viewed in the context of the global situation in healthcare. Canada and Ireland are not unique in the challenges that they face to provide their populations with health care services. In 2006, the World Health Organization (WHO) estimated that there was a shortage of more than 4.3 million health personnel across the world. (WHO Secretariat 2006) Low-income countries were particularly hard-hit by shortages: of the 57 countries identified as having a critical shortage, 36 were sub-Saharan African countries.

Though shortages have occurred in many occupations within health care, the current study is focused on the two largest groups of healthcare professionals, Doctors and Nurses. Because the international migration of doctors and nurses to developed nations has become increasingly visible, it is often seen as the main culprit behind the aforementioned shortages in low income countries. This has led to a polarized debate between the negative aspects of migration and the individual rights of health personnel to leave any country including their own. In this context, policy discussions often centre on the issue of compensation. The work jointly carried out by the OECD and WHO provides a detailed picture of the magnitude of health workers' migration and shows that the global health workforce crisis goes beyond the migration issue. The global economic crisis and events such as the A/H1N1 pandemic have recently increased the pressure on health systems and health personnel, and as a result are adding to the urgency to address the global health personnel crisis. I will leave the final word on this subject to the presenter at a recent OECD gathering in Montreal.

We should not be blinded by the short-term. Because of the crisis, there is admittedly still a lot of labour slack that needs to be absorbed in some OECD countries. But the long-term trends have not gone away. Baby-boomers are indeed starting to exit the labour force in increasing numbers, and young workers are fewer than they used to be. This will put downward pressure on labour supply over the coming decades. Consequently, labour migration will once again seem a valid option to help alleviate labour and skill shortages, along with greater labour force

participation among under-represented groups, primarily women and older citizens.

In fact, we seem to be heading towards a turning point for labour migration. OECD countries as a whole are much more open to labour migration than they used to be. Almost all OECD countries are indeed expecting to recruit more and more highly skilled migrants in the coming years, in occupations where the domestic supply is insufficient. Several have implemented reforms to increase attractiveness as a receiving country, for foreign workers in general and skilled workers in particular. Multilateral agreements have to a certain extent paved the way, such as the GATS for intra-corporate transfers, the Treaty of Rome for free circulation within the European Union, and NAFTA in North America for professionals in certain occupations. (Gurria 2011)

In this chapter I have mapped out the migration trends globally and in the two countries which are the subject of this study. I have also identified the migration trends and manpower issues in the two disciplines participating in this study. All of this data and discussion points to an ongoing situation of migration of both healthcare professional groups to both countries for the foreseeable future. Thus, it underlines the importance of a theory of transition to individual migrant healthcare professionals. *New Normalising* resolves the main concerns of the participants as they transition through the stages of immigration.

In the next chapter, I describe the details of this grounded theory study and address the issues of research methodology.

Chapter 4: Research Methodology

The difference between the particularistic, routine, normative data we all garner in our everyday lives and scientific data is that the latter is produced by a methodology. This is what makes it scientific. This may sound trite, but it is just the beginning of many complex issues. Whatever methodology may be chosen to make an ensuing research scientific has many implicit and explicit problems. It implies a certain type of data collection, the pacing and timing for data collection, a type of analysis and a specific type of research product. (Glaser and Holton 2004)

Introduction

This study uses classic grounded theory methodology to explain the way in which migrant healthcare professionals resolve their problems of transition through the theory of *New Normalising*. This theory was induced from data provided by migrant healthcare professionals in Ireland and Canada, and from a range of documents and audio-visual resources relating these transition experiences in both countries. A quick search of the extant literature produces reams of data on the study of migration, and of migrant health care workers in particular. (Bourgeault 2007, Jeans et al. 2005, Humphries, Brugha and McGee 2009a, Bach 2003, Humphries, Brugha and McGee 2008b, International Centre on Nurse Migration 2011, WHO Secretariat 2006, Adeniran et al. 2008, Carballo and Mboup 2005, Hancock 2008, Humphries, Brugha and McGee 2009c, Joel 2008, Khaliq, Broyles and Mwachofi 2009, Kingma 2008, Mesquita and Gordon 2005, Timonen and Doyle 2008) With particular reference to medicine and nursing there are numerous studies from recent years reporting on the migrants, describing their experiences, their reasons for migrating, and what happens to them when they arrive in the host country, among other things. Studies of migrant doctors and nurses are of special interest to governments because of the potential impact of migration on health care systems worldwide. (OECD 2010a, OECD 2011, OECD 2010b, Gol 2006, Moses 2006, Connell 2010, Joyce 2010, Adams et al. 2004) Most studies employ survey or descriptive research methodologies, producing statistical data and thick descriptions. What appears to be lacking from the literature is a theory which would assist migrant healthcare professionals to understand and negotiate the transition in the host country more expeditiously or at least with clearer direction; for it is

the transition that presents the greatest problem for individual healthcare professionals who migrate. This theory might also be beneficial to those migrant healthcare professionals who struggle with the transition, for whatever reason, to the extent that they never get back to working in their profession in the host country. Further, such a theory could prove useful to native professionals in the host country who seek to provide support to their migrant colleagues.

In this chapter and the next, I will describe the Grounded Theory method in some detail. In this chapter, I also outline the decisions that I was faced with from the outset of the study and how I resolved those decisions through the Classic Grounded Theory method (GT). Additionally, I explain how I arrived at my choice of research methodology.

No research method lacks for its critics and classic grounded theory is no different in this regard. Fortunately for this author, Glaser is well prepared to address these criticisms and has made it one of his life's works to support the research method he co-founded. (Glaser and Strauss 1967, Glaser 1978, Glaser 1998, Glaser 1992, Glaser and Holton 2007) In this chapter, I will address these critiques of grounded theory, which are several in the extant literature. I will also explain my stance in relation to the theoretical issues raised by these critiques, so as to position my own grounded theory study.

Classic Grounded Theory (GT)

In 1967, Barney Glaser and Anselm Strauss published a book entitled *The Discovery of Grounded Theory*, and subtitled *Strategies for Qualitative Research*, in which they outlined a general method whereby researchers could explain action in a substantive area through the generation of theory. (Glaser and Strauss 1967) This method, further elaborated in various additional texts by Glaser and Strauss (1971) and Glaser (1978, 1992, 1994, 1998, 2001, 2003, 2005, 2007), would challenge the social researchers of its day. Glaser and Strauss viewed the efforts of contemporary social research as that of attempting to verify

the theories of 'great men', rather than generating new theory which would be understood and could be used by those who were the subject of it. They believed social researchers of the time were forced into testing the theories of others and this resulted in their conducting verification studies, with all of the attendant preconceptions about the substantive area under study. This they contrasted with the use of flexible research methods.

The change of emphasis in sociology toward verification of theory, which has been linked with the growth of rigorous quantitative research, has had the unfortunate consequence of discrediting the generation of theory through flexible qualitative and quantitative research. The qualitative research is generally labelled "unsystematic," "impressionistic," or "exploratory," and the flexible quantitative research "sloppy" or "unsophisticated." These critics, in their zeal for careful verification and for a degree of accuracy they never achieve, have forgotten both the generation of theory and the need for carefully appraising the different degrees of plausibility necessary for sociology's diverse tasks. (Glaser and Strauss 1967, pp. 223)

Glaser and Strauss were critical of verification research where the data from the study was often forced to fit the preconceived theory. Grounded Theory, in contrast, was based on the discovery of theory from the data from the social world under study. Glaser and Strauss, therefore, claimed that their approach was more empirically accurate in that the emergent theory had relevance, fit and worked. (Glaser and Strauss 1967, Glaser 1978)

Grounded Theory (GT) is described by Glaser and Strauss as a general method of research. At a recent GT seminar in San Francisco Glaser clarified, "It is just one method among many. GT is a simple method for figuring out what the latent patterns are in any data. It doesn't have a particular perspective or epistemology or ontology!! ...It's just a simple method which can apply to anything." (Glaser 2010) This assertion, that GT does not have an epistemology or ontology, confounds the critics who would place Glaser and Strauss, and, by association, GT, in various schools of thought based on their academic backgrounds and formative education. (Morse 2008, Clarke 2005, Mills et al. 2007, Bryant 2003) Glaser acknowledges that the GT method was induced while using techniques taught to him in University.

GT was not thought up based on research maxims from positivism and symbolic interaction. IT WAS WRITTEN FROM METHODOLOGICAL NOTES I did during the research for *Awareness of Dying* and the methodological notes taken during several years of my analysis seminar at Univ of Calif, San Francisco. (Glaser 2003, pp.62) ...in fact, GT was discovered using Lazarsfeld's quantitative inductive data analysis techniques. (pp.83)

In "Basics of Grounded Theory Analysis", he further acknowledges that he and Strauss were influenced by their university professors and were able to create a "very productive collaboration and melding of two schools of training" during their work on "Awareness of Dying". It was this work that resulted in the documentation of the method of Grounded Theory.

GT, then, was a grounded theory itself, generated as a theory of research method, as Glaser and Strauss conducted their landmark research studies on "Awareness of Dying" and "Time for Dying".

Grounded Theory is based on the systematic generating of theory from data, that itself is systematically obtained from social research. Thus, the grounded theory method offers a rigorous, orderly guide to theory development that at each stage is closely integrated with a methodology of social research. Generating theory and doing social research are two parts of the same process. (Glaser 1978, pp.4)

Glaser is often quoted for his famous dictum, "All is data", which means that GT can use data of any kind and from any source. GT may include various philosophical perspectives, but the key point is that each perspective needs to earn its way into the particular theory on the same basis as any other part of the theory. (Glaser 2001)

Grounded Theory Procedures

GT is a method that generates theory based on a core category derived from the analysis of the data. It involves rigorous procedures in a process which the researcher must follow. These procedures include data collection, open coding of the data soon after collection, then selective coding, theoretical sampling, and ongoing *memoing*. During these stages the researcher moves back and forward in the process, analysing the data through constant

comparison and generating new areas to find more data – theoretical sampling. Of the data collected from interviews, Glaser says that there are four types of data that can be produced: baseline - the participant's best description; properline - what the participant thinks is the proper thing to say; interpreted - the trained professional's viewpoint; and vaguing out – vague responses given when the participant has no interest in sharing information. (Glaser 1978) Nevertheless, all of this is data for use in the study of what is going on in the substantive area. Soon after starting to collect data, the beginning of a theory starts to emerge through the merging of codes into concepts and concepts into categories. The direction of the research effort is now toward theoretical sampling, based on the emerging concepts and categories, with the purpose of confirming or refuting both and identifying their relationships to each other, as well as the core category. (Glaser and Strauss 1967, Glaser 1978, Glaser 1998, Glaser 1998)

In the beginning, the researcher postpones any knowing he might have about the substantive area and enters with openness to whatever discoveries he might make. In an effort to remain open to discovery in the substantive area, the literature review is handled differently in GT studies. This approach is directed towards limiting the potential for contamination.

The concern is brought out by the dictum to not contaminate one's effort to generate concepts from the data with *preconceived* concepts that may not really fit, work or be relevant, but appear so momentarily. The danger is, of course, to force the data in the wrong direction if one is too imbued with concepts from the literature. (Glaser 1978, pp.31)

It is hard enough to generate one's own concepts, without the added burden of contending with the "rich" derailments provided by the related literature in the form of conscious or unrecognized assumptions of what ought to be found in the data. The logic behind this dictum is clear. Grounded theory is for the discovery of concepts and hypotheses, not for testing or replicating them. Thus the license and mandate of grounded theory is to be free to discover in every way possible. (Glaser 1992, pp.31-32)

Raw data is open coded according to incidents, selectively coded and then divided into as many categories as possible, while the researcher writes memos on each. This coded data

leads the researcher to the next area to seek more data which will clarify the categories, concepts and emerging theoretical concepts. This “theoretical sampling” should be followed with further memoing as extensively as possible to achieve saturation. The core category may emerge sooner or later, as will competing categories and sub-categories. As stated above, all of the effort at this point is directed to fully developing the categories and their properties, and to achieving density. As constant comparisons progress, saturation in a category occurs when it becomes obvious that no more data is being generated in that area or that the same data is coming up again and again. At this point, that particular category is considered saturated. All of this time, the researcher is moving back and forward between one procedure and another, writing more memos, and writing memos on memos. These memos are vital for the later analysis and write-up.

The analysis is progressive in steps: from comparison of incident with incident with the purpose of identifying concepts, to the comparison of further incidents to these concepts, to the comparison of concepts with each other, in order to develop hypotheses about their relationships. Once saturation occurs, the researcher sorts the memos and starts to write the theoretical frameworks, using an analytical rule set. As he sorts, he may find that he needs to write more memos. The first write-up is usually an effort to get the theory outlined on paper. In the final write-up the researcher will edit for better integration of the theory. (Glaser 1978)

In the next chapter, I explain how these procedures were applied to induce the theory of *New Normalising* and its sub-categories of *Transplanting*, *Regressing* and *Adapting* in this study. (Glaser 1978)

Further Developments in Grounded Theory

Since its first publication, Grounded Theory became a popular methodological choice for researchers. However, without mentorship or guidance beyond the *Discovery* text, it proved to be a challenging method in its application. (Artinian, Giske and Cone 2009) Stern suggests that novice researchers have problems using the method appropriately and in providing a clear description of it. (Stern 1994) Glaser published *Theoretical Sensitivity* as a means of reinforcing the procedures of the method and, at the same time, elaborated on ideas and added additional ones. He gave further explanations of the procedures of theoretical sampling, coding and writing memos, as well as clarifying the concepts of theoretical sensitivity and theoretical coding. He also stated that not everyone would be able to do GT. The researcher would need to have an ability to conceptualise and be able to live with ambiguity; not everyone can do this. (In my case, my professional background in psychiatric nursing requires these same attributes. However, that is not to say that I was not challenged at various points in the application of this method. I constantly found myself referring back to the texts for clarification.) Glaser also suggested that some knowledge of theory development would be necessary, though this should not be in the field of current study. This knowledge would allow for an understanding on the part of the researcher of how to conceptualise and build a theory – integrating categories and data. It would give him awareness of different types of theories and options to choose from in fitting concepts together to create a series of hypotheses. However, he could only apply these if they met the criteria for judging the efficacy of GT studies – relevance, fit, work and modifiability. These statements by Glaser do not imply the naïve inductiveness suggested by some of the critics of GT. (Bryant 2003, Kelle 2005)

After the publication of *Theoretical Sensitivity*, the GT method continued to grow in its use, extending into many different fields of study. Due to the diversions and distortions in the use of GT, Strauss published a book of his own in 1987 and a second one with Juliet Corbin (his former student) attempting to clarify GT and its procedures. (Strauss and Corbin

1990) In doing so, he appeared to deviate himself from the original work described in the *Discovery* text and prompted a vociferous response from Glaser to retract the book and work with him to make corrections, in order that it might be made consistent with their original work. Glaser objected to the introduction of new procedures by Strauss (1987) and then Strauss and Corbin (1990), specifically axial coding and a coding paradigm – which meant labelling every single piece of raw data. Philbin clarifies further, “This involves an analysis of a pattern relating to a social event or process (identified as a category) in terms of the conditions of its occurrence, interactions among the people involved, the strategies and tactics they employ, and the consequences of the pattern.” (Philbin 2009, pp.20) These two additions to the procedures were followed by more additions in the 1990 text. “Potential grounded theory researchers were given guidance on how to think about data through, for example, the ‘flip flop technique’, ‘waving the red flag’ and making ‘far out comparisons’. The ‘conditional matrix’ was introduced as a tool for representing complexity and the inter-relationships of conditions relating to a particular category. And the notion of axial coding was again given substantial emphasis.” (Philbin 2009, pp.21) Glaser was shocked at the perceived violation of his intellectual property rights. He stated that these new procedures would result in too many codes, categories and properties that would not “pattern, sort or integrate out” and would end up in “an over-conceptualisation of a single incident.” (Glaser 1992, pp.40) He also critiqued the rewritten method as preconceived.

"In grounded theory we do not link properties and categories in a set of relationships denoting causal conditions, phenomena, context, intervening condition, action/interactional strategies and consequences. This would be preconception and forcing theoretical concepts on data to the max. The grounded theorist simply codes for categories and properties and lets whatever theoretical codes emerge where they may. To use this model out of hand will merely give the appearance of making the analyst think systematically about data and relate them in complex ways. In actuality it teaches the analyst to force a full conceptual description on data with no questions about whether the links are relevant to any emerging theory that really explains how the participants process their main concerns." (pp.63)

Unphased by Glaser's pleas to work with him to address his concerns, Strauss refused to make any changes to the text and proceeded with publication. Glaser then published his own text in which he published his letters to Strauss and stated, "Thus it is up to me to write a cogent, clear correction to set researchers using grounded theory on the correct path to discovery and theory generation...Basics of Qualitative Research cannot produce a grounded theory. It produces a forced, preconceived, full conceptual description, which is fine, but it is not grounded theory." (Glaser 1992, pp.3)

Since that time, Glaser has felt the need to defend grounded theory from misconceptions and misrepresentations, and has written almost one book every year, as well as numerous journal articles. Strauss persisted with the altered grounded theory method, though it proved confusing for many researchers. (Artinian, Giske and Cone 2009, Allan 2003)

Another of these 'deviations' from the original grounded theory is what is referred to as Constructivist Grounded Theory, whose main proponent is Kathy Charmaz. Charmaz's viewpoint is that it is not possible for an interviewer to engage in dialogue with a person without having preconceived ideas and without participating in the construction of the data that comes from that interview. She claims that there are two types of GT – objectivist and constructivist.

Constructivist grounded theorists take a reflexive stance toward the research process and products and consider *how* their theories evolve, which involves reflecting on my earlier point that both researchers and research participants interpret meanings and actions. Constructivist grounded theorists assume that both data and analyses are social constructions that reflect what their production entailed... In this view, any analysis is contextually situated in time, place, culture, and situation. Because constructivists see facts and values as linked, they acknowledge that what they see - and don't see - rests on values. Thus, constructivists attempt to become aware of their presuppositions and to grapple with how they affect the research. They realize that grounded theorists can ironically import preconceived ideas into their work when they remain unaware of their starting assumptions. Thus, constructivism fosters researchers' reflexivity about their *own* interpretations as well as those of their research participants. (Charmaz 2006, pp.131)

Charmaz goes on to compare this with what she calls objectivist grounded theory.

An objectivist approach to grounded theory contrasts with the constructivist approach. Objectivist grounded theory resides in the positivist tradition and thus attends to data as real in and of themselves and does not attend to the processes of their production.

This stance erases the social context from which data emerge, the influence of the researcher, and often the interactions between grounded theorists and their research participants. Note that most interview excerpts in published reports, including mine, do not give you a sense of how interviewers and their research participants produced the data. An objectivist grounded theorist assumes that data represent objective facts about a knowable world. The data already exist in the world; the researcher finds them and 'discovers' theory from them. (pp.131)

Charmaz was voicing not only her own position, but one shared by others who see GT as being based on an outdated idea of reality, from the positivist school of thought. (See e.g. (Clarke 2005, Mills et al. 2007, Bryant 2003) Glaser has countered these depictions of GT and Constructivist GT saying that the latter is a misnomer. (Glaser 2002) Referring to his writing in 2001 he reminds his audience that,

...It is not only what is being told, how it is being told and the conditions of its being told, but also all the data surrounding what is being told. It means what is going on must be figured out exactly what it is to be used for, that is conceptualization, not for accurate description. Data is always as good as far as it goes, and there is always more data to keep correcting the categories with more relevant properties. (Glaser 2001, pp.145)

Glaser then goes on to explain at length that Charmaz' position is untenable in GT, as it represents a concern with "worrisome accuracy", which is shared with most qualitative data analysis methods. In GT, the effect of the researcher's bias, if he has any, is patterned out by the use of large amounts of data, by the abstraction and conceptualisation of the data, and it is placed in the same position as any other data in that it must earn its relevance. In other words, if the view of the researcher is important to the study then it will arise again and again in the data and earn its place alongside any other relevant data. On the other hand, if it is just the researcher's perspective it will soon disappear from the data as a one off incident. "Remember again, the product will be transcending abstraction, NOT accurate description. The product, a GT, will be an abstraction from time, place and people that frees the researcher from the tyranny of normal distortion by humans trying

to get an accurate description to solve the worrisome accuracy problem.” (Glaser 2002, para.4)

Similarly, with feminist critiques of GT, Glaser reiterates that, like all other concepts from the data, gender must earn its way. In fact, one does not start out with any particular theoretical position – symbolic interaction, critical perspective, or any other. The data guides the researcher to what is important in this study. If it is gender, then it will emerge from the data. No theoretical perspective should be given credit prior to the study.

GT is just a relatively simple inductive model that can be used on any data type and with any theoretical perspective. It is just a general inductive model, or paradigm, if you will, that is sufficiently general to be used at will by any researcher in any field, any department and any data type. No one theoretical perspective can possess it. (Glaser 2005, pp.144)

Holton reinforces Glaser’s position when she comments on those who misuse the term grounded theory because they lack knowledge of it.

Qualitative researchers, in particular, have embraced grounded theory but often without sufficient scholarship in the methodology (Partington, 2000, p.93; 2002, p.136). The embrace renders many researchers unable to perceive grounded theory as a general methodology and an alternative to the dominant qualitative and quantitative research paradigms. Instead, various researchers seek to align grounded theory with particularistic epistemological and ontological assumptions. The result is philosophical confusion and an often unconscious remodelling of the original methodology. (Holton 2006, pp.52)

Those who argue against classic grounded theory, suggesting that it needs to move with the times or adapt to one research paradigm or another, fail to understand that it is not opposed to any particular method or perspective. Any data can be used in GT and any perspective can have relevance, even temporary. Perhaps, as Philbin has stated (Philbin 2009), these proponents of constructivism or post-modernism need to represent GT as they do, so as to position themselves and their research in a positive light.

In other words, classical grounded theory is not the adversary that is imagined by those who advocate a commitment to postmodern (in the case of MacDonald and Schreiber 2001, Clarke 2005) or constructivist (in the

case of Bryant 2003, Charmaz 2003, 2006) grounded theory. Yet without this imagined adversary, this nonexistent Other, it is difficult for constructivist or postmodern grounded theory methodologists to distinguish themselves. Rather than responding to the genuine challenge posed by openness and flexibility, there is probably more appeal in depicting oneself as a champion in a fight against positivism and objectivism - those perennial 'reds under the bed' in qualitative methodology literature. (pp.36)

Further, Philbin compared the work of Glaser (Glaser and Strauss 1965, Glaser and Strauss 1968, Glaser 1972) with that of Charmaz (1983, 1991, 1997) and only differences in style between the two were evident. Charmaz writes with more detail to the point that Glaser accuses her of story-telling. However, epistemological differences were harder to find and Philbin says, "Charmaz appears no less confident in her claims about social realities and no more reflexive than Glaser". (Philbin 2009, pp.37) With this kind of evidence, I don't find it persuasive that I should follow 'deviant' versions of GT versus following its original formulation. Therefore, in the next section, I will position my research in the light of these critiques.

Positioning my Research

I came to these PhD studies with an open mind in regard to which method to follow. The one stipulation I gave myself was that the choice of method should be different from any that I have encountered before, in order to satisfy my need for new learning which could add to my limited repertoire of research skills. Of course, the method would need to accommodate my research questions and be highly applicable to the contexts of the proposed study. (Polit and Beck 2006) I was not seeking to verify a theory that I already had in hand or to test some predetermined hypotheses. My years of practice in the field of mental health had taught me that though I may know my own experiences, I do not know much about what happens to anyone else, even in similar circumstances! Thus, a qualitative method of research was a more likely prospect to uncover the unknown.

The design for research studies is an emergent design – a design that emerges as researchers make ongoing decisions reflecting what has already been learned. As noted by Lincoln and Guba (1985), an emergent design in qualitative studies is not the result of researchers' sloppiness or laziness, but rather of their desire to base their inquiry on the realities and viewpoints of those under study – realities and viewpoints that are not known at the outset. (Polit and Beck 2006, pp.210)

My initial intention was to explore the transition experience for migrant healthcare professionals, to develop a theory that would explain how they resolve their main concern; the transition in the host country. I had the opportunity to gather data from two countries and, initially, I believed this would serve as a basis for comparison. However, as the study progressed, it was not the migrant healthcare professionals themselves or the places where they worked and lived that I was exploring, but the process of transition that impacts their lives, regardless of location or individual experiences. Thus, "the referent is the process itself and not the particular unit or units in which it was isolated". (Bigus, Hadden and Glaser 1994, pp.41) As a process-focused methodology capable of providing a conceptual overview, classic grounded theory methodology was an ideal choice for this study. Having spent long periods in previous qualitative research studies just looking at the data and trying to decide what to do with it, I was relieved to find a number of prescriptive procedures for data analysis in grounded theory. Moreover GT promised to provide a theory that is relevant to the people who are the subject of it. After development, it can also be used to inform and alter the experiences of those in the substantive area. (Artinian, Giske and Cone 2009) Glaser's advocacy for a theory that fits, is relevant, works and is modifiable (as new data are found) was appealing to me given my closeness to the migrant healthcare professional experience – as a member of this cohort. Additionally, GT offered a way for me to include my own data in a manner which would provide a two-way benefit. First, by analysing it alongside the data from participants and other sources, I could contribute to the development of the theory. On the other hand, being only one of many sources of data, I could pattern out my own bias through the GT procedures. Addressing researcher bias has been an issue for me in past studies I have conducted. (Collins 1995)

Based on the discussions above, and the rationales provided there, regarding philosophical issues in GT and the variants of the method on offer, I decided to proceed with classical grounded theory because I believe that Strauss and Corbin's approach will not allow me to induce a solid grounded theory. Charmaz's constructionist grounded theory appears too convoluted and confusing in trying to determine the variables at play in gathering data from interviews. It presents an unsolvable problem, in terms of her assertions about subjectivity and co-creation of data. It is a similar issue to one which I attempted to address previously in a study using critical ethnography as the research method. All of these methods carry an element of preconception and result in descriptions which do not allow the participants to progress in their understanding of their own situation. Additionally, GT allowed me to suspend what I knew about the situation and to discover things I did not know, and which surprised me.

One more factor influenced my choice of research method; the closeness and availability of seminars on GT, offered by Barney Glaser himself. Here was the opportunity for me to learn a research method from the founder and to have the support of the seminars to keep me on the right path. This was an opportunity I did not want to pass up!

In the next chapter, I will discuss grounded theory in more detail as I outline my application of the procedures during this study.

Chapter 5: Applying the Grounded Theory Procedures

Introduction

In this chapter, I present the unfolding of the study, and the emergence of *New Normalising*, as I applied the classical grounded theory procedures (Glaser and Strauss 1967, Glaser 1978, Glaser 1998) and worked with the data. In presenting 'what I did', I discuss the choices I made in regard to locations for the study, the participants and other sources of data, and the challenges that arose and impacted my progress at various points in the research process. In addition, I outline the ethical procedures which were applied to this study and the positions I took in regard to commonly identified issues of research rigour. As I address each of these items, I will use supportive statements from the Grounded Theory texts, to demonstrate how I tried to stay true to the procedures and the method.

Having emigrated from the UK to Canada, and being a healthcare professional myself, I was drawn into areas of professional practice in my host country where I could use my experience and knowledge to support other migrant healthcare professionals who followed me. In addition, I had taken on professional roles within the healthcare system in Canada, where I could work with others on developing and delivering educational offerings to support migrant healthcare professionals in their transition to competent practice of their profession in Canada. Further, I was nominated for a role as the representative of the Psychiatric Nurse Educators of Canada on the Federal Internationally Educated Nurses (IEN) Task Force and steering committees. This was a role I served for some 7 years between 2003 and 2010, before the Task Force was merged by the Advisory Committee on Health Delivery and Human Resources (ACHDHR), into an advisory group representing several healthcare professional groups. The mandate for this merged Task Force is "to address the impacts to Federal, Provincial and Territorial governments of the Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications (the Framework) while also addressing any outstanding policy issues related to internationally educated nurses (IENs), international medical graduates (IMGs) and other

internationally educated health professionals (IEHPs)". (ACHDHR Open Communiqué, September 30 2010)

Though I knew and thought I understood my own experience of transition (I didn't!), I encountered many migrant healthcare professionals whose experiences seemed somewhat different from my own. I was curious about the transition experience for healthcare professionals in general. In entering this study I read Glaser's comments on the need for openness on the part of the researcher. (Glaser 1998) He advises that, though it is not possible to change who you are, you can suspend knowing and commit to the emergent in the study. It is possible to drop one's preconceived ideas or "pet theories" and to discover what is going on for the participants in a substantive area. It is, nevertheless, necessary for the researcher to be motivated to conduct the study. "Studying an area of life cycle interest is vital for the researcher to have the motivation to get through the study." (pp.119) It was also reassuring to discover that I would not be the first grounded theory researcher to have to address this issue.

Most of the dissertation extracts in my reader "*Gerund Grounded Theory*" are motivated by studying the life cycle interests of the authors. The authors describe the drive to discover grounded theory as an abiding interest in a substantive area. This interest does not come with a need to preconceive the data. They show how they are not afraid to relinquish whatever their pet theories may be that came from life cycle experiences that led to their interest. Giving up their preconceptions did not kill their drive: rather, their discoveries enhanced it. (pp.49)

I decided to accept and try to follow Glaser's advice throughout my study; easier said than done. As I explain below, I encountered issues with this almost immediately. Nevertheless, when I did manage to get on-track, on occasion, my efforts to heed Glaser almost drove me to distraction, as I found myself constantly questioning whether I was forcing the data!

In studying an area of life cycle interest, the researcher must always keep in mind not to force the data with particularism. His job is to find out what is going on by looking at the patterns that emerge from many people. Thus his own particular problem embedded in an interest gets transcended to a grounded theory, which can then be brought back to help him understand the area of interest and his particular problem. (pp.49)

I saw the opportunity to collect data in Ireland, as well as Canada, as another means to resolving this issue. I certainly did not know what the transition experience was like for a migrant healthcare professional arriving in Ireland. In that particular context I was clearly open to discovery as a researcher. Additionally, in comparing the data from participants in Ireland with that from participants in Canada I would only be able to assign codes, selective codes, categories and concepts which were in both sets of data and which the grounded theory procedures would induce. This self-corrective measure gave me confidence that I could successfully generate a grounded theory in this substantive area.

Initial Efforts at 'Doing' a GT

Barney Glaser has stated that the future of GT belongs to the beginning researcher, because of his uninformed status, which keeps him open to discovery. (Glaser 2009) He also states that the only way to learn GT is to do it! (Glaser 1998) Initially, when I set out in this research study, my interest was in discovering the experiences of migrant healthcare professionals in regard to their efforts to achieve competent professional practice in the host country. My focus was on such things as education programs designed to assist these migrants (e.g. Bridging Programs in Canada and Adaptation Programmes in Ireland) as well as orientation programmes from employers and support from professional colleagues. I wanted to be able to generate a theory of education specific to migrant healthcare professionals. With this narrow focus in mind, I prepared information and consent forms, as well as a preliminary interview schedule (**APPENDIX A**) for potential participants in the study and submitted my proposal to the research ethics committee at Dublin City University (DCU). I had also written my initial research proposal on a similar vein. However, I was soon redirected by experiences that were directly related to the grounded theory methodology.

First, I was introduced by my research supervisor to a respected researcher in Dublin, who is also a Peer Review Editor with the Grounded Theory Review Journal. I was privileged to

meet with this individual at short notice, after presenting a brief overview of my intent. Within five minutes of our discussion starting, I became aware that my ideas and questions were far too preconceived and would not lead to the generation of a Grounded Theory. I decided there and then to withdraw from my position and to ask more general questions about migrant healthcare professionals' experiences of transition and how they resolve their problems of transition. Secondly, I was directed by this researcher to a number of key readings in grounded theory. As I began to read these texts, the same message came across about staying open throughout the process and avoiding preconceptions.

At later points in the research process, I encountered the importance of this truth first hand. I attended my first "trouble-shooting" seminar with Barney Glaser and several Fellows of the GT Institute in June of 2009. It became plain to me by the end of this three day seminar that I needed to study GT much more thoroughly and to allow participants to talk freely about whatever they wanted to discuss in relation to their experiences of transition. I needed to trust that a theory would emerge from this data by applying the Grounded Theory procedures.

When I conducted the first three interviews in Canada, I discovered that the participants talked to me as much, if not more, about their personal lives, before and after immigrating, as they did about their professional experiences. In analysing this data, I could see that they might not have much to say about my preconceived notions of their transitions.

As a result of these 'awakenings', I edited the information and consent forms (**APPENDIX B**) and rewrote the research proposal to be more consistent with the use of the GT research method. (**APPENDIX G**) This coincided with the need to submit an application for ethical approval to conduct data collection at a major teaching hospital in Ireland. The ethics approval was granted, thus allowing the data collection to continue.

Data Collection

In this study I collected data from a number of different sources in both Ireland and Canada. The GT method encourages the researcher to find any and all related data for comparison.

A basic tenet of grounded theory...is that "all is data". This is true research perspective on all incidents that come the researcher's way. It expands constant comparison and theoretical sampling. The briefest of comments to the lengthiest interview, written words in magazines, books and newspapers, documents, observations, biases of self and others, spurious variables, or whatever else may come the researcher's way in his substantive area of research is data for grounded theory. (Glaser 1998, pp.8)

I hadn't read or understood this yet when I first started work on setting up the study. During that time, I met with and communicated by phone or e-mail with regulators of health professionals, researchers studying experiences of immigrants in general and healthcare professionals in particular and read numerous resources, newspaper articles, government department websites, policy briefs and journal articles in areas other than my substantive area. I also attended a psychiatric nursing conference where I presented my proposal to a group of multinational participants and sought their input into their own experiences (if they had any) of working in another country as a healthcare professional. At the time, I saw this as a kind of piloting of my questions and ideas about the proposed research. I explained to the group upfront that I was embarking on this research study as part of my PhD studies. The group shared data which I now realize might be useful in developing a formal theory of *New Normalising* as the participants addressed the contexts of internal migration (within the same country) and even migrating from one unit to another within a health care facility. Of this group only three individuals had worked in another country. The constitution of the group, both nationally and by domain of psychiatric nursing practice, is presented in Table 1 below.

Table 1

	CLINICAL PRACTICE	ADMINISTRATION	EDUCATION	RESEARCH
*AUSTRALIA	1	0	0	0
CANADA	0	2	2	0
*NORWAY/DENMARK	1	0	0	0
FINLAND	0	0	0	1
IRELAND	2	0	0	0
MALTA	1	0	0	0
NETHERLANDS	5	0	*2	0
SCOTLAND	0	0	1	0
SWEDEN	1	0	0	0
USA	0	0	1	0

* 1 Psychiatric Nurse with experience of working in a different country

At a later point in the study, as I read and encountered more of the grounded theory method, and through attendance at more of Glaser's "trouble-shooting seminars", I became aware that all of this was data that I should analyse and compare with that from the interviews with migrant healthcare professionals. As Glaser says, "False starts, and starts which are close but not quite central, soon become corrected by the constant comparisons in theoretically sampling." (Glaser 1978, pp.44)

Also, at the beginning of the study, I intended to interview healthcare professionals from several main disciplines: physiotherapy, occupational therapy, medicine, nursing, pharmacy, psychology. However, I changed my position on this fairly quickly in order to advance the study and due to Glaser's admonition that "you can't do it all". At the time I was encountering difficulties in gaining access to various professional groups and seemed to be spending all of my time on this instead of collecting and analysing data. I decided to focus on the two main groups of migrant healthcare professionals; doctors and nurses. I believed it was important to keep two groups to enhance the quality of theory generation through constant comparison procedures, and to be able to maintain the focus of the study as one involving migrant healthcare professionals.

Throughout the study, I had access to migrant healthcare professionals in a number of venues. Some of the former graduates of The International School of Nursing and Health Studies Inc., Canada, a school which provided “bridging programs” for Internationally Educated Nurses, volunteered to participate in the study. I was the founder and owner of this school until its sale in 2005. I also had access to a number of migrant healthcare professionals through the organizations that they worked with. I met with doctors from the International Medical Graduates Association of British Columbia (IMG-BC) who volunteered to participate in interviews. In Ireland, doctors from a medical company which recruits international doctors to work in various parts of Ireland volunteered to take part in the study. I was able to use the same ethics paperwork to obtain permission to conduct the research with these doctors. Finally, I was given permission to interview international nurses and doctors at a major teaching hospital in Ireland. In fact, the administrators assisted me by recruiting volunteers to participate in the study. These were the formal institutions where I interviewed migrant healthcare professionals. I also had less formal contacts with a number of migrant healthcare professionals and those who are involved in their introduction to the health care system in Canada.

In total, I interviewed 38 people face-to-face and included data from a video documentary which included interviews with 13 immigrant doctors to Canada. (Gol 2006)

A breakdown of the sources of data collection is given below.

	CANADA	IRELAND	OTHER	
<i>All Interviews (face-to-face)</i>	16	22		
Interviews (Drs. & Nurs.)	10 (3+7)	11 (4+7)		
Regulators	3	2		
Admin	1	3		
Academics/Researchers	2	6		
Video Interview Data	13	0		
Conference Focus Group	-	-	20	
TOTAL	29	22	20	= 71

In addition to interviews, I had many chance conversations (brief and lengthy) with migrant healthcare professionals, reviewed policy documents in both countries, reviewed regulatory body websites for information designed to inform migrant healthcare professionals about registration, and read many newspaper articles and news bulletin information from health authorities in Canada and the HSE in Ireland. Also during this period of data collection, I continued to work as a member of the IEN Federal Task Force in Canada and was exposed to numerous reports, proposals and data updates. The face-to-face interviews were conducted between January and November of 2010.

All of this data was used for constant comparative analysis to generate the core category and its sub-categories in the theory of *New Normalising*.

Ethical Issues

As stated above, before commencing interviews I submitted an ethics application to the Research Ethics Committee at DCU. In the application I addressed the concerns that might arise in the study with regard to data collection, storage and use. Research Ethics committees have, rightly, become more rigorous in recent times due to violations of ethical conduct on the part of researchers, and due to the risks involved in many research studies. In particular, qualitative studies draw close scrutiny due to their use of detailed data from participants to explicate and produce thick, descriptive accounts. With small numbers of participants in many of these studies, the risks of inadvertent breeches of confidentiality are higher. In the GT method, this concern is somewhat ameliorated by the procedures and the end product. In GT the method itself protects confidentiality by raising the data to a conceptual level which is abstract of time, place and person. (Glaser and Strauss 1967, Glaser 1978)

Holton emphasises these issues of meeting traditional ethical expectations of research in a GT study, as she comments on her own approach.

However, grounded theory methodology does not make extensive use of the kind of detailed or lengthy quotes that traditionally raise concerns about compromising participant anonymity. Rather, grounded theory conceptualises data rendering it abstract of people, time and place and, as such, the strict adherence to standard ethical considerations of informed consent and voluntary participation are not only frequently impractical but, more to the point, unnecessary. These and similar challenges to meeting the logicodeductive requirements of many formal research ethics review processes are increasingly being questioned by qualitative researchers (van den Hoonaard, cited in Holton, 2006).

Holton explains further that, as the study moves through the GT procedures to the stage of theoretical sampling, full interviews or focus group sessions are no longer necessary, as they were at the beginning of the data collection. Now the data can come through brief conversations, which are often impromptu, or through field observations. Again, she explains the concerns with a traditional ethical approach in these circumstances.

Here again, to attempt to conform to strict requirements for ethical consideration, such as informed consent, would not only complicate the data collection process but could also jeopardise access to the very data required for conceptual elaboration and theoretical saturation. Accordingly, in this study, I employed procedures for ethical conduct where possible, but not to the point of compromising access to valuable data readily available within the field. Certainly, in all cases, those interviewed were aware of my research interests and engaged freely in sharing their experiences and perspectives. (Holton 2006, pp.60)

These experiences are similar to my own in this study. I obtained signed, informed consent forms from those that I interviewed in depth. When conversations were brief or volunteered as a contribution to assist my understanding, I did not seek informed consent as I was aware that the individual would never be identifiable from the theoretical constructs. I did assign codes to all of the interviews and stored the data under these codes to protect anonymity. I also ensured that I deployed as many defensive resources as possible within my electronic and online systems (computers and databases) to prevent the slim possibility of someone hacking the one of these systems. Whenever I travelled, I kept the data in my personal possession at all times.

Data Analysis

I completed the first three interviews in Canada in January, 2010. None of the interviews I conducted were recorded or taped. Rather, I did record the dialogue from these first three interviews, and also for the first three in Ireland, as fully as I could remember it and as close to the interview as possible – within an hour or two in most cases – and in written format. Once I had some substantive coding and categories, and once the initial effort at a core category had been attempted, I moved away from recording everything to completing field notes on the interviews, based on theoretical sampling.

Open coding was applied to these interviews immediately after recording them. This was followed by my first effort at creating categories from this data.

In the beginning he starts with *opening coding* which leads him to sample in all directions which seem relevant and work. (Glaser 1978, pp.46)

One codes by starting to read the data line by line and comparing the unit of comparison: the incident. The incident is found in a phrase, a sentence or two and seldom in as many words as a paragraph.(Glaser 1998, pp.140)

So, the researcher starts off by comparing incidents. As he reads line by line of the field notes, he constantly asks the question “what category does this incident indicate?”, or “what property of what category does this incident indicate?” and lastly “what is the participants main concern?” As categories get generated the next incidents are compared to the category which yields properties of the category. (pp.140)

These three interviews yielded some 272 open codes. **APPENDIX C** shows how these codes were recorded for these three interviews. Each code is intended to capture and conceptualize a part of the data. The process is conducted using gerunds as much as possible, as this captures the action in the substantive area. Many of the codes had similar intent and meaning and a comparative analysis of the codes produced some selective codes and preliminary categories which were then carried forward to the next set of interviews for clarification.

Interviews were planned at the convenience of the participants and, in the case of Ireland, to fit in to the short time frame that I was able to be on the ground. This posed challenges in attempting to develop theoretical sampling, as there was little time for analysis between interviews. In order to address this issue, I resorted to audio recordings of my field notes immediately after each interview. This allowed me to preserve the record of each interview in a similar fashion to the written records, though it was harder to do analysis without the written documents in front of me. Nevertheless, the outcome of this issue was a delay in producing written records of some of the interviews until I was back in Canada. At the same time it had the positive effect of creating some continuity as I was forced to carry the analysis from the Irish data into interviews in Canada to theoretically sample categories and their properties. I wondered, at this stage, if I had succumbed to one of the pitfalls identified by Glaser,

Since theoretical sampling requires joint collection, coding and analyzing, the analyst is forced to curb his zest for data collection by trying from the start to code and analyze. And it is a struggle to keep up this simultaneous activity because the strong tendency is to forget coding and analyzing and pile up interesting data, no matter what direction it takes. (Glaser 1978, pp.47)

At a trouble-shooting seminar I attended in New York (October, 2010), Barney Glaser told me that this was not an issue for the generation of grounded theory as the data can be put down for a period and taken up again at a later point without harm. As long as the procedures are followed the theory can still emerge from the data. (Personal Communication, Oct. 23, 2010) This was reassuring at the time, as I had already completed more interviews, collected more data and completed the development of the core category, sub-categories and the properties of each in the interim.

Following open coding, Glaser says that the core category and its sub-categories emerge quite quickly from the data. He also tells us that this emergence can depend on the skills of the researcher. Some, he says seem to naturally arrive at core concepts, while others back into them and yet others come in sideways. (Glaser 1998) Perhaps I was one of the latter

with regard to this study. While I was coding I was also *memoing* and trying to determine categories and their properties. The constant comparative method is an iterative one and this can be seen in the sample Memo at APPENDIX D. In this memo, I am conceptualising the data from the same three interviews and identifying categories based on the data. In a later iterative procedure I come back to this memo to compare it with the core category and its sub-categories.

Once I had established the initial core category of “International Professional Transplanting”, I started to use selective coding and theoretical sampling in the interviews. “Later on when the researcher discovers his core variables-the basic social problem and process-his sampling becomes *selective* along the lines of his focus on the central issues of his emerging theory.” (Glaser 1978, pp.46) This procedure produced data on the core variable and the sub-categories. In comparing incident with incident, concept with concept and category the theory of *International Professional Transplanting* emerged from the data. I continued to collect data and compare until I was able to generate a conceptual outline of the theory for presentation at another trouble-shooting seminar. (**APPENDIX E**) At this point, I needed to further develop the conceptual base, delimit the concepts and achieve parsimony. More comparative procedures assisted with this induction of the theory. I compared the sub-categories with the indices and then with the core category to develop hypotheses about the connections among and between them. A sample worksheet is enclosed at **APPENDIX F** which demonstrates these procedures. At the same time, I began to look for the emergence of theoretical codes (TCs) from the data to be able to organize the theory. In his books on ‘doing’ GT, Glaser provides a large number of theoretical codes and families for the researcher’s consideration. He also states that this is often the most difficult aspect of GT for novice researchers, so much so that he has written a whole textbook on this one aspect. “Researchers seem to have the most trouble at this stage of generating GT – sorting memos and writing up the theory with emergent TCs...Theoretical coding does not come easily as an emergent and has a beguiling mystique.” (Glaser 2005,

pp.1) However, he is kind in his assessment of novice researchers in saying that learning GT is a developmental process. It is better to have made an effort which does not succeed as long as the researcher intends to continue learning and developing their skills in the method. In my data I have found a stage theory which I provide full detail of in the next chapter. I believe that, with more experience in the GT method, I might have found other possible TCs with which to present this data.

Throughout the initial analysis of the data, I was working with the core category of “International Professional Transplanting”. As the analysis progressed, I became uneasy with this category as it seemed to fit less and didn’t work in resolving every incident. During the time that this was occurring, I had already ‘tried on’ *New Normalising* as the core category, but was unsure that it would work. I spent some time in preparing a paper for presentation at a conference in Dublin and, from this process, I experienced that sudden awareness moment that Glaser describes in *Theoretical Sensitivity* (1978) when the true core category jumped out at me from the data – *New Normalising*. This is what explains the most variation in the data and provides a resolution to the problems of transition for migrant healthcare professionals. I reorganised my theory with *transplanting* becoming a subcategory of *New Normalising*. Everything seemed to fit, work and become more relevant from that point forward.

In this chapter I have presented an outline of my activity during the study, in terms of the application of Grounded Theory procedures. I have discussed how I applied open coding, constant comparative analysis, selective coding, theoretical sampling, and theoretical coding to the data as indicated in classical grounded theory. I have also discussed how the core category and its sub-categories were arrived at and how the properties of each were saturated. In doing so, I have offered some sample data showing the emergence of the theory of *New Normalising* with its sub-categories of *transplanting*, *regressing* and

adapting. This and the previous chapter serve as the methodological prelude to the theory's explication in the next chapter.

CHAPTER 6: **New Normalising: the grounded theory of the transition for migrant healthcare professionals**

Introduction

Chapters 2 and 3 in this thesis laid down the background and context for understanding migration in the two countries where the data for this study was collected. Chapters 4 and 5 explained the research methodology used in the study and the application of its procedures to generate the grounded theory. In this chapter I describe the theory of *New Normalising* which emerged from the data and the application of those procedures. I begin the chapter with this introduction and then follow it with an overview of the theory, to 'set the stage' for the reader. After presenting the initial overview of the theory, I go on to present a more detailed explanation of each of the stages, the core category and its sub-categories and their properties. In concluding the chapter, I present a summary of the theory of *New Normalising* and position it in relation to the extant literature, which is discussed more fully in Chapter 7.

When healthcare professionals migrate to a new country, they face multiple challenges in transitioning to the new context of practice. Whilst a healthcare professional may believe himself to be competent in the country where he received his basic education, arriving on the ground in the country of immigration soon brings this into question. At least, it requires some adjustment from the individual healthcare practitioner to be perceived as competent by professional colleagues in the host country. At first this might seem obvious to the reader, but the significance of these statements is contained in the need for *New Normalising*, evident in the statements of migrant healthcare professionals and the implied responses of their indigent professional colleagues...

I was worried and frightened. I thought what if they do it differently here? What if I make mistakes? I didn't know anything about (country) or how they do it. I knew how to do nursing but what if they do it differently here?

I lost my confidence during that time. I felt incompetent as a nurse. It was like they were watching me all of the time.

The clinical staff were not very helpful to me. They didn't really bother. Even when I was in my first job, they left me on my own. I had to learn from my mistakes or from doing things right and then the outcome would tell me.

...I was warned off from doing that and told off from doing that by a colleague because one person complained. They (his colleagues) just saw litigation, saw a lawsuit coming and they told me to stop practicing that way.

While it is not the goal that is uppermost in the minds of all migrant healthcare professionals, becoming fully licensed and competent to practice in the chosen workplace of the host country is one indicator of successful transition. (Blythe et al. 2009) Therefore, perceived competence on the part of the migrant healthcare professional and that of his professional colleagues matters. The data analysed in this study, and conceptualised below, demonstrates that achieving this goal involves a much broader context than just that of the new location of professional practice. The experience and process of professional transition is also impacted by what occurs at a personal level. The individual healthcare professional and his family members' roles in, and experiences of, the transition also have an effect on the process.

This study conceptualises resolving of the main problems and challenges of transition for migrant healthcare professionals through the theory of *New Normalising*. *New Normalising* involves a basic social process which produces awareness and learning of the norms of the society and profession in the host country and adapting to them to the degree, and in whatever form, the individual healthcare professional chooses. *New Normalising* is a theory incorporating three stages for migrant healthcare professionals: *transplanting*, *regressing* and *adapting*. These stages are the three sub-categories of *New Normalising* which emerged from the data. Though these subcategories are described as stages in the process of resolving the problems of migrant transition, they are not linear stages. Rather, they overlap and loop back on each other and the third stage results in an ongoing process of *adapting* for some, a decision to settle for an alternative career for others, or a new beginning point in the next migration for yet others. Further, each subcategory of *New Normalising* has its own concepts, which emerged from the constant comparative analysis

of data in the study. The theory of *New Normalising* is described in full detail in the remainder of this chapter.

Overview of New Normalising

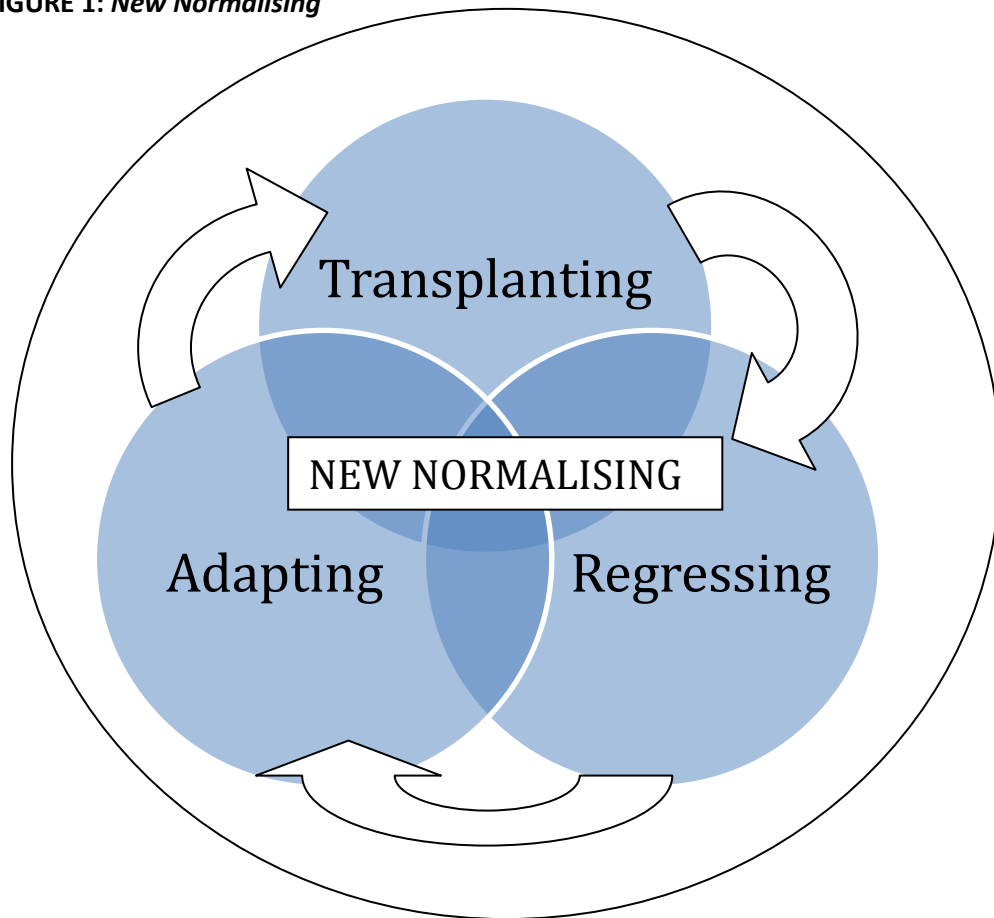
To begin the explication of *New Normalising* I will first provide a brief overview of the theory, so that the reader gets a sense of each of the stages before I enter into an elaborate discussion of the theoretical constructs in *New Normalising*. Following this overview, I will present the theory with elaboration on the properties of the sub-categories, and their relationships with the core category, keeping in mind Glaser's statement that grounded theory "...is not findings, but rather an integrated set of conceptual hypotheses. It is just probability statements about the relationship between concepts." (Glaser 1998, pp.3)

To resolve their main problem in the variety of contexts of transition, the migrant healthcare professionals in this study describe a process which I have conceptualised as *New Normalising*. Migration to a new country results in the loss of the familiar frame of reference for the practice of their profession. The rules change, as do technology, techniques, communication, environment and a multiplicity of other factors. This is true in every aspect of their lives and, consequently, produces a 'destabilization of living', not just professional practice. *New Normalising* is a process involving the re-establishment of order or personal and professional stability through the rebuilding of social and psychological structures that allow the migrant healthcare professional to function effectively in his personal and professional life. Generally, *New Normalising* refers to the stages and processes that migrant healthcare professionals go through as they encounter each issue and challenge to their personal and professional progress and competence in the host country. No matter what issue the migrant healthcare professional is faced with *New Normalising* allows him to resolve it one way or another.

None of the participants in this study expected that they could arrive in a new professional position, in a new country, and be able to function immediately as they had been doing to that point in the country that they migrated from. They knew there would be many things to learn, adjustments to make and that it would take time to make the transition to professional practice in the new environment. This learning involves everything from finding the correct regulatory body to make enquiries about application for licensure, to the complexities and nuances of language use and applications among interdisciplinary healthcare teams. Making progress with each small piece of accurate information or each step along the way is evidence of *New Normalising* activity which helps resolve the problems faced by migrant healthcare professionals. The process of *New Normalising* is not confined to the location of the host country. It begins almost as soon as the individual practitioner starts to consider migrating to a new country. Everything that happens from that point forward has an impact on the need for *New Normalising* and the degree of *transplanting, regressing and adapting* required or encountered before and after landing in the host country. *New Normalising* is experienced by migrant healthcare professionals as a process, but it has three identifiable stages which individually and together contribute to *New Normalising* as a whole. *Transplanting, Regressing and Adapting* are the subcategories of *New Normalising*.

In Figure 1 below the theory is depicted as three interactive stages of the same process, which may occur simultaneously, with each stage having an impact on the other. The stages and the whole process are presented as circles because beginning and end points are mostly unclear and imprecise.

FIGURE 1: *New Normalising*



The first stage is *TRANSPLANTING*, which starts with that first thought of making the move and ends some time after landing in the new country. This is both an exciting and stressful process for the migrant healthcare professional and his entire circle of contacts – family, friends, and professional colleagues. Transplanting involves uprooting oneself from the home environment; anticipating the future; reacting before, during and after arriving in the new location; the experience of landing in the new country; and the self-identification of having achieved initial settlement. (See Fig. 2 below) Transplanting impacts and is impacted by regressing and adapting; two more stages of *New Normalising*. Though these properties of transplanting are presented in a linear form below, the process for the individual migrant healthcare professional is an iterative one.

FIGURE 2: The Process of *Transplanting*

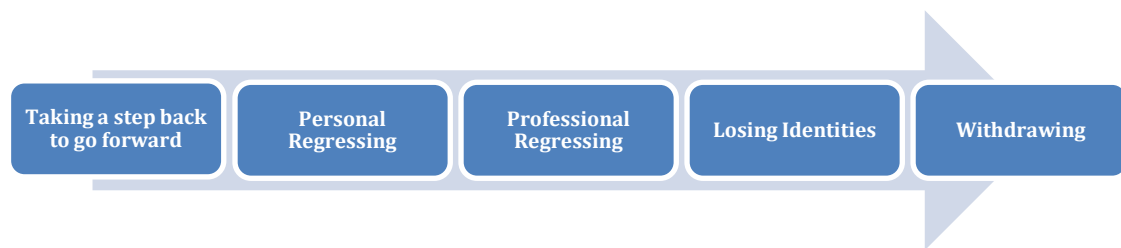


The second stage is **REGRESSING**, which involves a number of different outcomes for these migrants; positive or negative. *Regressing* is the product of the differences in norms, culture, and modes of operating within the new society, as well as its organisations and systems. It is also affected by the general perspective of the individual, his tolerance for stress and his repertoire of coping strategies. Generally, all migrant healthcare professionals experience a period of regression within their professional responsibilities and activities. In a sense, that is a given since it is not likely that any country would allow a healthcare professional from another country to land there and have free reign to practice however he decides. Legal and regulatory systems will always determine how it happens, but the individual migrant healthcare professional will always have to demonstrate that he has the professional competencies to deliver safe care to the public. Since these systems are different from jurisdiction to jurisdiction, it will be necessary for the migrant healthcare professional to go through *New Normalising* to resolve this issue. The *New Normalising* process in this particular area will almost invariably result in professional regression.

Professional regression may also be influenced by the degree to which the individual experiences personal regression. Personal regression may be experienced by the migrant healthcare professional, his individual family members, or some or all of them. *Regressing* includes the processes of taking a step back to go forward, personal regressing, professional regressing, losing identities, and withdrawing. (See Figure 3 below)

Regressing is impacted by the *transplanting* process and the pace of *adapting*. As with *transplanting*, *regressing* is an iterative process.

FIGURE 3: *Regressing*



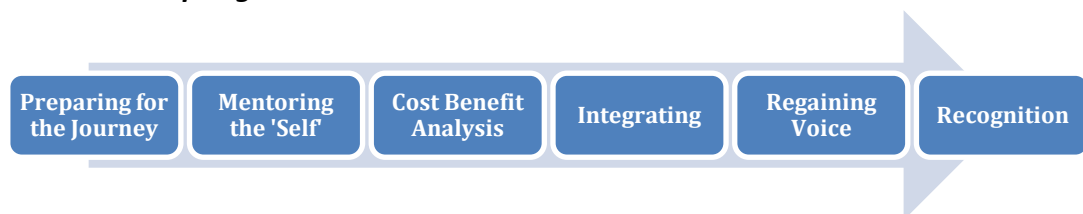
The third stage is **ADAPTING**. For the vast majority of migrant healthcare professionals this involves a process of mobilizing internal and external resources to cope with and manage the stress of transition, through to gaining recognition as a competent healthcare professional in the host country. Adapting facilitates *New Normalising* by providing the individual migrant healthcare professional with strategies to move forward. As the migrant healthcare professional learns and discovers the ways of being, of communicating, and of practicing within his profession and in everyday living, he makes decisions about what norms he will accept, to what degree he will accept and internalise them, and which norms he will reject and refuse to conform with. *Adapting* may lead to a decision to conform to norms which fit the individual's own values. It may also result in compromising values, previously held by the individual, in order to conform to the new norms. In other circumstances adapting may lead to withdrawing from the profession and changing careers, or to withdrawing completely. This is always a process involving risk-benefit analysis for the migrant healthcare professional. Refusal to conform runs the risk of alienating colleagues or being ostracised from the group. For example, if a medical or nursing procedure is performed in a certain manner in the host country, and that manner is somewhat different from the migrant healthcare professional's previous knowledge, skill and performance, or is even at odds with his professional judgment, then the

individual is faced with a decision to make. He could decide that the procedure is not in conflict with his professional values and adjust his practice accordingly. Alternatively, he could decide that he feels comfortable making some adjustments but not others and adjust his performance in line with this position. On the other hand, he may find himself vehemently opposed to the way the procedure is performed and will have to decide whether to withdraw from its performance, from his job or even from the profession. If the required change is sufficiently provocative enough, he may decide to abandon the transition completely. In the latter case, the migrant healthcare professional will start another *New Normalising* (beginning with *transplanting*) by preparing to move to the next country or he may return home.

Adapting includes the processes of preparing for the journey, mentoring the 'Self', cost benefit analysis, integrating, regaining voice, and recognition. This stage is less iterative than the previous two stages of *New Normalising* as the properties tend to occur in progressive fashion with each one leading to the next and with some forward momentum. (See Fig. 4 below)

The individual's ability to adapt as well as his pace of *adapting* is influenced by *transplanting* and the degree and form of *regressing*.

FIGURE 4: *Adapting*



The process of *New Normalising* involves an overlap among these three stages over an undetermined, individually-mediated time frame. Nevertheless, there are clearly stages in

the process. In cases where individuals have planned to move from country to country, perhaps staying only a few years in each, they may cycle through each of the stages repeatedly. In the next section I present the theory of *New Normalising* in more detail, using data from the study to illustrate the properties of each stage.

Elaboration of the Grounded Theory: New Normalising

In this section I will start by elaborating on each of the stages of *New Normalising*, including data to illustrate concepts where necessary. I will discuss the relationships between and among the stages and their properties, as well as their relationships to *New Normalising*. Finally, I will present *New Normalising* as the principle action in the substantive field which resolves all of the problems of transition for migrant healthcare professionals.

Transplanting

As stated above, *transplanting* is the first stage in the process of *New Normalising*. It is sometimes difficult to identify a beginning and end point for transplanting, though the former is obvious for some (forced migration). It might start with the individual thought of working in another country, some tentative exploration of the idea, and more in-depth investigation into the corollaries of immigrating, followed by a commitment to migrate to another country. This thought, plan or awareness moves the individual into this stage and triggers a period of destabilization in the life of the migrant healthcare professional. The participants in this study demonstrate a variety of stimuli which brought them into this stage of *New Normalising*.

I came from South Africa. I had been here on holiday before. My wife is English. I came for a spell, checked out the place and then came over here just over a year ago.

...there was a doctor who came there who used to ask people to go to (country) once a year for a month to do a job that he was covering for someone. He would invite different people to go each year and he asked me and I took the chance and came and loved it and went back home and said to

my wife, “pack up we are leaving and we're going to (country). I then pursued a position and came over and worked here.

However, I ran into family problems and decided to get out of the country and away from family.

During that time (the 3 years after graduating) I investigated (the country) and applied for permanent residency. I did my homework and came for a visit prior to moving.

Alternatively, *transplanting* begins with an abrupt and immediate event prompted by an imminent threat to life or welfare. Some of the participants in this study did not migrate of their own free will. Rather it was forced on them by police or soldiers arriving at their house, in their home country, and threatening that if they did not leave they would be killed! In yet other cases, individual healthcare professionals migrate to get married and be with their spouse. In cases of arranged marriage this may happen at short notice and without the agreement of the individual. In any situation of forced migration, the individual experiences the same process of destabilization in their life and is entered into the stage of *transplanting*. In these cases the beginning of this stage is clearly identifiable.

“The police arrived one night and told us we had 24 hours to leave the country or be killed!”

“My husband brought me straight over.”

Regardless of what stimulates the beginning of the process, the initial part of the transplanting process involves *uprooting*, *anticipating*, and *reacting*; properties which are discussed below.

While the initial stage of *transplanting* begins in the home country and is taken up with these processes, the data from this study indicates that *transplanting* continues after the physical move to the host country. There are still outstanding issues to settle back home, such as selling a house, banking and finance management, obtaining further evidence of credentials, adjusting relationships with family and friends. Some individuals maintain their professional employment position in the home country for a period of time after

migrating. This serves as a kind of insurance policy that, if things don't work out, there is a way back. To the extent that this happens, the stage of *transplanting* for that individual will be extended to at least the point where the "insurance" period comes to an end. Letting go of the employment position in the home country may be an indicator of progress with *New Normalising*.

As previously stated, *transplanting* occurs over different time periods and these periods can be lengthened or reduced by such things as preparation, preliminary visits, research and information retrieval, obtaining a position, obtaining or waiting for a visa or landed immigrant status, or the need to avoid being killed. The impact of these factors is illustrated by how migrant healthcare professionals talk about their preparations.

During that time, I investigated Canada and applied for permanent residency. I did my homework and I even came for a visit to check things out. I went to various places (of employment) and met various people. I was well aware of how things are in Canada by that time. When I went back home, I just packed up and moved here.

I did not know much about how things were in Canada. There was little or no information available about my profession and we did not know anyone.

I was worried and frightened... I didn't know anything about Ireland or how they do it. ...what if they do it differently here?

The experience of *transplanting* occurs at both the professional and personal level, and each has the ability to impact the other. The qualitative component of personal transplanting is influenced by such things as marital and family status, number of children, whether one takes one's family with them or leaves them behind, and the degree to which personal possessions need to be left behind, sold or given away. Migrant healthcare professionals, who encounter these issues, may not be aware of their own stress as they observe their family members dealing with them.

I think it has to do with my wife leaving home and missing her parents and her parents getting old and stuff like that. I have my work and that is going well, so perhaps I don't notice it so much.

Later in the discussion, he reveals that the fact that his family were stressed impacted him both at home and at work.

Yeah! I guess when I think about it, there were hard times...I call them our "down times". We were all affected. But we managed to get through it.

Risk-taking can also be a part of the *transplanting* process. In some cases, moving to a different country is an expectation, in others it is a choice and, in yet others, it is forced on the individual. Regardless of these factors, it represents a risk in that one has to give up one's career and separate from one's roots, to pursue a goal whose outcome is, as yet, an unknown.

Transplanting may be more painful after arriving in the new country and starting to discover all of the differences through comparing with them with what one was used to at home. There is a sense of sacrifice and loss in the transplanting process at this stage. After arriving in the new country, the process of transplanting, while still including the properties described above, now extends to include the processes of *landing* and *settling*. Thus *transplanting* for migrant healthcare professionals involves uprooting, anticipating, reacting, landing, and settling. I will now discuss each of these properties in more detail.

Uprooting

Uprooting is the process which begins with the healthcare professional considering and deciding to migrate to a new country, or receiving the announcement that it is to be forced upon him. It involves a set of procedures which lead to the separation of the individual from his employment, family, habitation and home location. It includes saying goodbye to family, friends, and colleagues and, for some, selling of prized possessions. The degree to which the individual migrant healthcare professional is affected by uprooting is proportional to the time period over which it takes place, and the quantity and quality of living he perceives himself to be giving up or risking. In addition family beliefs and responses to migration impact the confidence of the individual migrant and, thereby, the degree of trauma experienced in the uprooting process. Uprooting may also be prolonged

if the healthcare professional moves first, leaving spouse, children or other immediate family members behind to follow later.

(The Hospital) told me that they would give me three months and then decide whether to keep me or not. I couldn't bring my family, just in case. I was here for three months without my family. When they told me I was OK to stay, it took another three months to get their visas.

I came to (country) on my own, leaving behind my husband and my four children. So this was already a very stressful event for me, a very stressful decision, but I believed it would be a better one in the long run for me, my career and my family.

The duration of this particular separation is an unknown at the point when the healthcare professional immigrates. Separating family members also involves risks as recruitment and immigration policies can change at short notice. This might result in family members not being allowed to join the migrant healthcare professional for longer than was anticipated. Participants describe these processes as incorporating emotional pain which continues after landing in the new location and only subsides through progress in *New Normalising*. *New Normalising* allows the migrant healthcare professional to meet criteria which facilitate his family being able to join him in the host country. On the other hand, for those migrant healthcare professionals who are forced to leave their native land under threat, *New Normalising* can ameliorate the pain of never being able to see one's family again; it does not resolve it completely. Nevertheless, the individual can learn to live within their new norms.

I have to weigh everything against the fact that I am alive and have my husband and children, and we are safe and live in a peaceful country. This is preferable to being dead!

Uprooting is experienced in degrees: for some it is traumatic, due to the number of immediate losses and sacrifices, and the abruptness of it. For others, the trauma is lessened if their reasons or motivators for leaving are stronger than their reasons and motivators for staying. In extreme cases, uprooting is not only traumatic, but part of a crisis. For example, nurses and doctors who left unstable and potential or actual situations

of violence in their home country experienced less trauma from the uprooting because they could rationalise that their safety and that of their spouses and children were paramount over any other concern. This type of incident was repeated through the data. One illustration of this process in action is summed up in the following statement,

...in my country it is a dangerous place. As a (healthcare professional) you cannot go out in the street and do visits anymore because it's too dangerous, whereas here you can do home visits. ...we came here to have a family because it was too dangerous to have a family in (home country).

Anticipating

This part of transplanting involves a range of experiences among migrant healthcare professionals, their families and other significant people in their lives. It is to be found from the beginning of the transplanting process to the time of *adapting*. In most cases, the first response of the migrant healthcare professional to the idea of migrating is that of anticipatory excitement, as they consider the move to a new and (hoped for) better life experience. The intensity of these feelings increase as the date for leaving nears. Conversely, there are a number of factors which can influence this positive anticipation, mixing it with negative emotions. The migrant healthcare professional is not the only one who is anticipating, and the anticipation of others impacts their own experience of anticipation. Pressures, expectations and understandings of 'success' (in the context of the move) from family members and friends weigh heavily on the healthcare professional. Stories of others who had "failed" and returned to the home country are recanted at family gatherings, sometimes including predictions of the likely 'failure' of this particular individual, too. Added to this external stress, or even in cases where the external stressors were not evident, individuals create their own stress as they consider entering a healthcare system they do not understand and, in some cases, where they cannot yet speak the language. The fear of failure or of doing harm to patients is prevalent in the minds of these individuals as they anticipate the move. Indeed, this fear continues throughout the transplanting process and can only be resolved through progressive *New Normalising* in professional practice and in daily living.

By this time I was in a difficult position in having left (my country). I had left behind all of my family and friends, and my nursing colleagues. They were all looking on and watching me and I felt under a severe amount of pressure to succeed over here. Succeed means staying for a while and having a job here and getting money. I pushed myself into this position: no return without success. Going back early or going back without taking the job that I was offered would have put me under too much pressure at home and I would have been seen as a failure. That would impact my career back home.

No, it's family and friends who all know of someone who didn't make it. They all talk and it puts pressure on you. It makes you worry that it might happen to you.

I was worried and anxious about nursing. I was fearful of making errors because I do not know the system. I was thinking, I know nursing but maybe they do it differently over there?

Migrant healthcare professionals, who make their decision to move based on information (or even misinformation) about the practice of their profession in the intended location, as well as general information about living conditions there *anticipate* according to their findings. The degree to which each individual researches and explores this information varies widely among migrant healthcare professionals. Some only talked with a few colleagues locally, in their home country. Others attended an information session and interview with healthcare organisation personnel from the proposed host country. (These organisations were recruiting in the home country of those who decided to immigrate.) Yet other participants decided to visit the host country and explore for themselves. Thus the experience of anticipation was informed and impacted by the amount and type of information gathered in advance of the physical move. Again, this underlines the importance of *New Normalising* for the migrant healthcare professional who starts this process before leaving his home country. We have already seen that these efforts impact the experience of uprooting. They also have an impact on the duration of the transplanting process.

Reacting

Reacting mostly relates to the emotional and attitudinal responses of the migrant healthcare professionals as they progress through transplanting. It is closely related to and

influences anticipating. Some individuals they set their goal and stay focused, letting nothing impact them or sway them from their course. Others are very reactive to apparently small things and this can lead them into ambiguity about migrating. These reactions are prevalent throughout the stage of transplanting – before and after migrating - and are only resolved through successfully *New Normalising*. These reactions are mostly evident in the statements migrant healthcare professionals make about their experiences of *transplanting*.

I was fearful of not making it. I was particularly afraid of the shame I would bring on myself and my family, especially my Dad who thinks so much of me. This was a difficult time for me.

Most people give up, while others keep trying. I decided I am going to keep trying and I hope I will make it one day. There are others like me who are also trying. We just have to keep going and hoping.

Factors which affect these reactions are both intrinsic and extrinsic. For example, as we have seen in the first two properties of this category, family responses to migration vary from supportive to what was perceived by participants as downright opposition and criticism. This undermines the confidence of the migrant healthcare professional and makes the uprooting all the more painful. Family members at home, or even those on the ground in the new location, often do not understand the new set of norms and competencies for professional practice and the time and support required to negotiate them. As time passes without apparent progress (full licensure and earning income) the family become more critical. Part of this is also influenced by the amount of financial layout the family have invested without apparent results. The faster the individual can move through *New Normalising* the less this stress plays a role.

Other migrant healthcare professionals state that they became fearful of the unknown (meaning the new country and its healthcare system) before leaving their home country and that this continued after arrival. This fear was exacerbated in cases where language was also an issue. The most important *New Normalising* for these individuals was gaining

competence in the language of the host country. The sooner this can be accomplished, the sooner they are in a position to advance their adapting and, ultimately, *New Normalising*.

You know...I didn't know anything about it and I didn't speak the language. The language...that was the biggest problem. I couldn't explain myself and I couldn't talk to people. It was so hard...I can remember that right now.

I had very little English and I could hardly talk to anyone. My English was very bad and when I talked to people they did not understand, so it was very hard for me.

After arriving in the new location (landing), reacting takes on multiple and varied forms. The ability to progress with *New Normalising* is closely related to the individual's ability to activate his coping skills to deal with these reactions. Similarly, the stage of *transplanting* is influenced by this same individual capability. Whether affected by internal reacting, emotions and attitudes, or by pressures from the outside progress with *New Normalising* is influenced by the characteristics of the individual migrant healthcare professional.

Landing

Landing in the new location is a significant part of *transplanting*. It is, perhaps, the most problematic part of the process for the migrant healthcare professional and the one where *New Normalising* can't come quickly enough. Those migrant healthcare professionals who have never been in the country before encounter immediate culture shock. They have little or no frame of reference to apply to anything in the environment around them. Everything is new. Even for those who have made a preliminary visit there is a difference between visiting and moving in as a resident. However, landing is more of a defined stage from a temporal perspective. It tends to be immediate and short-lived. It instils an acute awareness among migrant healthcare professionals that they have left home, family, friends, employment and surroundings; everything that is familiar to them – they have uprooted. Landing involves the immediate negotiation of the initial bombardment with new data.

Arriving in Canada was shocking; nothing seemed familiar and I did not understand what I was observing and perceiving. This experience is unsettling and provokes anxiety.

Coming to Canada was very scary...very scary...a big fear. You know...I didn't know anything about it and I didn't speak the language.

The winter weather was very harsh...and we did not understand the social behaviours of people, so we felt as if we were standing out from everyone.

Landing is impacted by the experiences encountered during uprooting, anticipating and reacting. It can also completely overwhelm an individual, resulting in withdrawal at this stage – going home. Most, however, will carry on and, after negotiating the landing, begin the process of initial settling.

Well, I was feeling very strange because I was not used to people looking at me. It was all very weird. In (the country I came from) no one looks at you and men and women are separated. But I was on the bus here and out in public, and we didn't wear the head, wrist and ankle coverings and it felt really strange. But I got used to it after a few weeks. It was good to have freedom.

Settling

Settling is a complex part of transplanting and may take the longest to complete. Migrant healthcare professionals achieve settlement in what appears to be two phases: initial settlement and longterm settlement. In the case of the first, this occurs over the first few weeks to months after landing. Most identified an extended period averaging around 2 years before they truly had a sense of 'being settled'. Even then, many complex issues combine to create a continuing sense of guardedness in some individuals.

Even today I am not completely settled. I was made permanent at 2 years, but I don't trust that. I still worry that they could put me out if I make some small mistake. With all the things with the recession, it could happen. So, I feel better, but I am still not completely settled at work.

Settling is also closely aligned with the experiences of *uprooting, anticipating, reacting and landing*, all of which influence the migrant's ability to settle. Longer term settling is facilitated more so by the properties of *adapting*. However, *transplanting* speaks to the initial sense of settling, not the longterm one.

This initial settling is mediated by the same intrinsic and extrinsic factors mentioned previously. This includes the individual's ability to adapt and his repertoire of coping strategies to help him do so. It also involves family and significant other relationships and the nature of the interactions with these individuals or groups before the physical migration. Those migrant healthcare professionals, who express a sense of fear and unsettlement, as family watch on from afar to see the outcome of their move, arrive in the new location with their confidence undermined and this continues to hamper their progress both in personal and professional life.

Part of the settling process involves coming to terms with the loss of some parts of the self, through "not being able to behave the way you do in your own country ever again". With this aspect of *New Normalising*, "it affects your work when you cannot be yourself"; "you can't do the behaviour you would in your own country". The norms of behaviour have changed. The process of *New Normalising* will present the individual with options for resolving these kinds of conflicts. Moreover, this same conflict arises in the professional arena – you can't practice the way you did in your own country. The ability to obtain full licensure and regular employment has a major influence on how quickly an individual can settle initially. These elements are influenced by how quickly an individual can *New Normalise* and adapt to regulatory and practice requirements in the host country.

Unanticipated aspects of settling involve issues around racist responses from people in the host country. For example, trying to establish basic roots such as accommodation (a basic norm for humans) can be affected by such things as the colour of your skin, reactions to your name, or plain ignorance and fear of non-native people on the part of the indigenous population. It is hard to settle in a community when faced with these challenges. Discrimination, racism and misuse of power also impact the individual's ability to *adapt* (as we shall see in that stage).

Transplanting, then, is an unpredictable stage of *New Normalising*, in terms of what challenges come up for the migrant healthcare professional and the time frame from its beginning to its completion. The events that take place in that period prior to leaving the home country, plus the immediate experiences on arrival all have a bearing on how long it will take the migrant healthcare professional to move through *transplanting*, as well as the needs of the individual with regard to *New Normalising*.

Regressing:

Regressing means that a person or situation is reverting to a former level of development. While this is viewed as a negative event in society, generally, and by psychologists in particular, the data in this study present two sides to *regressing*, one of which proved to be positive in the perception and experience of the migrant healthcare professionals who identified it. A degree of *regressing* is inevitable when a healthcare professional moves to a new country. One cannot know all of the 'ins' and 'outs' of professional practice in this new context before encountering it first-hand. In the professional context of healthcare, where lives may be at risk, trust is not immediately extended to the migrant healthcare professional either; public safety is the number one priority. The same can be said of personal life, though some research and a preliminary visit have the potential to reduce this effect. In both of these domains - professional and personal - the same issues are further amplified, in terms of the degree of *regressing* the migrant healthcare professional encounters, when language is also an issue.

Five key properties of *regression* emerged from the data in this study, which can be applied to the context of healthcare professional migration: taking a step back to go forward, personal *regressing*, professional *regressing*, losing identities and withdrawal. A migrant healthcare professional may be subject to some or all of these as part of his unique experience of *regressing*. In other words, though all migrant healthcare professionals are subject to *regressing*, not all of them are subject to all of its properties.

New Normalising provides them with the opportunity to avoid some of the regression they might otherwise have encountered, as well as providing a pathway out of it.

Taking a Step Back to Go Forward

This is the first step in the process of *regressing*. The lived experience and/or perception of *regressing* are influenced by prior experience, status and credentials in the individual's home country. In the main, migrant healthcare professionals are experienced practitioners, with significant status in their home country or the first country they migrated to and completed *New Normalising* in. For the reasons given above in regard to patient safety, trust and professional regulation, it is usual for a migrant healthcare professional to land in a more junior position in the country of immigration, at least to begin with. Others are required to prove themselves competent to practice through assessments, education programs and exams. Their standing and ability to obtain a full practicing licence in the new country depends on the outcomes of these assessments, exams, and supervisor reports. In many cases, the assessments are conducted by individuals with less experience and education than the migrant healthcare professional. e.g. a nurse with 10 years experience and a graduate degree being assessed by a diploma level nurse. To the migrant healthcare professional, this is tantamount to being back in basic nursing school and a feeling that his career has really regressed at this point. In the words of the migrant healthcare professionals in this study, it is "taking a step back to go forward". Progress from here is dependent on *New Normalising* which will include performing to the expectations and standards implicit, if not explicit, in the aforementioned assessments – performing to the norms of practice in the host country.

A feature which underlies this problem is that credentials, status and experience are not always acknowledged the same way in the host country as they are in the home country. e.g. The value of a credential from an Asian country in a Western country has, historically, been less. In another scenario, a credential is required in the host country for certain practices where none was required in the home country. Thus a person's status and

perception of himself as a professional are altered. Awareness of this by the migrant healthcare professional may be immediate or may take time to uncover. Nevertheless, this represents a professional step back for the individual. He is not permitted to perform the nursing care he delivered to patients in his home country. This situation is only resolved, in time, by *New Normalising* – in this case it may involve taking courses, completing supervised clinical experiences, passing exams and any other gate/hoop he must pass through to obtain the credential/licence. In other situations faced by migrant healthcare professionals they move to the host country from having a settled and prominent position in their own country, only to find that even getting into the profession in the host country poses a major challenge. The migrant healthcare professional who is undergoing this *regressing*, because he believed he could do better in the long run in the host country, still hopes that *New Normalising* will bring success.

I am specialist doctor in pediatric medicine. I provided specialized cardiac services in (my country). I came to Canada because of the “American dream”, which we hear so much about in (my country). I believed I would be able to find a good medical position here and advance my skills... I left my family behind and moved to Canada on my own. I had no concept of what I would have to face in terms of becoming a doctor in Canada. It was actually shocking to me to discover that so few International doctors are able to become doctors in Canada. However, I am not one to shirk from a challenge and I determined then that I will be a Doctor one day in Canada.

Professional Regressing

The migrant healthcare professional experiences apprehension and fear of failure (through doing something the wrong way) both when he is anticipating his migration from his home country and after he moves to the host country. This fear translates itself into professional practice in the new context of care provision. It creates a disposition of over-cautiousness, causing the migrant healthcare professional to lose confidence in his own knowledge and skills. This, in turn, presents the individual to his new professional colleagues as lacking the competences for practice in the host country. The effect of this is to put the migrant healthcare professional in the position of learner; professional regressing.

Professional regression affects the individual's ability to *New Normalise* in personal life, as there will be consequences in that domain if he does not make progress in his profession. For example, some migrants arrive in the host country on their own, leaving family behind. Without this support system, they are more susceptible to struggling with personal settlement when professional regressing occurs. In other scenarios, families/spouses cannot move to the new country because they are not eligible to work there. They may be dependent on the progress of the migrant healthcare professional in order to meet eligibility requirements for entry to the host country. This situation puts a strain on families/spouses, thereby impacting personal progress. In yet other situations, where the family are together in the host country, the individual's lack of, or slow, progress in their professional career brings increased pressure at home from family members who cannot comprehend the issues.

The lack of progress, status, or the humiliation, fear and stress derived from the workplace, places increased stress on the individual who has no immediate support or on the family to which the individual returns each day. Further, when an individual feels stressed at work, the tendency at home is to withdraw and rest in preparation for the next experience to come. Moreover, negative professional experiences can lead to misperceptions and misunderstandings in the workplace which make it harder to recognize norms of the new professional culture and, consequently, to complete *adapting*. Without adapting, the individual cannot complete *New Normalising*.

As stated at the beginning of the section, not all regressing is negative. This can be true of professional *regressing*. Some individuals will regress in their careers and be satisfied with that. Some migrant healthcare professionals are happy to regress from positions of higher level responsibility. For example, *regressing* from owning a GP practice or being a senior nursing administrator to being one of a group of practitioners with less responsibility can be perceived as a positive change. This produces a situation of increased job satisfaction

for them. Thus, the consequences of regressing produce a positive outcome for these individuals.

At (one hospital) I can practice more or less independently whereas (at another) I am working with other people and scrutinized by them and held back by them and encouraged not to do things that I would normally do for patients such as getting involved closely with them. So, professionally, it's been a bit stressful and frustrating. At the same time I consider the job easy...very, very easy so it's not physically stressing and I get lots of exercise because of long breaks and I get to eat well. I feel that my quality of life has improved since I came to (this country).

Personal Regressing

Some migrants will experience personal regression through loss of family, networks, belongings, financial status and social status. Others do not experience this to the same degree, as conditions in the new country are so superior to the ones they came from that they are happier with general life. e.g. a Filipino nurse moving from a Middle Eastern country to the West is no longer under the same restrictions and codes of dress, behaviour and describes the "freedom" she experiences in the new host country. Even then, she needs to *New Normalise* because it feels strange to have this freedom and she is unsure how to behave.

However, not all personal regressing is bad or results in a negative consequence for the migrant healthcare professional. In some cases the Doctor or Nurse comes from a country they consider to be "very corrupt" to one that they perceive to be much less corrupt. In this circumstance, they consider their lives to have improved, even though they cannot gain full licensure and employment in their previous profession.

Personal regression will affect the individual's ability to *New Normalise* professionally. Participants describe the influence of life outside work on their ability to concentrate and progress at work. Experiences of racism, financial pressures, stress on a spouse or children or even personal experiences, like obtaining the right food, finding

accommodation etc. all impact the individual's perception and performance at work. As a whole individual, experiences from home life affect stress levels, confidence, motivation and concentration at work.

Lack of job satisfaction and frustration at work can put pressure on home life. It may cause the individual to generalise his stress into his home life and community/society, thus leading to dissatisfaction in the personal life. Not achieving the promised financial rewards or goals may also limit or slow the individual's or family's ability to integrate into society, by removing opportunities to do so. All of these circumstances can create conditions for personal *regressing*.

Some individuals regress in their personal life due to the consequences of *regressing* in their professional life (e.g. earning less salary). Migrant healthcare professionals also reflect on the material losses they encounter due to migrating to the host country. Migrating is an expensive process and, depending on financial status before moving, or the length of time between arriving and obtaining paid employment, it puts a strain on family resources. In turn, this becomes a worry for the individual professional which can, in turn, affect professional performance. This inter-relationship between personal and professional *regressing* is clearly expressed in the illustration below. It also supports the hypothesis that *New Normalising* addresses a migrant healthcare professional's whole life.

I had to grapple with the family pressures, the financial pressures, the birth and raising of my son, the pressure of having become a nurse in India and now having to become a nurse again in a different country, and come to terms with it all within myself. It was when I could believe in myself that I became confident.

Losing Identities

Before migrant healthcare professionals move country, they hold particular concepts of and about themselves and their professional and personal identities. Migrating brings these identities into question in the new location of practice and living. During the period

of regressing the individual's professional credentials and clinical competence are under scrutiny, and may even be questioned. This situation is compounded further by the individual's status as a person in the new society. Migrant healthcare professionals feel vulnerable when their immigration status is uncertain or temporary, and they are cautious about speaking on their own behalf in the face of questioning of their professional competence. Consequently, individual healthcare professionals wait for their immigration status (and that of their family) to be confirmed before they start to speak out and demonstrate their full professional capabilities. This situation is even more severe on the migrant healthcare professional when his family has remained behind in the home country and those family members have not been awarded any immigration status in the host country. The migrant healthcare professional feels caught in a trap as his own and his family's status as persons in the new society are tied to his demonstration of professional competence. Accordingly, he will conform to whatever is asked of him by the regulatory body, his employer and professional colleagues even if he thinks it is not just or based on an accurate assessment of his professional knowledge, skills, judgments and attitudes. The effect on the migrant healthcare professional is to hold him in a position of *regressing* until he is able to *New Normalise* his way out of it. The story from a migrant nurse below is a good illustration of this problem of transition.

This transition has been difficult, in terms of the way that people deal with each other,...the way they speak to me and to each other here, the gossip, and the dragging down, and belittling, and the seniority issues. I guess I'm also frustrated that I didn't have the position that I had in (my own country). I've had to sit on all of that because I felt vulnerable as a person on a work permit and having to wait for my landed immigrant status. Once I had that I felt more assertive and safe to speak up. I held a party the day my papers came through. I bought in food for the staff and drinks and all the trimmings and I did this on the unit. When everyone was there and enjoying the food, I announced to them all, "I'm not going to take anymore shit from anyone here..."

Withdrawal

Earlier in this thesis, I stated that *New Normalising* can result in different outcomes for different migrant healthcare professionals. Once he becomes fully aware of the host

country's normative processes and frameworks in a system, profession, organization, community, society etc. the migrant will decide how to adapt. One option is to refuse to conform at any level and withdraw.

For some migrant healthcare professionals, their experience of *regressing* is not something they are willing to accept. If regressing becomes unbearable or goes on for too long they resolve this conflict in a number of ways: 1. Withdraw completely and go back to the country from which they came. 2. Withdraw completely and move on to a third country. 3. Withdraw from their profession and move into an entirely new field - this choice is only made when the individual and/or his family do not encounter further regressing, or are satisfied with the level of regressing, in their personal lives. In particular cases of withdrawal, migrant healthcare professionals become bored, frustrated with lack of progress, cannot see a way into their profession in the new country, or the demands are too much and too expensive. Others are unhappy with the professional or social culture of their profession in the new country.

When I arrived and found out I had to do the exams and would not be likely to get a job even if I passed them, I looked around. I decided not to bother with medicine at that point. I started working at delivering Pizza.

...on the other hand I was incompetent in some of the basic nursing skills because I had not encountered them before. For example, very basic care like caring for a female patient and changing the hat, as they call it. Those things were shocking to me and lots of other things that are not done in India by nurses. This has been a bit stressful for me. I have not been able to practice the nursing I learned and I am thinking of moving on from (this country) and going to another country. My fiancée is working in another hospital in (this city) and we are now looking at moving to (another country).

I thought that I would be able to become a GP in (this country), as I had so many years of experience in (my own country). I was very surprised to learn that I could not do this. I tried for a long time to get back to my profession, but unsuccessfully. Eventually, I gave up because I had children and needed to get on with my life. I took several health-related jobs, until I landed in my current position as a coordinator of health promotion... I feel somewhat satisfied with this position because I have some autonomy and it is health related.

Regression can produce positive results for people in the new country, if it reduces stress, provides job satisfaction and creates conditions for a happier life. On the other hand, when

it results in loss of status, perceived reduction in quality of work or social life, or impacts the individual or family too negatively - too many losses - and there is no perceived prospect of that changing for the better, then most common response of the migrant healthcare professional is withdrawal.

Regressing is a stage in *New Normalising*. It results from the norms of the culture and practices in the new society and workplace being different from those where the healthcare professional migrated from. It is the loss of ability of the individual to fit in until he can perceive, assimilate and accommodate the new norms which are producing the *regressing*. At times, the awareness experience is abrupt; at others, it is more subtle or insidious.

New Normalising facilitates the understanding of both participants, Doctors and Nurses, in this study. Without knowing the normative structures and systems of nursing or medical practice at the new location, it would not be safe for the individual to be put into a position of trust. However, when the individual is able to learn the norms of practice in the new environment, or is assisted to do so by the supervisor or preceptor², the degree of humiliation, fear and lack of confidence is lessened and the person can adapt his practice accordingly.

Some of these experiences relate to differences of cultural practices which increase the stress level for the individual. Having support from people with the same norms, or those from the same culture who have already gone through this part of the transition and can translate it for them, makes a difference in ameliorating the associated stressors. It's the lack of understanding which leads to fear and apprehension, or simply withdrawal.

² An experienced healthcare professional who provides practical training to students.

New Normalising in one's personal life is different from the workplace of the migrant healthcare professional. e.g. Language use in healthcare is different from that on the street. The confidence of the individual healthcare practitioner in respect to the use of English is undermined by misunderstandings in practice areas.

If the new norms at work are intolerable to the migrant healthcare practitioner, then the stress level increases and adapting becomes harder. If structural norms, such as financial remuneration from employment, are not satisfactory or do not provide the preconceived means to improve standards of living then the individual may feel they have regressed. Further, identity is a major feature of being part of the new norm in the host country. Regulations, the pace at which bureaucracies move and individual attitudes can all frustrate the efforts of the migrant healthcare professional to complete *New Normalising*.

Regressing, as a sub-category of *New Normalising*, is bound up with the whole experience from transplanting to adapting. Some norms can be accepted or understood and accommodated over time, while others produce too much stress and overwhelm, and are likely to be rejected. When regressing is a positive step, it enhances the whole experience of transition.

Adapting:

Adapting is the final stage in *New Normalising*. Initial processes of *adapting* can be commenced before leaving the home country, but the preponderance of *adapting* takes place in the new location in the host country and occurs over a lengthy period. In fact, for the migrant healthcare professional who perceives himself to be settled, after *transplanting* ends and he moves beyond *regressing*, *adapting* continues into the future with an unclear end point. There is always more to discover about this new host country and its ways of being. It is difficult to tell if, at this juncture, this is the same new learning

as a native to the country would experience or if it is an ongoing consequence of the migrant transition. This question has not been investigated in this study.

Indubitably, individuals indicate various definitions and conditions of adapting which are unique perceptions in the eye of the beholder. Further, adapting results in a number of possible outcomes; from acceptance of, and conformity to, the new norms, through fitting in with some and not others, to rejection of the new norms and the decision to withdraw from the enterprise entirely – thus beginning a *New Normalising*, by migrating to another new location; or a *re-normalising*, by returning home. *Adapting* demonstrates a tendency toward forward momentum, moving the migrant healthcare professional forward in the process of *New Normalising*. It tends to move him on in the *transplanting* process and out of *regressing*.

Adapting has a number of key properties which emerged from the data in this study and which facilitate a successful stage outcome for the migrant healthcare professional: preparing for the journey, mentoring the “Self”, cost benefit analysis, integrating, regaining voice, and recognition. These are explained further below, with some illustrations from the data as needed.

Preparing for the journey

Adapting commences as soon as the migrant healthcare professional begins preparations for the transition. Already, he is starting a thought process which will have an impact on, and may even determine, the outcome of the migration transition. Additionally, some of the activities in anticipation of the physical move can assist with adapting after arrival. For example, gleaning information from those who have taken the journey before him can help the migrant healthcare professional with making connections between pieces of information after landing. Similarly, beginning or even completing the process of gaining licensure in the new country can advance the timeline to full employment, thus also affecting the time frame for completion of *transplanting* and *adapting*, and reducing both

the timeline and effects of *regressing*. He can also make efforts to obtain employment in advance of the move. Again, this allows for more *adapting* as he can make professional preparations in advance of the physical move. It is also reassuring to him and his family that they will have a degree of security on arrival in the host country. Thus it contributes positively to *adapting*.

On the other side of this coin, those migrants who are not prepared for the journey may encounter more difficulties in the host country. Sometimes the migrant becomes too absorbed by the effects of *transplanting*. This can have consequences for the migrant healthcare professional's ability to adapt and complete *New Normalising* at a later point in the process. It also impacts the degree of *regressing* experienced by the individual on arrival in the host country. Preparing for the journey is an important part of adapting that, if not engaged, can be a missed opportunity for migrant healthcare professionals to support their own *adapting* and *New Normalising*.

I knew absolutely nothing about Ireland and that it was just a Western country and the place that I would be able to learn. I was quite happy to take up the opportunity... I did not know anything about Ireland, the healthcare system, nursing or anything else but here I was traveling to Ireland. Making the move was not my biggest pressure and stress; at that point it was the fact that I was leaving my family who I am very, very close to ...especially my parents. I did not really think about the other parts at this stage. I came to Ireland and it was a major shock to my system. The first thing that hit me was the freezing cold as soon as I got out of the airport... I was frostbitten!!

I thought to myself, "Oh my God, what have I done? I don't even know where (this country) is. I don't know what it looks like, I don't know what the weather is like or anything", and I had that kind of moment of panic which passed within half an hour. I then had doubts as I arrived here and the place was freezing and I had never encountered this kind of cold before...so this was a really strange experience coming to a country that was so cold and windy and freezing. Even when the sun was out it was still cold!

Mentoring the 'Self'

One method of *adapting* that a migrant healthcare professional uses constantly, and apparently to good effect, is that of mentoring the 'Self'. In times of crisis, it helps him to persevere. At times of lower stress levels, it encourages and supports him to keep going.

Ultimately, it helps him to get through any challenge that he faces. The most often repeated phrases that migrant healthcare professionals say they tell themselves are along the lines of, "What's happening here? What are you doing? You can do it. You CAN do it! Just take a breath...take your time, you will succeed. You have done this before at home, you can do it here." Or "Just keep going. Don't give up! You will become a (nurse/doctor) here." When telling of this self-talk, the migrant healthcare professional states that the stress, fear or anxiety that he feels is "within me". "It's not external, so I can control it". This self-supporting strategy is used even when there are contradictory statements coming from family members or professional colleagues around him. With this mentoring (of) the self, the individual is able to adapt to the immediate circumstances, ride out the crisis, and move on with the transition.

Cost Benefit Analysis

Another part of adapting involves a kind of cost benefit analysis which the migrant healthcare professional engages in. This will most often happen when the individual is thinking of giving up and withdrawing, after a series of challenging experiences or when it feels like he is not making progress and never will. In these situations, he will find himself considering why he came to the host country in the first place. He will then compare the life he perceives himself to have now with what he believes he left behind. This cost benefit analysis usually begins from a place of negative cognition. He will repeat the phrase, "If it was so good back there, then why did you come here?" to himself, or he will have heard this from 'natives' of the new country. In doing this analysis, if he finds that there are more positives than negatives about the host country, or even if he just does not have the means right now to act on a decision to go home, he will reaffirm his decision to continue to live in the new location. This is a major turning point in the *adapting* process. Most migrant healthcare professionals report that they do not look back after this point in the process. If he is still in the *regressing* stage when this happens, the migrant healthcare professional seems to work his way out of it more effectively and within a short time frame. Cost benefit analysis is an import process of adapting through the migrant

transition. This cost benefit analysis may result from the mentoring of 'Self', as a means of self-encouragement and perseverance.

Another thing I did was talking to myself in the mirror. During that first year especially, I asked myself why I was here, why am I doing this? Why am I so far from home and not back there looking after my parents? Why am I putting myself through all of this? But I just talked myself through it. It helped to talk myself through the difficult times.

It as a step back to begin with. It takes time to adapt and get used to it and it's taken me one year and I'm only feeling I am beginning to adapt. I went through a down period after six months; wondered why I was here? What was I doing? etc. But you re-evaluate it, you ask yourself why you came? In (country) it is a dangerous place as you cannot go out in the street ...because it's too dangerous whereas in (country) you can. ...So these things about (this country) are a lot better and a lot safer than (my country).

Integrating

Another factor which influences the pace of *adapting* is the tendency on the part of the migrant healthcare professional to constantly compare situations, conditions, materials, quality and quantity of life with that which they had acquired and experienced before leaving the previous or home country. In the context of professional practice this can be detrimental to relationships and support offered by 'native' colleagues, if they perceive it as constituting an attitude of superiority. On the other hand, constant comparing is also a way of identifying and coming to terms with differences. It helps the migrant healthcare professional integrate the familiar with the new. Thus, it is part of an integrating process which supports adapting and leads to *New Normalising*.

Adapting involves making decisions about whether and how to conform to new norms or not; whether and how to integrate into the new society. Not all norms of the new society fit the values of the individual migrant healthcare professional. Decisions need to be made as to the degree of conformity and compromise one is willing to make on a case-by-case basis. These decisions can result in a variety of consequences for the individual professional. However, awareness of new norms, and decisions in their regard, facilitate the process of integrating into the profession, environment and society. Those who are not

yet aware that this is the problem, or those who have decided not to conform to these new norms, appear “stupid” to the indigenous population.

In the context of professional practice this process means coming to terms with, and accepting, different modes and models of practice and care delivery in the new location. In some circumstances this involves a cultural shift which challenges the values and beliefs of the migrant healthcare professional. This is not an easy transition to make and not conforming, or not being willing to conform, creates conditions where the individual practitioner appears incompetent. These challenges are occurring in contexts where migrant healthcare professionals are still being assessed, or where they are in the probationary period of their employment. Their practice is being scrutinized to determine whether they have the requisite competencies for full licensure in the new country. To adapt to these situations, migrant healthcare professionals have developed a number of strategies. One strategy is to try to work with colleagues who are from the same or similar culture to themselves. This allows the individual to be less conspicuous and lessens the threat. Another strategy they use is to pretend not to know what they do know, to allow the local healthcare professional to be in a position of teaching them. Feigning ignorance gives them permission to avoid conforming to the practices which are new to them until they have been fully instructed and have learned them. Learning what you already know is another strategy that they use in these circumstances. This is also a situation where migrant healthcare professionals will use self-mentoring to support themselves through this experience. A further strategy which they use is to seek support from other migrant healthcare professionals outside the immediate arena of practice. All of these strategies are aimed at helping the migrant healthcare professional to integrate into the profession in the host country.

Where the exposure to, and pace of, *New Normalising* is reduced all of these efforts at *adapting* can be prolonged. In order to address this problematic, the main method of *New*

Normalising used by migrant healthcare professionals is by “getting out there and mixing with the locals” (going native). In a professional sense, this means doing the work of the profession. However, the ability to obtain this experience can be impacted by lack of credentials and an inability to obtain employment due to lack of a work permit and/or the relevant immigration papers. To integrate into the new society and professional practice is a circular process requiring a place of experience and practice (exposure), the opportunity to demonstrate competence (learning), and fitting in with the “natives” which leads to further opportunities for exposure.

...But that's what you need to do. You need to practice in real situations with people. There is no point in learning from books, unless you are going to use it. You must do it if it is going to help. I would tell people that if I met IENs now. Get out among people and in as many situations as you can. No point in just going to classes and then going home where you can't use it. You need to go somewhere else and practice with people. Once you have the language, you can do better in nursing.

Regaining voice

During *transplanting* and *regressing*, migrant healthcare professionals experience the loss of their ‘voice’ in the everyday conversations of professional practice and social life. Without professional or social standing, they feel they have nothing to contribute or that what they would contribute would not be given the same value as it would be in the country they migrated from. Further, their concerns about achieving their goals of full licensure and employment, and the need to pass assessments or performance evaluations, leads to a lack of willingness to speak, for fear of upsetting someone or saying the wrong thing. The people who would witness this ‘indiscretion’ may be able to influence whether they achieve their goals or not. For those whose first language is not the same as the country of immigration, this fear is even more acute, and they are even less likely to speak up.

Language is a major component of *adapting* for many of the migrant healthcare professionals. Language acquisition allows one to adapt and conduct *New Normalising*

more accurately and completely. Certainly, comprehension of the norms and culture of a society and its organizations can only be fully understood in the context of the nuances of the native use of language. These kinds of situations that he finds himself in lead to a loss of 'voice' for the migrant healthcare professional. Consequently, adapting to the language and the rudiments and regulations of professional practice are ways of regaining one's voice in the new country. Additionally, *New Normalising* facilitates progress in the transition for migrant healthcare professionals, and this progress also allows the individual to regain voice as they take up professional positions of employment which are more akin to their professional experience and competence.

Adapting for migrant healthcare professionals involves two levels of establishing personhood in the new country: one as an individual person in society and the other as a credentialed individual in his profession. The migrant healthcare professional's *adapting* is contingent on a personal sense of having rights, status and a voice within both the profession and the new society. It is clear that being an immigrant is a place of vulnerability and perceived weakness. Having only a work permit makes this sense of vulnerability more acute. Even when immigration and professional status are achieved in the new country some participants continue to distrust the organization and community and are not convinced that they might not be sent home. This vulnerability is exacerbated by changes in political and economic circumstances in the new country. During the "global economic recession" migrant healthcare professionals voiced that they may be displaced by "home-grown" professionals due to the levels of unemployment in the particular society. Each of these aspects of personhood can influence progress with the other and, thereby, the *adapting* process as a whole. When only one aspect of personhood is an issue for the migrant healthcare professional, then it still has an impact on the ability of that individual to adapt.

...it took me a long time to become comfortable, confident, and totally competent in my position. After all, the work was new to me. In fact, the whole approach was new to me. The whole system was new to me. So it took some

time to get to grips with that. But once I got my registration I started to become pushy and more assertive, working for my rights and working for the rights of my patients, and demanding things go a certain way rather than just sitting back and accepting that I didn't know. I started to use the knowledge I had and show them that I actually knew things all along and I wasn't as stupid as they thought I was when I first arrived. It was as if I had to go back to repair the image I had given them of myself as an incompetent person; to demonstrate to people that the opposite was true, and to contradict what they had perceived of me before. Sometimes I just presented that it was with their teaching that made me confident. Even though I started to use it after I received my registration it still took some time to get to the point of being comfortable.

Recognition

Once a migrant healthcare professional has adapted to the point of integrating the new norms and culture into his life, he is better placed to succeed in his professional endeavour. Progress in passing the national exam(s) and obtaining a full professional licence allows the individual to integrate into the interdisciplinary team in the location of employment. As such, he can then begin to adapt local professional practices and procedures and this will allow colleagues around him to provide him with more recognition. Succeeding in his efforts to gain the professional licence brings a degree of stability to his situation, by securing his current employment and allowing him to apply for more positions if he so desires. It also brings the benefit of knowing that his migration a longterm project. The migrant healthcare professional is now recognized as a colleague on equal footing with his native counterparts. He is trusted in his work and communications around him are similar to those with other professional staff. Obtaining his licence may also facilitate the reunification of his family and the ability of his spouse to participate more fully in society.

Progress in these adaptations facilitates confirmation of employment status and success begets more success. All of this brings recognition of the person and the professional in the new location of practice and living.

Becoming aware of and learning the components and nuances of new norms puts the migrant healthcare professional in a position of being able to adapt. Regardless of the

adapting chosen, without awareness of how things 'work' in either the professional or personal context an individual cannot even begin to adapt. Thus the migrant healthcare professional has learning that needs to take place first which is not strictly academic in nature.

New Normalising

New Normalising, then, is a process involving the re-establishment of order or personal and professional stability through the rebuilding of social and psychological structures that allow the migrant healthcare professional to function effectively in his personal and professional life. Whether this results in continuance in the host country or not, practicing in their original profession or not, practicing at the same level or better than the one they left in their country of origin, *New Normalising* brings a resolution to the problems of transition. The stages identified in *New Normalising* - *transplanting*, *regressing* and *adapting* - involve an iterative process as they overlap and loop back on each other in real time. The third stage, *adapting*, demonstrates a tendency toward forward momentum in the process of *New Normalising*. The effect of the process in this stage is to assist the migrant healthcare professional to move on in *transplanting* and out of *regressing*. Defining time boundaries for these stages is problematic since they are mostly self defined by the migrant healthcare professional himself. Yet, they are identifiable stages. The theory of *New Normalising* provides a conceptualisation of the transition for migrant healthcare professionals in Ireland and Canada, which should be recognizable and useful to them. It has the potential for further development, which will be discussed at a later point in this thesis.

Summary

Migrant healthcare professionals are faced with multiple, varied and sometimes complex problems during their transition to practice of their profession in the host country. These problems can be resolved through the process of *New Normalising*. *New Normalising* is a

stage theory which incorporates a basic social process. There are three parts to *New Normalising*: Transplanting, Regressing and Adapting. In this chapter I have explained this theory and its parts, as well as each of their properties in some detail. I have shown how the concepts in each part relate to each other and to the core category, *New Normalising*. This substantive theory was induced through a grounded theory method (Glaser and Strauss 1967, Glaser 1978, Glaser 1998, Glaser 1992) from data collected from participants and sources in Ireland and Canada. In the next Chapter, I will compare this theory with the extant literature and comment on its position in relation to other theories and studies. It is my hope that this theory will fit, be relevant and work for migrant healthcare professionals going through transitions in Ireland and Canada. I believe that it is modifiable if new data should present itself for comparison.

CHAPTER 7: Comparing *New Normalising* with the Literature

Introduction

In Chapter 4 of this thesis, I explained that the extant literature in the field is addressed differently in Grounded Theory (GT) studies. The intentional avoidance of the literature in the substantive area until the theory begins to formulate is designed to prevent contamination by preconceived ideas that may not fit, or have the potential to tempt the researcher unwittingly into forcing categories and concepts on his data. Before and during the process of developing the theory of *New Normalising*, I was working in this field and exposed to literature and data from my membership on the IEN Federal Task Force. Further, as a subscriber to multiple nursing and health journals, I constantly received updates and contents alerts in my e-mail in-box. I applied two main strategies to deal with this problem, in order to protect myself from preconceiving the study data. Firstly, I collected most of the journal articles in folders without reading them. Secondly, since the categories of *New Normalising* began to emerge fairly quickly, I was able to begin reading selected literature from the field, to compare in my analysis in specific areas or set aside as irrelevant. Some literature that I encountered vicariously (committee members and colleagues) I sought out the original article to include as data for the study.

In this chapter I will review the literature from a number of different areas and discuss its relevance, or not, for *New Normalising*. First, I examine literature on migration itself and question its relevance for my study. Then I compare some of the more prominent research studies on the migration experiences of nurses and doctors in recent years with this study of *New Normalising*. In the final part of this chapter, I compare Meleis' theory of transitions with *New Normalising*. Her theory comes from her research studies in nursing practice. This theory may have the potential to support or add to the theory of *New Normalising*. One of the criteria for the measurement of a grounded theory is that it is modifiable when new data is found.

Migration Theory

From the amount of literature being produced on migration one could easily get the impression that this is a growth industry in its own right. Perhaps that should not surprise us, in the light of the history and more recent data reviewed in the early chapters of this thesis. However, much of that literature is focused on issues such as globalisation, global economic issues and the movement of skilled workers across the world. Not surprisingly, then, much of this production is driven by international organizations, who seem to be growing in number - World Health Organization (WHO), United Nations (UN), Organization for Economic Development (OECD), International Organization for Migration (IOM), The European Migration Network (EMN), International Labour Organization (ILO), the Global Commission on International Migration (GCIM). In addition, there are commissions, migration institutes, and centres all focused on migration studies, and professional groups have their own international organizations, e.g. the International Centre on Nurse Migration. Theories of migration abound, yet none seem adequate in doing justice to what is happening with migration and to migrants around the globe. For example, Castles provides detail on “economic theories”, “historical-structural” and “world systems theories”, “interdisciplinary theories” and “transnational theories”. (Castles and Miller 2008) Purcell adds to these two more models – push/pull and chain migration. (Purcell 1995) While supporting the economic model of migration, and focusing on globalisation as the driving force, Zolberg and Benda add ecomigration as another model. (Zolberg and Benda 2001) Jones, claiming that globalisation of world economies is happening fast and unabated, advocates for the same open model of migration, where citizens of the world can move where and when they want. (Moses 2006) These models and theories are aimed at uncovering explanations of ‘big picture’ migration, understanding why people move from one location to another, identifying which factors are at play in a particular migration movement at any given point in time, and with a view to forming national and international policy in these regards. While aspects of each of

these theories have relevance for migrant healthcare professionals, they do not address the problems of transition as *New Normalisation* does.

The lack of theoretical rootedness and largely descriptive nature of much empirical work has haunted the improvement of theories. As a result of the general lack of common theoretical thread, most empirical work – especially from outside migration economics – remains isolated, scattered, and theoretically underexplored. Real progress in the understanding of the factors determining the fundamental *heterogeneity* of migration and development interactions is only possible if more empirical work is designed to test theoretically derived hypotheses and, hence, to improve the generalized understanding of migration-development interactions. (de Haas 2007, pp. 4)

While they highlight the structures and processes which facilitate migration globally, all of the migration theories are of more practical use to governments seeking to predict such things as future economic growth, in-migration and out-migration, the development of ethnic minorities in their communities, as well as issues related to definitions of citizenship in a globalised world. They do not address the experiences of individual migrants or groups of migrants nor provide them with a theory they can apply to resolve their problems of transition. *New Normalising* does this in the substantive area of migrant healthcare professionals.

Healthcare Professional Migration

Most of the recently published research on aspects of migration involving migrant doctors and nurses is limited to a few areas. First, there are the studies which seek to assess the extent of the issue; measuring current numbers of immigrant and emigrant doctors and nurses, and predicting future numbers. These studies are mostly designed to serve as policy briefs. The data in this regard is unclear or incomplete to the degree that the extent of healthcare professional migration in any particular country is unknown. (Ruhs 2005, Chew et al. 2010, Cross 2011, Irish Medical Council , Barrett and Rust 2009, Blythe et al. 2009, Humphries, Brugha and McGee 2008a, Irish Nursing Board 2009, Watanabe, Comeau and Buske 2008) Many jurisdictions are now working to improve the accuracy of their databases as it is predicted that the need for migrant healthcare professionals will

continue for the foreseeable future. (OECD 2011, IOM 2010, OECD 2010b, Connell. 2010, Cross 2011, Milke 2008) This data will only tell us how many individuals, and in what professions, are going through the migrant transition.

A series of policy briefs published by the Nurse Migration Project in Ireland found evidence of similar issues to those conceptualised in this study as *transplanting* and *regressing*. For example, in Policy Brief 2 (Humphries, Brugha and McGee 2008c) and Policy Brief 3 (Humphries, Brugha and McGee 2009c) the issue of migrant nurse retention was discussed. In the first paper, the researchers conducted in-depth interviews with 21 migrant nurses. Only four of these interviewees stated that they were planning on staying in Ireland on a longterm basis. Three had already made definite plans, with a further eight stating they were likely to leave within the next five years. The issues identified by the respondents for *withdrawing* were related to “the desire for stability and to maintain the integrity of the family unit...” (Humphries, Brugha and McGee 2008c, pp.2) Migration policies in Ireland posed a number of challenges which affected such things as reunification of adult and extended family members and the status of adult children who would need to pay non-EU fees for third level education and would have no automatic right to employment or residency on completion of those studies. Additionally, there were issues around lack of entitlement to citizenship in Ireland which did not facilitate a sense of *settling* among these nurses. In Policy Brief 3, the researchers used a quantitative survey method to study factors which might affect retention of migrant nurses. They found that, similar to the qualitative study in Policy Brief 2, only 19% were planning to remain in Ireland longterm and that immigration and citizenship issues were key in this decision. The authors listed the top 5 reasons to stay or leave Ireland as follows. The reasons for staying were getting residency/citizenship, salary levels, job security, career opportunities, and “other reasons” (not stated). The reasons for leaving were uncertainty over residency/citizenship, the recession in Ireland, career opportunities overseas, to retire and no family reunification opportunity. The issue of recession is further explained by

participants, “The recession has made us questions ourselves: how long is the country going to need us? Being on a work visa only renewable every 2 years we are unsure of security and stability here.” (Humphries, Brugha and McGee 2009c, pp.2) The issues of immigration status are captured in the theory of *New Normalising* as *losing identities*, a property of *regressing*. The data in these studies is comparable to that which was provided by the participants in this study. Further, in a fifth Policy Brief (Humphries, Brugha and McGee 2009b) these same authors explored the subject of “Career progression of migrant nurses in Ireland” using data from the same survey previously reported. They found that less than half of the respondents in the survey were working at the same level as they did before coming to Ireland. They also found that a quarter of the cohort in the study stated that they were working in a position at a lower or much lower grade. Only 7% of the group had achieved a promotion since coming to Ireland. This is reflective of *professional regressing*, conceptualised in the theory of *New Normalising*. There is also evidence here of *positive regressing* in a statement included from one respondent, “I don’t like any promotion. I’ve been there before. I need a less stressful job.” (pp. 2) It is reinforcing of the theory of *New Normalising* to see that other researchers are finding similar data in their studies with migrant nurses in the same location.

Further “Policy Briefs” are now being worked on for the Doctor Migration Project in Ireland. It will be interesting to compare that data with *New Normalising* when it becomes available.

In Canada, Blythe and her colleagues studied migrant nurses, too, and obtained types of data which are reflective of the categories and their properties in the theory of *New Normalising*. They published two papers from this data. (Blythe et al. 2006, Blythe et al. 2009) They used focus groups and interviews to collect their data, using an extensive interview schedule. In all, 39 migrant nurses (IEN) participated in 5 focus groups and 10 interviews. The study also interviews “informants”; twenty nine in total. These individuals

were from a range of institutions having contact with IENs. The focus of the study was predetermined as participants' perceptions of "becoming a nurse in Ontario, barriers and facilitators, and recommendations for change." In the 2009 report, some of the findings reported are consistent with the data from which the categories and their properties were generated. For example they state that "information acquired before migration allows migrants to strategise about the most expeditious ways to re-establish their lives and professions." Discussing this further they assert that IENs could reduce the time to registration and employment by completing the necessary paperwork for assessment of their credentials by the regulatory body before arriving in Canada. This is presented in this thesis as something that could have an influence on the timeframes and effects of *transplanting*, *regressing* and *adapting*. They also found that IENs encountered difficulty with their colleagues' perceptions of them as incompetent through miscommunication and misunderstandings. Further, they found that some nursing practices in Canada were very different from what the IENs in their study were used to. They state, "In general, IENs left if they could not adapt." In *New Normalising*, this similar phenomena is conceptualised as *withdrawing* and is a part of *adapting*.

Similar studies in the medical field have reported on the experience of International Medical Graduates (IMG) or Doctors (ID), though they tend to be more concentrated on issues of clinical practice and patient needs. Retention of IMG and ID is a bigger issue because they tend to move on to another country with five years. (CIHI 2010b) In Canada, two studies by Lockyer and her colleagues studied "what (IMG) physicians learn and what resources do they access in adapting to practice in Alberta...?" (Lockyer et al. 2007) and used a needs assessment to examine "the clinical medicine learning challenges faced by international medical graduates (IMGs) from the perspective of both the IMGs and medical leaders." (Lockyer et al. 2010) In the first study, the authors claim that they use the Grounded Theory method in their study, but the procedures they describe do not match the method. They conducted telephone interviews of 20 minutes duration with 19 IMGs.

Though the authors were focused on answering their questions about medical practice, some of the comments of the participants were similar to the data from which *New Normalising* was generated. For example, the authors state that less than half of those interviewed intended to stay in Canada. The majority of those who did not intend to stay were physicians who had already been in several other countries. Some of these stated that they intended to go back to their country of origin. In another interview, an IMG is quoted as saying that he is losing skills in Alberta because he is not allowed to do what he was doing in his home country. In *New Normalising*, this kind of data was conceptualised as *professional regressing*. In Lockyer et al's 2007 study, it is not clear whether it was a positive regression or a negative one for the IMG. In the 2010 study, Lockyer et al investigated the learning needs of IMGs by using focus groups and interviews with 27 IMG and 10 medical leaders. Most of this study focused on clinical practice issues, but one finding that was pervasive in the study was the differences in perception between IMG and the medical leaders. Where medical leaders believed that supports were in place and guidelines were clear, IMGs did not perceive this and found the opposite to be true. Information exchange and differences in perception between healthcare professionals was evident in the emergence of *New Normalising*. One aspect of this was the accuracy of communication among migrant healthcare professionals and their host country fellow-professionals. Other studies have found similar issues with comprehension of the medical system in the host country by IMGs. (Curran et al. 2008, Hall et al. 2004, Chen et al. 2010) If the migrant healthcare professional becomes overly frustrated or thwarted in his efforts to *New Normalise*, he will withdraw. In the case of these particular physicians, the author's study three years earlier had identified that more than 50% were thinking of leaving.

The study mentioned above by Curran and colleagues seems to capture the same broader understandings of the experiences of transition for migrant doctors to Canada. Having collected data by telephone interview of 19 IMGs, the authors analysed the data using ethnographic research methods. Their conclusion to the study included the comment, "Our

findings suggest that orientation processes for new IMGs must be attentive to both professional and personal needs, comprehensive, multifaceted and sustained. Orientation that is responsive to the various needs of new IMGs and their families may contribute to enhanced retention.” (Curran et al. 2008, pp.163) This compares with the theory of *New Normalising* where the issues of both personal and professional life are seen to be interconnected in terms of their impact on *adapting*.

In another study of IMGs’ migration experiences during “recertification training”, Wong and Lohfeld report that the results of their phenomenological study produced four themes: “training entry barriers; and a 3-phase process of loss, disorientation and adaptation. International Medical Graduates must complete this 3-phase process in order to feel fully integrated into their professional environments.” (Wong and Lohfeld 2008, pp. 53) This 3-phase process compares with the theory generated in this study. This data could fit into the categories of *transplanting*, *regressing* and *adapting*.

The studies reviewed above seem to find pieces of data that could fit with various categories or their properties in the theory of *New Normalising*. Most were designed to obtain quick information about the current situation with a view to responding to immediate needs or to use the information for policy and program development. They provide data on the experiences of migrant healthcare professionals when they first enter the host country and the practice environment. They identify issues in clinical practice, often from the perspective of the migrant healthcare professional, his colleagues, managers and educators. All of these studies serve to provide data to further saturate the core category, *New Normalising*, its sub-categories and their properties. In the conclusions to these papers, authors make recommendations as to how the issues can be resolved with reference to various systems in the profession, the healthcare organization, the regulatory authorities in the jurisdiction, and in government. With continuing shortages of healthcare professionals around the world, we can expect that doctors and nurses will be in demand.

Yet, this statement may be misleading to migrant healthcare professionals who will have to undergo a complex transition to practice in the host country.

The Theory of Transitions and the Theory of *New Normalising*

In 2000, Meleis et al published their theory of transitions in the article entitled, *Experiencing Transitions: an emerging middle range theory*. (Meleis 2000) The theory has three parts to it – the nature of transitions, the transition conditions and the patterns of response. The *nature of transitions* includes the types, patterns, and properties of transitions. In this regard there are four types of transitions identified by the authors in their theory: developmental, situational, health/illness, and organizational.

Transitions that are natural parts of the progression of life are labelled developmental, e.g. birth, marriage, death. Events such as migration, relocation, and role changes are named situational transitions. The third type, health-illness transitions, involve the process of getting ill and recovery, access to healthcare services, and use of traditional healing practices. Organizational transitions refer to transitions that occur in systems such as those in the healthcare system. (Im 2009, Im 2009, Im 2009) With regard to *New Normalising*, it would appear that only the second type of transition would apply.

The authors state that everyone experiences developmental, situational, and health/illness transitions at some time during their lives. “Transitions may occur as single unrelated events, but often occur in multiples, sequentially or simultaneously. Despite the distinct nature of these typologies, it is recognized that multiple, simultaneous transitions often occur together and can have a compounding effect.” (Baird 2009) This statement is accurate in relation to some of the migrant healthcare professionals in this study. Those who were forced to leave their country by threats of death are likely to experience several transitions at once. Similarly for those who are being thrust into arranged marriages; they would experience both situational and developmental transitions at the same time.

The properties of transition are identified as: awareness, engagement, change and difference, time span, and critical points and events. (Meleis 2000) These properties are then explained individually. Awareness is when a person perceives and knows that he is going through a transition. Awareness is a precondition for starting to manage the transition. This concept is highly applicable to *New Normalising*. An individual migrant healthcare professional can only adapt if he perceives the issue or situation. This would be the same in both professional practice and in his personal life.

Change and difference refers to an individual's perceptions of how the transition has affected his life and its impact on the quality of life. Again, this concept could be applied to *New Normalising*. It might be compared with reacting in *transplanting*, professional regressing, personal regressing, and losing identities in *regressing*, and to cost-benefit analysis in *adapting*. These are all parts of the theory in this study which relate to the perceptions of the migrant healthcare professional about his transition.

Time span refers to the individual's perception of the length of time he is in transition. Some transitions may have definable beginnings and endings and others may be ongoing. Similar explanations of 'timeframe' emerged in *New Normalising* in regard to the beginning and ending of stages.

Critical points and events are somewhat self-explanatory. They are important events and junctures in the transition process. She gives the example of the incident leading to a forced migration as one such critical event. There are critical points and defining events in the process of *New Normalising*. However, this concept may not fit well with a stage theory, as critical points and events are unpredictable and can occur at any time and in any stage. In *New Normalising* the data pointed to what specific events were relevant to the progress of the migrant healthcare professional.

These five properties are interrelated and are reflective of the subjective experience of the transition. The individual and others may have different perspectives on what was important in the transition. There may also be identifiable patterns that can be generalized to certain types of transition experiences. (Im 2009, Meleis 2000) This part of the theory is rather vague. The Grounded Theory method draws patterns out of the data to explain the theory. With regard to this study of one substantive area, this is already complete. Meleis et al are developing a middle range theory. It would seem to be closer to formal theory in Grounded Theory parlance.

Transition Conditions

The second part of the theory, *transition conditions*, refers to those things that process or inhibits the transition. These can be personal or community factors, or social conditions.

Personal factors include subjective meanings associated with the transition, cultural beliefs and practices, socioeconomic status, preparation and knowledge, and religion. Community conditions include the presence or absence of available resources and social support such as friends, family, or support from healthcare providers. Societal factors include policies and laws, economic conditions, and social values that either support or discriminate against refugees. (Im 2009, pp.420)

The factors described and the associated conditions can either have a mediating or a modifying effect on the process or outcome of a transition. In designing intervention for those going through transitions, it is necessary first to explore the mediating and modifying factors.

I believe that *New Normalising* will be more helpful to migrant healthcare professionals, as it is more specific to their situation and identifies these mediating and modifying factors. It also provides the resolution of their problems of transition through *New Normalising*.

Patterns of Response

The third part of the theory of transitions is *patterns of response*. These patterns may be process or outcome indicators. Process indicators indicate how well the individual is managing the transition process. Outcomes are viewed as either positive or negative. Positive or successful transitions are characterized by mastery and fluid integrative identity. "...Mastery is the extent to which individuals demonstrate mastery of new skills and behaviors needed to manage their new situations or environments." (Meleis 2000, pp. 25) Fluid integrative identity refers to an individual's ability to incorporate new aspects of the self along with their previous self in order to change and grow in response to their new environment. As an individual adapts to a new environment or culture there is evidence of a reformulation of personal identity. (Meleis 2000) Meleis goes on to apply the model to nursing therapeutics – nursing interventions.

Patterns of response are self monitored by migrant healthcare professionals. While they recognize the need to adapt to the host country and its systems of operation, as a person and a professional, most would have no interest in reformulating their personal identities. In the midst of the transition the theory of *New Normalising* was generated from data that pointed to the need for the individual to mentor and care for the 'Self', not change it.

This theory was previously applied to experiences of migrant transition. (Clingerman 2007) Clingerman applied it to the situation of Migrant Farmworker Women in the USA. However, she found that the model needed adjustment to reflect their specific situation. *New Normalising* is also a theory generated in a substantive area. While Meleis et al's theory of transitions has applications in some of its concepts, many of them have not earned their way in the data from this study. Nevertheless, transitions theory could serve as comparative data for the modification of *New Normalising*, if there was a need or desire to extend it to a formal theory.

There is a dearth of theoretical literature in the substantive area of migrant healthcare professionals. Most of the studies are of a descriptive type of research method. Descriptions are helpful in identifying experiences and phenomena. However, they are problematic because they cannot generate theory which is relevant and can be used by those in the substantive area. Nevertheless, the data from this literature can be added to the study data and help to confirm categories and their properties or modify them. However, “this is for the next study”, as Glaser would often say during the seminars!

CHAPTER 8: Further and Final Comments on *New Normalising*

In this study, transition experiences of migrant healthcare professionals have been viewed as their main problem in re-establishing an 'ordered' life. *New Normalising* is the main resolution of these issues. In this final chapter, I reflect on the theory of *New Normalising* from a number of perspectives. First I address the evaluation and worth of the research. Glaser (1978, 2001, 2002, 2003, 2004) has systematically reviewed the general criteria for evaluating the worth of qualitative research and decidedly rejected its measures and concepts as irrelevant for Grounded Theory (GT). I will present a brief overview of this argument, before moving on to use the criteria for assessing the worth of GT, proposed by Glaser in the various texts cited below. Later in this chapter, I will consider the potential uses of this research in the substantive area and more broadly. Lastly, I will reflect on my use and learning from applying the GT method. In reviewing each of these perspectives, I will point to the limitations of the study and future options for further research. I finish the study by making some concluding remarks.

Evaluating the Research

Qualitative research is renowned for its struggle to find effective measures of evaluation. (Lincoln and Guba 1985, 1999; Wuest, Baker and Stern 1992; Miles and Huberman 1994, Denzin and Lincoln 2011) Lincoln and Guba are two prominent authors in the field who have written extensively on the matter of credibility of qualitative research. According to Polit and Beck,

The criteria currently thought of as the "gold standard" for qualitative researchers are those outlined by Lincoln and Guba (1985). ...these researchers have suggested four criteria for establishing the *trustworthiness* of qualitative research: credibility, dependability, confirmability and transferability. ...These standards are often used by qualitative researchers in all major traditions. (Polit and Beck 2006, pp.332)

Donovan and Sanders, in the 2005 Handbook of Health Services Research, struggled with the concept of rigour in qualitative research, as they were not able to define it clearly.

After using references to the works of all of the main proponents in the field throughout their chapter they concluded,

Qualitative researchers are broadly agreed that the quality and rigour of their research must be judged on its own terms, rather than measured against the benchmarks of quantitative research (positivism). A number of checklists of criteria for judging the quality of qualitative research have emerged in recent years, but none has been universally accepted. The quality of such research remains a judgment based on rigour and transparency of methods of data collection and analysis and, most crucially, the plausibility of the findings. (Donovan and Sanders 2005, pp.529)

However, Glaser has shown that this search for trustworthiness, and Lincoln and Guba's "worrisome concern" with accuracy, is not applicable to GT. (Glaser 2003, Glaser 2004)

The GT method is not designed to produce facts, findings or accurate descriptions. Instead, it creates a series of integrated conceptual hypotheses about the relationships between the concepts that form the theory. It is concerned with proposing a theory, not establishing proof. Glaser has stated many times that a GT is moment capture; it captures data from an ever-changing scene. Therefore, the theory is modifiable with new data. "...Grounded theory requires careful procedural grounding in data and then conceptual modifications when new data emerge." (Glaser 2003, pp.135)

GT is multivariate in nature. This arises from the complexity of social behaviour and produces several integrated hypotheses and these cannot be easily isolated and are not subject to traditional verificational procedures. The pace of verification studies is not fast enough to capture the constantly changing arena of social behaviour (Glaser, 2001), whereas the hypotheses of GT are constantly open to modification as new data comes in. The criteria that Glaser and Strauss (1967) initially proposed, and that Glaser (1978) added to in *Theoretical Sensitivity* are fit, relevance, work and modifiability.

Fit is another word for validity. Does the concept adequately express the pattern in the data which it purports to conceptualise? Fit is continually sharpened by constant comparisons. (Glaser 1998, pp.18)

With regard to the theory of *New Normalising* I make the claim that it does. The migrant healthcare professionals in this study were constantly dealing with issues related to their transition to the host country. As I collected data, I formed codes and concepts to try to capture the essence of the incidents taken together. In the course of this research, I went through a few different labels to reach this one. This is the best fit with the data at this point. Since completing the study, I am, of course, much more sensitized to data from this substantive field. As more data comes to me, though I am no longer actively seeking it, I consider alternative formulations.

Workability means do the concepts and the way they are related into hypotheses sufficiently account for how the main concern of participants in a substantive area is continually resolved? (pp.18)

I believe this to be the case. It was no easy task to find a theory that works, as categories changed in line with new data. However, in referring back to incidents the hypotheses seem to explain the action in the area being examined. At this point, I can say that it certainly works on paper. It also works with data coming in from the literature. My next quest is to discover if it continues to work in the 'field'.

Relevance makes the research important because it deals with the main concerns of the participants involved. To study something that interests no one really or just a few academics or funders is probably to focus on non-relevance or even trivia for the participants. Relevance, like good concepts, evokes instant grab. (pp.18)

It is my contention that this research is highly relevant to migrant healthcare professionals. It addresses their main concerns with transition and offers something they can use in their personal experience of transition. It will also be relevant to those in the substantive area who seek to assist migrant healthcare professionals, as it gives them a new understanding of their colleagues' experiences and the challenges they face.

Modifiability is very significant. The theory is not being verified as in verification studies, and thus never right or wrong.it just gets modified by new data to compare it to.... New data never provides a disproof, just an analytic challenge. (pp.19)

Throughout the development, and up to a late point in the analysis to generate the theory, I found myself modifying the categories, and had to make a final decision in regard to two possible core categories. It was the data which was driving these formulations and it was new data which resulted in the need to modify further. Even now, after doing this final write-up, I am inclined to write more memos and incorporate more data from my observations and ruminations about *New Normalising*. While I believe that the theory is well developed at this point, I know that it can be modified at any time. As Glaser points out, the scene is always changing. Social life does not stand still. (Glaser 1978)

The Usefulness of the Theory of *New Normalising*

Resource for Migrant Healthcare Professionals:

This theory has a number of possible applications within the substantive area. Firstly, it should be recognizable by migrant healthcare professionals and provide them with some language and ways to explain their experiences. It can also provide support to them to know that they are not isolated in their experiences and that, indeed, there are many others before them and currently who have faced the same issues of transition in the host country. More importantly, and this is the difference between just producing a descriptive study and developing a theory, it will provide them with some understanding of how to anticipate and resolve problems on a day-to-day basis. Further, it provides them with a framework to explain to, and teach, others about what is happening to them. Perhaps most significantly of all, it provides a tool for migrant healthcare professionals to use with their families for discussion and joint planning around transition issues. Indeed, it may serve as a tool to help healthcare professionals decide if they even want to migrate in the first place.

Migrant healthcare professionals are the main focus of this theory and it needs to benefit them most of all. However, they can also benefit from the thoughts, actions and affective

responses of those who co-exist in their substantive area or have input into it. *New Normalising* has application for them, too.

Resource for Healthcare Professionals:

The theory of *New Normalising* can be used as a tool to educate healthcare staff about transition experiences of migrant healthcare professionals. Szekely et al, found that there were a number of areas where healthcare staff could benefit from education and information about areas of diversity in the workforce. (Szekely 2007) *New Normalising* might prove to be a tool that could be used in these programs. Secondly, in this regard, those who are preparing orientation and education programs for migrant healthcare professionals could also learn from this theory and make use of it in designing their programs. Adeniran and her colleagues found that a program for migrant nurses in the USA, addressing similar areas of transition, was successful in helping the nurses and their colleagues with adaptation. (Adeniran et al. 2008)

Resource for Health System and Government Planners

As governments and health planners worldwide try to come to terms with manpower shortages and the effects of migration, *New Normalising* could add some insights into their discussions and provide potential solutions to some of the issues they are attempting to address. Thus, *New Normalising* might inform policy development in this substantive area. I provide some recommendations in this regard below.

Learning to “Do” GT, Limitations, and Future Research Options

The limitations on this study are mostly imposed by my circumstances during the research and the effects that had on the process and application of GT procedures. As a novice GT researcher, I was subject to the minus mentoring process that Glaser refers to in his texts and in articles in the GT Review. (Glaser 1978, Glaser 1998, Glaser 2009) For most of the time, I was studying and conducting the research at a distance from my university. The

nature of my work life only provided for data collection in specific time periods, which initially resulted in my having data overwhelm and to not having sufficient time for data analysis between interviews. Perhaps this explains why it took so long to decide on a core category? After conversations with my supervisor, I made significant progress in this regard. I also had a conversation with Barney Glaser, at one of the seminars, who reassured me that it was OK to have gaps and even to leave the research for a while and come back to it. I still don't feel good about this part of the process...perhaps Barney is right? Only the reader and the migrant healthcare professionals will be able to know for sure. But any feedback that comes in, in this regard, will serve as comparative data to modify the theory. Of that, I am sure!

Another challenge I faced was in learning how to write memos in a way that would produce useful theoretical data for the study. I think I had just begun to get the hang of it, when it came time to write up the study. Indeed, I might add that comment to the study overall. My position now is that I believe I know how to conduct a GT study. I have a fuller understanding of the rationale for each procedure and what to expect. Glaser's statement that GT is in the hands of novice researchers is not too reassuring at the minute! I look forward to the next GT.

General Implications

Now I turn to the general implications of this study for future applications and research. I will start with myself, as I know the data. One experience I have had repeatedly is that of seeing *New Normalising* everywhere – another thing that Glaser warns about in his seminars. On one occasion I was listening to a sports radio show and the host was talking to two Hockey players about their experiences of moving to Vancouver from Sweden. As they talked about all of the ways that they dealt with the transition, I wanted to call in and say, “That's *New Normalising!*” It's exactly what the nurses and doctors in this study were telling me.

The usefulness of the theory of *New Normalising*, then, is not confined to the healthcare sector and to migrant healthcare professionals. Since developing the theory, I have had many conversations with individuals outside the healthcare sector and they all had perspectives on its usefulness for their own situations. It has implications for people in any situation of transition – from children attending school in a new country and trying to adapt, to workers in any field transitioning after migration. As the psychiatric nurses in Malta suggested, it could prove useful to anyone who is moved from one location at work to another or from one city in a country to another. One individual suggested to me that it has implications for a couple getting married as they are bringing together two different ways of living and transitioning to a new set of norms!

With all of these potential applications in mind, I'm thinking that there may be an opportunity to do a Formal GT.

“A Formal Grounded Theory is a theory of a SGT [Substantive Grounded Theory] core category's general implications generated from, as wide as possible, other data and studies in the same substantive area and in other substantive areas” (Glaser 2006)

It would be too soon for me now, as I would want to do another substantive study first, but I'm thinking that there is likely data out there that would contribute to such a study. In the meantime, I would like to incorporate some of the data from the literature I cited in this study into the current data to see if the theory can be modified. With the predictions that healthcare professional migration will increase again in the future, it would be helpful to be able to offer them something that they can readily understand and use.

Also, with regard to future research, there were stages in this process where it seemed that I might have two or more studies or could pursue data in other directions. Most of these conversations happened during the days of the trouble-shooting seminars. In the beginning it was suggested that, because of the difficulties I was having as an outsider in gaining access to particular parts of the field, that I could do a study of access. This might

be something that could inform both researchers and the “gatekeepers” in professional fields. Perhaps it could lead to an easing of boundaries or inform a researcher how to negotiate the boundaries and cultures of professional groups in health care? Another suggestion was to study only the *transplanting* stage of *New Normalising*, since this was proving to be a large area with various potential avenues for further study – e.g. family at home experiences of transition when a migrant healthcare professional leaves.

Lastly, in regard to further research, there is potential for verificational research. For example there might be some interest in developing a tool to evaluate the degrees of ‘destabilization of life’ and to be able to predict the need for *New Normalising*. There might also be a measurement tool that could predict the degrees of regressing likely in a number of situations that migrant healthcare professionals have to face. These tools might be of some value?

Recommendations

Out of this research come some fairly obvious suggestions of the need for policy changes in dealing with migrant healthcare professionals. If a country wishes to use in-migration as one approach to the resolution of its labour force issues, then it would be helpful to the settlement of those migrants, and to the quality of their work, if there were policies and mechanisms to facilitate the maintenance of family unity. In this regard, the immigration policies of Canada are more supportive than those in Ireland. Additionally, more certainty is needed by migrant healthcare professionals around their immigration status in the host country, as this impacts their ability to settle and focus on their work and has implications for retention. One assumes that if the healthcare system invests in going out and recruiting foreign workers, that it is not prudent to then allow that investment of time, money and manpower to be wasted by not attending to what is required to retain those workers. This study has highlighted a number of areas where support could be provided to migrant healthcare professionals, e.g. maintaining family unity, providing information ahead of

migration to support the transition to full licensure in the host country, providing some level of job security to prevent prolonged unsettlement and angst.

The theory of *New Normalising* could also inform the development of bridging/adaptation curricula. Most countries prepare these programs on the basis of what host country “experts” believe is required for safe practice in that country. However, *New Normalising* suggests that programs need to be more holistic in their approach, addressing social life as well as professional practice. They should also put emphasis not so much on content as on process and assisting migrants to comprehend the structure and norms underlying a practice. They need to understand how practices work as much as that do that these practices are required. Educators can also use this theory to assess where each individual is at in their transition. Knowing this can provide information about what specific supports are required at that particular point in time.

Concluding Remarks

Migrant healthcare professionals are arriving in Canada and Ireland on a regular basis. They face some serious challenges to the stability of their existence during the transition to the host country, which begins from the moment they start to consider a move. Regardless of transition challenges, *New Normalising* resolves their main concerns in this regard. At present, the studies being conducted in this substantive area are producing descriptions of one kind or another which contain data which could fit with one category or another, one property or another in *New Normalising*. These studies are mostly aimed at informing policy positions and development of orientation programs. *New Normalising* offers a comprehensive view and understanding of the transition and conceptualises all of it that is relevant into the theory. The development of the theory has been a learning experience for me, as a novice Grounded Theorist. Though I am content to offer *New Normalising* as a solid substantive theory, I am aware that the field is changing and that makes the theory modifiable. (Glaser and Strauss 1967, Glaser 1978, Glaser 1998)

APPENDIX A

Information for Research Participants (Plain Language Statement)

Participant Consent Form

Interview Schedule

Research Study Participant Information

TITLE OF STUDY: From theory to practice: developing a grounded theory of learning for migrant healthcare professionals, in the context of multicultural, multigenerational adult education.

Principal Investigators: 1. Dr. Carmel Mulcahy Head of School (Supervisor)
2. John Collins
MA, Dip. Ed., BA(Hons), DPSN, CMS, RN, RPN PhD Student

Address: School of Education Studies
Faculty of Humanities and Social Sciences
Dublin City University
Dublin 9

Telephone: +353 (0) 1 700 5000

E-mail: 1. Carmel.Mulcahy@dcu.ie
2. John.collins2@mail.dcu.ie

YOUR PARTICIPATION IS VOLUNTARY

It is up to you to decide if you want to participate in this study. Before you decide it is important for you to understand what the research involves and what you will be asked to do. This statement and the consent form will tell you about the study, why the research is being done, what you will be requested to contribute during the study and the possible benefits and risks of your participation.

If you decide to participate you will need to sign the consent form. If you do decide to participate in this study, you are still free to leave at any time, without giving any reasons, and with no consequences for your professional education or licensure or employment. If you decide not to participate, you do not have to provide any reasons for your decision.

Please take the time to read all of the information provided here before making your decision.

I. Introduction to the Research Study

Driven by globalization, opportunity and workforce shortages, many healthcare professionals are migrating to new countries and to new contexts of professional practice. Though many of these migrants are successful in their new professional practice environment, some are not successful while others have to endure long waits and multiple steps in the transition process before they reach success. One element of this transition is the further education required to meet the professional competencies in order to receive full licensure to practice in the new country. This study aims to develop a theory of learning for migrant healthcare professionals specifically, which could be more helpful in the transition process and help migrant healthcare professionals achieve more success, more efficiently. It may also facilitate better quality and more focused teaching, thus assisting educators and clinical supervisors and preceptors in their work with this group. The study will use a research method which obtains data from all of those involved in the transition process to independent licensed practice in order to induce a theory from this data (Grounded Theory). You are being invited to participate in this study to contribute your valuable knowledge and experience to the development of the learning theory.

II. Details of what involvement in the Research Study will require:

All participants will be asked to attend an interview with the researcher for one to one and a half hours. This interview may be audio-taped. Because the research method requires clarification of concepts arising from interview data, it may be necessary to contact you again for a second interview. There will likely be a gap between the first and second interview. It is hard to predict what the time frame for the

second interview will be because this is dependent on the progress of the emerging theory. The study could also involve observations of your practice environment by the researcher. You will be informed after the first interview if these observations are being requested. You will be given precise details of day, time and location in advance. The observations are solely to collect research data and are not related to any form of evaluation of your practice. Neither the interviews nor the observations will have any impact on your progress in your course or your employment.

III. Potential risks to participants from involvement in the Research Study (if greater than that encountered in everyday life)

There are no significant risks to participants in this study. If you experience any negative effects from your participation in this study please feel free to contact the research supervisor (#1) at any time.

IV. Benefits (direct or indirect) to participants from involvement in the Research Study

Firstly, there will be a small direct benefit to you from your participation in this research in the form of a book token/certificate to the value of 40 Euros/\$60 CAD which could support you in your studies/transition. You might also benefit in this study from the opportunity to talk about your experiences and from having someone listen to you. The study itself will be beneficial in providing the opportunity for you to influence the future for professional colleagues migrating from your country. Should this learning theory achieve its goals, you will be able to claim to have been a part of a study which developed the learning theory. For your part in this you can rightly take credit.

V. Advice as to arrangements to be made to protect confidentiality of data, including that confidentiality of information provided is subject to legal limitations

The research methodology will provide you with confidentiality and anonymity since the focus is on inducing a theory of learning from the data in the two case studies and will not report what any particular person says. Reports will relate only concepts, categories and properties of theory. Your anonymity will also be protected in the management of the records and data. The researcher will keep personal information separate from the interview data by the use of alpha-numeric codes. A code will be assigned to you at the start of the research and your name will not appear on any record. As with any research study or collection of documents, they can become the subject of legal proceedings. In this unlikely event, only the minimum data necessary for the legal purpose would be revealed.

VI. Advice as to whether or not data is to be destroyed after a minimum period

Data from this study will be destroyed six months after the study is completed unless you are notified otherwise in writing by the researcher and your further written consent is obtained for whatever uses the researcher has in mind at the time.

If participants have concerns about this study and wish to contact an independent person, please contact:

The Secretary, Dublin City University Research Ethics Committee, c/o Office of the Vice-President for Research, Dublin City University, Dublin 9. Tel 01-7008000

Informed Consent Form

TITLE OF STUDY: From theory to practice: developing a grounded theory of learning for migrant healthcare professionals, in the context of multicultural, multigenerational adult education.

Principal Investigators: 1. Dr. Carmel Mulcahy Head of School (Supervisor)
2. John Collins
MA, Dip. Ed., BA(Hons), DPSN, CMS, RN, RPN, PhD Student

Address: School of Education Studies
Faculty of Humanities and Social Sciences
Dublin City University
Dublin 9

Telephone: +353 (0) 1 700 5000

E-mail: 1. Carmel.Mulcahy@dcu.ie
2. John.collins2@mail.dcu.ie

Purpose of the Study

This study aims to develop a theory of learning for migrant healthcare professionals specifically, which could be more helpful in the transition process and help migrant healthcare professionals achieve more success, more efficiently. It may also facilitate better quality and more focused teaching, thus assisting educators and clinical supervisors and preceptors in their work with this group. The study will use a research method which obtains data from all of those involved in the transition process to independent licensed practice in order to induce a theory from this data (Grounded Theory). You are being invited to participate in this study to contribute your valuable knowledge and experience to the development of the learning theory.

Requirements of the Study:

Participant – please complete the following (Circle Yes or No for each question)

<i>Have you read or had read to you the Plain Language Statement</i>	Yes/No
<i>Do you understand the information provided?</i>	Yes/No
<i>Have you had an opportunity to ask questions and discuss this study?</i>	Yes/No
<i>Have you received satisfactory answers to all your questions?</i>	Yes/No
<i>Are you aware that your interview will be audio-taped?</i>	Yes/No
<i>Are you aware that you may be asked to provide a second interview?</i>	Yes/No
<i>Are you aware that you may be asked to allow the researcher to observe your practice environment?</i>	Yes/No

Your participation in this study is voluntary:

If you decide to participate you will need to sign the consent form. If you decide to participate in this study you are still free to leave at any time without giving any reasons, and with no consequences for your professional education or licensure or employment. If you decide not to participate or sign this consent form, you do not have to provide any reasons for your decision.

Confidentiality

The research methodology will provide you with confidentiality and anonymity since the focus is on inducing a theory of learning from the data in the two case studies and will not report what any particular person says. Reports will relate only concepts, categories and properties of theory. Your anonymity will also be protected in the management of the records and data. The researcher will keep personal information separate from the interview data by the use of alpha-numeric codes. A code will be assigned to you at the start of the research and your name will not appear on any record. As with any research study or collection of documents, they can become the subject of legal proceedings. In this unlikely event, only the minimum data necessary for the legal purpose would be revealed.

Signature:

I have read and understood the information in this form. My questions and concerns have been answered by the researchers, and I have received a copy of this consent form. Therefore, I consent to take part in this research project

Participant's Signature: _____

Name in Block Capitals: _____

Witness: _____

Date: _____

DRAFT INTERVIEW SCHEDULE

TITLE OF STUDY: The transition to independent, competent practice in the host country for migrant health professionals: a Grounded Theory

Principal Investigators:

1. John Collins
MA, Dip. Ed., BA(Hons), DPSN, CMS, RN, RPN PhD Student
2. Dr. Carmel Mulcahy Head of School (Supervisor)

Address:

School of Education Studies
Faculty of Humanities and Social Sciences
Dublin City University
Dublin 9

Telephone: +353 (0) 1 700 5000

E-mail:

1. Carmel.Mulcahy@dcu.ie
2. john.collins@dcu.ie

Introductory Questions

Professional Education and Practice in the Home Country:

Could you please start us off by providing a summary of your professional education in (country)? It will be helpful if you mention the timelines and dates as you do this.

Tell me about your personal experience of learning during your professional education and training. When you speak about this, could you say something about how you learned and how teachers taught?

Could you now tell me about your career after graduation in (country)? Can you talk here about the specific areas of health care that you worked in and how your basic education had prepared you for this.

I'd like to hear some specifics about the challenges in the jobs you had and perhaps you could give some examples of how you addressed new skills, knowledge and

competencies that you had to learn to be able to do your job and address these challenges.

Could I ask you to think of some other healthcare professionals in your home country? Could you state, or speculate about, how they would describe the basic education experience for healthcare professionals?

Migration

Now, I'd like us to talk about your migration to (Ireland/Canada). Would you say something about how you reached the decision to leave (country) and what you knew or were thinking about Ireland/Canada around the time you made your decision?

If I could ask you to explore this a bit more...tell me how you explored your options, learned about health care in Ireland/Canada, and, specifically what and how you learned about your own profession in Ireland/Canada?

Before you made your move, were you aware of any education needs you might have in your new practice environment?

Have you worked in any other country, other than your home country, at any other point in your career? (If yes, explore further.)

Do you know of any other healthcare professionals who moved from (country) to Ireland/Canada? (If yes, explore further what the participant learned from this person.)

Professional Education and Practice Experiences in Ireland/Canada

I wonder if we could move on now to your experience of the transition to independent, competent practice in Ireland/Canada? Could I ask you to first outline what education you were required, or chose, to complete in order to be eligible for registration or to prepare you for practice in Ireland/Canada?

Can you talk about how this education and practice was the same or different from your previous education and practice experiences?

I know when I moved to Canada and started to work, I went through a period where I had lots of different feelings about living, learning and working here. Would you be

willing to share with me some of the experiences you went through during your introduction to professional education and practice in Ireland/Canada?

I wonder if you think that there was adequate support for you when you started to work here and you were going through all of this transition and adaptation?

Could we turn now to some detailed issues around your transition to the new clinical practice context? It would be really helpful to this research if you could tell me in as much detail as possible about your experience of, and feelings about, this transition. [Remember that anything you tell me here is not being cited anywhere in the study report, but that how I intend to use this information is to induce concepts, categories and properties of theory from it, by comparing it with what everyone else in the study is telling me – in both Ireland and Canada.]

Let's discuss the educational component of your transition for a bit? Tell me about how this was laid out and organized and whether you think it was a good fit with your own learning style and past education experiences? Were you able to learn in an efficient way during this experience? In other words, how did the education fit with assisting you to transition yourself to independent, competent clinical practice? On reflection, do you think there was a more efficient way for you to learn what you needed to achieve clinical competence in this country?

[Further questions at a more detailed level will be prompted by the participant's responses to these questions]

APPENDIX B

Information for Research Participants (Plain Language Statement) v2.2 **Participant Consent Form v2.2**

Version 2

Research Study Participant Information (v2.2)

TITLE OF STUDY: The transition to independent, competent practice in the host country for migrant health professionals: a grounded theory.

Principal Investigators:

1. John Collins
MA, Dip. Ed., BA(Hons), DPSN, CMS, RN, RPN PhD Student
2. Dr. Carmel Mulcahy Head of School (Academic Supervisor)
3. Prof. Geraldine MacCarrick (Academic Supervisor)

Address: School of Education Studies
Faculty of Humanities and Social Sciences
Dublin City University
Dublin 9

Telephone: +353 (0) 1 700 5000

E-mail:

1. john.collins@dcu.ie
2. carmel.mulcahy@dcu.ie
3. geraldinemaccarrick@rcsi.ie

This study is being conducted as part of a requirement for the award of PhD to the Principal Investigator (P.I.). The P.I. is a student at Dublin City University.

YOUR PARTICIPATION IS VOLUNTARY

It is up to you to decide if you want to participate in this study. Before you decide it is important for you to understand what the research involves and what you will be asked to do. This statement and the consent form will tell you about the study, why the research is being done, what you will be requested to contribute during the study and the possible benefits and risks of your participation.

If you decide to participate you will need to sign the consent form. If you do decide to participate in this study, you are still free to leave at any time, without giving any reasons, and with no consequences for your professional education or licensure or employment. If you decide not to participate, you do not have to provide any justifications for your decision.

Please take the time to read all of the information provided here before making your decision.

I. Introduction to the Research Study

Driven by globalization, opportunity and workforce shortages, many healthcare professionals are migrating to new countries and to new contexts of professional practice. Though many of these migrants are successful in their new professional practice environment, some are not successful while others have to endure long waits and multiple steps in the transition process before they reach success. This study aims to develop a theory of that transition for migrant healthcare professionals, which could help migrant health professionals achieve more success, more efficiently. It may also facilitate better quality and more focused teaching, thus assisting educators and clinical supervisors and preceptors in their work with this group. The study will use a research method which obtains data from all of those involved in the transition process to independent licensed practice, in order to induce a theory from this data (Grounded Theory). You are being invited to participate in this study to contribute your valuable knowledge and experience to the development of the theory.

II. Details of what involvement in the Research Study will require:

All participants will be asked to attend an interview with the researcher for about one and a half hours. This interview will NOT be audio-taped. Because the research method requires clarification of concepts arising from interview data, it may be necessary to contact you again for a second interview. There will likely be a gap between the first and second interview. It is hard to predict what the time frame for the second interview will be because this is dependent on the progress of the emerging theory. Certainly, all interviews will take place within a one year period. These interviews will not have any impact on your progress in your education or your employment.

III. Potential risks to participants from involvement in the Research Study (if greater than that encountered in everyday life)

There are no significant risks to participants in this study. If you experience any negative effects from your participation in this study please feel free to contact the research supervisors (#2 or #3) at any time.

IV. Benefits (direct or indirect) to participants from involvement in the Research Study

Firstly, there will be a small direct benefit to you from your participation in this research in the form of a book token/certificate to the value of 40 Euros (Ireland)/\$60 (Canada) which could support you in your studies/transition/practice. You might also benefit in this study from the opportunity to talk about your experiences and from having someone listen to you. The study itself will be beneficial in providing the opportunity for you to influence the future for professional colleagues migrating from your country. Should the substantive theory developed in the research achieve recognition, you will be able to claim to have been a part of a study which developed the theory. For your part in this you can rightly take credit.

V. Advice as to arrangements to be made to protect confidentiality of data, including that confidentiality of information provided is subject to legal limitations

The research methodology will provide you with confidentiality and anonymity since the focus is on inducing a theory from the data in the two case studies and will not report what any particular person says. Reports will relate only concepts, categories and properties of theory. Your anonymity will also be protected in the management of the records and data. The researcher will keep personal information separate from the interview data by the use of alpha-numeric codes. A code will be assigned to you at the start of the research and your name will not appear on any record. All notes from interviews will be transcribed to encrypted software on the PI's computer, which has added firewall, antivirus and antispyware programs to prevent violations of confidentiality and anonymity. As is the norm with research for a degree, the academic supervisors will have access to the data. As with any research study or collection of documents, they can become the subject of legal proceedings. In this unlikely event, only the minimum data necessary for the legal purpose would be revealed.

VI. Advice as to whether or not data is to be destroyed after a minimum period

Data from this study will be destroyed six months after the study is completed (when the researcher graduates), unless you are notified otherwise in writing by the researcher and your further written consent is obtained for whatever uses of the data the researcher has in mind at the time.

If participants have concerns about this study and wish to contact an independent person, please contact:

The Secretary, Dublin City University Research Ethics Committee, c/o Office of the Vice-President for Research, Dublin City University, Dublin 9. Tel 01-7008000

Date: September 01, 2009

Informed Consent Form (v2.2)

TITLE OF STUDY: The transition to independent, competent practice in the host country for migrant health professionals: A Grounded Theory

Principal Investigators:

1. **John Collins**
MA, Dip. Ed., BA(Hons), DPSN, CMS, RN, RPN
PhD Student
2. **Dr. Carmel Mulcahy** Head of School (Academic Supervisor)
3. **Prof. Geraldine MacCarrick** (Academic Supervisor)

Address: School of Education Studies
Faculty of Humanities and Social Sciences
Dublin City University
Dublin 9

Telephone: +353 (0) 1 700 5000

E-mail:

1. john.collins@dcu.ie
2. carmel.mulcahy@dcu.ie
3. geraldinemaccarrick@rcsi.ie

Purpose of the Study

This study aims to develop a grounded theory of the transition to independent, competent practice in the host country for migrant health professionals, which could help migrant health professionals achieve more success, more efficiently. It may also facilitate better quality and more focused teaching, thus assisting educators and clinical supervisors and preceptors in their work with this group. The study will use a research method which obtains data from all of those involved in the transition process in order to induce a theory from this data (Grounded Theory). You are being invited to participate in this study to contribute your valuable knowledge and experience to the development of the theory.

Requirements of the Study:

Participant – please complete the following (Circle Yes or No for each question)
Have you read or had read to you the Plain Language Statement, dated

<i>September 01, 2009</i>	Yes/No
<i>Do you understand the information provided?</i>	Yes/No
<i>Have you had an opportunity to ask questions and discuss this study?</i>	Yes/No
<i>Have you received satisfactory answers to all your questions?</i>	Yes/No
<i>Are you aware that you may be asked to provide a second interview?</i>	Yes/No
<i>Are you aware of the risks in this study</i>	Yes/No
<i>Are you aware of, and agree to, the procedures for the management of the data related to your participation in this study.</i>	Yes/No

Your participation in this study is voluntary:

If you decide to participate in this study you will need to sign the consent form.

If you decide to participate in this study you are still free to leave at any time without giving any reasons, and with no consequences for your professional education or licensure or employment. If you decide not to participate or sign this consent form, you do not have to provide any justifications for your decision.

Confidentiality

The research methodology will provide you with confidentiality and anonymity since the focus is on inducing a theory of learning from the data in the two case studies and will not report what any particular person says. Reports will relate only concepts, categories and properties of theory. Your anonymity will also be protected in the management of the records and data. The researcher will keep personal information separate from the interview data by the use of alpha-numeric codes. A code will be assigned to you at the start of the research and your name will not appear on any record. Interviews will NOT be taped. All notes from interviews will be transcribed to encrypted software on the Principal Investigator's (PI) computer, which has added firewall, antivirus and antispyware programs to prevent violations of confidentiality and anonymity. The only other persons who may have access to the data are the academic supervisors of the PI. All records will be destroyed at the end of the study, unless they reveal data which could prove useful in a further study. In this event, you will be contacted again to give your permission and consent for the further use of your data.

As with any research study or collection of documents, they can become the subject of legal proceedings. In this unlikely event, only the minimum data necessary for the legal purpose would be revealed.

Signature:

I have read and understood the information in this form. My questions and concerns have been answered by the researcher and I have received a copy of this consent form. Therefore, I consent to take part in this research project.

Participant's Signature: _____

Name in Block Capitals: _____

Phone: _____ **Email:** _____

Witness: _____

Date: _____

Principle Investigator

Signature:

Name in Block Capitals:

Date:

APPENDIX C

PRELIMINARY OPEN CODES SHEET

Preliminary Codes

Interview #1	Interview #2	Interview #3
Change	Graduating	Graduating and Immigrating
Liking Job	Immigrating Without Experience	Lacking Experience
Being Competent	Hearing Negative	Feeling Competent and Confident
Fearing	Feeling The Weight Of Others' Expectations (Family)	Learning Through Practice
Scared	Apprehending	Maximizing Opportunities
Not Knowing Anything	Fear Of Failure And Bringing Shame On Family	Reinforcing Confidence
Not Knowing The Language	Fear Of Failing Others' Expectations	Spousal Supporting
Fearing The Country	Feeling Competent	Ineffective Communicating
Fearing The System (Health Care)	Confident	Fearing The Unknown
Knowing	Self Believing	Fearing Incompetence
Fearing Doing Something Wrong	Hearing Negative	Trying To Communicate
Trying To Pass	Fear Of Failure	Crying In Frustration
Taking Tests	Feeling Unsettled	Persevering
Not Understanding Scores on Tests	Feeling Pressure	Sharing Problematics
Kept Trying/Going	Extrinsic Motivating	Supporting
Persevering	Depending On Husband	Gaining Insight
Taking Courses; Classes	Culturing	Committing To Nursing
Finally 'Getting' English	Knowing Language	Isolating
Pressure To Finish	Lacking Initial Confidence	Depending
Pregnant	Lucking Out	Studying Language
Holding On	Passing ESL	Attending
Race Against Time	Failing Exam	Forcing Learning
Doing Nothing (at first)	Fearing Failure	Succeeding In Language
Not Knowing The System	Challenging	Determining
Avoiding Mistakes	Self Aware	Persevering
Avoiding	Going Through The Motions	Goal Setting
Being Ready	Pleasing Others	(Hard) Bargaining
Fearing Catastrophe	Pleading For Help	Undermining
Stressing	Losing Confidence	Hearing Negative

Resilience	Disbelieving	Rising Above Challenges
Hard	Mistrusting	Self Talking
Losing Confidence	Confused	Self Coaching
Passing By Not Passing (A Test)	Conforming	Determining To Go On
Learning to Pass the Test	Acquiescing	Laying Down Conditions/Ultimatum
Test is Meaningless	Prioritizing Personal Needs	Learning
Fearing Nursing	Losing Confidence With Passing Time	Succeeding
Releasing/Relaxing	Feeling Unsupported	Knowing What You Know
Knowing But Not Able To Demonstrate It	Becoming 'A Failure'	Rising Above Personal Challenge To Succeed
Knowing Nursing/ Fearing Canada's Differences	Knowing What I Need	Learning And Succeeding With Support
Holding Back - Fearing Mistakes	Family Ignorance	Finding Support
Self Coaching	Blocking	Being Mentored
Doing Everything	Feeling Guilty	Learning From Others
Overwhelming Expectations	Compelled To Study	Appreciating Support
Not Knowing (what to do)	Fear Of Failure and Shame	Increasing Confidence
Telling IENS/Not Helping	Pressured By Higher Stakes	Being Supported/Accepted
Needing To Be Told	Feeling Reassured	Recognizing Own Strengths
Knowing But Not Knowing (in Canada)	Knowing Her Needs Can Be Met	Awareness Of Independence
Telling Them What They Know	Worrying About Personal Reputation Reacting To Pressure, Rumour and Innuendo	Progressing In Practice
Self-Talking		Self Believing
Reassuring	Confident of Nursing	Persevering
Ameliorating Fear	Living In Trepidation Of Family Talk	Come What May
Feeling Bad	Progressing By Learning Style	Keeping On
Not Expecting Individual Support	Getting Stuck And Unstuck	Persisting
Isolating	Needing Answers	Working Hard
Mingling And Learning Doing It	Feeling Uncomfortable Not Knowing	

Transitioning	Supporting Colleagues	
Easing in (not)	Asserting Individuality	
Taking Steps To Competence	Own Learning Style	
Experience	Interacting With Instructors	
Happy/Settled	Seeking Information/Answers To Questions	
Competent At Job In China/Confident	Feeling Isolated/Unsupported	
Communicating/Not Connecting To People	Learning From Mistakes/Outcomes Self- Mentoring	
Remembering/Fearing	Feeling Supported By Possible Outcomes Of Decisions	
Feeling Different/Isolated	In-Charge	
Knowing/Lacking Language Competence	Responsibilities	
Disconnecting	Growing Towards Competence	
Inner Experiencing	Increasing Confidence	
Trying To Connect/To Progress	Graduating Approach	
Trying To Gain A Foothold	Being Encouraged/Pushed By Classmate	
Failing, Improving, Then Regressing	Risking Competence	
Not Comprehending	Recognizing Own Competence	
Challenging	Arriving	
Frustrating	Going Forward	
Studying/Ongoing	Self Confidence	
Attending Classes	Self Assurance	
Passing/Meeting Requirement	Independent	
Gaining Entry/Accessing	Experiencing	
Needing Live Experience	Self-Believing	
Practicing/Learning	Gaining Confidence From Experience	
Needing To Connect With People	Forgetting	
Expanding Vocabulary	Lacking Confidence After	

	Learning	
Worrying	Legitimizing Competence (Self and Others)	
Performing Under Pressure	Feed Backing – Various	
Continuing Living	Conquering Fear	
Doing ‘Nothing Nursing’	Struggling Internally	
Communicating With Ease	Grappling With Pressures	
Apprehending	Coming To Terms	
Avoiding Getting Ready		
Generalizing Fear		
Losing Confidence		
Self Mentoring		
Passing Nursing Requirement		
Credentialing		
Doubting		
Differencing		
Confusing		
Feeling Incompetent		
Continuing Apprehension		
Releasing		
Misrepresenting Competence		
Withdrawing Due To Fear Of Failure		
Inner Evaluating		
Cultural Shifting		
Broadening Nursing		
Expanding Scope		
Confined Nursing		
Expecting		
Developing Awareness And Competence		
Orientating Not Learning		
Supporting		
Telling What We Know		
Reiterating		
Canadianizing		
Changing Culture		

Seeking Reassuring		
Seeking Confirmation		
Needing Permission/Verification		
Unhelping		
Unasserting		
Acculturating		
Feeling Bad		
Applying Learning		
Connecting With People		
Exposing		
Applying and Practicing Learning		
Preparing For Nursing		
Integrating		
Individual Transitioning		
Living: Growth and Development		
Timing/Developing		
Graduating Approach		
Challenges		
Being Misinformed		
Being OK		
Achieving		

APPENDIX D

SAMPLE MEMO

SAMPLE MEMO

February 9, 2010 11:45pm I need to go to the departure lounge for my plane, but I also need to write this down now:

Interviews #1, #2, #3

What Do I have in this data? What is this a study of? I just read this again. I am thinking about the three interviews thus far and trying to answer this question. In comparing the data, or transcending each individual one, I seem to be studying how people deal with the stress and pressures of **redeveloping their identity** as a **competent nurse** in a new country. But, it's more than that. There is something very important here about **individual living** and **survival skills** in the face of (apparent) **fierce opposition**? (not literally). What they are facing is a **major life transition**, not just career transition, because **life goes on** while they are working on **becoming a nurse again**. Language is the **gateway into practice**.

NOVEMBER 19, 2010: Comparing this data/memo with later interviews and with categories, it is clearly evidence of the transplanting process, as well as demonstrating the new normalising of life that immigrant professionals need to develop to resolve the problems of having uprooted their lives from their native country.

APPENDIX E

Core Category Development

INTERNATIONAL PROFESSIONAL TRANSPLANTING: a grounded theory of the transition to competent practice in the host country for migrant health professionals (October 22, 2010)

Core Category: International Professional Transplanting

Sub Categories: Uprooting, Personal and Professional Regressing, Adapting/Personal and Professional Progressing, Reconstituting

Uprooting From the decision to immigrate to the point of leaving. Includes deciding and rationalizing, resigning and leaving employment, risking, planning, packing-up, apprehending, anticipating, stressing, hearing negative, separating, studying and researching, obtaining (papers).

Personal and Professional Regressing All participants stated that they took a step backwards in their profession when they first arrived in the host country. The same was true in their personal lives and each one impacted the other. The experiences they went through were Shocking, Fearing failure, Humbling, Humiliating, Deskillling, Communicating Incompetently (Language), Disillusioning, Encountering Discrimination.

Adapting This stage involved making various adaptations to life in the host country. All of the participants said that this takes time. However, there seemed to be a point at which this adapting really took off. All of the participants indicated that they reached a point of questioning and re-evaluating their decision to immigrate. This part I am referring to as 'Stock-taking'. It seems that once a person did this it reaffirmed their commitment to the process and they made significant progress in their 'adapting' from this point forward. It included progressing professionally and personally and was facilitated by (Human and Professional) Credentialing, Resocializing, Timing, Self Talking, Comparing, Becoming a Person, Communicating Competently, Letting Go, Persevering, Networking, Concealing and Revealing Competence, Capitalizing on Opportunity, Acculturating, Compromising, Gaining Confidence, Reinterpreting, Reuniting Family.

Reconstituting This is the end stage of the transition and the beginning of 'continuing to live'. It is about recapturing ones professional

self and professional voice, and recreating one's self. Most participants identified that they had settled or adapted at this stage and felt the same level of competence in their profession as they had before leaving home. A few did not reach the point of adapting into the same profession, but were content to make progress at what they were now doing. In personal terms, the major focus is back on the progress and ambitions of the individual, family and significant others. For others, they had reached a point of readying for the next challenge. There was a kind of "been there, done that" attitude and they were considering another transplanting in a new country.

APPENDIX F

SAMPLE

Subcategory and Core Category Comparative Analysis - Transplanting

NOTE: This data is drawn from an Excel spreadsheet. The boxes were lined up side-by-side and the data was matched up from data to memos to hypotheses to further memos (on this process). The Core Category was placed in a column by itself to facilitate comparison with every other component. A screen shot of the spreadsheet is shown below, but it is not possible to read the data from it. Hence the boxes have been copied to this word document to allow the reader to read this sample.

Hypotheses

As whole people, professionals transplant both their professional and private lives. Professional transplanting only happens if the individual's career is established and competence has been achieved.

New graduates have been planning to leave on completion of their program for some time or they leave because of marriage - to follow their spouse. Completion of transplanting is compounded by the degree to which the new country's social, professional and cultural norms differ from the individual's original experiences. Transplanting is also influenced by aspects of the individual's personal ability to adapt and his/her repertoire of coping strategies [evidence in this data but could be another study of its own!!].

Transplanting takes place before and after leaving the home country. Part of the transplanting process involves the loss of self, through not being able to behave the way you do in your own country ever again. With 'new normalising', "it affects your work when you cannot be yourself", "you can't do the behaviour you would in your own country." (IE#5 LYN Feb 12, 2010).

Unanticipated aspects of Transplanting involve issues around racist responses from people in the host country. For example, trying to establish basic roots, such as accommodation can be affected by such things as the colour of your skin, reactions to your name, or plain ignorance and fear of non-native people. – Immigrants are perceived as challenging the norms of a host society!

Transplanting comes in another form; the product of marriage. Several of the participants moved countries to be with their new spouse. They still had the same experience of uprooting from family, friends, work and location, but their motivation to move may have been stronger?

Transplanting means giving up the norms of your own country and realizing that you have little or no awareness of the norms in the new country. It is stressful, risky and frightening, since you are entering the unknown and what you know no longer applies. Transplanting is a risky business for some. It involves putting yourself out there for others (at home) to watch and see if you can succeed. This presents itself as a negative stress and pressure on the individual and can result in a "no way back without success" attitude.

Family beliefs and responses to migration impact the confidence of the individual migrant and, thereby, the degree of trauma experienced in the uprooting process. (This may also extend to the rate of adaptation in the new environment?)

MEMOS

All of the participants, bar one, in this study provide evidence of having been established in their career either in their home country or another. However, the effects of transplanting are also experienced by those who only went through their basic professional education in their home country. Having an established career elsewhere is a property of transplanting, but not a requirement. A sense of belonging or commitment can also impact the quality of the experience of transplanting. Transplanting is experienced in degrees: for some it is traumatic, due to the number of losses and sacrifices. For others, it is less traumatic if their reasons or motivators for leaving are stronger than their reasons and motivators for staying. In extreme cases, uprooting is not only traumatic, but part of a crisis - e.g. if you must leave or be killed. Transplanting occurs over different time periods and these periods can be lengthened or reduced by such things as preparation, preliminary visits, research, obtaining a position, obtaining or waiting for a visa or landed status, or the need to avoid being killed. The professional experience of transplanting is also strongly influenced by personal transplanting. The qualitative experience of personal transplanting is influenced by such things as marital and family status, numbers of children, whether one takes one's family with them or leaves them behind, the degree to which personal possessions need to be left behind, sold or given away. Risk-taking can also be a part of the transplanting process. In some cases, moving to a different country is an expectation. In others it is a choice and, in yet others, it is forced on the individual. Regardless of these factors, it represents a risk in that one has to give up one's career and separate from one's roots, to pursue a goal whose outcome is, as yet, an unknown.

Sometimes the transplanting is more painful after arriving in the new country and starting to discover all of the differences from what you were used to at home. There is a sense of sacrifice and loss in the transplanting process at this stage.

Family responses to migration vary from supportive to downright opposition or criticism. Respondents indicate that this undermines their confidence and makes the uprooting all the more painful. In some cases, the individual is glad to finally leave the family.

PROPERTIES OF TRANSPLANTING

Uprooting, Anticipating, Reacting, Landing, Initial Settling

Relationship to 'New Normalising'

Transplanting is the first stage in the process of 'New Normalising'. It is sometimes difficult to identify a beginning and end point for transplanting, though the former is obvious for some. It may start with the individual thought of working in another country, some tentative exploration of the idea, more indepth investigation into the corollaries of immigrating, followed by a commitment to migrate to another country. Alternatively, transplanting is an abrupt and immediate event prompted by an imminent threat to life or welfare. Participants in this study indicated that transplanting continues after the physical move to the new country. There are still issues to settle back home, such as selling a house, moving money, obtaining further evidence of credentials, adjusting relationships with family and friends. Some individuals maintain their professional connections in the home country for a period of time after migrating. This serves as a kind of insurance policy that, if things don't work out, there is a way back. To the extent that this happens, the transplanting process for that individual will be extended to the point where the "insurance" period comes to and end. **[This raises questions as to whether this has an impact on how easy it is to settle or does it leave the person more unsettled for a longer period of time?]**

Family members at home, or even those on the ground in the new location, often do not understand the new set of norms for professional practice and the time and support required to negotiate them. As time passes without apparent progress = registration and money, the family will become more critical. Part of this is also influenced by the amount of financial layout they have invested without apparent results. The faster the individual can new normalise the less this stress will play a role.

Screenshot of Category Comparison Sheet

COMPARATIVE ANALYSIS TRANSPLANTING - Microsoft Excel

Home Insert Page Layout Formulas Data Review View Add-Ins

Clipboard Font Alignment Number Styles Cells Editing

G3 All of the participants, bar one, in this study provide evidence of having been established in their career either in their home country or another. However, the

Hypotheses	MEMOS	PROPERTIES OF TRANSPLA	Relationship to 'New Normalising'
<p>As whole people, professionals transplant both their professional and private lives. Professional transplanting only happens if the individual's career is established and competence has been achieved. New graduates have been planning to leave on completion of their program for some time or they leave because of marriage - to follow their spouse. Completion of transplanting is compounded by the degree to which the new country's social, professional and cultural norms differ from the individual's original experiences. Transplanting is also influenced by aspects of the individual's personal ability to adapt and his/her repertoire of coping strategies [evidence in this data but could be another study of its own]. Transplanting takes place before and after leaving the home country. Part of the transplanting process involves the loss of self, through not being able to behave the way you do in your own country ever again. With 'new normalising', "it affects your work when you cannot be yourself", "you can't do the behaviour you would in your own country." (IBS UN Feb 12, 2010). Unanticipated aspects of Transplanting involve issues around racist responses from people in the host country. For example, trying to establish basic roots, such as accommodation can be affected by such things as the colour of your skin, reactions to your name, or plain ignorance and fear of non-native people. - Immigrants are perceived as challenging the norms of a host society! Transplanting comes in another form, the product of marriage. Several of the participants moved countries to be with their new spouse. They still had the same experience of uprooting from family, friends, work and location, but their motivation to move may have been stronger? Transplanting means giving up the norms of your own country and realizing that you have little or no awareness of the norms in the new country. It is stressful, risky and frightening, since you are entering the unknown and what you know no longer applies.</p> <p>Family beliefs and responses to migration impact the confidence of the individual</p>	<p>All of the participants, bar one, in this study provide evidence of having been established in their career either in their home country or another. However, the effects of transplanting are also experienced by those who only went through their basic professional education in their home country. Having an established career elsewhere is a property of transplanting, but not a requirement. A sense of belonging or commitment can also impact the quality of the experience of transplanting. Transplanting is experienced in degrees: for some it is traumatic, due to the number of losses and sacrifices. For others, it is less traumatic if their reasons or motivators for leaving are stronger than their reasons and motivators for staying. In extreme cases, uprooting is not only traumatic, but part of a crisis - e.g. if you must leave or be killed. Transplanting occurs over different time periods and these periods can be lengthened or reduced by such things as preparation, preliminary visits, research, obtaining a position, obtaining or waiting for a visa or landed status, or the need to avoid being killed. The professional experience of transplanting is also strongly influenced by personal transplanting. The qualitative experience of personal transplanting is influenced by such things as marital and family status, numbers of children, whether one takes one's family with them or leaves them behind, the degree to which personal possessions need to be left behind, sold or given away. Risk-taking can also be a part of the transplanting process. In some cases, moving to a different country is an expectation. In others it is a choice and, in yet others, it is forced on the individual. Regardless of these factors, it represents a risk in that one has to give up one's career and separate from one's roots, to pursue a goal whose outcome is, as yet, an unknown. Sometimes the transplanting is more painful after arriving in the new country and starting to discover all of the differences from what you were</p> <p>Family responses to migration vary from supportive to downright opposition or criticism. Respondents indicate that this undermines their confidence and makes the uprooting all the more painful. In some cases, the individual is glad to finally leave the family.</p>	<p>Uprooting, Anticipating, Reacting, Landing, Initial Settling</p>	<p>Transplanting is the first stage in the process of 'New Normalising' sometimes difficult to identify a beginning and end point transplanting, though the former is obvious for some. In the individual thought of working in another country, an exploration of the idea, more indepth investigation into of immigrating, followed by a commitment to migrate to country. Alternatively, transplanting is an abrupt and im prompted by an imminent threat to life or welfare. Part study indicated that transplanting continues after the new country. There are still issues to settle back for selling a house, moving money, obtaining further eviden credentials, adjusting relationships with family and frie individuals maintain their professional connections in t country for a period of time after migrating. This serves insurance policy that, if things don't work out, there is a the extent that this happens, the transplanting process individual will be extended to the point where the "instur comes to and end. [This raises questions as to whether th on how easy it is to settle or does it leave the person mor longer period of time?]</p> <p>Family members at home, or even those on the ground i location, often do not understand the new set of norms practice and the time and support required to negotiat passes without apparent progress - registration and mor will become more critical. Part of this is also influenced of financial layout they have invested without apparent faster the individual can new normalise the less this str role.</p>

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APPENDIX G

Research Proposals:

Version 1 Feb. 2008

Version 2 Oct. 2009

PhD Research Proposal (Version 1)

From theory to practice: developing effective education interventions in multicultural, multigenerational teaching and learning contexts for Internationally Educated Healthcare Professionals

**Presented to: Professor Carmel Mulcahy,
Dublin City University**

by

John Collins MA, Dip. Ed., BA(Hons), DPSN, CMS (Dist.), RPN, RN

**Director of Education, Delta View Campus of Care, Delta, BC;
Nursing and Education Consultant, John Collins Consulting,
Coquitlam, BC Canada**

Home Phone: 604-945-5452

Work Phone: 604-596-8842 ext. 317

Cell: 778-882-2413

E-mail: isnhs@shawbiz.ca OR jcollins@deltaview.ca

Preliminary Comments

This proposal has been developed with awareness of the two schools of thought in regard to PhD proposals which say, on the one hand, there should be a well-formed research question and precise design and, on the other hand, that one begins with a research area and the research question and the precise design is refined through the process of doctoral level study. This particular proposal, in the main, adopts the second approach and as a result, the following research design should be regarded as an initial framework.

Though not yet fully informed and developed, then, this proposal does pose some key questions that the study would seek to answer. The literature cited here evidences a preliminary search, which takes account of the emergent research design suggested in the proposal. Nevertheless, it is likely that the literature will form a data source to be included as part of the simultaneous process of data collection, analysis and comparison. Thus, the proposal is consistent with the Grounded Theory method suggested for this study (Glaser & Strauss, 1967).

From theory to practice: developing effective education interventions in multicultural, multigenerational teaching and learning contexts for Internationally Educated Healthcare Professionals

Introduction

“Why are we learning about this?” “What do we need this for?” “What use is this in the real world?”. These are questions which are often repeated in classrooms/schools around the world, by learners of all ages and types. They posit the notion that humans don’t just want education for its own sake, but want to learn something which can be put to use (applied) in their lives; something which will have meaning for them or allow them to make meaning of their experiences. Accordingly, one might reasonably postulate that education includes both theory and practical components; teachers teach theory and how to apply it and learners learn the theory and make use of it in their lived environments. However, the assumptions underlying these statements are ones which have previously been grappled with and debated by philosophers, educators, social scientists and anthropologists. Learning ‘theory’ and applying it to practical situations in the real world is not as straightforward as these initial statements imply. This paper proposes further study of this issue, in the context of the author’s education practice; the education of Internationally Educated Healthcare Professionals (IEHP)³, whose constituents represent multiple cultures and multiple generations. The challenge for IEHP is to achieve and evidence in practice the required competencies of their chosen healthcare profession in their new country.

The Education literature is replete with researchers, educators and practitioners who describe the same problematic in regard to the application of theory to practice. This problematic of how to facilitate learning such that it is possible for learners to apply it to good effect in the practice context is as old as the study of education itself (see discussion below). Though the context of education changes through time, this issue remains a perennial challenge.

³ IEHP are individuals who have obtained a professional healthcare credential or designation in their home country and are seeking to obtain, or have already obtained, the same or similar credential in their adopted country.

For the early Romans, education needed to prepare citizens who would be effective both economically and as military personnel. Assumedly, success or failure in translating theory into practice could be identified by the wealth attained by the individual or by the outcomes of military conquests, and the actions of individual soldiers (Halsall, 1999). In early Greek civilization, the need was to develop a strong citizenship model with emphasis on leadership. In this case, one might assume that they determined the application of learning by the degree of loyalty of individuals to the country and by the achievements of its leaders (Halsall, 1999). George Berkeley (1685-1753) (cited in Bronstein et al, 1964), in his statement of “The Principles of Human Knowledge”, elucidates the integration of thoughts or ideas and how this comes to produce knowledge of the existence of objects in the real world. He, likewise, emphasizes the importance to acquisition of knowledge (theory) of the ability of the individual to perceive (application). David Hume (1711 -1776) (cited in Bronstein et al, 1964), in his “Inquiry Concerning Human Understanding”, claims, “We have said that all arguments concerning existence [or matter of fact]⁴ are founded on the relation of cause and effect; that our knowledge of that relation is derived entirely from experience...” (p. 307). In making this claim, he is alluding to the significance of the relationship between ‘thinking’ (theory) and ‘doing’ (practice), in the education of humans. Rousseau (1712-1778), too, made claims that significant learning occurs by discovery (integrating theory with practice) (Archer, 1964). With his emphasis on group learning, John Dewey (1859-1952) stressed the importance of practical experience to the application of theory. Moreover, he claimed that learning from experience consisted of psychological and social aspects which could not be divorced from one another without causing harm to the learner and to society (Dewey, 1897). In the writings of these philosophers and historical commentators the problematic alluded to in this paper is an ever-present.

Though serious energy, thought and effort have been afforded the issue in numerous contexts over a considerable period of time, it is still one which challenges educators today (see e.g. Child, 1984; Brown and Atkins, 1988, Mott et al. 2005). The problematic extends from the need to apply what we learn to live situations and events, in order to achieve or improve performance and outcomes. In the context of this proposal, this problematic has serious implications for instructors and learners, and the individuals who depend on their services.

⁴ Added by this author

Theory-practice issues in the context of educating healthcare professionals

Nowhere is the concern over the application of theory to practice more pronounced than in the context of the provision of health care services. After all, the very lives (or deaths) of people depend on the ability (or inability) of the health care practitioner to apply what he/she has learned. Yet, again, healthcare literature evidences the ongoing concerns of what has been referred to as the “theory-practice gap”. In more recent times this concern has been debated in the knowledge transition/utilization literature. The question continues to be asked as to why healthcare professionals do not make use of the available researched evidence in their practice (see e.g. Eastabrooks, 1998, 2001; Pyra, 2003; Newton, 2005).

‘Knowledge Transfer’ in the current healthcare context

While the questions of application of theory to practice are explored, healthcare systems worldwide are dealing with what seems to them to be more pressing questions of critical manpower shortages which threaten their ability to deliver any service, never mind the level of quality these services can provide (Prystay, 2002; Bach, 2003; Buchan et al, 2003; Fifty-seventh World Health Assembly, 2004; Trossman 2002, Van Eyck, 2004). In order to address this concern, health care employers are engaged in recruitment of international healthcare professionals from any and every part of the world to try to bridge the manpower gap and maintain a level of service acceptable to the public and their governments. While the practice of recruiting healthcare staff internationally was in place for most of the second half of the 20th century, it has now been accelerated and extended as the shortage becomes more acute.

In turn, our notions of multicultural societies have been expanded to include many more cultures and races, bringing with them their own unique understandings of the world of healthcare. Complicating the picture further is the trend among the immigrant and indigenous population towards a multigenerational workforce, each generation with its own world view. Furthermore, these trends intensify the pace of change in the development, delivery and complexity of healthcare services (Kirkby, 2002).

In terms of the original concerns expressed in this paper, the theory-practice conundrum in the current education and practice contexts presents a challenge to

educators of healthcare professionals, which has, heretofore, been given little attention in either discipline: healthcare or education. Indeed, this author's preliminary search of the literature in these areas demonstrates a dearth of educational theory or practice which could assist educators of healthcare professionals to address this issue. There seem to be few answers for healthcare educators who would ask, "how can educational offerings best facilitate the transition from theory to competent practice for the IEHP in the new dominant culture?"

Research Question(s)

Given all of the foregoing statements, the focus of this research is to add new knowledge to the area of educating IEHP in their chosen new context of practice. The initial question this research sets out to address is: What education interventions can educators of healthcare professionals design and deliver, to enhance the ability of learners in a multicultural, multigenerational learning environment to translate knowledge into competent practice in their new dominant culture?

Research Design

It is proposed that the research be conducted in two steps.

Step 1 will be designed to develop a theory of education intervention(s) to enhance the ability of IEHP in multicultural, multigenerational classrooms/clinical practice arenas to apply knowledge to healthcare practice in the dominant culture, in order to become competent in that practice.

Because of the nature of the subject matter and for the sake of strengthening the theory through comparisons, it will be important to use a wide source of information from international sources to develop the new theory. This will involve the selection of research venues and participants in two to three different countries. Since most countries require IEHP to undertake some kind of transition course before being allowed to practice independently, it will likely be possible to identify a significant number of potential informants without much difficulty. Additionally, it could be beneficial to the theory development to be able to access healthcare professionals, originating from the same country, in more than one new country.

Step 2 will involve the testing of the new theory of educational intervention(s) in either a pre-post test or randomized controlled trial (RCT).

Depending on the extent and depth of the work undertaken in Step 1, and the expert advice of the supervisory committee, Step 2 may constitute a proposal for post-doctoral work.

Research Methodology

Step 1: Grounded Theory (Glaser and Strauss, 1967; Glaser 1994)

The nature of the question posed in this proposal is such that it will only lend itself to an inductive research method. The intent is to develop a theory of education intervention, and this can be achieved through the use of a qualitative research method. Comparing quantitative methods with qualitative methods Polit and Beck (2006) state,

“In qualitative research, by contrast, the study design typically evolves over the course of the project; qualitative researchers *design* as they *do*... The design for qualitative studies is an emergent design – a design that emerges as researchers make ongoing decisions reflecting what has already been learned. As noted by Lincoln and Guba (1985), an emergent design in qualitative studies is not the result of researchers’ sloppiness or laziness, but rather of their desire to base the inquiry on the realities and viewpoints of those under study – realities and viewpoints that are not known at the outset.” (p.210)

Grounded Theory was first described by Glaser and Strauss in 1967. Coming from the school of symbolic interactionism, their interests lay in understanding the manner in which people make sense of social interactions and the interpretations they attach to social symbols. Through the constant comparative analysis of concepts and data, the researcher using this method is able to induce and deduce a theory which explains the social situation or some aspect of it (Stern, 1980). Thus, it is a method which can address the research question identified in this proposal.

Grounded Theory includes in-depth interviews and participant observations. At the outset of this study the author surmises that the interviews would include IEHP who are currently students in transition programs, recent former IEHP students of the same programs, IEHP who have developed successful careers in their new host country, healthcare educators and experienced healthcare practitioners. It may also include conducting a second round of interviews with all relevant sources of data who/which arise out of the first process, to ensure data saturation. However, as stated above, the research design may change to accommodate discoveries made along the way, since, “A fundamental feature of grounded theory research is that data collection, data analysis and sampling of participants occur simultaneously.” (Polit and Beck, 2006)

Step 2: Pre-post Test or RCT

Test out the new theory of education intervention in a program of study for IEHP. Adjust the theory further based on the data from Step 2.

Research Sample

Step 1: In keeping with the Grounded Theory method, this is referred to as ‘theoretical sampling’. The purpose of sampling is to contribute data toward the development and explication of the emerging theory (Glaser and Strauss, 1967).

“As researchers analyze their materials and develop theoretical categories, they frequently discover that they need to sample more data to elaborate a category. Because researchers only develop theoretical categories through the analytic process, they do not know in advance what they will be sampling. Thus, theoretical sampling differs from the kind of selective initial sampling most qualitative researchers engage in as they set criteria for their research problem.” (Charmaz, 1994; p. 111)

Thus, all sources of data which are related or can provide further data through comparison, in two/three Countries (Canada, UK or Ireland and USA), will be

researched. This may include IEHP of various disciplines, educators of healthcare professionals, practice personnel (peers, managers, clinical educators), government personnel and any other individuals or groups who emerge from the preliminary research as potential informants. In addition, data may be provided from literature which supplies data for categories, concepts, or clarification of either (Charmaz, 1990).

Step 2: The most likely scenario for this step will be the use of convenience samples in Canada for pre-post test or randomized samples for RCT. The rationale for this decision is that the author will have ready access to convenience samples, already has a number of key networks and will readily be able to access resources to support the study.

Research Ethics

There will, of course, be a need to consider the informed consent of all participants in the research studies. This may involve some additional effort on the part of the researcher to ensure participants fully understand their participation, by translating consent documents into the first language of participants who are still in the process of learning their second language.

Secondly, there may be a need to seek permissions from various organizations – educational and healthcare – which could become participants or participant sites in the research. This may involve seeking permissions and ethical approval from organization managers and ethics committees.

Thirdly, there will be a need to consider the effects of the presence of the researcher and trial interventions on the outcomes for participants. Conceivably, this may include the need for the provision of support to healthcare educators and extra support for students of IEHP Programs. The method suggested here allows for meeting ethical obligations by way of clarifying data, categories and concepts with participants on more than one occasion.

Further, there will be a need to address the questions of data use and research outcomes. It will need to be clear to all participants and those who are involved at any level how the data will be used and who it can be shared with. The final reports will be made available to all participants.

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PhD Research Proposal (Version 2)

The transition to independent, competent practice in the host country for migrant health professionals: a Grounded Theory

Presented to: Dr. Carmel Mulcahy, Dublin City University

by

John Collins MA, Dip. Ed., BA(Hons), DPSN, CMS (Dist.), RPN, RN

Director of Education, Delta View Campus of Care, Delta, BC;

Nursing and Education Consultant, John Collins Consulting,

Coquitlam, BC Canada

Home Phone: 001-604-945-5452

Work Phone: 001-604-596-8842 ext. 317

Cell: 001-778-882-2413

E-mail: john.collins@dcu.ie OR isnhs@shawbiz.ca

Updated: October 12, 2009

Preliminary Comments

This proposal has been developed with awareness of the two schools of thought in regard to PhD proposals which say, on the one hand, there should be a well-formed research question and precise design and, on the other hand, that one begins with a research area and the research question and the precise design is refined through the process of doctoral level study. This particular proposal, in the main, adopts the second approach and as a result, the following research design should be regarded as an emerging framework.

The literature cited here evidences a preliminary search, which takes account of the emergent research design suggested in the proposal. In fact, proponents of classic grounded theory suggest that the a priori literature review should be a broad theoretical level. Nevertheless, it is likely that the literature will form a data source to be included as part of the simultaneous process of data collection, analysis and comparison. Thus, the proposal is consistent with the Classic Grounded Theory method suggested for this study (Glaser & Strauss, 1967; Glaser 1998).

The transition to independent, competent practice in the host country for migrant health professionals: a Grounded Theory

Introductory Statement

The Global Village is established! The European Union, Free Trade Agreements, International Economic Cooperation and Interdependency, for example, will testify to this. Travel between one part of the “Village” and another can be achieved in shorter time frames than ever before. The desire to grow and develop personally and professionally has led to significant increases in travel and migration (Statistics Canada, 2007; Szekely, 2007; Workpermit.com, 2006). Additionally, labour shortages around the “Global Village” are reaching critical proportions (CIC, 2008; Isadore, 2007; The Economic Times, 2008). Healthcare professions are no less affected by this than are other professions (CIHI, 2005; Buchan and Seccombe, 2004; MoH, NZ, 2006; RCN, 2007). Opportunities to travel and relocate, together with the need for their professional expertise and services, have resulted in a willingness on the part of healthcare professionals to migrate and heavy incentives for them to do so. But moving to a new location in the “Village” is not without its problems for the healthcare professional, the employer who would hire him/her, and the recipient of his/her services. Issues of culture, culture shock and related stressors, communication, education requirements, and adaptation to the new practice environment call for a support system which will provide successful outcomes for all. As a migrant healthcare professional and educator, I am interested in discovering what learning philosophies, theories and approaches (among other interventions) would prove most beneficial to supporting this transition to the new context of practice. In particular, I am interested in developing a theory of the transition to independent, competent clinical practice for these healthcare professionals. In the context of this study, I will limit the participation of migrant healthcare

professionals to doctors and nurses, two of the largest and most significant groups in terms of their global mobility and service provision.

Education and the “Transition”

With regard to my interests in professional education, I am eager to learn how this affects, or could affect, the transition in a positive way. Most curricula to assist these individuals and groups adjust to their new environment are developed by educators and professionals who ‘know’ what is required to be clinically competent in practice arena of the host country. It appears that they also know how best to organize and deliver the curriculum, since they do so without reference to the participants. Yet, these programs of study also report significant levels of attrition (Jeans et al, 2005; Smith et al, 2007). This attrition means lost investments for the individual, the educational institution, the government, the healthcare system and society at large. It also means lost healthcare professionals to the country of settlement, in an environment of critical shortage. There are numerous studies and papers in the extant literature exploring the transition to the new context of practice for migrant healthcare professionals. These studies focus, in the clinical practice domain, on issues such as language, communication systems, beliefs and values, racism, discrimination and prejudice, and patient responses to the migrant healthcare professional (Szekely R. 2007). In relation to the theoretical side of their transition, the authors highlight issues of access to higher education, attitudes among students, staff and the general population, the need for further teacher education and curriculum content, as impacting program participants (Pearson-Evans et al, 2007).

As far as this researcher is aware, there are no studies which directly explore the transition experience itself and the learning experiences of these healthcare professionals. Nor has this researcher come across studies which attempt to formulate

a theory of this transition, built from the ground up (Glaser and Strauss, 1967). This process will involve developing a theory for migrant healthcare professionals by interviewing and observing the migrant professionals themselves, as well as those who are involved in their “transition”. The researcher believes that such theory building has the potential to enhance the education of migrant healthcare professionals, resulting in not only reduced attrition rates, but also higher levels of clinical competence at an earlier point in the transition. However, at this juncture, this belief is only based on conjecture without evidence to support it.

Education in The Context of The “Transition”

The Education literature is replete with researchers, educators and practitioners who describe the same problematic in regard to the application of theory to practice. This problematic of how to facilitate learning such that it is possible for learners to apply it to good effect in the practice context is as old as the study of education itself (see discussion below). Though the context of education changes through time, this issue remains a perennial challenge.

For the early Romans, education needed to prepare citizens who would be effective both economically and as military personnel. Assumedly, success or failure in translating theory into practice could be identified by the wealth attained by the individual or by the outcomes of military conquests, and the actions of individual soldiers (Halsall, 1999). In early Greek civilization, the need was to develop a strong citizenship model with emphasis on leadership. In this case, one might assume that they determined the application of learning by the degree of loyalty of individuals to the country and by the achievements of its leaders (Halsall, 1999). George Berkeley (1685-1753) (cited in Bronstein et al, 1964), in his statement of “The Principles of Human Knowledge”, elucidates the integration of thoughts or ideas and how this comes to

produce knowledge of the existence of objects in the real world. He, likewise, emphasizes the importance to acquisition of knowledge (theory) of the ability of the individual to perceive (application). David Hume (1711 -1776) (cited in Bronstein et al, 1964), in his "Inquiry Concerning Human Understanding", claims, "We have said that all arguments concerning existence [or matter of fact]⁵ are founded on the relation of cause and effect; that our knowledge of that relation is derived entirely from experience..." (p. 307). In making this claim, he is alluding to the significance of the relationship between 'thinking' (theory) and 'doing' (practice), in the education of humans. Rousseau (1712-1778), too, made claims that significant learning occurs by discovery (integrating theory with practice) (Archer, 1964). With his emphasis on group learning, John Dewey (1859-1952) stressed the importance of practical experience to the application of theory. Moreover, he claimed that learning from experience consisted of psychological and social aspects which could not be divorced from one another without causing harm to the learner and to society (Dewey, 1897). In the writings of these philosophers and historical commentators the problematic discussed in this section is an ever-present.

Though serious energy, thought and effort have been afforded the theory-practice issue in numerous contexts over a considerable period of time, it is still one which challenges educators today (see e.g. Child, 1984; Brown and Atkins, 1988, Mott et al, 2005). The problematic extends from the need to apply what we learn to live situations and events, in order to achieve or improve performance and outcomes. In the context of this proposal, this problematic has serious implications for instructors and learners, and the migrant healthcare professionals who depend on their support and services.

Theory-practice issues in the context of educating healthcare professionals

⁵ Added by this author

Nowhere is the concern over the application of theory to practice more pronounced than in the context of the provision of health care services. After all, the very lives (or deaths) of people depend on the ability (or inability) of the health care practitioner to apply what he/she has learned. Yet, again, healthcare literature evidences the ongoing concerns of what has been referred to as the “theory-practice gap”. In more recent times, this concern has been debated in the knowledge transition/utilization literature. The question continues to be asked as to why healthcare professionals do not make use of the available researched evidence in their practice (see e.g. Eastabrooks, 1998, 2001; Pyra, 2003; Newton, 2005).

‘Knowledge Transfer’ in the current healthcare context

While the questions of application of theory to practice are explored, healthcare systems worldwide are dealing with what seems to them to be more pressing questions of critical manpower shortages which threaten their ability to deliver any service, never mind the level of quality these services can provide (Prystay, 2002; Bach, 2003; Buchan et al, 2003; Fifty-seventh World Health Assembly, 2004; Trossman 2002, Van Eyck, 2004). As previously identified in this paper, health care employers are engaged in recruitment of international healthcare professionals from any and every part of the world to try to bridge the manpower gap and maintain a level of service acceptable to the public and their governments. While the practice of recruiting healthcare staff internationally was in place for most of the second half of the 20th century, it has now been accelerated and extended as the ‘shortage’ becomes more acute.

In turn, our notions of multicultural societies have been expanded to include many more cultures and races, bringing with them their own unique understandings of the world of healthcare. Complicating the picture further is the trend among the immigrant

and indigenous population towards a multigenerational workforce, each generation with its own world view. Furthermore, these trends intensify the pace of change in the development, delivery and complexity of healthcare services (Kirkby, 2002).

In terms of the original concerns expressed in this paper, the theory-practice conundrum in current education and practice contexts presents a challenge to educators of healthcare professionals, which has, heretofore, been given little attention in either discipline: healthcare or education. Indeed, this author's preliminary search of the literature in these areas demonstrates a dearth of educational theory or practice which could assist educators of healthcare professionals to address this issue. There seem to be few answers for healthcare educators who would ask, "how can educational offerings best facilitate the transition from theory to independent, competent practice for the international doctor or nurse in the new host country?"

Research Question(s)

Given all of the foregoing statements, the focus of this research is to add new knowledge to the areas of understanding the transition experience and educating migrant doctors and nurses in their chosen context of practice. The initial questions this research sets out to address are: What is the transition experience for migrant doctors and nurses? What interventions (educational or otherwise) can managers, educators and colleagues of migrant doctors and nurses provide, to enhance the ability of these healthcare professionals to become independent and competent in their clinical practice in the most efficient way?

Research Design

I am not starting out in this study with any hypotheses about how migrant healthcare professionals can best be supported. I do not know the answer to this or any other

research question; hence the need for the study. Given that I am not testing any “grand theories”, I propose to use a research method which can facilitate a broader investigation. Since the intent of the study is to produce a substantive theory specifically about the transition of migrant healthcare professionals, I intend using a classic grounded theory method. This rigorous research method is applicable to situations where little or no theory is already available and where the intent is to induce a theory from data derived from the participants involved in the ‘problem’.

Grounded Theory is a systematic research method which will allow the induction of theory from the two case studies – Ireland and Canada. Data will be collected primarily from interviews, though some observations and literature may provide additional, comparative or clarifying data. Participants will be asked to partake in one and half hour interviews. It is possible that some participants may be requested to provide a further interview to check data, clarify categories, concepts or properties. This cannot be predetermined and, therefore, all participants will be alerted to this possibility. Data analysis will begin as soon as the first data is collected. The data will be collected in the form of field notes and coding will be used first to identify, name, categorize and describe phenomena from the text of the interviews and observations. These will then be analysed to identify emerging theory and to compare further data using this emerging theory. The next stage will involve “purposive theoretical sampling” in order to broaden the theory and search for different properties. This is where it may be necessary to include more participants or other sources of data, such as observations, literature and documents. When all of the data and its properties are saturated, sorting takes place in order to prepare for and begin writing the theory. The theory should explain the phenomena under study and make sense to the participants. The method includes an iterative process to achieve this clarification.

The plan for this research project is to conduct two case studies: one in Ireland and one in Canada. In this study, and in order to build this grounded theory of the transition, I will need to approach and recruit a number of migrant healthcare professionals who

are at different stages of the settlement process – from those who have recently arrived to those who have been practicing for a number of years. I will also need to interview educators and clinical supervisors of these migrant healthcare professionals, as well as personnel at each of the regulatory bodies. All of these individuals and groups have perspectives to contribute to our understanding of the transition to independent, competent clinical practice in the host country.

Research Methodology: Grounded Theory (Glaser and Strauss, 1967; Glaser 1994)

The natures of the questions posed in this proposal are such that they will only lend themselves to an inductive research method. The intent is to develop a theory of the transition for migrant doctors and nurses, and this can be achieved only through the use of a rigorous research method based in the context itself. Comparing quantitative methods with qualitative methods Polit and Beck (2006) state,

“In qualitative research, by contrast, the study design typically evolves over the course of the project; qualitative researchers *design* as they *do*... The design for qualitative studies is an emergent design – a design that emerges as researchers make ongoing decisions reflecting what has already been learned. As noted by Lincoln and Guba (1985), an emergent design in qualitative studies is not the result of researchers’ sloppiness or laziness, but rather of their desire to base the inquiry on the realities and viewpoints of those under study – realities and viewpoints that are not known at the outset.” (p.210)

While Classic Grounded Theory is an emergent research design, it is not considered qualitative by its authors. It is possible to include both quantitative and qualitative data in the method. Grounded Theory was first described by Glaser and Strauss in 1967. Coming from the school of symbolic interactionism, their interests lay in understanding

the manner in which people make sense of social interactions and the interpretations they attach to social symbols. Through the constant comparative analysis of concepts and data, the researcher using this method is able to induce and deduce a theory which explains the social situation or some aspect of it (Stern, 1980). Thus, it is a method which can address the research questions identified in this proposal.

Grounded Theory includes in-depth interviews and participant observations. In fact, Glaser would say that nothing can be excluded from data – “all is data” (Glaser, 2009). At the outset of this study the author surmises that the interviews would include migrant doctors and nurses who are currently in different stages of the transition, educators, mentors and experienced healthcare practitioners. It may also include conducting a second round of interviews with all relevant sources of data who/which arise out of the first process, to ensure data and category saturation. However, as stated above, the research design may change to accommodate discoveries made along the way, since, “A fundamental feature of grounded theory research is that data collection, data analysis and sampling of participants occur simultaneously.” (Polit and Beck, 2006)

In Grounded Theory method, sampling is referred to as ‘theoretical sampling’. The purpose of sampling is to contribute data toward the development and explication of the emerging theory (Glaser and Strauss, 1967).

“As researchers analyze their materials and develop theoretical categories, they frequently discover that they need to sample more data to elaborate a category. Because researchers only develop theoretical categories through the analytic process, they do not know in advance what they will be sampling. Thus, theoretical sampling differs from the kind of selective initial sampling most

qualitative researchers engage in as they set criteria for their research problem.”

(Charmaz, 1994; p. 111)

Thus, all sources of data which are related or can provide further data through comparison, in the two Countries (Canada and Ireland), will be researched. This may include migrant doctors and nurses, educators and mentors, practice personnel (peers, managers, clinical educators), government personnel and any other individuals or groups who emerge from the preliminary research as potential informants. In addition, data may be provided from literature which supplies data for categories, concepts, or clarification of either (Charmaz, 1990).

Research Ethics

There will, of course, be a need to consider the informed consent of all participants in the research study. This may involve some additional effort on the part of the researcher to ensure participants fully understand their participation. It is even conceivable that translating consent documents into the first language of participants, who are still in the process of learning their second language, may be necessary.

Secondly, there may be a need to seek permissions from various organizations – educational and healthcare – which could become participants or participant sites in the research. This may involve seeking permissions and ethical approval from organization managers and ethics committees.

Thirdly, there will be a need to consider the effects of the presence of the researcher on the outcomes for participants. Conceivably, this may include the need for the provision of support for interviewees who become anxious as a result of the interview(s). The method suggested here allows for meeting ethical obligations by way of clarifying data, categories and concepts with participants on more than one occasion.

Further, there will be a need to address the questions of data use and research outcomes. It will need to be clear to all participants and those who are involved at any level how the data will be used and who it can be shared with, how it will be stored and, ultimately, destroyed. The final reports will be made available to all participants and their organizations.

Other ethical issues will evolve as the study progresses and the time for interviews and data collection nears.

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