THE EXPERIENCE OF EXPATRIATES QUALIFIED NURSES IN MALTA:
AN EXPLORATORY STUDY

DISSERTATION SUBMITTED IN PART FULFILLMENT OF THE REQUIREMENTS FOR THE MASTERS IN HEALTH SCIENCE (NURSING STUDIES)

BY

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The Experience of Expatriates Qualified Nurses in Malta: An Exploratory Study

I hereby declare that I am the legitimate author of this Long Essay/Dissertation/Thesis and that it is my original work.

No portion of this work has been submitted in support of an application for another degree or qualification of this or any other university or institution of learning.

Signature of Student

HELEN ATTARD BASON
Name of Student (in Caps)

23/09/11
Date

4.03.2011
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ABSTRACT

This study offers the opportunity to discover and comprehend the experiences of expatriate nurses employed in an acute general hospital, in Malta. The evidence in the literature suggests that when nurses migrate to other countries to work, they often encounter difficulties in adjusting to the new environment to which they have migrated. Efforts to enhance their adjustment to work have been recommended in the literature. Due to the fact that there has been no local studies carried out in this area of expatriation, an interpretive phenomenological approach was considered most appropriate, with the aim of producing rich and meaningful data.

Data was collected from a purposive sample of ten expatriate nurses originating from Bulgaria, Romanian and the Philippines, who had been working within the acute care hospital for a minimum of two years through in-depth semi-structured interviews. All the ten interviews were recorded and transcribed. Following transcription, only nine interviews were analysed as during this stage one of the nurses from the initial sample decided to terminate participation in the study. Analysis and interpretation of the data from the nine interviews was achieved through use of interpretative phenomenological analysis (IPA), a distinctive approach in conducting qualitative research that is concerned with understanding lived experiences.

The findings demonstrate that several contributory factors exist in influencing the nurses to migrate to Malta, mostly related to financial incentives and better working conditions. However, on migration, it was evident that these nurses had to face some
challenges; a major challenge which was common to all the participants is related to the difficulty in communication, especially because of the wide use of the Maltese language across patients and staff. Nevertheless, although for some, the initial experience was shocking and frustrating mostly because of the referred language barrier, most of the participants adapted quite positively to the new environment. There are some factors that have emerged from the analysis of the data which had influenced the adaptation process of these participants mainly their own clinical knowledge and their previous working experience in their home and other countries. A positive collegial relationship and trying to cope with the language barrier by pursuing a programme of studies in the Maltese language, or learning some phrases have also emerged as measures which have facilitated the nurses' adaptation to the new environment.

The findings clearly indicate that nurses lacked formal organizational support on arrival to Malta and that they had to be self efficient in finding their way and adapting to their new environment. The findings suggest that nurses need support during their initial period on the clinical area and this could be provided through the induction of preceptorship programm that will also serve as a performance analysis of these nurses' competencies. More research could also be done exploring the Maltese nurses' experience of working alongside the expatriate nurses, while taking a longitudinal approach to studying such an experience. The findings will hopefully inform administration and management accordingly.
Keywords: expatriate nurses, international recruited nurses, experience, challenges, adaptation, qualitative, interpretative phenomenology.
ACKNOWLEDGEMENT

First and foremost I would like to thank my heavenly Father for giving me the strength to travel this journey. To my supervisor, who had supported me and remained by my side throughout my journey. Dr Cassar, thank you for believing in me and leading the way, through most of the challenging and difficult times. You are a terrific supervisor who truly knows how to encourage and support your students. I truly appreciate your words of encouragement and your knowledge that you had continuously shared with me. To my family, my husband Tonio, my two daughters, Marie Claire and Michelle and my parents and in laws, who willingly sacrificed some of our precious time together so that I could pursue my study. My thanks also go to my Nursing Officer, Ms Maria Pace, for the support, patience and understanding especially when she kindly approved my vacation leave, to be able to carry out my study and finish in time according to schedule. I am so grateful for all these people who were always there for me whenever I needed to be encouraged and who always believed in my ability to complete my study. I would also like to thank all the nursing officers in charge of the clinical areas, for their cooperation in accessing the participants of the study. Finally, a big thank you to the participants who willingly accepted to participate in my study, by dedicating some of their precious time in sharing their experience and insights with me.
CHAPTER 1

INTRODUCTION
1.1 Background of the study

The scenario of a shortage of nurses has always been a consistent issue within various health care systems across the world. This had been the result of various reasons such as, more career choices for women, an ageing nursing workforce (Walters, 2005), increasing demand on the health services because of an ageing population, and the poor image of the profession (Gerrish & Griffith, 2004). Several countries have struggled to recruit and maintain adequate numbers of qualified nursing staff to meet the demand of the respective healthcare system. Malta is no exception. The opening of a new general hospital in 2007 and the continuing expansion of the rehabilitation hospital, together with the need to continue to expand services especially in the fields associated with the care for the elderly and in the community, appears to have accentuated the shortage of adequate human resources in the healthcare, particularly those pertaining to the nursing profession (Galea, 2009).

Against a backdrop of a perceived shortage of nurses in the country, the Maltese government initiated a series of strategies to address such shortage over the last few years. Measures for attracting more applicants to nurse education programmes and encouraging unemployed nurses to return back to work were gradually rolled out (J. Sharples, personal communication, 23rd November, 2010). Furthermore, in tandem with pressure from the leading union for nurses and midwives in the country, it was gradually acknowledged that recruiting foreign nurses into the Maltese health service should be an absolute priority target for the government (Malta Union of Midwives and Nurses,
MUMN, 2009). As a result of this, in 2007, the health division had taken the initiative and established a policy, to start recruiting foreign nurses from both the European Union and other non-European countries, as a drive to address staff shortages. The period between 2008 and 2010, had registered significant recruitment of nurses from overseas, with the largest number coming from Bulgaria and Romania (Council of Nurses and Midwives, Malta (CNM), 2008). Table 1.1 and 1.2 illustrate the number of Maltese and foreign nurses who applied for registration with the CNM of Malta in 2008 and 2009, and the actual number of nurses who were successfully registered. Registration with the CNM of Malta is an obligatory pre-requisite to working as a nurse in the country.

1.2 Significance of the Study

Studies cited in the literature provide insights into the experiences of international recruited nurses when they migrate to different countries to work (Yi and Jezewski, 2000; Daniel, Chamberlain and Gordon, 2001; Allen and Larson, 2003; Alexis and Vydelingum, 2004; Gerrish and Griffith, 2004; Matiti and Taylor, 2005; Taylor, 2005; Palese et al, 2007; and Okougha and Tilki, 2010). However, no studies have been carried out to understand the practice and the experience of expatriate nurses in Maltese health care institutions. This lack of data and evidence limits the development of policies pertaining to the future recruitment of expatriate nurses in our health care institutions. Moreover, information sourced by the public media regarding this matter can be very misleading and inaccurate (Buchan, Parkin and Sochalski, 2003).
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In addition, there appears to be a wide consensus in the literature (Konno, 2006), that this drives on recruitment to address a shortage; need to be coupled with initiatives to enhance the retention of expatriate qualified nurses. Various studies (Gerrish and Griffiths, 2004; Konno, 2006, Smith, Allen, Henry, Larsen and Mackintosh, 2006) have highlighted the importance of developing effective supportive intervention programmes to meet the particular needs of expatriate nurses in order to make their transition to the new environment smooth in terms of both organisational and humanitarian considerations. The optimal adjustment of expatriate qualified nurses is believed to lead to a longer job retention rate, while their greater contribution to multicultural nursing practice will be facilitated (Konno, 2006). It is in view of this, and in view of the ongoing debate regarding the strategy of recruiting foreign nurses to Malta, in seeking to address the perceived prevalent nursing shortage, that this qualitative study was designed. The aim was to explore expatriate nurses’ experience of working in Malta.

Therefore this study sought to:

1. Gain insight into the experience of expatriates working as nurses in Malta.
2. Explore the factors which influence their adjustment to the context of Malta.
3. Identify the strategies and interventions that nurses undertake to adapt to their new environment from a personal and professional perspective.
4. Determine strategies that may help expatriate nurses experience a favourable transition and optimal adjustment to the context of working as a nurse in Malta.
1.3 Definition of Expatriate Nurses

For the purpose of this study expatriate nurses are nurses who have left their home country to undertake employment in another country for a long period of time (Bozionelos, 2009). The terms expatriate nurses, foreign nurses and internationally recruited nurses are used interchangeable in this dissertation and share a common meaning.

1.4 Nature of the Study

This research study sought to address the noted prevalent dearth of evidence, pertaining to the specific context of Malta. The philosophical constructs of hermeneutic phenomenology provided the theoretical framework of the research study which sought to gain an in depth understanding and meaning of the experience of expatriate qualified nurses in Malta. In view of the fact that an exploratory research design that would accommodate the researcher’s pre-understanding of the phenomenon, developed through the researcher’s own experience of working alongside expatriate nurses was needed, a phenomenological approach using Heidegger’s (1962) perspective on hermeneutic was adopted.

Data was generated through in-depth semi structured interviews with ten expatriate nurses coming from Bulgaria (n=3), Romania (n=6) and Philippines (n=1), who had been working in the local acute general hospital for more than one year. The interview process
yielded a vivid picture (Sorell and Redmond, 1995) of expatriate nurses' day-to-day experience in Malta. Transcripts of the interviews were analysed using Interpretative Phenomenological Analysis (IPA). The use of IPA is widely recommended when seeking to understand and explore in depth how participants are making sense of their day-to-day particular experience (Smith and Osborn, 1996). Moreover, the use of IPA is widely correlated with the adoption of Heidegger's notion of interpretative phenomenology (Smith, Flowers and Larkin, 2010). IPA also emphasizes that the researcher should have an active role in the research process (Smith and Osborn, 1996), which means that throughout the analysis process of the data, the researcher is obliged to incorporate one's own perspectives in order to make sense of the participants' experience, through an interpretative manner. It is against this backdrop that the researcher found IPA to fit the purpose of the research study. This dissertation accounts for the perspectives of the researcher, as a researcher student but also as a qualified nurse, who worked in the same hospital as did all the participants of the study.

The researcher's own experience of working alongside expatriate nurses with the healthcare system in Malta, and through the ongoing discussions that the researcher have with other Maltese nurses working with these expatriate nurses, related to the practice and employment of such nurses, revealed to the researcher that the employment of these nurses do pose some significant challenges both for them personal, and for the Maltese nurses who will be working with them. Such challenges appear to arise around issues of communication both with staff and patients, and around disparities between what expatriate nurses may have learned and practised in one's own country and the way
nursing care is delivered in Malta. The findings of this research study will hopefully inform the support provided to expatriate nurses, thus enhancing their respective experiences, and also contribute to the recruitment of expatriate nurses in the future. The next chapter provides a review of the literature pertaining to the topic under study.
CHAPTER 2

LITERATURE REVIEW
2.1 Introduction

2.1.1. Scope and timing of the literature review

In qualitative inquiry, researchers often embark on the study prior to reviewing the literature about the topic under study, so that they would not be directed in their research, since this may in turn invalidate the findings (Holloway and Wheeler, 1996). However, since in Heideggerian phenomenology the researcher’s preconceptions are integral to the entire research process (Lowes and Prowes, 2001) it was decided that in the research study reported in this dissertation, a literature review was to be carried out at the start of the study, since this may also help the researcher to develop further understanding of the context being studied (Smith, Flower and Larkin, 2010). The literature search and review however remained ongoing through the whole course of the research study, as in IPA studies the findings should always be related to new emerging literature (Smith, Flowers and Larkin, 2010). In addition, a literature review in a hermeneutic study serves as a framework of knowledge that can help to identify a gap in the area under study, which the research question can subsequently address (Smith, Flowers & Larkin, 2010) as well as to ensure that the questions asked during, and the data arising from the interviews were consistently relevant. (McConnell-Henry, Chapman and Francis, 2009).

Literature was collected through a search on the following databases EBSCO, CINAHL, Medline, E-JOURNALS, GOOGLES, and GOOGLE SCHOLARS, dating back a decade from the time of the study. The following key words were used to conduct the search: qualitative studies, intercultural relationships, phenomenological studies, lived
experiences, international recruited nurses, expatriate nurses, foreign nurse and adaptation. Further literature was located through the manual search of reference lists and bibliographies of retrieved sources. No studies regarding the experience of expatriate nurses in Malta were located. The majority of international studies that were found (Appendix 8) were conducted in the United Kingdom, (Likupe, 2005; Taylor, 2005; Buchan, Johanputra, Gough and Hutt, 2006; Okougha and Tilki, 2010; Alonso-Garbayo and Maben, 2009). Other studies were conducted in the United States (Yi and Jezewski, 2000; Dicicco-Bloom, 2004 and Edwards and Davis, 2006) and Australia (Hawthorne, 2001; Takeno, 2010). One study was conducted in Italy. The Italian research study was very similar to the one being reported in this dissertation in that it explored the transitional experiences of a small sample of Romanian nurses, in Italy (Palese et al, 2007). The majority of studies cited in this literature review used a qualitative approach to explore the experience of nurses when they migrate to other countries to work. One-to-one interviews and focus groups were the most common methods of data collection.

Traditionally in qualitative inquiry the trustworthiness of a study needs to be established by the researcher, by having the researcher produce a faithful description of the events, influences and action taken throughout the research process (Koch, 1993) together with a clear description of the theoretical underpinnings of the methodology used (Whitehead, 2002). However, possibly due to publication restrictions, many of the studies located in the literature failed to provide such descriptions, rendering it difficulty to establish the studies' trustworthiness. In general, limitations of the located studies are those ascribed to qualitative designs, such as the issue of generalizability. The studies which were
reviewed are presented in Appendix 8. As noted earlier, the terms expatriate nurses, migrant nurses, international recruited nurses (IRNs) and overseas trained nurses are used interchangeable since different sources in the literature adopt any of these four varying terms when referring to the same cohort nurses under study.

Shortages of nurses is an increasing challenge, mostly in many industrialised and developing countries worldwide (Kingma, 2006). Many developed nations such as Australia, Canada, the United States (US) and the United Kingdom (UK) have sought to redress deficits in their nursing workforce through the recruitment of internationally educated nurses (Allen and Larsen, 2003), the major donor countries being the Philippines, India and other South Asian countries (Blythe and Baumann, 2009). The literature demonstrates various reasons why nurses from the latter countries decide to migrate; the primary reason being perceived economic advantage (Smith et al, 2006; Aborderin, 2007; Troy, Wyness and McAuliffe, 2007), that is, better salaries, safer environments and improved quality of life for themselves, their children and often also for their extended family (Kingma, 2006).

These factors are clearly evident in the findings of a study carried out by Alonso-Garbayo and Maben (2009) which sought to identify the reasons why nurses originating from India and the Philippines migrate to work in the UK. In this qualitative study that utilised a qualitative interpretative approach, data was collected by means of sets of longitudinal and cross sectional interviews with nurses recruited from India (n=6) and the Philippines (n=15). The longitudinal study was carried out with six Indian nurses who were
interviewed three times over eight months from the date of arrival in the UK, together with ten of their mentors and managers. This was done in order to be able to analyse the data through a comparative approach; comparing the reported experience of the Indian nurses at different stages of their migration and adaptation. The Philippine nurses were divided into two groups, the first group composed of six nurses who had been working in the UK for eighteen months, and the second group composed of nine nurses who were recruited four years earlier. A cross-case analysis (Alonso-Garbayo and Maben, 2009), was carried out by comparing nurses with different years of experiences in the United Kingdom; comparing participants with previous migratory experience with others coming directly to the United Kingdom, as their first experience of migration, and also by comparing the experience of the Indians with that of the Philippine nurses. The findings of this study were presented in three different themes which identified the reason for migration; individual perspective, social and cultural nature. In the individual perspective theme, nurses reported economic and professional reasons, validating other findings from previous studies (Buchan, 2002; Allan and Larsen, 2003; Buchan et al, 2006 and Smith et al, 2006). For the group of nurses coming directly to the United Kingdom, from India or the Philippines, the economic motive, that being specifically the search for a higher salary was highly expressed to be a motivation factor that influenced the nurses to migrate, together with the ability to provide a better standard of living and education to their family and children. However, for those who the UK was not their first migratory experience professional and personal factors were more influential. Participants here clearly sought to practice in an environment with higher standards of care and heightened professional environments. This was their main reason for migration to the UK. Although
one cannot generalise the findings of this study due to the small size of the sample, the findings from this study by Alonso-Garbayo and Maben (2009) corroborate with the findings of a study carried out by Allen and Larsen, (2003) who explored the motivations and experiences of sixty seven internationally recruited nurses in the United Kingdom. Data for the study of Allen and Larsen was collected from participants coming from eighteen different locations in Africa, South Asia, and Australia, North America and various European countries, through focus groups, following a pre-focus group questionnaire. The findings show that the motivation of nurses to go and work in the United Kingdom was shaped by their personal, social, professional and financial expectations. The focus groups specifically sought to explore the experience of expatriate nurses, as regards the professional aspect of their experience. The aim was infact to provide recommendations to improve the professional recruitment, adaptation and contribution of expatriate nurses to health care services in the United Kingdom. Although, there is evidence in the literature that suggests that when nurses migrate they make a valuable contribution to patient care in the receiving country (Taylor, 2005), findings from Allen and Larsen’s (2003) study revealed that nurses did however have to face many significant challenges throughout their professional working experience in the receiving country. Communication difficulties with colleagues and patients, difference in the practice of nursing care delivery, isolation, discrimination and racism, exploitation and lack of recognition of skills and expertise were experiences which echoed through the data collected by Allen and Larsen (2003). These challenges have been determined in other international studies (Yi and Jezewski, 2000; Daniel et. al.2001; Alexis and Vydelingum, 2004; Gerrish and Griffith, 2004; Matiti and Taylor, 2005; Palese et al,
2007; and Okougha and Tilki, 2010). Such consistent evidence highlights the stresses and difficulties that these nurses experience in adapting to their new environments.

Taylor (2005) utilised an exploratory qualitative study in attempt to discover the views and experiences of nurses who had studied overseas and were employed within the British National Health Services (NHS). This qualitative study consisted of both participant observation and focus group interviews with eleven overseas nurses who had migrated to the United Kingdom from various countries that included the Philippines, China, Finland, New Zealand, Nigeria and South Africa. The strength of the study by Taylor (2005) lies with the fact that, acknowledging that through verbal enquiry, data will be limited to the cognitions of the respondents, Taylor chose to carry out participant observation besides a focus group in an attempt to enhance the rigour of her study. According to Taylor participant observation had further revealed diversity in behaviour that may not be described by participants through one to one interviews. This is further supported by Savage (2001) who asserts that participant observation would give a deeper understanding of the participants' world than would through a verbal enquiry. Six major themes were identified including communication, differences in the nurses' role, the deskilling of overseas nurses, and the status of overseas nurses, racial discrimination and pastoral support (Taylor, 2005). Taylor reports that the experience of participants may have varied, due to the fact that their ethnic and cultural origins were different, with the non-white nurses having to struggle harder to adapt and be accepted in the UK, than those nurses coming from Finland, New Zealand and South Africa.
In a review carried out by Newton, Pillay and Higginbottom, (2011) which sought to explore the experiences of international educated nurses when migrating to and transitioning into health care systems of the destination countries, the authors claim that most of the major challenges that nurses face on transitioning into a new environment, such as communication and language differences, experience of discrimination and deskillng, feelings of being an outsider and difference in nursing practices are all significantly counter production and defeat one of the main purposes for expatriate nurses recruitment, that is to redress the nursing shortage. Acknowledging that the exodus of nurses migrating to other countries, may have profound effects on health care provision in the countries where they migrate, while the migrant nurses will need considerable support in the host country, the authors through this literature review wanted to increase their knowledge and understanding of the issues that arise during the migration of these nurses in order for such issues to be addressed globally to enhance success with the transition.

It is evident that there is considerable agreement between the above cited sources, that while migrating some nurses do have positive experiences, the majority of such nurses experience some level of discrimination, face communication challenges, while they are being expected to adopt roles that differed from what they had expected (Newton, et al., 2011). The differences which exist between different countries especially with respect to structures of respective health care systems, which in turn continuously change according to socio-economic, political and cultural circumstances, may offer an explanation for
such registered experiences. In turn such challenges may affect the adaptation of migrant nurses to the social and health care environment, in the host country.

In view of this, the major challenges identified in the literature, which expatriate nurses appear to encounter when they migrate to other countries will be reviewed in the following section of this chapter. Collectively the literature identifies three main challenges. These pertain to (i) communication and language skills, (ii) cultural differences leading to different types and degrees of discrimination and (iii) incongruence across the role and the nature of nursing care delivery in different countries and contexts. Strategies that seek to minimise these challenges of transitioning of nurses between countries will be reviewed at the end of this chapter.

2.2 Challenges pertaining to communication and language skills

Communication is a cornerstone of patient care delivery (Kingma, 2006). A key aspect which determines nurses’ experience is the ability to communicate which is in turn significantly related to language proficiency. Bola, Driggers, Dunlap and Ebersole, (2003), claims that lack of communication skills can hinder foreign nurses from assuming professional nurses’ roles and responsibilities effectively. This contention, echoes through the literature (Winkelmann-Gleed and Seeley, 2005; Okougha and Tilki 2010). Such language and communication barrier has been also reported by the British Royal College of Nurses (RCN, 2005) in their document ‘Success with International Recruited nurses’. This document that had drawn on other research studies conducted earlier by the
RCN, had demonstrated the many challenges that international recruited nurses in the UK, mostly coming from Asian countries such as India and Nigeria, face. One of the challenges identified associated with the language barrier is the frustration that these nurses experience, because although for such expatriate nurses the English language would be their second language, communication between them and patients is often limited by colloquialisms and local dialects used by English-speaking patients (RCN, 2005). The differences in medical terminology, abbreviations, medication names and even the names of common items may also create a problem for these nurses (Bola et al, 2003). Winkelmann-Gleed and Seeley, (2005) who carried out a study amongst Asian nurses working in the UK, have also reported that when language was the second or third language for the migrant nurses, the migrant nurses encountered prejudices from their British colleagues, as they were perceived to be less knowledgeable, because of the fact that they were not English speaking. Conversely, one of the participants in Winkelmann-Gleed and Seeley’s, (2005) study claimed, that his multiple language skills was an asset and gave a valuable contribution to patient care delivery, because he used to be asked to translate and communicate with minority ethnic patients, whose language he was proficient in.

This language problem has been highlighted in a study by Okougha and Tilki (2010) which sought to describe the experiences of nurses recruited from Ghana and the Philippines by a London NHS Trust. To investigate the perception and experiences of these nurses the authors took a grounded theory approach using focus groups. Although the nurses participated in two different groups according to their home country, it resulted
that their experience was noted to be very similar, with challenges pertaining to language skills and use, being a major theme common in the data gathered from all the participants. The speed at which colleagues and patients spoke a language, and the jargon and colloquialisms used, presented difficulties to the participants. For example, when a patient had told a Philippine nurse that “he was feeling sick”, the Philippine nurse misinterpreted the complaint because the patient was specifically referring to wanting to vomit, but for ‘this nurse feeling sick meant that the patient was feeling unwell’ (Okougha and Tilki, 2010, p.3).

In conclusion it appears that challenges in communication can be a source of anxiety, even when nurses will be adequately knowledgeable and skilled in the rest of the clinical aspect of the profession (Bola et al, 2003). Moreover such challenges can also lead to social exclusion and possible discrimination between staff members from different ethnic and social backgrounds (Allan, Cowie and Smith, 2009). These unfavourable scenarios seem to arise when staff members do not communicate effectively amongst themselves. The next section reviews the literature pertaining to such arising socio-cultural challenges.

2.3. Challenges pertaining to socio-cultural aspects

Other international qualitative studies utilising both focus groups and individual interviews to study the experience of expatriate nurses, have also reported various distressing and frustrating situations during which these expatriate nurses did not only
reveal problems with regards to communication issues but also described their
disappointment and frustration related to their discriminatory experiences. Newton et al,
(2011) indicate that such discrimination is often due to various factors such as race,
gender, culture and language. Incidences of perceived discrimination against expatriate
nurses are evidenced in various studies (Taylor, 2005; Alexis and Vydelingum, 2004;
Alexis, Vydelingum and Robbins, 2007; Nichols and Campbell, 2010). In such studies
expatriate nurses have reported prejudice while claiming that their knowledge and their
professional skills have been underestimated by the nurses of the host country. Expatriate
nurses have also described incidences when nurses refused to help them. Such
unfavourable scenarios, which in turn reportedly led to increasing their sense of isolation
(Hawthorn, 2001; Smith et al, 2006; Kingma, 2007) are widely present in the literature,
coupled with evidence that suggests experiences of racist discrimination and abuse by
expatriate nurses (Allen, Larsen, Bryan and Smith, 2004; Taylor, 2005; Smith et al,
2006).

A number of studies (Appendix 8) carried out in the UK report racist discrimination
(Allen and Larsen’s, 2003; Alexis and Vydelingum, 2004; Taylor, 2005; Likupe, 2006). Asian
born nurses working in Australia and USA have also reported unfavourable
experiences at their workplace as nurses, perceived to result from the fact that they were
of a different colour and place of origin (Hawthorne, 2001, DiCicco-Bloom, 2004). In
such studies racist discrimination led the overseas nurses to experience minimal peer
support at work, humiliation, rejection by patients and peers, stereotyping by colleagues
and the public, and even to institutional racism. Expatriate nurses reported incidences
when they were not given the opportunities for promotion or career advancement because of their immigrant status. (Allen et al 2004; DiCicco-Bloom, 2004; Alexis, Vydelingum and Robbins, 2006; Kendall-Raynor, 2008). Such experiences may have an overwhelming psychological effect on the individual expatriate nurse, resulting in lowered self-esteem and professional effectiveness, and not least their quality of life (Larsen, 2007; Allan, Cowie and Smith, 2009).

Allen and Larsen’s (2003) study referred to earlier in this chapter (p.14), provides much evidence of perceived prejudice arising from differences in skin colour, language and culture. The evidence of these nurses in Allen and Larsen’s (2003) study is so strong that expatriate nurses were led to question whether other staff viewed them as equal human beings, and thus clearly led them to feel vulnerable to racial harassment. These findings are congruent with the findings of Alexis and Vydelingum, (2004) phenomenological study who explored the experiences of black and minority ethnic nurses recruited in the British National Health Services. Encountering racism in the form of inequality of opportunities was one of the concerns of the twelve nurses who participated through in depth semi-structured interviews, carried out amongst nurses coming from the Philippines, South Africa, Caribbean and Sub Sahara Africa. Nurses in this study had also claimed that they went to the UK expecting opportunities to be based on ‘equality of worth and merit not on the colour of their skin’ (p.16). Additionally some of the participants also articulated their frustration and their uncomfortable feelings when they encountered bullying and lack of support, associated with their racial characteristics. This lack of support had created anxieties and difficulties in adjusting to the new environment.
Unlike other research studies reported in this section, in Alexis and Vydelingum, (2004), one of the researchers was a black nurse. This may have influenced and determined the nature of the specific data collected in this study and moreover the interpretation of the data collected. One may alternatively argue that, the fact that a black nurse was the researcher may have also have helped the participants to feel comfortable and talk openly about their experience, thus enhancing the rigour of the study (Smith, Flowers and Larkin, 2010).

Migrant nurses’ lack of recognition of their previous knowledge and experience have also been identified as factors that make migrant nurses feel more vulnerable to exploitation and discrimination, thus undermining their self confidence (Kingma, 2007). Such feelings appear to translate into migrant nurses feeling marginalised and discriminated in their clinical area thus leading to de-skilling (Taylor, 2005; Smith et al, 2006). Kingma, (2007) explain that therefore such discrimination, besides having a negative effect on the individual who experience it, since it leads to emotional and professional discontentment, can also be of a serious concern to the safety of the patient. Research studies (Allen and Larsen, 2003; Alexis and Vydelingum, 2005; Taylor, 2005; Aboderin, 2007) have reported that nurses, who in their home countries used to run hospitals or provided expert clinical care, may be obliged to do purely domestic chores at their workplace. This form of discrimination have been also highlighted in a study by O’Brian (2007) who explored this issue with overseas nurses from three UK national health service trusts and concluded that although expatriate nurses are usually highly trained and proficient in technical skills, the system to which they are recruited to expects them to perform roles
within remits that are incompatible with the expression of their own clinical skills and expertise. O’Brian (2007) explains that the fact that expatriate nurses are routinely recruited to NHS hospitals and care homes on lower nursing grades, leads to situations where deskilling occurs. This echoes Kingma’s (2008) concerns regarding the resultant patient safety issues referred to above.

Coupled with wide evidence of unfavourable incidences of such discrimination (Daniel, at al.2001; Winkelmann-Gleed and Seeley, 2005; Alexis, et al., 2006), the literature also documents evidence of positive experiences in that in other studies expatriate nurses had also experienced fair and respectful relationships from their colleagues, praised the support that they were given by their host nurses whenever they needed to learn something, and even by patients who had appreciated the care they had received (Alexis et al., 2006).

2.4. Challenges arising around differences in nurses’ roles and in the nature of nursing care delivery

A feeling of deskilling and devaluation often resulted because migrant nurses were not allowed to perform procedures; they routinely performed when practising as nurses in their own country (Yi and Jezewski, 2000; Daniel et al., 2001; Matiti, 2005; Sherman and Eggenberger, 2008; Brunero, Smith and Bates, 2008). For example in Matiti and Taylor (2005) UK study a Mauritius nurse had claimed that she was not trusted to carry out certain procedures like for example changing of a dressing. She believed that this was
because of her being a foreigner in the UK. Matiti and Taylor (2005) using a phenomenological approach to study the cultural lived experience of internationally recruited nurses identified significant cultural issues that had influenced the experience of these nurses, who came from Mauritius, the Philippines, India and Nigeria with a previous nursing experience ranging from 3 to 12 years. The most prominent issue that had an influence on the nurses' professional adaptation was the difference that migrant nurses encountered in the nursing practice, compared to their home country. Most often, the nurses had stated that they were not allowed to do tasks that they were already familiar with in their country, while a few also acknowledged that some skills, ranging from peg feeding, and using certain equipment like a dynamap, to more basic skills like bed baths were new to them, According to Matiti and Taylor (2005) this incongruence of roles and remits led nurses to feel fragmented and devalued which in turn influenced the adaptation process of these nurses.

The literature suggests that there are fundamental differences in what is perceived as basic nursing across different countries (Alexis and Vydelingum, 2004; Matiti and Taylor, 2005; Magnusdottir, 2005; Taylor, 2005; Smith et al, 2006; Palese et al, 2007). In most of studies, most nurses, irrespective of their country of origin, expressed feelings of shock and frustration (Yi and Jezewski, 2000) when they realised that as part of their role as nurses, they had to perform certain skills, such as bathing of the patients. Some countries prefer nurses not to perform such skills (Omeri, 2006) as bathing a patient, since they associate such a skill with the role of health care assistants (Alexis and Vydelingum, 2004). The fact that the majority of the participants participating in most of
the cited studies came from Asian countries, may also offer an explanation to these findings. In most Asian countries caring and providing basic care such as bathing and toileting are more perceived to fall within family’s responsibility that is the care offered by informal carers than formal carers. In turn nursing care delivery in Asian countries, comprises a more technical and therapeutic approach drawn on a medical model, with nurses routinely transcribing drugs and performing cannulation (Withcell and Ouch, 2002). Such skills and not bathing and toileting are regarded as basic nursing skills. It is interesting to note that, the frustrations were not only described in terms of losing clinical skills but also in relation to the being unable to deliver optimal patient care (Taylor, 2005).

This latter concern carries significant weight in that it suggests that the quality of patient care may be potentially compromised. Hence it indicates the importance of studies of the nature as the research study being reported in this dissertation, which seek to explore the experience of expatriate nurses with the intent to identify ways and measures of contributing effectively to the enhanced experiences of expatriate nurses. A qualitative study carried out by Takeno (2010), amongst a very small sample of Japanese and Korean nurses who went to work in Australia, although it may have significant limitations, most by pertaining to its small sample size, had also revealed interesting findings which provide different insights. The experiences of the Asian nurses was that in Australia, nurses dedicate more time and commitment to bedside nursing care, in that they are often with patients helping patients with toileting and bathing. This differed to what they practiced in their own country of origin, but the nurses in Takeno (2010) study
supported the Australian role and remit of nurses, because they found that such tasks enabled them to address patients’ psychological needs contrary to what they practised in their country. The participants claimed that the most prominent aspect of nursing, especially in Korea, were technical skills and medication administration, which in turn believed to fall short of accommodating the psychological needs of patients in an effective way.

In addition to the relevance of toileting and bathing to the role of the nurse, lack of familiarity with newer technologies, (Sherman and Eggenberger, 2008), the different levels of documentation, accountability for patient assessments (Palese et al, 2007; O’Brian, 2007) and the varying presence of interdisciplinary roles (Allan, 2007), have also been highlighted as sources of differences in the nursing roles, in studies investigating expatriate nurses’ experience. With most studies, these differences challenged a positive transition to a new context of nursing practice. For example, in a descriptive study describing the experience of seventeen Romanian nurses during their first six months in Italy, Palese et al (2007) compared the nurses’ roles between the two countries. Their findings indicate that the procedures that nurses are allowed to carry out, according to the law in the Italian hospital culture, and the relationship that nurses had with other health care workers, differed so much from what they used to do in their home country, that change for these nurses was difficult. This study had been the first to examine the experiences of Romanian nurses’ migrating to the European countries (Palese et al, 2007). It identifies specific areas of nursing care that were different from the ones that Romanian nurses used to practise in Romania; not only did nurses
experienced problems with the language and nursing practice and skills, but they had also been required to act more independently, be more autonomous and to take certain decisions on their own. The disparity in the training received by Italian nurses, which was at a university level, while that of Romanians was at a lower post secondary level, may offer an explanation to why the roles determined for nurses in different countries were so varying. Similar difficulties were observed with the nurses interviewed by Sherman and Eggenberger (2008) in the United States, highlighting the fear that some nurses coming from India and China had experienced when working in the USA, partly related to the emerging need for them to independently assess patient when they have been used to have physicians directing the care of patients.

It is clear from the above that the greater the difference between the host country’s health care system from that of country of origin, and more specifically the nursing practice norms related to the nursing competences, and ways of managing nursing care, the greater the challenges are for expatriate nurses as regards with integration in the new health care system (Newton et al., 2011).

2.5 Strategies which seek to address the challenges experienced by migrating nurses

Successful strategies to ease the transition of migrating nurses into their host country and into its respective health care system have been suggested by many authors (Withcell and Ouch, 2002; Gerrish and Griffith, 2004; Magnusdottir, 2005; Konno, 2006; Palese et al,
There is also evidence in the literature that demonstrates that the development of effective supportive interventions which seek to meet the particular needs of these nurses, such as effective orientation programmes, mentoring, support and supervision (Lin, 2009; Cummins, 2009) are essential in order to make their transition to the new environment smooth in terms of both organisational and humanitarian considerations (Gerrish and Griffith, 2004; Konno, 2006). Moreover such initiatives are believed to result in good quality care to the patients (Kingma, 2008). Snow (2006) and Allan, (2010) had both suggested, that overseas nurses should undergo a period of mentoring, while all healthcare staff in the host country should be given diversity awareness training to facilitate the reception and integration of migrant nurses. The resultant more positive experience of overseas qualified nurses should lead to longer job retention rate amongst migrant nurses (Konno, 2006). However, such mentoring preparation has to be tailored to the specific needs of a specific cohort of overseas nurses, and should take into consideration that these nurses are qualified nurses who have been trained in a different system, and also have different learning styles (Allan, 2010).

In recognition of the importance of supportive programmes that can improve the transition of overseas nurses in their new environment, a number of researchers have conducted studies to explore the importance and effectiveness of adaptation programmes in their quest to ease the transition of expatriate nurses to a new environment. Gerrish and Griffith (2004) sought to evaluate an adaptation programme for nurses recruited from overseas into the UK. They interviewed overseas nurses as well as ward managers, mentors, educators and senior nurse managers. Their findings found that the level of
support and the organisational context in which they were hosted influenced the ease with which overseas nurses became integrated into the workforce. Gerrish and Griffith (2004) findings emphasised the importance of ensuring a formal organisational policy that supports diversity in the workforce, encompassing training and orientation opportunities which are congruent to the needs of migrant nurses rather than collective uniform opportunities to all nurses.

The challenges incurred in securing effective mentoring, preparation and orientation have been addressed in the literature. In an attempt to discover the barriers to effective and non-discriminatory mentoring in clinical placements for overseas nurses in the UK, Allan (2010) conducted a secondary analysis and discussion of the findings emerged from individual in depth interviews in a previous ethnographic interpretative study carried out in the UK by Smith et al (2006), that had emerged in relation to mentoring of overseas trained nurses. The issue of bullying and discriminatory practices during the period of supervised practice was revealed by the overseas nurses participating in Smith et al (2006) study, in that they claimed that they were constantly being criticised both from their mentors and colleagues. Moreover, mentors who were also interviewed during the study stated that, as mentors, they were only prepared to mentor pre-registration nursing students, and not overseas nurses, and this led them to feel frustrated because often expatriate nurses would not learn in the way that mentors expected them to learn (Allan, 2010). Allan’s analysis in fact revealed that such practice by mentors, results in confusion amongst and over pressure for the mentors, while expatriate nurses felt that their pre-existing knowledge was ignored and that they were being treated as pre-
registration nursing students. Recommendations were devised to improve such mentoring programmes in an attempt to enhance mentors’ ability to facilitate leaning, and thereby improve overseas nurses’ experience of adaptation and adjustment to a new context of work (Allan, 2010).

2.6. Conclusion

The literature search revealed a number of studies, all of which are summarised and presented in Appendix 8, and reviewed along this chapter. All the located studies were qualitative in nature and often comprised very small samples. As discussed, however, the findings of each referred studies hold significant weight in that, in the least, they identified some of the facets of the clearly multi-faceted phenomenon of migrant nurses. Besides being all qualitative in nature, most of the studies comprised a cross sectional data collection exercise and therefore evidence about variances and changes of experiences of the referred nurses overtime remains untapped. In addition, nearly all the referred studies, studied the phenomenon through an exploration of the experiences of the nurses by collecting data from the migrant nurses, most of them migrating from Asian countries only. Evidence regarding the experience of migrant nurses, as perceived and analysed by others, such as managers and other members of the health care team remains limited
While many developed countries heavily rely on expatriate nurses to overcome the shortage of nurses and maintain adequate workforce supplies (Newton et al., 2011), this literature review provides evidence that expatriate nurses often experience major challenges, which mainly arise from difficulty in communication, differences in culture and nursing practice. It is in view of all this, in addition to the lack of local research regarding this phenomenon, coupled with the increasing drive to recruit more expatriate nurses to overcome the prevalent perceived shortage of nurses in Malta, that an interpretative phenomenological study to understand the experiences of expatriate nurses working in a local acute general hospital was indicated to be beneficial. The research study reported in this dissertation sought to address one of the identified gaps in the literature and the absence of evidence pertaining to the specific context of Malta with regards to the experience of migrant nurses taking up employment at the local acute hospital.

The next chapter outlines the method used in the course of the research study.
CHAPTER 3

METHOD
3.1 Research Design

A qualitative research design was used adopting a phenomenological approach to the research study reported in this dissertation. Hence, participants were ‘allowed to tell their story in their own words’ (Broussard, 2006, p.212). Such a qualitative approach is typically used to find out and understand people’s feelings and experiences (Fade, 2003). Broussard (2006) support this notion in saying that qualitative research designs allow understanding of the most complicated details about feelings, thought and emotions that are often difficult to explore using other research methods.

It is against this backdrop that the adoption of a qualitative approach to address the research question in this study was thought to be appropriate. The intention of this study was not to build theory, but to explore in depth descriptions of life experiences. This in turn is congruent with the philosophical underpinnings of phenomenology which provided the theoretical framework to guide this research study. Phenomenology ‘a voyage of discovery’ (Finlay, 2009) is a philosophical research tradition that was developed as an alternative to the empirically based positivist paradigm (McConnell-Henry, et.al. 2009). The central focus of phenomenology is on discovering a fresh and complex vivid description of a phenomenon (Finlay, 2009), achieving a deeper understanding of the nature and meanings of everyday lived experiences of an individual.
3.2 Philosophical underpinnings of Phenomenology: an overview

The origins of this approach can be traced back to the German Philosophers Husserl (1859-1939) and later extended by philosophers such as Heidegger (1889-1976) and Gadamer. Husserl, a mathematician, is regarded as the founder of phenomenology, his fundamental concern being an epistemological one, that is, to provide a foundation for knowledge (Todres and Wheeler, 2001). In Husserl’s phenomenology, the goal is to describe human experience as it is lived, and that which is experienced in the ‘consciousness of the individual’ (Smith, Flowers and Larkin, 2010, p.13). He believed that an understanding of the world or lived experiences cannot be achieved through empirical science, but one can understand what is really in the world through intuition (Fade 2004), free from bias, preconception or presupposition (Jasper, 1994). Husserl further suggested that one needs to consider the consequences of the taken-for-granted ways of living in the familiar everyday world of objects (Smith, Flowers and Larkin, 2010). This is done through reduction or bracketing the taken-for-granted world, involving the researcher to become aware of one’s consciousness, concentrating on the phenomenon, becoming absorbed in it and seeing it as if for the first time (Rose, Beeby and Parker, 1995).

However, for the purpose of this study, an interpretative approach based on Martin Heidegger’s (1962) philosophical paper Being and Time, was adopted. The main reason for the selection of this specific approach was because Heidegger’s interpretative phenomenology, unlike Husserl, concentrates on the need to study human perceptions
and focus on the real world that the participants subjectively experience (Maggs-Rapport, 2000). It emphasizes understanding rather than description (Draucker, 1999) and this reflects the main aim of this research study, that is, to understand the nurses’ experiences of their practice in another country, rather than to elicit a description of the nurses’ experiences. Researching lived experience within Heideggerians philosophy is an act of interpretation of the transcribed text, known as hermeneutics phenomenology. The word hermeneutic comes from the Greek word *hermeneusin*, meaning to understand or interpret (McConnell-Henry et al., 2009). Heidegger (1927-1962), a student of Husserl, believed that people are situated in the world and that one cannot separate oneself from the world in which one lives. Therefore, Heidegger stressed the importance of the beliefs and opinions that the researcher brings into the research, as having a profound influence on the understanding of phenomena (Draucker, 1999). Heidegger’s hermeneutic phenomenology appeared to be most appropriate method to use to address this study, particularly because of the researcher’s own extensive experience of working with expatriate nurses in hospital. It is believed that bracketing or complete reduction of such experience, and preconceptions, as suggested by Husserl, would have been difficult to achieve. Heidegger’s method appeared to fit the purpose of this research more appropriately.
3.3 Method

It is important that qualitative research reports give enough methodological details to enable readers to understand what has been done and so make their judgments about the quality and usefulness of the work. This chapter presents a detailed account of the method used to collect and analyse the data. Interpretative Phenomenological Analysis (IPA), which is strongly influenced by phenomenology, guided the hermeneutic study being reported here (Smith, Flowers & Larkin 2010). This decision to choose IPA as an approach to data analysis, was taken early on in the development of the study as suggested by Smith, Flowers and Larkin, (2010), and guided the strategies taken throughout the research process such as, the planning of data collection methods, choosing the right sample of potential respondents who had experienced the phenomenon in question (Fade, 2004), and negotiating access to participants. IPA emphasizes the important active role of the researcher within the dynamic research process (Smith and Osborn, 1996). Therefore, the researcher sought to account the researcher’s role in each of the stages of the research process in the course of this chapter.

3.4 Constructing a Research Question

Before formulating the research question and the subsequent interview schedule, a literature review was carried out, in order to widen the researcher’s knowledge of the various aspects related to the expatriation of nurses, to formulate the research question,
and to establish that this study can make a useful contribution (Smith, Flowers and Larkin, 2010). The determined research question was: ‘What is the experience of expatriate qualified nurses working in Malta?’

3.5 Sampling

Burns and Grove (2009), state that the purpose of qualitative research is to get an in-depth understanding about a particular experience, situation, cultural element or historical event. Moreover, the aim is not to generalise the findings but to get an insight of a purposefully selected sample. Unlike in quantitative research, in which the sample size must be large enough to identify relationship among variables or to determine differences between groups, in qualitative studies the primary concern is with a detailed account of individual experience (Smith, Flowers and Larkin, 2010). Therefore as it is suggested by Polit and Beck (2004) and Burns and Grove (2009) the sample size in phenomenological research should be determined by the depth of information that is needed to gain insight into the phenomenon under study. Nevertheless, it is difficult to predict sample size using this research method because sampling should continue until saturation of information is achieved in the study area (Burns and Grove, 2009). A sample size should be considered sufficient when interpretations are visible and clear and no new findings and meanings are being discovered.

Various authors recommend very small samples of participants for a phenomenological interpretative study (Polit and Beck, 2004; Burns and Grove, 2009; Smith, Flowers and
Larkin, 2010). A sample size of ten expatriate nurses, the majority coming from Bulgaria and Romania were initially selected for the study. The decision to choose participants from these two countries was that Bulgarians and Romanians nurses represented the main source of expatriate nurses to Malta between the years 2008 and 2009, the latter being the year that the author designed and sought ethical clearance for this study. The original plan regarding sampling directed that ten nurses were to be interviewed and saturation was to be checked and verified along the process. Moreover, the size of the sample was also determined because of the time limit that the researcher had in order to conduct the interviews. Time was limited because the study was part of an academic programm. Additionally one kept in mind that, having to analyse a vast amount of qualitative data, would be overwhelming and difficult for the researcher who is a newcomer in qualitative analysis (Smith and Osborn, 1996). An interim report (Appendix 7) prepared after the analysis of the all the data gathered from the interviews by the researcher indicated saturation. This was verified by the academic supervisor.

Inclusion criteria were established to ensure that a homogenous sample is obtained and that all participants were able to articulate their nursing experience in Malta. Participants were included in the study if (i) they had been working in Malta for a minimum of two years, (ii) worked in the acute general hospital of Malta and (iii) spoke English fluently. The first criterion regarding a minimum of two years experience was taken as it was felt that these two years experience would provide sufficiently in depth information required for the study, while ensuring that all participants had indeed lived the experience as an expatriate nurse in Malta for a significant amount of time which should allow for the
sought account of one’s adaptation or otherwise. The second criterion allowed for homogeneity across the sample in that other health in Malta, are different in many ways, such as in organisational management and culture. The third criterion was essential in practical operational and feasibility terms, since the researcher has a good command on the Maltese and English language only and the research study, in being part of an academic programm, was to be presented in English language.

After approval was sought from research ethics committee, of the University of Malta (UREC), purposive sampling was used to identify participants from the acute general hospital. Purposive sampling, a non-probability sampling technique, is the type of sampling which is widely used in phenomenology as it provides an opportunity to select participants whose qualities or experiences allow an understanding of the phenomena under question (Polit and Beck, 2004; Gerrish and Lacey, 2006). Permission to access the expatriate nurses working in the acute general hospital was sought from the Director Nursing Services the referred hospital (Appendix 2). After this approval had been sought a list of wards where expatriate nurses were deployed within the acute general hospital, was issued by the Human Resources Department. The nursing officers of the respective wards were contacted and granted the researcher permission approval to access potential participants. The researcher then approached expatriate nurses personally and asked them to participate in the study. The first ten nurses who were approached and who met the stated criteria, six Romanians, three Bulgarians and one from the Philippines, and who were willing to participate in the study were included in the sample. After introducing oneself, an explanation of the purpose of the study, clarifying exactly what
the participants were to be asked to do was provided. In addition the participants were also informed about the length of the interview and how much of their time will be taken. An information sheet (Appendix 3) on the study and a schedule of the interview (Appendix 5) was also given to them.

3.6 Data Collection

3.6.1 Pilot Study

A pilot study was conducted prior to the original study with one qualified expatriate nurse chosen from the same population as the participants for the main study (Polit and Beck, 2004). The pilot study was carried out at a location agreed by the researcher and the participant. Unforeseen problems can arise in the course of a research project (Polit & Beck, 2004) and a pilot study, is designed to obtain the necessary information about what needs to be modified and also assess whether the main study is feasible to be carried out (Burns and Grove, 2009). The pilot study was mainly done so that as Gerrish and Lacey (2006) suggested, the researcher will ensure that the questions in the research instrument were easy to follow, understood and that they are appropriate to obtain the required data. Moreover, being the first time of conducting an interview, the pilot study offered the researcher the opportunity to familiarize oneself with such interviewing skills, as well as to make sure that the recording equipment which was new, was appropriate and that it gave rise to clear recordings. The pilot study showed that there was the need to change a
word in the questions of the interview schedule, which was not clearly understood. In
question ten, “hindered” was changed to “obstruct”. These were the changes which were
done to the interview questions as the analysis of the data collected satisfactorily
demonstrated that the interview had achieved its aim, in that it elicited the experience of
the participant in the pilot study. The interview took about an hour and a half.

3.6.2. Conducting the Interview

For this research study data was collected through one-to-one, recorded semi-structured
interviews. Interviews are widely believed to be the optimum method for data collection
in both Husserlian and Heidergerrian phenomenology research (Wimpenny and Gass,
2000). A number of phenomenology studies in the literature review have alternatively
utilised focus groups as a method of data collection. Focus groups is a method of data
collection were participants interact together as a way of accessing data (Webb and
Kevern, 2001) giving the method a high level of validity (Krueger, 1994) because what
participants say can be confirmed, reinforced or contradicted within the arising
discussion. However, the appropriateness of the use of focus groups in a
phenomenological study is debatable. A phenomenological approach requires that an
individual describes their experiences in a relatively “uncontaminated way” (Webb and
Kevern, 2001, pg.800) and therefore a group method of data collection involving
interaction between several participants is arguably not compatible with
phenomenological research. In addition, as pointed out by Daniel et al (2001) a focus
group can be chaotic unless the researcher has significant skills to manage it. It is for this
The main advantage of using interviews is that they generate rich, meaningful insights into the participants’ experiences (Holloway and Wheeler, 1996; Gerrish and Lacey, 2006). This concurs with the aim of Heidegger phenomenology which is to describe people’s experiences of phenomena and how they understand it. Conversely, an interview can be expensive and time consuming especially to conduct and transcribe and analyse the collected data. It also requires interviewers to be significantly skilled (Polit & Beck, 2004) especially in the use of reflection and listening skills (Jasper, 1994). These skills will enable the researcher to get the lived experiences without contaminating the data. Apart from this being a time consuming method, Holloway and Wheeler (1996) postulates that an interview needs some form of structure with a list of topics to be covered especially when the interviewer is inexperienced. Therefore, following a preliminary review of the relevant literature, an interview schedule was developed purposely for this study under the supervision of an academic research supervisor and this was piloted accordingly as noted above. The interview schedule was mainly used to guide the researcher to ask questions about the same specific issues in the same consistent manner. Smith, Flowers and Larkin (2010) strongly suggest that in such qualitative studies an interview schedule is used in a flexible manner. All the interviews were conducted in a relaxed conversational style, and were all proceeded by a few minutes of chatting with the participants to make them at ease and to establish a favorable environment and rapport (Burns and Grove, 2009). The interview was conducted in the
English language. Moreover in accordance with qualitative interview technique and the indepth semi-structured approach, the structure of the interview rarely followed the interview guide, as the researcher tried to explore the participants’ own experience and concerns through a relaxed conversational manner. There were times when both the Romanians and Bulgarians participants had found some difficulties to express themselves, in view that the English language is not their mother language. This has also created an additional challenge and limitation in carrying out the interviews.

Once an appointment to carry out the interview was fixed, a decision had to be taken about the place where the interviews were to be conducted. Field and Morse (1995) advocate that participants should choose the setting themselves as if a venue is considered inappropriate or inaccessible potential participants will be reluctant to take part and the participants may feel that their privacy is threatened (Gerrish and Lacey, 2006). A quiet and a pleasant environment is necessary if the participants need to feel relaxed, able to concentrate and free to talk without any interruptions (Burns and Grove, 2009). Six of the interviews were carried out on the respective wards at which the expatriate nurses worked. This was the preferred site requested by these participants although the place of the interviews created some challenges, because very often we encountered many unexpected interruptions like for example the telephone or the patient buzzer ringing, and people entering the room to get something. Participants wanted to be interviewed during their break time of their working day. Four of the participants requested that the interview be carried out at a private house.
Prior to every interview that lasted between forty five minutes to an hour, a reminder about the purpose of the study was provided to ensure that the participant was well informed and understood. The consent form was then signed by both the participant and the researcher (Appendix 4), ensuring that confidentiality and that no names of staff were to be used anywhere. The nurses were to be identified by an agreed pseudonym to ensure anonymity during the reporting of both the findings and analysis of the results. All this was explained once again to the participants at this point. Consent was also important to make sure that the interview could be recorded (Burns and Grove, 2009). Although audio tape was the most common form of recording during data collection, field notes were also used (Gerrish and Lacey 2006). The field notes comprised recorded observations throughout the data collection by the researcher, such as non-verbal's demonstrated by the participants while answering their questions.

After the eight interview, the researcher noted that participants' experiences related to the phenomenon under study was quite similar and was not leading to any more new information, while the data emerging was becoming repetitive. It was evident that data saturation was being attained, that is the point at which no additional information was achieved (Polit and Beck, 2004). However, to ensure that no other relevant data was missed out, an additional two interviews as was initially planned were conducted.
3.7 Ethical Issues

Protection of participants’ rights is a fundamental aspect of any research study. This was addressed through the signing of informed consent, ensuring anonymity and confidentiality of the data (Ryan, Coughlan and Cronin, 2009). A consent form was given and explained to the participants once the nurses volunteered to take part in the study. (Appendix, 2). It is important that informed consent is verified before data collection starts, giving the participants ample time to reflect on whether they wish to participate or not (Ryan, et al., 2009). Moreover, the principle of informed consent demands that participation is voluntary and the participants are aware not only of the benefits of the research but also of the risks it entails (Holloway and Wheeler, 1996). Hence, participants were informed that participation is on voluntary basis and that they have the right to choose not to participate or terminate their participation at any point (Holloway and Wheeler, 1996). Permission to audiotape the interviews was also sought from the participants. Moreover, in order to ensure ethical soundness, authorisation for the recruitment of these expatriate nurses was sought from the respective authorities and ethical clearance sought from the University Research Ethics Committee (UREC) (Appendix 1)

3.7.1 Anonymity and Confidentiality

Phenomenological study is often personal and intimate and the maintenance of anonymity and confidentiality is therefore important (Field and Morse, 1995). On the
other hand it is not always possible and not easy to protect identities and ensure total anonymity, especially when data collection is done through face-to-face-interviews with a small sample that is typically required in a qualitative study (Holloway and Wheeler, 1996). In this study anonymity was guaranteed and participants were assured that their names and identity will not be revealed as a result of the collection, analysis and dissemination of results. (Gerrish and Lacey, 2006). Each of the participants was asked to choose their own pseudonym to be used throughout the study. This should have helped them to understand that confidentiality of participation was being seriously addressed (Gerrish and Lacey, 2006). It was also important to guarantee that all data including the tapes, notes and transcriptions will be maintained securely. The participants were reassured that these will be stored in locked, secure storage and in password protected computers (Ryan, al., 2009). Data was to be available to the researcher and academic supervisor only. Recordings of the interviews and field notes were destroyed on completion of the study.

3.8 Trustworthiness

'Trustworthiness of a study may be established if the reader is able to audit the events, influences and actions of the researcher' (Koch, 1993, p.91). Issues of reliability, validity and generalizability are not usually used in a phenomenological study as these lend themselves better as the central concepts in determining rigour in quantitative research (Emden and Sandelwoski, 1998; Tobin and Begley, 2004). Nevertheless, a variety of modifications of these concepts of reliability, validity, and generalizability have emerged
to fit other research paradigm. One such modification that was made in order to ensure trustworthiness is that of Lincoln and Guba (1989). Their work translated the concepts of validity, reliability and generalizability with the following four major criteria: credibility, conformability, transferability and dependability (Polit and Beck, 2004).

In an attempt to secure an adequate level of credibility, the researcher tried to employ reflexivity by keeping a reflective diary or a field journal to record the way in which one’s ‘horizon’ was working (Koch, 1994, p.93). Taking such notes of the researcher’s experience, observations and interactions encountered with these expatriate nurses throughout the process of the study are believed to have further enhanced the rigour of the study (Ryan, et al., 2009). Such reflexivity had also helped the researcher throughout the data collection, to step back to reflect on the meaning of the participants experience rather than accepting their interpretation at face value. Another exercise that was taken to enhance the credibility of the findings was to carry out member checks, which involved taking the transcripts back to the participants to ensure that interview transcript and notes taken during the interviews accurately reflected the data provided by the participants, thus minimising researcher bias and determining trustworthiness of the data collected. Sandelowski (1993) stated that member check can be problematic and complex. She points to the fact that participants and researchers have different agenda. Members are more interested in their own unique experiences and want to tell their own story while the researcher needs to place the data of one interviewer in the context of the rest of the research study. All attempts to keep a favourable professional rapport with the participants were done by the researcher, acknowledging the fact that participants may
become aware and anxious that they have disclosed ideas that might be judged as unacceptable by the researcher or a reader of a report. In addition the member check took place soon after data collection, and the initial stage of analysis, in order to avoid having the participants' experience change with time.

Transferability refers to the extent to which the findings in one context can be transferred to similar situations or participants. This was established by providing sufficient description, in the methodology section of this dissertation, about the settings, the participants and the whole research process, so that not only can the research be audited but judgement of its transferability to other settings can be made by the readers (Ball, 2009). Dependability may be achieved through providing an audit trial where other researchers or readers will be able to examine the researcher's documentation of data, methods, decisions and the end product of the study (Tobin and Begley, 2004). The research thus sought to provide as detailed an account of the whole research process as possible. Confirmability was achieved by demonstrating how interpretations had been arrived to and that such interpretations are clearly derived from the data (Tobin and Begley, 2004). Moreover, going back to the participants with the transcripts and the initial analysis of the respective collected data, sought to address conformability of the data collected and analysis.

Another important aspect that is believed to enhance the rigour of a study is having congruence between the philosophical underpinnings of a study and the method of the
study (Koch, 1996). The relevance of the method adopted in this research study to the philosophical underpinnings of the study, was explained in the initial part of this chapter.

3.9 Data Analysis

The purpose of data analysis in phenomenology is “to preserve the uniqueness of each lived experience of the phenomenon while permitting an understanding of the phenomenon itself” (Banonis, 1989 cited in Jasper, 1994, p312). As had already been stated in previous section, interpretative phenomenological analysis (IPA) was employed as a structure to analyze the phenomenological data (Smith and Osborn, 1996). IPA, a relatively recent qualitative approach (Ritchie, Weldon, Macpherson and Laithwaitel, 2010) is most commonly used in hermeneutic approach to studies (Finlay, 2009), especially in the fields of health, clinical and social psychology (Ritchie et al, 2010). Its theoretical origins in phenomenology lend itself well to such areas of study. Consistent with its phenomenological origins, IPA is concerned with exploring in detail the participants’ subjective experience of the topic under study (Balls, 2009) and understands the content and complexity of the meanings rather than measuring their frequency. IPA acknowledges that the analysis produced by the researcher is always an interpretation of the participant’s experience, therefore the researcher’s reflection on one’s own values, prejudices, assumptions and beliefs, which could have influenced the interpretation of the data, was of utmost importance. Lathlean (2006) suggests that analysis of qualitative
data needs to be rigorous and systematic, and how it is carried should be consistent with
the particular chosen approach.

There are two approaches to IPA, as described by Smith et al (1999), the ideographic
case study approach and the theory building approach. For this study the ideographic
case-study approach was used. This approach comprises a method that is suitable for
small samples of up to ten respondents and that will enable the researcher to make sense
of the data through his own interpretations, while using verbatim quotes to ground these
interpretations in the participants’ actual experience (Clarke, 2009). In this research
study, IPA was applied to the interview data that were recorded and transcribed verbatim
immediately after an interview was conducted. The first step of the analysis involved
listening carefully to the audio-recording and repeatedly reading each transcribed
interview several times to become familiar with the content (Quinn, Clare, Pearce and
van Dijkhuizen, 2008), thus facilitating entry into the participant’s world (Smith,
Flowers and Larkin, 2010). In addition field notes were written down to describe any
observation such as non-verbal communication, tone of voice of the participant and the
respondent’s ability to retrieve or articulate information for discussion. This stage of
analysis was time consuming, but it provided an opportunity to become familiar with the
transcripts, and helped to identify any abstract concepts that could help the researcher
derive the meaning in the participants’ account.

Following the described first step of analysis, each individual transcript was again read
several times in an attempt to identify any significant and striking issues within the
transcripts that were noted down (Fade, 2004). In order to facilitate this task each
transcript was organized onto a document with a wide margin down the left hand side
(Appendix 6). In this margin notes were documented after highlighting any text from the
transcript that seemed important, and for each highlighted part of the data, comments
were written in the margin. The comments largely noted why a specific highlighted
excerpt of the data was thought to be important and relevant, by the researcher. At this
stage, some of the transcripts were returned back to the interviewees accordingly, in order
to reinforce validity, and to check whether or not the interpretation of quotations was
done correctly. They were also asked to write down any comments or delete any part of
the interview that they deemed should not be used for the study. One participant
commented on some minor spelling mistakes that were done in his transcript, like for
example the name of his country was not written correctly. Any such minor alterations to
the transcript that were deemed necessary by this participant were made. Moreover, it
was at this stage that one of the participants had refused to participate further in my
study, without any explanation to why she was retrieving her consent to participate.
Otherwise none of the other participants had any remarks to do with regards to the
transcripts and primary analysis of their interviews.

Once the initial noting was completed, further analysis was conducted to the initial key
points, to identify emergent themes that reflected not only the participant’s original words
and thoughts, but also the researcher’s interpretation. The emergent themes were inserted
in bold italics, in the text itself next to the specific data it related to (Appendix 6). This
process of identifying emergent themes involves breaking up the narrative flow of the
interview, which according to Smith, Flowers and Larkin, (2010) represents one manifestation of the hermeneutic cycle. This means that while the analysis was in progress, the original whole of the interview became a set of parts but as stated by Smith, Flowers and Larkin (2010), these came together in another new whole, during the write up at the end of the analysis. However, no attempt has been made to omit or select any particular passages as an entire transcript is to be treated as data (Smith and Osborn, 1996). Moreover, in this part of the data analysis, frequent analysis of the original transcript was needed to ensure that the themes that were emerging were relevant and representative of what the participants were actually saying (Smith and Osborn, 1996).

After the entire transcript of each individual interview had been analyzed, and an initial list of preliminary themes had been established, the emergent themes were listed on a separate document and connections between them were sought (Appendix 6. Table, 4). At this stage, themes were ‘moved around’ so as to try to make sense of the connection between them, in an attempt to form clusters of related themes. However, not all the emergent themes were incorporated into this stage of analysis; some were discarded since it was thought that they did not fall within the aim and objectives of the study. In order, to facilitate the analysis at this stage, for each group of emergent themes a new document was established and each cluster of themes was given a new name (Appendix 6. Table 5) what can be called a ‘super-ordinate’ theme (Smith, Flowers and Larkin, 2009). All the relevant transcript excerpts related to the theme were noted down, accordingly to the referred document. This process also ensured that the themes did reflect the actual data collected from the participants. Once each individual interview had been analyzed in this
way, the process was conducted with all of the interviews. Special attention was paid during this stage so as to bracket the ideas emerging from the analysis of each interview, as to allow new themes to emerge with each case.

The next stage was to compare the summary lists of the super-ordinate themes and the sub-themes of all the interviews that were gradually clustered together in order to get a super-ordinate list of themes that would best fit for the whole data gathered across all the interviews. This stage of analysis was challenging since themes had to be re-organized in a way that best addressed the scope of the research study. In choosing, grouping and merging the themes, consideration was given to the occurrence of that theme within the data, to the richness of the particular excerpt passages which gave rise to the themes and to the congruence between the themes with others (Smith and Osborn, 1996). Finally a table was produced that shows each super-ordinate theme and the sub-themes that compose it (Table 2. p.58).

The next chapter presents the results of the data analysis, which involved the translation of the emerged themes into a narrative account that is constituted by excerpts of data collected.
CHAPTER 4

FINDINGS
4:1 Biographic Profile of the participants

Prior to each interview participants were requested to provide some biographic data. This was done, firstly to get to know the participants and secondly to make the participants at ease so to establish a favourable and comfortable rapport between the researcher and interviewee (Burns and Grove, 2009). One participant was from the Philippines, three were from Bulgaria and five were from Romania. Seven of the participants were married and two were divorced. Three of the married participants indicated that their spouses were still in their country of origin because it was not possible for them to find a job in Malta. Six of the participants were recruited through an agency after a call for application for employment in Malta, and had to undergo an interview in their country before seeking registration with the Maltese Nursing and Midwifery Council. One of the participants decided to come and work in Malta after she was invited by some of her friends who were already working in Malta, while the other two nurses came on their own initiative, with one of them stating that her daughter was studying at the local university. Data reveals that all participants were highly experienced nurses having 15 to 35 years of nursing experience within different area of practice both in their country of origin, and in other countries, mainly in the Mediterranean region.
4:2 Introduction and Background data

Having analysed the whole data emerged from the interviews and trying to make sense of what the participants have said, this section will provide an interpretative account of what nine of the participants said during the interviews, a large proportion of this chapter is constituted by transcript excerpts. As had already been stated in a previous section, only nine interviews were analysed as one of the participants did not want her interview transcript to be analysed further. Her decision to withdraw from the study was respected by the researcher and all of the data from her interview including the audio-taped recording were destroyed. The analysis of the participants' interview generated four super-ordinate themes. The first relates to the reasons for migration, the second refers to the barriers to work place adjustment, the third deals with factors that had influenced their adaptation and the final theme relates to the post arrival support network. Table 2 overleaf, shows each superordinate theme and the sub-themes that compose it. The data pertaining to each of the subthemes is presented in this chapter. Pseudonyms have been used to protect the identity of the nurses taking part in this study.
### Table 2: Table of themes.

<table>
<thead>
<tr>
<th>Super-ordinate themes</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reasons for migrating and associated challenges</td>
<td>In search for better salaries</td>
</tr>
<tr>
<td></td>
<td>Poor working conditions</td>
</tr>
<tr>
<td></td>
<td>The social perspective</td>
</tr>
<tr>
<td></td>
<td>Disappointments</td>
</tr>
<tr>
<td>2. Barriers to work place adjustment</td>
<td>Language variances</td>
</tr>
<tr>
<td></td>
<td>Differences in practise and roles</td>
</tr>
<tr>
<td></td>
<td>in care delivery</td>
</tr>
<tr>
<td>3. Strategies towards adjusting to the new environment</td>
<td>Favourable physical environment</td>
</tr>
<tr>
<td></td>
<td>Familiarisation with the Maltese language</td>
</tr>
<tr>
<td></td>
<td>Favourable reception and treatment by colleagues</td>
</tr>
<tr>
<td></td>
<td>Previous work experience in other countries</td>
</tr>
<tr>
<td></td>
<td>Nursing in Malta being less stressful</td>
</tr>
<tr>
<td>4. Nurses’ experience of organisational support</td>
<td>I had to do it by myself</td>
</tr>
<tr>
<td></td>
<td>Induction programm</td>
</tr>
</tbody>
</table>


4:3. Theme 1: Reasons for migration

This superordinate theme related to the reason why participants had applied for employment in Malta and the challenges they encountered when leaving their country of origin.

4:3:1. In search for better salaries

There was a general sense within the data that financial reason was a central motivating factor that pushed the participants out of their country, the sub-theme, in search for a better salary to provide the basic needs for them and their dependants, being the most major issue. The words of one participant, a 38 year old divorced mother of a nine year old reflected the words of other participants. The interviewee said:

".....Because of the social political conditions in my country I decided to go, because if I was alone it wasn't so bad but I have a daughter and so I can't do anything for her future, anything.... so my salary was only for gas, electricity..... and the basic needs." Ella, p.1

The hardship that participants had to go through in their own country before they migrated and left their family behind was significantly felt during the interviews and was described by all the participants. In fact Ella emotionally, added to the reason why she had left her country, describing how back in her country, she could not afford to take her daughter for a holiday near the sea. Ella described her anger towards the system when she stated:
"........but I cannot forget one thing that.... to show to my little girl the sea I had to take a loan from the bank, you can’t imagine to take a loan from the bank to go and see the sea in your country... Interviewer: Why... because it is far away? No because I couldn’t afford it is not far away 200km three hours to stay one week near the sea I cannot forget it or forgive it, I cannot after twenty years of work nothing .... 

Ella- p.7

Furthermore, data had also revealed that it was highly important for some of the participants to have a good income that would enable them to provide their children with a better standard of education and living. One interviewee noted:

"........no you cannot understand this because you’ve never been in another..... system of government, I mean the communist regime before it’s completely different...., you cannot understand.......... there were many obstructions, so we look like slaves .... let say..... when you graduate you are not going to choose, to choose and to search for your job they tell you, you are going in that hospital..... in that ward to work...... because all we need............My daughter with her agency..... she just started three years ago and you know you have to help her with some capital, some money to start business, it’s too difficult now in this crisis.......... 

Nikolai- p.5

Another interviewee said:

I need money because in Bulgaria salary was very low and in Libya was a bit better, and after that my daughter started to study and needed money 

Rosalie – p.2
4:3:2: Poor working conditions

The above excerpts of both Nikolai and Rosalie also reflect the participants’ experience of the poor working conditions that they had to struggle with back home; unfavourable working conditions seems to have been a strong motivation for the participants to leave their country in search for better conditions. In the above excerpt Nikolai emotionally recalls her experience of how back in her country as nurses were treated like slaves.

4:3:3: The social perspective

This subtheme relates to other social factors that had driven some of the participants out of their country. One of the factors was to seek a better employment opportunities for their spouse.

‘The main reason was my wife because we were trying to get some job in Kuwait actually we couldn’t find. (Interviewer: your wife is a nurse as well?) my wife is working in a different area in a bank. She was working in Rumania as well as an officer. We tried to get a job in Kuwait but the problem was the language they are asking everywhere Arabic language .... ...the people coming to the bank and other places where we tried and they do not know all of them English and how you would deal with them?.’

Dragula - p.1

“.............. mostly I came because of my husband, because my husband is a Nepalese not Indian, Nepalese, from Nepal. I met him in Iraq because I worked in Iraq .............. that is the reason I choose Malta because he speaks English....and I said lets go to Malta because England was a little bit difficult for him....”

Nina - p.12
Other participants were inspired by other factors such as the warm climate and the perceived beauty of the country. This was expressed by Rosalie, a fifty seven year old married female participant who apart of the social environment that influenced her decision to migrate, she was also influenced by other colleagues and friends who were already living and working in Malta.

My friends invited me here for vacation and I saw nice place.... and we lived together in Libya... I worked there, we were together and after that they invited me for Easter...here, and I came.... and I saw a beautiful place (very amazed-tone of voice changed)... I like the sea and hot weather, I don't like cold I like the winter time.....but in winter time is not good in Bulgaria, and I prefer hot weather, I survived 40 degrees than minus twenty. I prefer hot. – Rosalie - p.1

Family members appear to be influential in the decision to migrate to other countries. This was expressed by the Filipino nurse who spoke about how her cousin who at that time was living in Malta and had a sick husband, had encouraged her to come and help her, during which time she was also encouraged to pursue her nursing studies.

...actually I had my cousin here, not working, living, with her husband, and, she told me... she told me why don't you give me your.....papers ...maybe I can apply for you in Malta since.... because she was alone and she had a sick husband, she wanted me to come, to help her out. At the same time she wanted me...she wanted me....., that she was going to help me to continue nursing abroad. Felipe - p.1
4:3:4 Disappointments

The decision to migrate was clearly taken for specific reasons by the participants. The data reveals that the resultant experience of migration at times translated into a sense of disappointment in that the needs, hopes and expectations underpinning the reason for migration were not met, after the migratory process. Some of the participants expressed their disappointment when they found that it was not easy to find a job for their spouse in Malta despite the fact that they were both all European citizens. This concern was clearly expressed by Dragula in the following quote:

...... ...eh it's like everywhere even since one year I couldn't get a job for her (referring to his wife). I couldn't.....we went to ETC (Employment and Training Corporation) to register and they didn't agree to register her. Can you imagine that, and we are in Europe, you know how it is, the black people which are coming, the refugees, they will get a job as soon as they arrive here and my wife with an economic degree from university and marketing she can't get a job eh speaking English, and Italian and French and she can't get ..........It's really a pity, anyhow...... Dragula- p.1

Moreover, an important element that was articulated strongly amongst some of the participants was the fact that their working conditions had not turned up to be what they had been promised during the interviews. Promises, like for example, that they were going to be treated equally and fairly like any other Maltese nurses, were often perceived as deficient and misleading especially with regards to employment conditions and
salaries. This is strongly demonstrated by the following quote from taken from Nikolai’s and Martha’s interview transcript:

\[
\text{Not really (laughing) because they told us that we were having 1,700. You can have......I said it was very good....But somebody told me that only with the premium you can have but not every month... Marthe - p.8}
\]

\[
\text{In the employment letter it is written you are going to be treated like the Maltese With every obligation......Nikolai - p.13}
\]

Moreover, this frustration of some of the participants towards the low salary they got in Malta can be also related to the fact that the vast experience that they had prior to their migration was not recognised, and they were employed at the lowest nurse employment grade as new graduates would be employed. This meant that the salary that they earned did not reflect their nursing experience. Most of the participants had voiced their anger to the fact that although on application they requested nurses with experience however, such experience was not recognised and acknowledged by the authorities especially with regards to their salaries and promotion. The feelings that these nurses expressed about such lack of recognition of qualification and experience are summed up in the following extracts taken from Marcus and Nikolai’s interviews.
One thing that I didn't like. On one hand they said we want experienced nurses and when we came in here the scale was a minimum one so what for you are asking for experience.............. So what do you give me for that experience...... nothing.... That is not nice.... I have now fifteen years I can be scale... I don't know. scale ten but no I'm the one like the one who have just finished two years ago This is another thing that it is not fair..... I am not like the one who had just finished. It's not only me. All of us.... has the same thing so.... Yes, I feel the same... that you don't recognize my experience that you had asked for ..... but you didn't do nothing.

Marcus - p.6/7

..... here they treat me like a person with no experience ... like just graduated with low basic, if they count my thirty years experience, you can imagine what scale I will have, here... I am 12, and it's not fair'-...... feel I'm not content with that, because with my experience...... actually they don't count my experience.... but they use it as well ..... and I am working half and not less than the other I can say more, because I never eh..... eh... refuse to do whatever there is therefore.... Em... I can do anything they require from me, because my education...... gave me this ...... I can say I can manage with anything, any situation in front of me, so it's not fair to compare me with one nurse who just graduated- Nikolai - p.3

This sense of disappointment was also felt when Darinka recounted her anger towards the fact that because of the low salary she had to work overtime so that she could cope with the perceived high cost of living in Malta, which according to her is one of the most expensive countries in Europe. This disappointment was also related to the fact that a well knowledgeable and experienced nurse is paid less than any other healthcare professional with fewer qualifications.
In fact both Marcus and Darinka had further expressed their view that a higher salary would motivate them to stay longer in Malta. Moreover Darinka, who lives in Malta with her family, claimed that her intention is to migrate to England where she knows that her experience is recognized and she will therefore receive a higher pay accordingly.
"For one motivates the person to work money especially because I had to leave home"

   Marcus - p.7

"Yes I think so because it makes a difference when you get a salary of 1, 600 Euros... I think I am doing my registration now... and if I find good places to work I would go there because there I would not start from scratch and here it will take me maybe till I got retired to get the highest scale. (Interviewer: If you get a higher pay you would stay here then?) Yes because here the whether is nice, I got used to the people, I have friends but

   Darinka - p.6

With one participant, feelings of disappointment were mostly related to the difficulties she had encountered with the issuing of an entry visa to Malta for her husband. This is clearly depicted in the following quote were Nina strongly expressed her frustrations when she had to struggle with ‘her emotions’ in being apart from her husband, because of the problems they encountered with securing authorisation for her husband to join her in Malta.
“.........I was frustrated....I couldn't afford myself to bring for half a year my husband, imagine how frustrated I was. It is not about documents, all documents were ok but they didn't want to give him the visa ... despite the fact that the documents were OK. Since I am European citizen and since I work here legally with a work permit, what is the reason you don't give him the visa to come here to stay with me, who are you to decide my life whether to stay with my husband or not...pause..... so next time they make him life hard I will leave and I will make sure that everybody knows why I leave ..... so what exactly do they want? so what do you want, you want me to divorce? I was very upset and nobody wanted to listen to me.... You want only me as a nurse but what about my family? ............ we want only nurses and that's all we want to replace.... Number, exactly what about my emotional...how to say...”

Nina - p.4/10

The above quote also demonstrates the anger this participant had towards the related authorities. The fact that family relationships that Nina really values, were not respected, and that she was not treated holistically, was clearly disturbing. She felt that she was being used as a number to fill up the vacancies.
4:4: Theme 2. Barriers to workplace

This superordinate theme addressing barriers to workplace, relates to the initial obstacles that these expatriate nurse had encountered when moving to a new country especially in a different health care service system. The analysis of the data revealed two sub themes; (i) those related to the language differences and (ii) those related to differences in nursing practices and roles.

4:4:1 Language variances

Most of the participants strongly commented that they were shocked and unprepared for the extensive use of Maltese language within the local health care setting. There was a general feeling within the data that these participants were not adequately informed about the extent with which the Maltese language is actually used within the health care setting. The actual use of the Maltese language was underestimated in the perceptions they held before migrating to Malta. This is clearly depicted in the following quotes of Martha and Marcus. Their comments clearly portray their frustration and confused emotions as regards the way they felt that they were misled during the interview, in that they were not prepared for the different languages which were spoken in Malta, because they thought that everyone would speak English. They said that they felt upset and deceived because they were not given the right information during the interview.
"...but I expected that everyone knew English, because when they told me on the interview oh...that everybody speaks English you will not have any problems .... no I don't have problem but you hear all the time you know.....Maltese language and ....somehow I get annoyed"  *Martha - p.2*

"...even for me was a bit of was surprised...when I came here. At the interview they were talking English they didn't tell me nothing..... a single word that in here you have another language like Maltese.... but they didn't tell me listen you are open to work in a place for example that except English you will hear another language ..... they didn't say anything to me. When I was at the airport I said 'with what they are talking here' cause I didn't know that you have Maltese..."  *Marcus - p.3*

Some participants had initially also found it difficult to cope with the language barrier especially when delivering nursing care to elderly patients who do not know how to speak English. This was strongly further stated by Marcus who had expressed his feelings of frustration because of his difficulties when he had to communicate with patients especially elderly patients who did not speak English.
“Even the patient has the right to speak to someone who can understand him and cannot force the patient listen you have to speak to me in English. I don’t speak Maltese I only speak English, so... if the patient is talking in English it is OK....Yes sometimes yes we do have old people and are complaining of something and I cannot do anything. I have to call someone come and help me because I don’t know what he is saying”. Marcus - p.5

Ella had also expressed her embarrassment when she realised that the patients are not able to speak in English. Moreover, although during interviews none of the participants had specified that they had any problem with their English language, both Ella and Dragula expressed their concerns to the fact that on employment their competency in using the English language had not been assessed, and that the authorities had employed everyone, (referring to other expatriate nursing colleagues) who were not fluent in English, which in their opinion was not appropriate.
embarrassed I didn’t know that here people are speaking Maltese, they told us English...I think... but when I came and I saw that in fact nobody speaking English as a normal language.....I was going back and I was upset, and I was upset, I said they were lying to us...why...because...its better you know what you would find.....I would come anyway. I would come...because this was the situation, but was better to know what you will face....my opinion and my opinion they did a mistake, because they needed so much I mean they took even people who couldn’t speak English.........Ella - p.5

No actually...I don’t know....no I think there is a big problem because, eh... actually when they did the interview in Romania they had done with...lets say...they filling....for some of them and they said Ok lets arrange for them to come they will start learning. after that......no the problem is that like they did like with Pakistan...I know the story....the same they brought them here and they found they do not know English. That’s not the way. Dragula - p.2

For Darinka, this disparity in language, apart from being a stressful experience as very often she was unable to engage in dialogue with her colleagues especially during the patients’ handover, made her also feel disabled. She described herself as “deaf” in some specific circumstances.
"...In the beginning I was very, very, stressed, I was very stressed... For me for the first maybe three months they were very difficult because...... in spite of the fact that I had long years in......, but you know there was ....different language .......... I was told that in hospital the official language is the English language, that's why I didn’t realise that ... I knew that the language is different because I had already been in Malta before I came to work here but I thought in hospital at least the language is English ....even in the morning during the report very often lets say ..... we have these over sheets in which is written in English of course, but the discussion about the patient is in Maltese. ......And yes you have to understand that most of the time I'm feeling like deaf ...like I’m deaf, even to socialise it is difficult...." Darinka - p.2

4:4:2. Differences in practices and roles in care delivery.

The data revealed that when participants got to Malta they experienced work practices which varied from their experience of care delivery in their home country. The participants expressed mixed feelings about such differences in practice that varied from shock to frustrations, especially when they realised that they were expected to contribute to aspects of patient care delivery which in their country did not fall within the remit and role of the nurses, as is the bathing of patients, which in most countries falls within the remit of an auxiliary nurse, not a qualified nurse.
'...... Yes.... Because the first thing I went it was in (mentioned two different surgical wards) and ah!!!!!! To wash the patient!!!... And ah ......what we have to wash the patient? Yes we have to change the nappies, Yes ...... because its more of nursing in Philippines, em....we have these auxiliaries, they do wash the patient, and us we do the charts, the medicines, the dressings, more of nursing, nursing ......tifhem'.

Felipe - p.6

We have some... how to say some criteria about work ...eh when we are in Rumania we don’t wash patients, maybe the others were telling you about.... because we didn’t do that job in Romania, washing of the patient are done by nursing aides, even in Philippine, in Kuwait , even in other places they are not doing it , so nurses are just doing just the nursing job....second in Romania and also in Kuwait where I was working, you’ll do.... from the beginning when the patient is entering the ward you are responsible for that patient so you are doing an admission in the system , you take care of venflow, blood collection, treatment, everything. So if you do those things I don’t think that you have time to wash the patient’

Dragula - p.5

The participants associated the bathing of patients with wasteful practices and inappropriate use of nurses’ time and skills. In noting, that qualified nurses should engage in other useful nursing practises, one participant said:
"Oh that is our responsibility... for example having 24 patients, 20 patients must be taking their blood in the morning... we take them (Interviewer: do you wash the patients?) No, no that is our advantage in the morning as soon as we take over we start preparing to take the blood, we start parameters, we start preparing the treatment, we start things like that... In the beginning I found it that we waste our time and our skills washings, especially with old people with geriatric people who are here just for care all right... it is a pity " Nina - p6

Another participant acknowledged the detrimental affect such inappropriate activities adopted by the nurses, has on the quality of patient care delivery provided by the qualified nurses.

".........but we have a lot nursing assistance and they participate... let say in the morning ... eh... during the toilet they participate a lot... but it wasn't such a priority the washing of the patient like it is here because very often here I don't have time to read the file of the patient to......because the first thing here is to wash the patient and meanwhile until I am washing the patient the consultant is coming..... and they want to finish with the ward round as quick as possible they are coming during these washings and they start asking questions and if you don't have time to read the file or briefly the history of the patient you start uh... uh I don't know... I don't know and it is quite embarrassing........ In my country this washing and changing the nappies the nursing aides they are doing". Darinka - p.3

However, although at the beginning there was a feeling that the participants were uncomfortable with this practice, it resulted that they all had to accept such practice as it
was the norm and they were expected to fit. The fact that they were experiencing lighter workload, less stress, less responsibility and better staffing levels in Malta, than they used to have in their country, seemed to have helped participants accept the new reality that they were living in. This is reflected in the following quote by Nicolai who used the metaphor ‘I am singing’ to compare her work experience in Malta with that in her country where she said that in her country she had ‘no time to breath’. She says,

"...Don't see any difficulties to work here, For me I told you I am singing when I work (laughing) because we say if it is easy to work, because in my country our system, it was like that we have too much responsibilities you have no time...to breath. and for example I am alone, alone nurse for example 30/40 patients I am alone on night duty me and a carer and the doctor and I am everything there, as a nurse as a doctor as a carer, if I mean but I am alone not like here not like here 2 persons in a roaster to help each other, and sometimes they are coming 2 for example, 2 urgent patients for operation are we have to take decision, the doctor will come and tell me first this one and do your job. One by one I will go and prepare both of them and the other one what about other if at the same time somebody will complain of pain and discomfort able I will go there and tell the patient when I finish I will come to you, And dressing we are doing by ourselves. ......". Nicolai - p.9

"it is not a joke....., On my night shift with thirty patients it’s me and my carer, this is my night shift I told my mother I am becoming afraid to go night at work because I cannot call I am afraid to call them,(you worked under stress) very stress, that's why it was difficult to relax when I came her.... it was like another world. I never was with so many people around and to have even doctors to call if you want, if you need, no it was awful ... (So how do you feel here?) and here I feel very well"

Ella - p.4
One aspect of care delivery that all the participants had claimed that they were not allowed to do in Malta, and which fell in the remit of standard nursing practice in their home country, is related to cannulation and phlebotomy.

"......, here I can say it is a bit constricted eh.....as a nurse, because in my country as a nurse you have to do the venflows, and...... then you have to give the treatment, because it is safe for us to do the treatment, for example, because ...you know why....because all the IV treatment we used to do, not we used we still do.....eh the skin testing, , whatever IV treatment is given' Felipe, p.6

" ......some of the doctor's job is ours in Romania like we are taking bloods, we are inserting venflows.... it is our job, the doctor will not get dirty with stuff like this, because we have short of staff of doctors... we are doing...the writing the files, but everybody was doing this, like the examination of the patient, because the doctor is one... only... they don't have like MO or senior". Ella - p.3

This difference in nursing practice with regards to cannulation resulted in a degree of frustration to the participants because of the fact that they could not carry out a procedure that they were competent at, in the best interest of the patient. The health care system in Malta does not lend itself to the practice of such skills by nurses working on the wards in the hospital. Although the general response to this practice was mostly negative, some
participants expressed a more positive note regarding this. This can be seen in the following quotes where the nurses explained that as a result of their unique competence in certain specific skills such as venepuncture, they were able to help the newly qualified doctor learn, who very often has limited training in phlebotomy, and thus they felt that they were in turn beneficial to the patients. This was also felt throughout the interview when participants demonstrated a source of pride because they felt that they were perceived by the medical profession as being helpful and efficient.

'No I'm feeling pity for the patients ....Sometimes I'm putting the venflow, I am taking blood because they come (referring to the doctors) and will ask my help, because they know I am good in that....you can ask the doctors who I am and how I am doing.......... (because they can trust you) Actually let's put in another way....eh... you are a patient and you are coming in the hospital, and the doctor is trying 5 times to get a blood from you, or 10 times and to put a venflow... how you feel? I don't think ....you know first of all its unfair, second you make a pain for that patient, it's not just a little pain because some of them, they will try....you know, the problem is they have no training done for these things an nobody teach them how to do it, (even nurses are not trained to do it, in their curriculum they are not trained) No, I mean for the doctors you know (even nurses) yes but the nurses in their what do you call it , in their nursing profession, it is not written nothing about..... taking the blood and putting the venflow, it's not their role.' Dragula - p.9

.........go and see the doctors how many times they prick the patient but the patient does not say anything because it is the doctor,( tone of voice tails off)........ I never miss the vein from the first time but sometimes it happens (but you give IV treatment) ...........yes the IV treatment is ours, even the drips the IV antibiotic but the venflow to be inserted and the blood taken is their responsibility (doctors). But sometimes they know, you know how the doctors they turn every month they rotate different places they know that we I mean foreigners the Bulgarian and Rumanian, much experienced and they ask us for help, they are talking between them, they say that in that ward there is one nurse she can help you with any venflow. Nikolai - p10
Martha and Marcus both expressed their satisfaction regarding the fact that during the night and in an emergency, they would insert a cannula themselves, while through their competence they would also teach the new and junior house officers. The appropriateness of such practice is debatable.

In the night time like I feel I am doing my job you know because I'm alone......to be honest I am very used to do cannula, and everything I do it alone (laughing)..... I don't call house officer but not all of them if I am busy. when I have something to do, I call them. But usually when I am not busy I prefer it to do it alone. Sometimes I intended to learn to tease them, to tell them to do like that...... to teach them, to teach the doctors...I don't know........maybe not all of them maybe they like.......em.....if I saw them Martha - p.6

When for example every six months the doctors are changing and sometimes I help those new (with cannulation), ......but for example if during the night we will need a venjlow for example for patient...in emergency, I will do it ......back home I never had any complains but in two years I forgot (laughing) I will do it ,but if it is the system in here what can I do. Marcus - P.4
4:5. Theme 3: Strategies towards adjusting to the new environment

As discussed above nurses had faced significant challenges on migration to Malta. This superordinate theme relates to the participants' strategies to overcome these challenges, in seeking to adjust to the new environment. The analysis of the data revealed five sub-themes that are all related to the factors that had facilitated the expatriate nurses' adjustment to their new context. These include (i) a favourable physical environment, (ii) familiarisation with the Maltese language, (iii) favourable reception and treatment by colleagues, (iv) previous work experience in other countries, and (v) nursing in Malta being less stressful.

4:5:1: A favourable physical environment

Despite the initial challenges that participants had found related to the low salary, language used, lack of recognition of experience and the differences in the nursing system, most of the participants noted an overall positive initial experience and described which factors were instrumental in helping them to adapt to their new environment. This can be reflected in the following excerpt when Nikolai spoke about how she had accepted the difference in nursing practice and what had influenced her acceptance.
The nurses' coping strategies with the situation were noted to be influenced by a number of factors. For some nurses in the study, initial adaptation was sustained because of the warm Maltese climate, a similar culture to what they are used to live with, and a new modern hospital fully equipped with modern equipment which facilitates nursing care delivery. These are reflected in the following quotes.
I felt for two weeks, a little bit I was like in a cloud until I got used to it... my salary was much lower than I expected... but... for me... it is a new hospital, that why I like, it is a nice environment I can't complain about it... I like the country where the weather is very nice... - Martha - p.4

...You know long period I was in Libya the people there are different, different culture and here I found them very friendly people ... good people where they accept us, ... The people are culturally (difficult to articulate word)good because you know in Libya it is completely different ... Rosalie - p.2

Same habits same food not the same but close to each other and so I didn’t find any difference... Nikolai - p.6

'The thing to adapt to the culture is not difficult because we are same, the same culture...' Dragula - p.7

'.....I immediately adapted to your culture, because we are both Roman Catholics.....so it goes through behaviour, beliefs, how you deal with people....I think....it helped. ‘Exactly, it is like this, the same like Philippines, I mean... what we do here is really important, the religion like..... you since I am a catholic’- Felipe - p.2

4:5:2. Familiarisation with the Maltese language

As described earlier, most of the participants shared their shocking experience, which resulted from the fact that they were unable to understand the spoken Maltese language around them. Some had also expressed their embarrassment and frustration because of this barrier when nursing their patients. This seemed to result from the fact this language
barrier had very often obstructed their communication with the patient and with their work mates. However, to overcome this obstacle most of the participants seemed to have consciously attempted to learn some words and expressions in Maltese, with the aim of reducing the language barrier especially when delivering nursing care to the elderly patients.

"...I'm trying to do my best and I catch quite a lot of words and expressions in Maltese nowadays but I don't agree when I ask them for example 'can you tell me what are you talking about' they always tell me 'mela you should learn Maltese by now' but I told them I didn't come to study Maltese......We have sometimes patients but some of them I manage to communicate with them first because I have... I told you few expressions in Maltese that are common like 'hu nifs bil mod, hu nifs fil fond, ikkalma fiit, zomm dritt, ohrog ilsinek or something like that I can take some information if the patient needs more conversation I call my colleagues..... I help them otherwise with their patients. Darinka - p.3"
...I tried and still trying... I speak in Maltese with the patients, but because the first thing I told to myself... my God before I used to work night and sometimes when your partner will go to rest you'll be alone and then there are Maltese. During the day I have to learn at least the basic things, if they are in pain, because this is surgical, if there are in pain... where, what, what is this... what is this... you know or 'pipi' or No 2.... I have to know these simple things, the basic things... and then they were teaching me my colleagues.' Felipe - p.5

Some participants admitted that they were willing to pursue a course in the Maltese language if offered the opportunity to do so. There seemed to be a feeling that learning the Maltese language would help these nurses feel more at ease when caring for the Maltese patients.
I should say to go first of all to a Maltese course. I want to speak at least the basic not for them (the staff) because they understand English but for the patients, a lot of patients they don't understand, and they are embarrassed, Ella - p.5

.... more than 20 years I was practicing English, I cannot say that my English is perfect, no, no, but, what I know I know ..... Eh...my English is not so good but even I cannot find the ...the proper word I can explain to be understand... So this is..... question of experience too. And now I start a course of Maltese. Nikolai - p.3

I know some words if patient is hurting... but still when the patient does not speak Maltese language because I can't communicate with the .....this is one thing I was trying last year to search for Maltese.......some nursing officers from other ward were complaining that some nurses don't speak English good so they have to teach them English and I was saying why don’t they teach us some basic words that we should know in Maltese, why they teach them in English why they don’t teach us listen this means I don’t feel good I want water .....these kind of words for example during the night when we are short be cause the other is on break I need to know......the basic. Marcus - p.5

Moreover, to reduce and to cope with this communication barrier a number of participants tried to adopt certain actions such as asking the help of their colleagues in an attempt to ease nursing care delivery to the patients.
"If I don't understand something I ask because it is the first better asks and you stop than making mistakes. I came here and nobody invited me and for this I have to adapt here with Maltese nursing, to Maltese people because I came, I wanted to come nobody invited me I am not speaking Maltese but I understood what they want somebody will speak English or I call my colleague what they want or need..." - Rosalie - p.4

".....lets say... of there are patients who don't know English there are always somebody who can translate either a nurse or other patients" Nina - p. 8.

Maltese language because I can't communicate with the patients although after two years I know some words if patient is hurting... but still when the patient does not speak English I better call someone to be sure Marcus - p. 5

For one nurse, Dragula, communication with exclusively Maltese speaking patients, was the least challenging. His knowledge of other languages appears to have provided him with the tools he needed to communicate with these patients.
"...I got used with the system very soon because I know the language having 8 years of Arabic and it wasn't difficulty for me to understand Maltese. I know Italian as well so you have either Italian or also there are what do you call, some French ...not so many but there are few, and I get used to the system.....I had no problem even in Maltese I have no problem I can understand what they want, what they mean, it's not a big deal. I know few sentences which they are correct, spelling in Maltese......" Dragula - p.7.

4:5:3. Favourable reception and treatment by colleagues.

For most of the participants, it appears that the ability to adapt to the Maltese system was sustained through the support from their Maltese colleagues on the wards. This is reflected and summed up in the following quotes.

"........ 'Yes they helped me a lot'" – Marcus - p.4

'........but they are very amazing........ the staff here, I was lucky, I was lucky ....I told to everybody ....that I was lucky to come here‘- Ella - p.1

Similarly, Nina and Nikolai had confessed that in adopting a positive and a natural approach towards their colleagues and work was instrumental to integrate into the new environment.
Even the colleagues in the ward they accept me very, very, kind, very easy I am such a person to make contact easy.... and they accept me very well, and they treat me as a part of them... they trust me ....Even..., they are always ask me about my experience.... how I am doing it, how to help them, to show them. Nikolai.- P.7

Yes...It is very important to have a support...... not necessary support but a nice environment, to joke..... to say a joke...you have to work on these because things are how you settle them to be........ you can’t request to give you warmth and you say you give me first warmth and then I give you wood, no first you give wood then you will wait a little bit and then you will feel the result. So you share with them what you have to share and then you will get the result it depends on your approach...genuinely, you show to everybody how you are It is impossible that people wont appreciate sooner or later that you are a good person, that you do your..., you do, you see your business, it is impossible....Nina - p.11.

For Ella and Felipe the nursing officer of the ward where they worked played a significant role in supporting this positive collegial relationship which in turn had facilitated their adaptation the new environment.

"......... they are extremely nice.... I was really, really, really lucky, but they are really nice, even on a personal plan......for example if I call them that I need something, for example I moved, the man with the big car could not make it......... so I called a colleague of mine and she said I have to go night but told me we can do it in 20 minutes. They are really nice from the Nursing Officer in my opinion the Nursing officer is doing this......Me I’m from the happy part of the foreigners because there are even....... the other way” Ella - p.7
Moreover, the comments made by Felipe, also reflected the important role of the nursing officer in making expatriate nurses feel that they belong and are accepted in a ward.

"Eh....regarding my colleagues, no, because, because.....this ward we have a lot of foreigners, even before when I started, two of us are Philippines, now we have Albanian, we have one Nigerian, and ....now it's mixed as well, so it's like its open, its equal... we're treated equally, even from the in charge they know like ....you feel .........not like an intruder" Felipe - p.5

4:5:4. Previous work experience in other countries

There was a general sense within the data that the vast working experience that the nurses had in other countries might have also facilitated a positive experience and to the adaptation to the Maltese system. This is portrayed in the following quotes:
"For me it's very easy because I've been living in many other countries even in Arabic countries ... I worked in Iraq so me it's good every where because I know how to behave..... I socialise people I ...em.....my great of empathy is very high so I understand people so...)In my point of view it went...any problem even with the medication because before I use to work in Iraq with the American, with the medical terms the Americans they use the same terms like TDS, BD so...."

Nina p -2

"Not very difficult... consider the fact that I was working in England, so I was having a bit of experience how to get ...independent in a foreign country....." Marcus - p.3

For Nikolai, having worked in other Mediterranean countries before, had encouraged her to come and work in Malta because she was familiar with and worked in such climate of a Mediterranean nature.

"I got two offers in England but I rejected because I don't like the...the ... climate there and I used to be in a Mediterranean countries so I know the character, the people and I feel more close to them I decided to come and when I saw the advert for the interview for Malta I applied. I've been in many countries, a lot of experience it's obvious so that I will manage here" Nikolai - p.5

4:5:5.Nursing in Malta being less stressful

When speaking about their experience of adaptation, participants repeatedly commented on the fact that nursing care in Malta is easier and less stressful compared to their country of origin. This is strongly recalled by Ella who spoke about how comfortable and sate
she feels in Malta, compared to her country where she had reached an extremely high level of stress in view of the poor conditions that she was working in.

"......But for example imagine that it will be which consultant on call not an MO. So you can bother him I have result or something.... you have to learn to do it by yourself what is to be done I mean I cannot call a consultant because somebody needs glycerine supps, somebody to see the results.... he will start to get confused ....and it happen not only this because he need glycerine, or panadols not a big deal, but they will start shouting with you , you do not know what to deal with hypertension,...... it is not a joke...., I told my mother I am becoming afraid to go night at work because I cannot call I am afraid to call them,(you work under stress) very stress, that's why it was difficult to relax when I came her.... it was like another world, I don’t know how to explain......it's awful there........ They are days.... when I feel like fainting. Ella - p.5"

Martha also spoke positively about her experience in Malta mainly because in comparison she held very negative experiences of working as a nurse in her country of origin.

"For me it is easier here to be honest..... You need to go with the doctor, here it is easier, because doctor will go alone... I was surprised, ehe will tell you what to do...... Here ...this is different also, not the house officer is doing bloods and venflow, the house officers in my country they are doing nothing(laughing) they just come with the seniors on a visit watching what is happening.... I will do what the doctor says, we do everything for the doctor they don’t go in to the room if the nurses are not with him I don’t like the attitude....it was one of the reason I left the country ...they treat you like a slave not like a colleague. Nurses are doing everything in Romania and believe me I will be working with 24 patients alone......

Yes you are alone with twenty four patients. Martha - p.6"
4:6. Theme 4. Nurses’ experience of organisational support

This theme relates to experience of organisational support offered to the participants on arrival, that is the formal support provided by management authorities to expatriate nurses who engage in employment within the public services in Malta.

4.6.1. I had to do it by myself

The participants within this study expressed conflicting views with regards to the support that they had initially received when they arrived in Malta. There was a general sense of feeling amongst the participants that they had minimal formal support to help them initially to adjust to the new system. Some expressed their negative views characterised by expressions of loneliness.

"Two three weeks I was quite......but I was quite depressed, maybe I changed everything and was by myself ......I was all by myself but in two months I was ok" - Martha - p.5

"There is something to be done because for example nobody explain us exactly what is going on with our salaries, with our.... even for over time but nobody is coming to explain us ......em.....to tell us ....you have those rights or you can do that eh....to improve your condition......or you we have to search it by ourselves". Nikolai - p.13

Other participants, like Marcus, when asked about what sort of formal support or information they had prior starting on the clinical area, stated that none was provided to
him. Marcus described how on his first day he went to the administration office from where he was told to which clinical area he was going, without any further guidance, not even directions on how to reach the ward.

.....I came here and started working.......... I stayed at the administration and came around two.... I remember and I came here (referring to his ward) and I said this is the ward so we started working that's it.... At the beginning I was working as a day nurse and every day I was with another nurse at the beginning. Marcus - p.6

4.6.2. Induction Programme

When participants were asked if they had any induction programme on arrival, they gave very vague answers. The participants appeared to have found it difficult to articulate the answer. It is unclear as to whether the question asked was unclear or whether the vague answers indicated that a formal induction period had not been offered and taken place.

“.........induction programm about the hospital all the departments everyone was talking about his department..... t was it of some help for you?) yes because know about hospital, about environment everything what's going on around here, how the things are going here” Dragula - p.7

“Yes..... it was few hours... the Hospital presentation about the system and that one after I came here.....I don't know I think in November we had and an English course ....one week, it is nothing but it was very nice and the teacher were extremely nice.......”. Marcus - p.5/6
Marcus had also suggested there should be an induction programm pertaining to the language and skills:

"It can be nice to have an induction in Maltese language..." Marcus - p.6

On the other hand Felipe, who was employed in Malta years before the Romanians and the Bulgarians, has very positive experience with respect to the way she was oriented and assessed prior to her registration with the Nursing and Midwifery Council of Malta. This data seemed to indicate that orientation assessments were provided for, coupled with more formal support in the past. In the case when the Romanians and Bulgarians were employed there appears to have been a significantly rushed process, which might have overlooked the provision of proper orientation programme.

'... first of all I really like what they did to us.....I mean what, what they have done, the orientation program, two weeks here , two weeks there, it will make a difference and feedbacks from the NO, and then the interview, which was the final exam, it was like a verbal examination, insomma, it was good because then they would know the skills through the orientation and for the interview for the knowledge. It's fair enough' Felipe - p.7

Rosalie talked positively about the initial orientation that she got, through being supervised when she started working on the ward. Rosalie was the only participant who had talked about this supervision that was carried out by one of the practice development nurses. However this appears to have been the result of the personal initiative of the referred practice development nurse.
"...he worked with me like this to see how I work and if ......I don't do not correct he told me supposed to be like this.....I think he observes only foreigners, but no... he observes every one nurse, even nurse who is working long period...yes.....it is good......For the beginning it was difficult because for example... I don't know were is the store, I don't know where is the IV fluids or something like this and look ....look it is in front of me....I didn't see..... every beginning is difficult” Rosalie - p.5

In the following chapter a discussion of these findings is presented.
5.1 Introduction

This chapter discusses the main findings located in the data. The themes which emerged from the findings in the previous chapter will be discussed in the following sections, which hold the identified themes as the respective titles:

1: Reason for migration and associated challenges
2: Barriers in the workplace
3: Strategies towards adjusting to a new environment
4: Nurses’ experience of organisational support

The literature cited studies that were conducted mostly in Australia, United Kingdom (UK), United States (US), Ireland and Canada (Appendix 8) which are the countries receiving the largest number of migrant nurses, with the major donor countries being India, Philippines, South Africa and Canada (Kline, 2003; Buchan et al, 2006). Only one study was found that explored the experience of Romanian nurses migrating to Italy (Palese et al, 2007). Eastern countries have also been a relevant source of migration for Western Europe, the most attractive destinations for both Bulgarian and Romanian nurses being Italy, Spain and Greece (Mileva, 2008). As already stated no studies have been carried out in Malta, possibly because this migration trend is new to Malta. The employment of foreign nurses in Malta, is expected to continue as more nurses are continuously required due to the expansion of the health care systems in Malta. This study was carried out amongst Romanian nurses (n=5), Bulgarian nurses (n=3) and a Philippine nurse (n=1), it had yielded findings which echo the findings presented in the
literature of previous work in this field of expatriation among nurses across the whole globe.

5:2 Reasons for migration and associated challenges

This section discusses the reason why expatriate nurses participating in this study had left their country in order to come and work in Malta together, with the initial unexpected challenges that they encountered on migration to Malta. Most of the expatriate nurses in this study had come through agencies and had to undergo an interview in their country. The next step involved seeking registration within the Nursing and Midwifery Council of Malta (NMC). Only two of the participants, one Bulgarian and the Philippine nurse, had come on their own initiative, independent of recruitment agencies. Seven of the nurses participating in this study, had left their family, spouse or young children to work in Malta, which according to Nicholls and Campbell (2010) indicates a powerful motivation for migration.

This study supports findings from international studies in that economic and financial reasons are the key rationales for migration from developing countries to other countries (de Voe et al, 2004, Aborderin, 2007, Palese et al, 2007, Troy, Wyness and McAuliffe, 2007, Vladescu and Olsavsky, 2009). The main motivation stems from a need or desire of finding a better living and salaries to support their family at home. These international studies suggest that there are several other factors that attract nurses to migrate. These
can be described in terms of push and pull factors (Likupe, 2005). Push factors are
generally present in donor countries and pull factors pertains to receiving countries. The
primary reason that nurses migrate is because they venture in search of higher salaries,
better working conditions and professional development that was not attainable in their
country and opportunities for their family members to work and study. All these factors
demonstrate push and pull factors. (Kline, 2003). Other international studies have also
cited that such motivation is also driven by the career development opportunities that are
unavailable in one’s home countries. (Daniel et al. 2001; Allen and Larsen, 2003).
However, the latter motive did not emerge from this study as most of the participants had
claimed that they left their country because of the poor wages and employment.

Financial aspects emerged from the data as a common factor that pushed the participants
of this study, to leave their country. They would leave their homeland in search for a
better income to be able to provide the basic needs in life for themselves and their
dependents. Kingma (2006) asserts that worldwide, nurses are relatively underpaid and
thus the economic motivation for migration is highly prevalent. For the majority of
Bulgarians and Romanians participating in the study, the main reason for migration was
the economic hardship in their home country with a high rate of unemployment that
resulted in poor pay levels. According to Rangelova and Vladimirova (2004) in the case
of Bulgarian and Romania income per capita is about 27-29% of the average of EU
countries with salaries in Bulgaria being lower than in Romania (EurActiv’s report,
2008). The wages of nurses in both the public and the private sector in Bulgaria do not
exceed 300 Euros per month. (Vladescu & Olsavsky, 2007). Therefore, this may explain significantly well why nurses will leave their country; looking for better payment abroad.

In researching the social phenomenon of migration in Romania, Rotila (2008) was concerned about the causes that encourage migration, among medical staff from Romania. Rotila carried out three research studies between 2006 and 2007. Across the three studies, sixty five percent of respondents declared that they were tempted by the prospect of working abroad because of the high salary, which indicates the problem of poor salaries as being the main cause of migration. The findings of these studies are congruent with the findings derived in the local study, being reported here where respondents claimed that in Romania they have insufficient salaries to ensure a comfortable standard of living, while in Malta nursing wages are significantly higher than in Romania, Bulgaria and the Philippines. One Romanian nurse claimed that she used to get 400 Euros a month and explained that this was ‘only for gas, electricity and the food’ (Ella, p.1). According to the latest statistics a state registered nurse in Malta at the lowest payment scale on initial employment earns approximately 19,000 Euros yearly, before tax. Aspirations of a better standard of living, and low salaries at home featured strongly during the interviews amongst all the Bulgarian and Romanian nurses participating in the study. These conclusions, that economic and financial factors are the strongest push factors are supported in the findings of other international studies across the world (Allen and Larsen, 2003; DiCicco-Bloom, 2004; Smith et al, 2006). For example, in Aboderin (2007) qualitative study who sought to explore the migration motives and experiences of twenty five (n=25) Nigerian expatriate nurses working in the UK had also concluded that
the major reason for the participants to travel to the UK was the poor economic situation back in their country, which left the participants ‘without money to meet their daily living’ (p.2241). The participants stated that they had to look for somewhere else to meet the demands of daily living, and that will help them to provide a better education to their children’ (Aborderin, 2007). This again is resonant with the data from the study being documented in this dissertation.

The data from the Philippine nurse in the study reported in this dissertation sums the notion of most of the other participants, because although she explained that she had left her country in order to support a close relative with a sick husband, she also claimed that supporting financially her family back home was a primary motivation to come and work in Malta. Migration from Philippines characteristically stems from the push factors of the economic conditions of oversupply, minimal employment opportunities, poor salary packages and aggressive export policy prevalent in the country (Hawthorne, 2001).

However, although the economic crisis and the low pay, were perceived as strong ‘push’ factors by most of the respondents, expectations related to these factors were not satisfactorily met amongst the participants upon moving to Malta. Some nurses participating in this study expressed their feeling of disappointment when throughout their initial period of migration in Malta they discovered that the salary that they got in Malta was relatively low and insufficient to keep up with the challenging cost of living and noted that food and electricity bills in Malta are expensive, making it difficulty to live in Malta. In fact one of the participants claimed that ‘she works like crazy
overtime' (Natalia, p.6), because if she doesn’t she will only earn 1000 Euros every month, following the payment of 600 Euros monthly in tax. The relatively low pay which expatriates received compared to that of many of other nurses working in the same hospital was because when they came to Malta they were employed as if they had just qualified, with the minimum salary scale. It is clear from the data that nurses in this study all had a wide range of experience in a variety of clinical areas that would underpin the reason why these nurses should have qualified for senior grades. The general reaction to this lack of unfavourable scenario was that of frustration and anger, with one participant claiming that his fifteen years of nursing experience should have warranted immediate appointment to higher grade and not to the lowest grade as they were employed. His feelings of anger had expressed the general views of his colleagues, as he explained that although on application the employer had asked for experienced nurses, on arrival to Malta, these nurses were recognised as inexperienced nurses who had just qualified. This scenario was seen to be particularly unfair in the light that some of the nurses were EU citizens and therefore were not being treated equally and giving the same opportunities as other Maltese employees. This finding merits serious attention. Participants very often felt deceived by the authorities and they felt that the information received during the recruitment process was often perceived as lacking and misleading. In fact these participants emphasised the point that they were not intending to stay much longer in Malta, unless they receive an increase in pay. One participant claimed ‘money would motivate me to stay’ (Maurius, p.7). A higher salary, which would reflect better their level of experience, would determine their choice to stay or leave. This is in accordance to what Alonso-Garbayo and Maben (2009) suggest that the information provided to
nurses who are in the process of migration in another country is vital because of the
influential effect that this can have on their decision to stay or to leave the host country
after a while. Such information determines expectations; while the extent to which such
expectations are met, or not will influence one’s length of stay. This data, noting high
levels of discontent with the salary that these nurses earn when they work in Malta,
suggests two avenues following the validation of the data with the respective authorities:
(i) a review of the payment structure and possibly the initiation of a process which will
allow that these nurses are employed at a higher better salary; and (ii) a review of the
career ladder structure and possibly the introduction of a process where nurses joining the
workforce from overseas have the opportunity to climb career ladders in an identical way
to Maltese nurses in the same workforce. As it stands, despite their years of experience,
expatriate nurses cannot apply for a promotion at their workplace because of the fact that
they are pegged at the lowest of the employment scale.

These feelings of frustration appears to correspond with evidence from various research
studies carried out across the globe (Allen and Larson, 2003, Gerrish and Griffith, 2004;
Matiti and Taylor, 2005, Smith et al, 2006; O’Brian 2007). All these studies (Appendix 8)
raised concerns pertaining to scenarios where nurses migrating to other countries to work
were not employed effectively and their skills and experience are not recognised
accordingly. Often one’s competence as a nurse is questioned in a host country (RCN,
2003), stemming from the challenges which arises from the unfavourable reality that
although the role and remit of the nurses share common cornerstone elements across the
world, the training and education that prepares one for such a role and remit, differs
significantly across the world. This dissonance in the training and education of nurses across the world possibly gives rise to the noted questioning of the competence of nurses arriving from overseas. One may note here that indeed Europe has witnessed significant milestones in harmonising nurses’ education programmes across the continent. The European Union strictly regulates and monitors the quality of nurses’ education within its member states and defines strict parameters within which nurse education may be offered, which results in a degree of homogeneity. Outwith the European Union member states nurses’ education and training is less homogenous, resulting in further significant challenges across borders.

In a study carried out by Smith et al, (2006) examining the experiences of overseas trained nurses and some other health professionals in the UK, nurses with a significant number of years of experience felt frustrated when they were employed at low scales of employment, thus restricting them to perform skills that they had previously performed in their own country. Moreover, this lack of recognition of previous experience led to deskilling and skill waste (Smith et al, 2006). However, this concept of deskilling has not emerged from the study being reported in this dissertation. On the contrary nurses expressed their satisfaction to the fact that their work experience and associated skills were informally recognised by their colleagues on the floors in the practice area. These nurses in this local study reported in this dissertation are well trusted and perceived as very competent nurses by their Maltese colleagues. Infact their colleagues had often consulted them for their advice. Such acknowledgements of expatriates’ experience by their direct colleagues can be correlated to another finding, favourable positive collegial
relationship, which will be discussed later in relation to the participants’ adaptation to the new environment.

Additionally some of the participants were intrigued into migration to Malta, because they believed that by applying to work in Malta, they would facilitate their spouse’s employment, especially knowing that the English language was commonly spoken. Such reasons compliment the reasons that were given by nurses, in an international study, when they were asked what motivated them to leave their country (deVeer et al, 2004; Troy, et al. 2007). Nurses (n=980) in de Veer et al’s, quantitative study stated that the main and important reason for them to migrate to the Netherlands was for personal reasons such as marriage, and their spouse’s employment. However, nurses in the study carried out in Malta, expressed their concern and frustration with regards to the problems they were encountering with finding employment for their spouse, often despite the fact that they are EU citizens. Another participant had also expressed her frustration to the bureaucratic burden that she had encountered with the issuing of a visa that will permit her Nepalese husband to take up residence in Malta. These nurses strongly expressed her disapproval to the way she was treated from the relevant authorities, which she believed challenged her sound family values.

The noted reasons for migration and moreover the associated challenges, call for the attention of the respective authorities, in an attempt to establish more realistic pull factors, minimise unfavourable push factors and moreover to secure increased congruence between fostered expectations and actual feasible realities.
5:3 Barriers in the work place

Travelling to a new country as an expatriate and moving from a familiar culture to one that is unfamiliar is a stressful experience, since expatriate nurses have to work to understand and adjust to their new world, and its associated practices (Woodbridge and Bland, 2010). For nurses, the transitioning into different health care environments can result in dramatic and overwhelming experiences, and the process of adjusting to a new culture can be met with conflict, frustration and struggle (Woodbridge and Bland, 2010). In this study this experience of acculturation was often dominated by challenges which stemmed from communication and language differences and differences in nursing practice. As noted earlier, these findings reflect the experience of the nurses who participated in studies in the USA, the UK and Australia (Yi and Jezewski, 2000, Di-Cicco-Bloom, 2004). For example Yi and Jezewski (2000) studying the adjustment of twelve Korean nurses to US hospital settings, talked about the most common obstacles for immigrant nurses, being the English language, gender and professional role expectations and a dissimilar nursing scope of practice (Yi and Jezewski, 2000).

The most pertinent challenge encountered by most of the nurses in this local study correlates with the language barrier that the nurses experienced in the context of the prevalent use of the Maltese language. Nurses in this study articulated their feelings of shock and even embarrassment, when they encountered this language barrier associated with the wide use of the Maltese language, which according to the participants, were not prepared for. From the interviews it emerged that the participants felt deceived because
they were not informed during their employment interview, that they will have to face people who only spoke the Maltese language. The participants described how this language barrier had created difficulties and stressful situations, both for them and the patients, especially when caring for elderly patients. Miller et al (2001) indicate that communication is closely linked to comprehension of culture and language, while good communication is fundamental to the nurse patient relationship and quality of nursing care (Newton et al, 2011), which in turn requires competency in a language (Troy, et al, 2007). Indeed, difficulties in adjusting to new cultures due to language barrier have been articulated in most of the literature (Allen and Larsen, 2003; Magnusdottir, 2005; Palese et al, 2007; Cummins 2009). The participants of this study did explain that indeed their whole process of adjustment to the new context that they had joined was significantly hampered by the referred language barriers.

This language barrier has also been identified as problematic by the Malta Union of Midwives and Nurses (Busuttil, 2010), and in the findings of a small scale survey which was carried out amongst members of the Maltese population (Galea Debono, 2010). The findings of the survey essentially revealed that the Maltese people did not oppose the recruitment of foreign nurses, just as long as they were fluent in the English language, because they thought that the inability to speak English can be of great concern with the elderly and those with low education levels, and in emergency situations where there maybe no time to try and explain things. These unfavourable consequences of language barriers are widely documented in the literature. Omeri (2006) argues differences in the
use of language can result in dissatisfaction, misdiagnosis and even death. Kingma (2007) sustains that patients need to convey their concerns, describe their pain and report symptoms to professionals who need to understand. In addition, the inability to communicate a change in the patient’s condition can delay care and can cause injury (Bola et al, 2003), while misunderstanding can bring anxiety to both patients and nurses, and hampers the possibility of including patients to participate in their care (Palese, et al, 2007). Moreover, nurses themselves often undervalue their competence in providing nursing care (Omeri, 2006). As with the nurses in this study which was carried out in Malta, nurses participating in studies carried out elsewhere, noted that their competence as nurses was similarly compromised as a result of their inadequate command of their English language in that this translated into limited understanding of essential medical terms, abbreviations, terminology, and drugs which was particularly unfavourable during hand over and other such communicative activities amongst professional members of staff (Daniel, et al, 2001; Deegan and Simkin, 2010).

In view of the extensive awareness and wide consensus about the challenges posed by language difficulties, which are clearly prevalent also in the data from the study being reported here, it is evident that in the process, and indeed the momentum gained in the phenomenon of nurse migration across the globe, the specific central importance of language proficiency is being underestimated and at times possibly even overlooked. This discussion highlights the importance of language skill assessment in the recruitment process of expatriate nurses. The use of standard international language proficiency tests in the recruitment process of nurses has been debated in the literature.
Indeed the use of such tests is advocated in the literature (Troy et al, 2007; Newton et al 2011), but the use of this test poses new challenges in that it may have a negative influence on a recruitment process, in that it may result in fewer nurses being recruited. According to Buchan (2007), English proficiency tests as a revised requirement for international nurses may restrict successful applications to some countries, as in the UK, thus creating a ‘bottle neck’ of international applications, subsequently leading to further shortages of nurses. The challenge therefore lies upon determining how to best address the language needs of potential recruits in the Maltese nurses’ workforce in an attempt to facilitate their transition.

According to Withcell and Ouch (2002) displacement of nurses may also involve challenges which go beyond the use of language. The expatriate nurses in this study experienced changes in both the way nursing was practised and in the parameters which defined one’s role. With regards to the nursing practice two aspects of the Maltese nursing care organisation and delivery emerged from the interviews, as being different from the nursing care organisation that these nurses had been used to in their home country. The first was the bathing of the patients, and the second was related to cannulation. This study has produced findings that are similar to what international studies have found (Yi and Jezewski, 2000; Daniel et. al.2001) in which nurses migrating from other countries encountered different ways of providing nursing care, differences with the use of medical terminologies, and differences across the use of technology and equipment in the clinical area.
While in the Maltese health care system bathing of the patients still falls within the role and remit of the nurse, all the participants claimed that such a procedure is regarded in their home country as the health care assistants’ job. Washing the patients in bed, giving a bedpan and feeding a patient are different aspects of basic nursing care that are still in the job description of Maltese nurses. For the participants of this study, bathing of patients was perceived as wasteful. They indicated that they are quite busy with other routines such as cannulation, blood collection, wound care and drug round and thus bathing of patients comprised waste of time and skills. These findings indicate that care in their home country was very technical and as nurses, their role used to overlap a lot with that of doctors. One participant emotionally expressed her feelings when she stated that in her country nurses were treated as slaves from the medical doctors, and they used to do most of their work like cannulation because as she stated ‘doctors will not get dirty with stuff like this’ (Ella, p.4)

The participants felt surprised that in Malta they were not allowed to carry out venepuncture and cannulation. These are two skills that they had learned during their basic training programme and had been part of their daily routine job as nurses in their country. Against this backdrop, this can also raise the question of whether these two procedures should be added to the current list of competences of the Maltese nurses. In view of the pressure from the public, where a letter in a local newspaper recently questioned “Why does a patient have to be left for 8 hours without a venflow and thus no drip because the doctor came eight hours late when such a thing could be performed by a nurse on other occasions” (“Bed ‘remodelling exercise’, 2011), and in view of the fact
that international studies which have explored the experience of international educated nurses, indicate that many IRNs see these skills as basic nursing duties and central to their nursing role (Gerrish and Griffith, 2004; Smith et al, 2006; O’Brien 2007; Cummins, 2009) the need to amend the list of competences of nurses in Malta is strongly indicated. The nurses in the study being reported here felt that the Maltese system was a bit restricted when it had prevented them to use these skills, however unlike participants who participated in other studies these nurses did not feel de-skilled. One participant expressed he just felt sorry for the patient who was suffering as he had to unnecessarily wait long for a venflon to be inserted. Nevertheless, the nurses in this study seemed to have adapted to this situation without questioning it, which according to Matiti and Taylor (2005), could be, because, they had no choice, but to fit in. On the other hand, some of them had also expressed their pride and satisfaction to the fact that many times they were asked to help out with cannulation often by inexperienced junior doctors.

The degree of autonomy particularly pertaining to decision making, and the degree of stress, particularly related to patient: nurse ratios are two factors which appear to differ across different health care systems (Daniel et al, 2001; Vladescu and Olsavsky, 2007). It is therefore not surprising that nurses participating in this study noted differences of these natures between their country and their experience as nurses in Malta. Nursing care in Malta was portrayed to be much easier and less stressful because of the good ratio of nurses to patient in the clinical areas in Malta, and because of the good supply of doctors in Malta. The findings of this study are identical to those of a phenomenological study that had explored the experience of a purposeful sample of eleven overseas nurses in
Iceland (Magnusdottir, 2005). Although the nationality of the participants was not specified, they all agreed that they experienced less work load, rush and stress and better staffing than they were used to. Despite the congruence in the findings of different studies carried out in different countries, that migrating nurses experience more favourable work conditions, beyond financial remuneration and salary scales, in their host countries, the query as to whether migrating nurses do in fact seek to migrate in search of such better working conditions, other than enhanced simply financial packages, remains unanswered. The findings of this study and the located literature clearly identify enhanced financial remuneration for the job as a central impetus for migration, but falls short of, clearly, identifying other factors.

Another issue which has been recognised as challenging with respect to the new working environment that nurses in this study found in Malta, arose from the working relationships between nurses and the nursing aides. One of the participants expressed her concern about the lack of discipline some health care assistant exhibited. The participant explained that back home healthcare assistant should carry out specific tasks and follow instructions without questioning a qualified nurse. There was a general feeling within the data that some of these nurses also felt frustrated because in their opinion the healthcare assistants lacked adequate control and discipline. In turn this feeling echoes within the literature. This disparity between roles had created a poor working relationship and conflicts between the expatriate nurses and the health care assistants in a study carried out in the UK by Smith et al (2006). This finding is also in agreement with Aborderin (2007) findings who found that Nigerian nurses (n=25) working in an independent nursing home
found themselves struggling with their carers over designated authorities, because by virtue of their professional qualification, they believed they had the right to supervise and delegate to carers and aides. Situations where unqualified carers assume power appear to be common (Smith et al, 2006; Aborderin, 2007). The revision of the distribution of roles and responsibilities and authority across professional staff as are nurses, and non-professional staff as are aides and assistants is indicated.

One other factor which posed challenges to the participants of this study was their expressed unfamiliarity with the technology and information management systems at the clinical area. A similar experience is reported by Palese et al (2007) study who found that although the Romanian nurses had reported improved perceptions of overall professional integration during their six months in their new environment, most still felt they had limited competence with respect to managing information system. In sum, all this suggests that the greater the difference of the health care delivery system from the country of origin, and more specifically the nursing practice norms related to information and technology, the greater the challenges are experienced with adjustment (Newton et al, 2011). However nurses after their second year in Malta had claimed that they had adjusted well to such technology, which suggests that given support and time, meeting the challenges successfully is possible.
5:4. Adjusting to the new environment

In this section the experience and strategies used by these nurses to adjust to the different environment they encountered on migration will be discussed. As has been discussed in the previous section, during the initial period of migration to Malta, nurses had to overcome significant obstacles and challenges such as financial challenges, difficulty in communication because of language barriers, changes in professional roles and responsibilities and dealing even with new technologies. Similar experiences are located in the literature which documents nurse mobility across different parts of the world (Yi and Jezewski, 2000; Daniel et al. 2001; DiCicco Bloom, 2004, Magnusdottir, 2005; Emerson et al. 2008). According to Bozionelos (2009) such challenges can lead to weaknesses within the experience of migration or failure of the nurse in the host country. On the other hand, Wong (2002) maintains that this resettlement period of migration can also prompt individual to adapt actively to their environment in order to avoid disequilibrium by adopting coping strategies to deal with the challenges, and with the circumstances which cannot be changed easily (Quinn et al, 2008).

The data of this study supports Wong’s (2002) argument, because it suggests that most of the participants had in fact adapted by time and seemed to accept certain situations that seemed unalterable, like for example when nurses had to adjust to the difference in nursing practices, whereby they had to be responsible for bedside nursing care, such as bathing, feeding and adjustment to. As with nurses studied in other studies, expatriate nurses in this study have put in efforts and managed their adaptation by developing
practical and coping strategies in order to deal with these job related challenges, financial difficulties and language barrier (Yi and Jezewski, 2000). This might have also helped the expatriate nurses to accept reality more willingly (Wong, 2002). The nurses in this study being reported in this dissertation, coped with being treated as novice nurses when their previous experience was not recognised. Moreover, a willingness to learn the Maltese language, adopting a positive attitude and a positive working relationship with their colleagues, were all coping strategies taken by the participants that have emerged from the analysis of the interviews as being instrumental in facilitating the adjustment process in Malta. Additionally, previous work experience in other countries (Beechinor and Fitzpatrick, 2008) such as Greece, Libya, Cyprus and Israel that are quite similar in culture to Malta, the favourable hospital physical environment, good staff to patient ratio and the warmness and kindness of the Maltese people were all factors that helped nurses to adjust easy to the new environment. Moreover, the latter seemed to have had a great impact on their social adjustment. Brunero, Smith and Bates (2008) suggest that choosing a country which has a similar health care system as one’s home, together with engaging in a position that nurses had prior to their migration (Kawi and Xu, 2009) is believed to facilitate adaptation and job satisfaction. Most of the nurses in this study were allocated to a clinical area that was relevant to their experience in their home country. This may explain why their adjustment was significantly successful. Such measures pertaining to the deployment of expatriate nurses are to be reinforced.

In addition, the amount of clinical knowledge and experience held by an individual nurse could also be influential in adapting to the difference in nursing practice. One of the
participants explained how his previous experience of working in the UK has helped him to become independent and develop him personally, thus facilitating his adaptation to Malta. It can be argued that because many of the expatriate nurses in this current study, had the experience of working in other countries especially in countries within the Mediterranean region, prior to coming to Malta, they would have been more familiar with the demands of migration and therefore were able to develop coping skills to decrease the stress that results from the demands of migration. This is similar to the intercultural model described by Cai and Rodriquez (1997) who maintain that when individuals draw on previously successful behaviours, they can adapt easily, as they can recall behaviours that have been effective in the past. These people can better accomplish their goals than those people who have no behaviour or previous experience to recall. Negative experiences are likely to result in ineffective adaptation or withdrawal (Cai and Rodriquez, 1997). This notion can also be supported by findings from Beechinor and Fitzpatrick’s (2008) comparative descriptive study, studying the experience of Canadian and Philippine nurses working in USA and Hawaii. The Philippine nurses experienced less stress compared with those of the Canadian due to the fact that nurses from Philippines were used to migrating to other countries and therefore through their experience had developed coping skills to decrease their distress. The Philippine nurse participating in the study being reported in this dissertation projected a very positive experience especially during her adaptation period and this could also be due to the fact that she had also the social support of a close relative who was also living in Malta at the time of her employment. As will be discussed in subsequent sections, according to Furnham, (2007) and Beechinor and Fitzpatrick, (2007), such informal support from
family and friends can also be a valuable resource that may help decrease the experience of stress during difficult situations.

Moreover, one participant also expressed her appreciation towards the financial aid that they were given from the state that she was given on employment which she used to buy a computer that had facilitated her communication with her daughter who remained in her home country. Although this financial benefit was only mentioned by one participant, throughout the interviews, this might have been also given to other nurses which according to Magnusdottir (2005) can be an additional strategy that can help expatriate nurses with the adaptation experience. It can also be argued that participants' reason for migration might have also been instrumental in helping these nurses to adapt to their new environment. Knowing the financial hardships that they had to endure in their country, nurses seem to be most willing to adapt to the new environment despite the challenges. This can be correlated to what Wong (2002) found in his qualitative study that explored the stage specific and culture specific coping strategies used by Mainland Chinese immigrants in Hong Kong. Although the sample used was not related to nurses, the results can well support the discussion related to why the reason of migration may be instrumental in facilitating the adaptation process. Participants in Wong study have used optimistic and positive thinking to find meaning to travel to Hong Kong which they perceived, to offer a better future for their children, thus the hardships they experienced were worth enduring. This is referred to as 'cognitive strategy of positive comparison and optimistic and positive thinking' (Wong, 2002 p.494). This according to Wong can help
an individual to see their hardship in a more positive light, by comparing the present to the unfavourable past.

As was discussed above differences in ethnicity and linguistic background can pose significant challenges to developing collegial or therapeutic relationships and to be able to offer optimal care. In this study most of the participants claimed that learning some key phrases and words in Maltese that they used in their everyday nursing practice especially with their patients helped them, to converse at least to some extent. This language ability to learn key phrases to help them initially with their contact with the patients seemed to play a vital role in the process of change to the new context. Clearly communication is critical to proper adjustment. (Newton et al, 2011). This is synonymous with findings from Robertson, Gaggiotti and Low (2007) who interviewed twelve English speaking expatriates who were working within the Kazakhstan Institute of Management, in Kazakhstan. Similar to what the expatriate nurses stated in the study carried out in Malta, the respondents in Robertson et al (2007) study also expressed their surprise that language was a problem as they had previously assumed that most of the people would have at least a basic understanding of English. The training that these participants had taken in the Russian language had afforded them to learn some key phrases and words which in turn had facilitated their adjustment. Moreover, participants in the study conducted in Malta, had also actively engaged in activities such as asking their colleagues to translate what was being said by the patient so to case their language problem. This strategy was clearly used to resolve difficulties associated with understanding the Maltese language.
As had already been revealed before, the participants also referred to the positive nature of their relationship with their colleagues and ward managers that was crucial in enabling them to overcome the initial challenges and adjust to the new work environment. This informal support that the nurses received was beneficial to their adaptation. Informal support here refers to the developmental of collegial relationships that are initiated and evolve on the clinical area (Bozionelos, 2009) which in turn can lead to job satisfaction and lower levels of stress (Beechinor and Fitzpatrick’s, 2008). When talking about their positive clinical experience nurses talked about how staff had made them feel welcome and were a source of help especially to integrate to the new environment. Challenges for migrating nurses include a need to be trusted and valued by the host nurses (Magnusdottir, 2005). The data suggests that such trust was rallied to migrant nurses working in Malta. The feeling of being made welcome on the ward was also attributed to the role of the ward manager. This concept of supportive leaders and management is referred to by many researchers in the literature, who refer to how it can have a positive influence on acculturation for expatriate nurses. (Gerrish and Griffith, 2004, Magnusdottir, 2005, Sherman and Eggenberger, 2008, Bozionelos, 2009). Moreover both Robertson, et.al. (2007) and Bozionelos (2009) suggest that collegial relationships in the work place can also provide similar functions to that of a mentor, especially in the socio emotional domain that includes friendship, and role modelling.

There are similarities between the feelings expressed by the nurses in this study and those described by the nurses in Matiti and Taylor (2005). Matiti and Taylor’s phenomenological study investigated the cultural experiences of internationally recruited
nurses in the UK. The sample consisted of twelve nurses coming from Mauritius, the Philippines, India and Nigeria and all spoke English as their second language similar to the expatriate nurses in this current study. Nurses also claimed that the support that they got from their host healthcare workers also influenced their adaptation process. They were really grateful to the number of nurses, patients and other staff for the general support they had received to settle in the country and while working on the wards.

This is in contrast with what other international studies have reported in which nurses mostly coming from the Asian and African continent described injustices and discrimination that they experienced and which they attributed to their ethnic identities, and they claimed to have experienced racism (Allan et al, 2004; DiCicco-Bloom, 2004; Alexis and Vydelingum, 2005; Aborderin, 2007; Deegan and Simkin 2010). Some migrant nurses have reported dramatic situations on the job where colleagues purposefully undermined their professional skills, refused to help and sometimes bullied them thus increasing their sense of isolation (Hawthorne, 2001, Allen and Larsen, 2003). Such racism or other types of discrimination may frustrate or anger nurses which may then negatively affect the quality of care they provide to patients and their own quality of life (Dicicco-Bloom, 2004). Similarly, in Deegan and Simkin’s (2010) study five of the nine nurses coming from India, China, Philippines, El Salvador and the Czech Republic reported that they had perceived discrimination and lack of support on the basis of their ethnicity background. DiCicco-Bloom (2004) had also investigated the experiences of a group of immigrant women nurses from Kerala India, educated in India and actively employed as nurses in the United States. The author had conducted semi structured in
depth interviews with ten immigrant female nurses from India, resulting in experiences of racism and sexism. Participants claimed that they were discriminated against, with regards to promotions and career advancement because of their immigrant status. They expressed the challenges that arose in facing potential discrimination from either patients or co workers. Also, nurses in Alexis et al’s (2007) describe how a lack of opportunities to demonstrate leadership, to develop confidence and achieve promotion, and to be included by peers had largely stemmed from being ignored by management, colleagues and patients because of cultural and racial differences.

Although it is clearly very present in the studies located in the literature, the issue of racism or discrimination did not emerge in the study carried out in Malta. In contrast, the participants unanimously expressed their contentment on the way they were treated and welcomed in their clinical environment. For the Philippine participant the support that she had found from her colleagues as well as from her manager gave her "a sense of belonging" (Filipe, p.5). Nevertheless, it would be significant to support further such findings through an observational study because through observation one would be able to validate such experiences and provide a more complete account of the noted experiences. The researcher is aware that these nurses do work a lot of overtime and thus spend many hours a week at work. This might also be a factor that can foster a positive peer support and increase their confidence and enhance their interpersonal skills. Working extensive hours in a new environment is believed to foster favourable outcomes (Kawi & Xu, 2009).
Organisational Support

Linked to the above discussion where participants had expressed their satisfaction with the support that they had found from their colleagues on the clinical area, the data presented some conflicting views regarding the organisational support that nurses had initially received when they arrived in Malta. Despite the provision of some logistic support, such as airport greetings and the provision of accommodation, some had expressed their concerns and noted that organisational support was inadequate, especially with regard to information given related to salaries, benefits and actual accommodation conditions. There was evidence in the data that the participants had to be self sufficient in seeking information regarding salaries, and rights and obligations with regards to furthering their career through promotions at the workplace. Moreover this lack of formal support may have well contributed to feelings of depression and loneliness that were expressed by some of the participants. However, despite this lack of formal organisational support, participants had managed the situation through their social network support particularly that of their fellow Romanian or Bulgarian nurses, as social groups. The Philippine nurse, besides the support she found from her colleagues, had the support of a close relative who was living in Malta. Such social systems and informal support is known to be beneficial in reducing adaptation stress and subsequently to have positive outcomes (Smith et al, 2006; Beechinor and Fitzpatrick, 2008). The benefits of a social network was clearly explained by Furnham (2010) who postulated that an individual can find different support networks that are instrumental in integrating with the new environment. One of the support networks that the individual may find include other
sojourning co-patriots, during which ethnic and cultural values can be practised and expressed (Beechinor and Fitzpatrick, 2008). The individual may also find support through a network where one will develop social relationships between migrants and the host nationals, such as nurses in the clinical area. This relationship is instrumentally in facilitating the professional inspiration of the migrants. Moreover the migrant individual can also build up a multicultural network of friends and acquaintances the main function is to provide companionship for recreational, non cultural and non task oriented activities. All these networks of support had been established by the participants in this study in facilitating their adaptation to Malta. Furnham, (2010) argues that the amount of social support rather than who provides is more important, which is perhaps a plausible explanation to why and how expatriate nurses in this study coped, despite the lack of formal organisational support when they reached Malta and engaged in the new employment. Nonetheless, the need for the development and provision of formal support structures are indicated.

When participants were asked about whether they had an orientation programm most of the expatriate nurses were unclear in their response, with some of the participants saying that they had a language course, a general induction programm which was the same one organised for Maltese new recruits to the nurses’ workforce at that time, including new graduates. Some of the expatriate nurses, as already stated in other section, were allocated with one of the senior nurses on the ward, who acted as a mentor, or preceptor. This lack of clarity regarding any orientation programm that nurses were given on their arrival may have arisen from the fact that this orientation programm was not specifically designed for
these expatriate nurses as indicated in the varying responses of the participants. Literature highlights the importance of such an induction programm geared specifically at expatriate nurses (Gerrish and Griffith, 2004; Cummins, 2009) Nonetheless the adoption of a buddy, preceptor or mentor system for new expatriate nurses which was offered to the expatriate nurses in this study is commended. The development of further initiatives to support the orientation of migrant nurses in Malta is however indicated. A preceptorship or a buddy system is strongly suggested in the literature as it is known to offer valuable support to migrant nurses during integration (Gerrish & Griffith, 2004, Magnusdottir, 2005, Sherman & Eggenberger, 2008, Bozionelos, 2009).

This discussion has highlighted the challenges, the initiatives and the gap that exists related to the expatriate nurses’ experiences working within the local context, in the light of the recruitment strategies that had been initiated to make up for the shortage of nurses that exist in health care facilities in Malta. This study demonstrates that the process for expatriate nurses’ who decide to migrate in search for better working and living conditions both for them and their family is not an easy one. Therefore, one can conclude that the collaboration of all those involved in the process, both from an individual and organisational perspective is vital if the national and healthcare targets, which seek to address shortages of healthcare professionals are to be successful; and moreover if the well being of expatriate healthcare professionals and optimal healthcare delivery are to be secured.
CHAPTER 6

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS
6.1 Conclusion

This phenomenological study about this phenomenon, being the first to be conducted in the context of Malta, has made a new contribution to the literature and to the nursing profession in Malta by specifically addressing the views of the expatriate nurses in Malta. The findings cannot be generalised, though, the findings of this study echo those which are found in international studies. The main challenges associated with the migration of nurses appear to be consistent across different contexts and countries. Nonetheless, the need for a programme tailored towards the specific needs of different cohorts of expatriate nurses is indicated in the findings of the study, being reported in this dissertation.

There is ample evidence in the literature that demonstrates that better adjustment experiences of overseas qualified nurses will lead to longer job retention rates amongst such nurses, and their greater contribution to multicultural nursing practice will be facilitated (Konno, 2006). This research study was carried out in an attempt to contribute to the development of effective strategies which would, in turn, facilitate the transition of future overseas nurses recruited in the nursing workforce of Malta. The findings of the study have identified the main challenges experienced by expatriate nurses, and determined that; (i) a comprehensive induction programme specifically tailored for expatriate nurses, together with (ii) a framework of training for Maltese nurses and healthcare professionals designed in increasing cultural competency across the workforce and the entire healthcare system and delivery are indicated. Kingma (2008) suggest it is
vital to build a positive practice environment that will contribute to create a dynamic team through valuing and acknowledging the skills and abilities of expatriate nurses, and that this consequently will facilitate the integration of these expatriate nurses in their host country.

The findings of this study should contribute significantly to development of strategies which would secure optimal experiences amongst expatriate nurses in Malta and significantly address the gap pertaining to evidence regarding the experience of expatriate nurses who join the nursing workforce in Malta.

6.2 Limitations of the research study

Hermeneutic phenomenology has been widely acknowledged as an approach that, if used well, will provide both philosophical and methodological support in attempting to capture and express the meaning of the lived human experience in a rigorous manner. However, such a method has its own limitations with the central one being the demand that an phenomenological approach places on time especially with interpretative analysis, in that it has to be carried out systematically and comprehensively (Smith, Flowers and Larkin, 2010). Furthermore, the small sample size together with the unfavourable high degree of homogeneity of the sample in that it comprised expatriate nurses, from only Romania and Bulgaria, with only one Philippine, added a further limitation. Although interpretative phenomenological studies generally have a small number of participants, including more expatriate nurses from a wider range of countries may have added breadth to some of the
themes emerging from the collected data. Therefore, the results of this study need to be considered with caution as they could not be generalized to the wider nursing workforce in Malta even more so since tens of Asian nurses have joined the workforce in the recent past months.

The literature indicates that phenomenology can be overwhelming to a novice researcher, in view of its complex philosophical theoretical base (Snow, 2009). However, although being a novice researcher to phenomenology, the researcher seriously engaged in learning about phenomenology prior to embarking on the study. The researcher pursued appropriate programmes in research methodology and sought to study various resources regarding hermeneutic phenomenology and IPA. Coupled with ongoing reflection, which is characteristic of such hermeneutic inquiry (Koch, 1996), the researcher also engaged in significant learning about oneself. The adopted method offered the opportunity to explore issues with expatriate nurses at a deeper level, giving voice to the nurses in a confidential manner that would have been unlikely to have been obtained through other approaches (Garbayo and Maben, 2009). In being a novice to IPA, the analysis of the results was challenging. This phase of interpretation can be very time consuming to the novice researcher (Smith, Flowers and 2010) and indeed it was, in the case of this study. The fact that all the participants were interviewed in English, and English language was their second language and also that of the researcher, made the interpretation of their thoughts and experiences very challenging. These challenges were addressed through continuous consultation with the academic supervisor and also through returning to the participants of the study for verification of the analysis and interpretation of the collected data.
One other limiting factor to the study was time constraints. In being part of an academic program, the researcher had to carry out the study within defined academic timelines. Also, resources which may have supported the researcher with carrying out the research study, as an inputting and filing of data, were absent. Hence, the limited time available to the researcher, had to be thinned out across several activities which could have been better spent on the actual analysis process.

6.3 Recommendations

Based on the conclusions reached, the following recommendations were determined.

1. The development of pre-recruitment information booklets which will include information pertaining to the cultural aspects of the country, information regarding salaries and scales, accommodation, work conditions, language spoken and any central aspects of the nurses' role in the country. An online website would be even more favourable since it easily accommodates the need for continual upgrading. Expatriate nurses should be well prepared to develop a cultural understanding of the host country, the destined health care environment and how it operates, and their role in the destined clinical environment. Courses in the English language and Maltese languages should also be offered.
2. Less generic induction programmes are needed. Intensive orientation programmes should be offered on recruitment tailored to the specific needs of different cohorts of expatriate nurses. Initiatives in collaboration with the academic community within the Faculty of Health at the University of Malta may be explored.

3. This study recommends that it is not only expatriate nurses who need to change their ways of working in the Maltese health care systems. The authorities have to be aware of and manage effectively the realities which will arise from among diversity and differences across staff in the healthcare system. Such diversity may compromise the highest standard of care, and therefore measures to manage it effectively and efficiently such as introducing cultural competency courses for all health care workers. Also expatriate nurses’ previous knowledge and experience should also be taken into consideration and recognised accordingly as an important resource in the health care system when addressing diversity.

4. Mentoring, preceptorship or buddying programmes should be introduced and tailored to the need of expatriate nurses taking into consideration the varying knowledge and experience they already have on commencement of employment. Moreover it is vital that mentors should be trained beforehand to be competent in mentoring expatriate nurses from culturally diverse background. Here again, the development of cultural competence need stand as a learning outcome of pre-registration and post registration programmes.
5. The working conditions of expatriate nurses need to be reviewed by the respective authorities in an attempt to ensure that local, EU and international laws, regulations and obligations are being thoroughly respected.

6. It is suggested that future studies should be done with other recruited expatriate nurses, using both method and data source triangulation. Hence, integrating other methods of data collection such as observational methods, and other nurses from different countries is recommended. Moreover, further research is suggested to be carried out with Maltese nurses and managers to explore their views and perceptions with regards to the recruitment and the practice of expatriate nurses in our health care systems. Such data source triangulation will enrich the evidence pertaining to this phenomenon of migrating nurses to Malta, by securing confirmability to the evidence and also completeness to the evidence (Fade, 2003).
References:


APPENDIX 1

UNIVERSITY ETHICS PERMISSION
### To be completed by Faculty Research Ethics Committee

We have examined the above proposal and advise:

<table>
<thead>
<tr>
<th>Acceptance</th>
<th>Refusal</th>
<th>Conditional acceptance</th>
</tr>
</thead>
</table>

For the following reason(s):

Signature: [Signature]
Date: 8/10/96

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### To be completed by University Research Ethics Committee

We have examined the above proposal and grant:

<table>
<thead>
<tr>
<th>Acceptance</th>
<th>Refusal</th>
<th>Conditional acceptance</th>
</tr>
</thead>
</table>

For the following reason(s):

Signature: [Signature]
Date: [Date]
APPENDIX 2

DIRECTOR OF NURSING APPROVAL
Ms Cham1aine Attard  
Director Nursing Services  

Dear Ms. Attard  

I am currently pursuing the Masters Degree in nursing organised by the Institute of Health Care and in part fulfilment, I plan to carry out a research project that will examine the views and experiences of internationally recruited nurses' adaptation to the Maltese nursing practice. No such study has ever been carried out in Malta, but evidence in the literature provide insights into the stresses and difficulties experienced by these nurses when they migrate to work in a different country. Efforts to enhance their adjustment to work and life in the country where they were employed have been recommended in the literature. Knowing that recruiting overseas qualified nurses has become an increasing vital component of the Maltese nursing workforce, I have decided to carry out such a study with foreign recruited nurses who have been working at the acute general hospital for at least one year. This will be done through individual in depth recorded interviews.

I am therefore asking your permission to allow me to access foreign nurses, and ask them to participate in my study. All ethical issues would be considered throughout this study. While I thank you in advance, should you require further details regarding my study do not hesitate to contact me.

Yours truly  

Helen Attard Bason  
Deputy Nursing Officer-NPICU  

Tel-25455451/0/8
APPENDIX 3

INFORMATION TO PARTICIPANTS
Dear Sir/Madam

I am currently pursuing a course at the Faculty of Health Care leading to a Master of Science in Nursing and in part fulfillment, I plan to carry out a research project entitled:

'The experience of foreign recruited qualified nurses working in Malta'. I am a deputy nursing officer at the Neonatal and Pediatric Intensive Care Unit (NPICU). The aim of my study is to explore the individual experience of nurses during their first year in Malta. No such study had ever been carried out in Malta but evidence in the literature provide insights into the stresses and difficulties experienced by international recruited nurses when they migrate to work in a different country. It is in view of this that data for this research study will be carried out from foreign recruited nurses who have been working in Malta for at least one year through individual in depth recorded interviews. Although one interview with each participant is planned, there is a possibility of a follow up interview if deemed necessary.

Voluntary Participation in and withdrawal from the Study: The decision whether to participate in this study is entirely up to you. You can refuse to participate or withdraw from the study for any reason at any time if you so decide. You may also decide to participate but not answer all of the questions. There are no costs or any remuneration for participation in this study.

Anonymity and Confidentiality All information you supply during the research will be held in confidence and unless you specifically indicate your consent, your name will not appear in any report or publication of the research. Anonymity will be respected and codes will be used instead of your names. Your data, will be used solely for the purpose of the study, it will be safely stored in a locked facility and will be destroyed upon completion of the study. Confidentiality will be provided to the fullest extent possible by law.

Questions about the Research? If you have any questions about the research in general or about your role in the study, please feel free to contact me either by telephone Mob: 79860113 / 25455451/0/8 or by e-mail habason@maltanet.net. This research has been
reviewed by the relevant hospital authorities, the ethics committees and the data protection board has granted their approval. Furthermore if you require any emotional support due to the sensitive nature of the topic we can offer help through our support services on the telephone number indicated below:

Thanks for your cooperation

Helen Attard Bason (426163M)
Work no: 25455458/ 25455451
Mobile: 79860113
STATEMENT OF CONSENT

STUDY TITLE: ‘The experience of expatriate qualified nurses in Malta’

I acknowledge that I understand the information given to me regarding the above study and that all of my questions have been satisfactorily answered. I understand that my participation is voluntary and that I am free to withdraw at any time.

I agree to participate in this study and give my consent to the audio recording of the interview in which I have accepted to take part.

Participant’s Name ___________________

Participant’s Signature ___________________

Date ------------

I certify that I have explained fully to the above participant the nature, purpose and the procedures of this study

Researcher’s Name: HELEN ATTARD BASON

Researcher’s Signature

I.D. _______________ 

Date: ________________

Supervisor’s Name DR MARIA CASSAR

Supervisor’s Signature

I.D. _______________ 

Date: __________________
APPENDIX 5

INTERVIEW GUIDE
INTERVIEW GUIDE

1. Which country do you come from?

2. How long have you been here?

3. How were you recruited to come and work in Malta?

4. May you describe what preparations you had to come to work in Malta.

5. How was your experience in Malta?

6. May you please describe your experience at work?

7. Has it changed? In what ways?

8. What do you think were the factors that contributed to your adaptation both personally and professionally?

9. Can you identify any differences between the nursing practice in your country and what is practiced in Malta.

10 Can you think of anything (e.g. Education, Staff support, Organisational changes) that could help future recruited nurses to ease their transition from their country to Malta.
APPENDIX 6

STAGES OF ANALYSIS
<table>
<thead>
<tr>
<th>Researcher's analysis of transcript (exploratory notes)</th>
<th>.................She can't come and work in Malta (referring for his wife)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married but his wife is still working in Romania. Difficult to work in Malta because of the language. Very surprised as he didn't know that in Malta they speak Maltese as well, kind of weren't told the truth.</td>
<td>Not even think to come because even for me was a bit of was surprised when I came here. At the interview they were talking English they didn't tell me nothing anything a single word that in here you have another language like Maltese and I told you in Malta, but they didn’t tell me they didn’t ask me listen you are open to work in a place for example that except English you will hear another language... they didn’t say anything to me (sense of deceitfulness). When I was at the airport I said ‘with what they are talking here’ cause I didn’t know that you have Maltese... I knew that here you were a British colony that’s it...</td>
</tr>
<tr>
<td>Not so difficult to adapt in Malta because of the fact that he worked already abroad – self sufficient</td>
<td>How were you qualified?</td>
</tr>
<tr>
<td>Difference in nursing practice because of the high technology in a new hospital .....Difference in Nursing practice – taking blood, inserting venflows</td>
<td>At that time it wasn’t part of university now it is part of university... so it was like ....like...another school three years......nursing school ...nothing else just nursing ....after high school ....so twelve years and then another three years ...now is another part of university training, like a degree. I am a diploma nurse</td>
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<td>...However he adjusted to our system, feel proud that he can help the new doctors with cannulation</td>
<td>How was your experience in Malta?</td>
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<td></td>
<td>Not very difficult... consider the fact that I was working in England (easy adaptation- self sufficient) so I was having a bit of experience how to get ...independent in a foreign country.....</td>
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<td>May you tell me about your experience at work especially during your first year.</td>
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<td>How do you feel about it?</td>
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<td></td>
<td>All right I mean.............different although all this technology that you have because of a new hospital...the pneumatic tube the equipment, all result coming on the computer and everything.....(difference in nursing practice)...in England was a bit different, (Interviewer: in which specialty you worked?) in Romania? I was in surgical but in England I worked with the company, and I was like a reliever.... few months in there, few months in there..... The work is different in Malta than in Romania....(difference in practice) we don’t have like I told you so enough equipment to help you ....em...we are doing so much things that you do here, over there (ref. to Romania) you don’t have doctors to take blood or to do a venflow we do it (difference in roles).... and when I came in here and I said ok we have, I don’t know, cpk troponime they tell me the doctor .......why? to take the blood...I can take it......why? it is not our job ok so.....</td>
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<td>How do you feel about it?</td>
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<td>I don’t know ...I don’t know if I would get in trouble or not. When for example every six months the doctors are changing and sometimes I help those new, and it is good for me, cause.......but for example if during the night we will need a venflow for example for patient...in emergency, I will do it ....back home I never had any complains but in two years I forgot (laughing) I will do it, if it is the system in here what can I do.</td>
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This answer is completely different from what I had previously received from other participants, as some of the other Romanian participants had given me the impression that they work most of the time without any medical doctors around.

Had been offered the choice where to work. He acknowledged everything is new to him. It is evident that Maurius had no orientation before starting on the wards.

Positive collegial relationship facilitated his adaptation.

Language barrier, especially when the patient does not know English although in two years he had learnt some words that can help him in his nursing care of the patients.

Feel frustrated about the language barrier especially when he has to nurse old people and cannot understand what they want especially when they don’t know to speak English.

A short program was given as an orientation to the new context.

Anything else...that you find different in nursing.

Yes in here you are more independent as a nurse...I mean you can take your decisions of course you are more responsible for them but back at home for everything you call the doctor ask the doctor (difference in roles) you don’t do it without a doctor I am talking about decision even to give something for patient if you see...out here if you have the treatment and you have something you can give it any time.....

So you came to a medical ward?

I went to ....was at that moment in charge and when I came he said where do you worked I told him in surgical. Where do you want to work I don’t know you tell me even if you send me to surgical still I will take it from zero because it is new, so I don’t think I could have a preference listen I want to go there I don’t know about the hospital, the system, (no knowledge about the new hospital environment) so send me whenever you want.

So you came to the medical...... was it difficult to adapt?

Yes they helped me a lot (referring to his colleagues) (easy to adapt – helpful colleagues)

Do you think that things had changed since you have started?

Now......At the beginning I was a little bit afraid....you know .... but now ....I don’t think I have any problems. (adapted) (Interviewer: You consider yourself as a Maltese now.) No....(laughing) I prefer Romanian. (proud to be Romanian)

Have you had any experience that might have hindered your adaptation?

Maltese language because I can’t communicate with the patients (difficulties in communication – language barrier) although after two years I know some words if patient is hurting...but still when the patient does not speak English I better call someone to be sure... (coping with the barrier)and this is one thing I was trying last year to search for Maltese (trying to learn Maltese)...ETC was doing it but I don’t know where...for example when I came in here I came in June and others came in September the other NO Tommy was telling me look some Nursing officers from other ward were complaining that some nurses don’t speak English good so they have to teach them English and I was saying why don’t they teach us some basic words that we should know in Maltese, why they teach them in English why don’t they teach us listen this means I don’t feel good I want water ....these kind of words for example during the night when we are short be cause the other is on break I need to know......the basic. Even the patient has the right to speak to someone (acknowledge the language problem for the patients) who can understand him and cannot force the patient listen you have to speak to me in English yes I tell him I don’t speak Maltese I only speak English, so... if the patient is talking in English it is OK.

Were you given an induction program when you came?

Yes.....it was few hours... the Hospital presentation about the system and that one after I came here.....I don’t know I think in November....
Searching for connections (clustering) across emergent themes emerged from the analysis of the above whole transcript.

- Never heard about Malta – p.1
- Recruitment was easy - p.2
- Sense of deceitfulness – p.3
- Lack of recognition - p.6
- Frustrated about the lack of recognition for their experience - p.6
- Lack of rights as an EU citizen – p.7
- Difficulties in communication – p 4/5
- Difference in practice – p.3
- Acknowledge that there is a language problem for the patient – p.4
- Difference in nursing role – p.3
- Easy adaptation – self sufficient – p.3
- Easy to adapt – helpful colleagues – p.4
- Proud to be Romanian – p.4
- Coping with the barrier – p.5
- Work experience quite positive – p.6
- Induction programm on the language – p.6
- Allocated to ward without any guidance – p.6

The super-ordinate themes emerged from each cluster of themes from the same interview analysis

**Mode of employment**
- Saw the advertisement for the job – p.1
- Requirements for the job – p.2
- Recruitment was easy - p.2

**Initial challenges**
- Sense of deceitfulness – p.3
- Frustrated about the lack of recognition for their experience - p.6
- Lack of rights as an EU citizen - p.7
- Lack of recognition - p.7
- Difficulties in communication – language barrier – p.4/5
- Coping with the barrier – p.4/5
- Acknowledge the language problem for the patients – p.4
- Frustration communication – p.5
- Communication barrier – p.6

**Easy adaptation** - self sufficient – p.3
- Easy to adapt – helpful colleagues p.4
- Adapted – p.4
- Work experience quite positive – p.6

**Difference in nursing practice**
- Difference in practice – p.3
- Difference in nursing roles – p.3

**Support**
- Induction programm on the language – p.6
- Motivation to stay - p.7
APPENDIX 7

INTERIM REPORT
Interim Report

This study was done to gain an understanding of the experience of expatriate nurses working in the Maltese health care system. The participants (n=10) were from Romania, Bulgaria and Philippines who were chosen purposefully on the criteria that they would have been working in Malta for at least two years. Data was collected from all of the ten participants through individual semi-structured interviews. After the eight interview, the researcher noted that participants' experiences related to the phenomenon under study was quite similar and was not leading to any more new information, while the data emerging was becoming repetitive. It was evident that data saturation was being attained, that is the point at which no additional information was achieved (Polit and Beck, 2004). However, to ensure that no other relevant data was missed out, an additional two interviews as was initially planned were conducted.

After the interviews were transcribed and taken back to the participants to ensure that the transcripts are a clear version of the participants' view, one of the nurses decided to back out of the study, requesting that her data would not be used in my study. Her decision was respected and only nine interviews were analysed further. On the whole the participants showed interest in describing their experience to someone for the first time since they have started to work in Malta. The interviews sought 1) to gain insight into the experience of expatriates working as nurses in Malta, (2) to explore the factors which influenced their adjustment to the new context of Malta (3) to identify any strategies and interventions that nurses undertake to adapt to their new environment from a personal and professional perspective and (4) to determine strategies that may help expatriate nurses experience a favourable transition and optimal adjustment to the context of working as nurses in Malta.

The analysis of the interviews had also indicated data saturation when the same themes had emerged in the data. The majority of the participant had articulated a positive experience although some of them had expressed their concern that some of their expectations that they had before coming to Malta had eroded, most of them because of
the barriers that they had encountered. The major challenges that they had experienced was related to the language barrier that they had encountered because of the Maltese language, followed by some differences in the nursing practice and the fact that their previous experience and knowledge were ignored resulting in them being employed in lower grades with their qualifications and experience being ignored. Some of them had also expressed their anger to the fact that they had also initially encountered problems with getting their spouse over to Malta. Recommendations include more recognition of these expatriate nurses' qualifications, policies on the recruitment of these nurses and further research in the light that more nurses are being recruited from other non-European countries. Expatriate nurses can provide an important resource for the healthcare workforce in the delivery of patient care,
APPENDIX 8

TABLES OF RESEARCH STUDIES
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<th>Authors</th>
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<th>Method</th>
<th>Main Findings</th>
<th>Limitations</th>
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<tr>
<td>Yi &amp; Jezewski, (2000) - United States</td>
<td>To investgate how Korean nurses adjust to USA hospital settings, and to identify the stages of adjustment</td>
<td>A purposive sample of twelve Korean nurses, their age ranged from 25-57 and average stay at the USA ranging from 1 to 23 years.</td>
<td>Grounded theory methodology, using semi-structured interviews as data collection method</td>
<td>Korean nurses faced challenges and needed adjustment in five areas: high psychological stress, overcoming language barriers, accepting U.S nursing practice, adopting U.S problem-solving strategies and adopting U.S interpersonal relationships.</td>
<td>Homogenous sample, thus findings are influenced by Korean culture, thus reducing applicability of results to other ethnic groups of nurses migrating to U.S.</td>
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<td>Daniel, Chamberlain &amp; Gordon (2001) - United Kingdom (UK)</td>
<td>To identify initial expectations and experiences of Philippine nurses at a London Hospital</td>
<td>One group of 15 Philippine nurses who had been in the UK for at least 3 months and were seeking to be registered after completion of a 6 month adaptation programme. The second group comprised of nine Philippine nurses who had been on the hospital 2 week orientation program and had only been in the clinical area for 1 hour to observe.</td>
<td>Exploratory qualitative approach using focus group interviews</td>
<td>Nurses had arrived in the UK with expectations pertaining to career progression, training opportunities and better salaries, as well as expectations for a different nursing role and clinical environment. However, according to the author it was too early to gauge if such expectations were reached. Nurses from the first group had experienced difference in nursing with a key feature being the minimal amount of input in actual patient care delivery from the patients' own families, unlike in the Philippines. They had also experienced a lower staff ratio compared with their country, difference in the role of the nurse and the organisation of care, and mentioned problems with communication due to language barriers.</td>
<td>Limitations due to the homogenous group both from ethnicity and gender, and those that pertain to using focus groups as a method of data collection during which the expressed view of one individual does not mean it represents the view of the whole group, particularly because the researcher acknowledges that a few individuals had dominated the discussion during the focus groups. Another limitation is the difference in the length of experiences of the different participants, therefore this limits the consistency of the analysis and derivation of themes across the two groups.</td>
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<td>Wong (2002) - Hong Kong</td>
<td>To explore the clinical and cultural coping strategies used by Mainland Chinese immigrants in Hong Kong to handle psychological stressors experienced during the resettlement stage of the migration process.</td>
<td>A purposive sampling technique was used to select thirty adult immigrants aged 18 or over who had resided in Hong Kong for less than two years at the time of the interview.</td>
<td>A qualitative exploratory study utilising one to one semi-structured interviews that had followed randomly an interview schedule with open ended questions constructed around the type of coping strategies used by immigrants to handle specific areas of resettlement difficulties.</td>
<td>Immigrants used different types of coping strategies to handle different types of problems encountered during resettlement. Three sets of coping strategies were extracted from the analysis of the interviews: i) direct action coping strategies, ii) cognitive coping strategies and iii) emotion-focused coping strategies. It was recommended that immigrants should be provided with counseling to help them find ways of tackling their problems effectively, to understand and accept the limitations posed by reality of lives in Hong Kong and to assert themselves when necessary.</td>
<td>Although the findings are indirectly relevant to nursing, however it does shed light on the challenges nurses face when they seek employment in new contexts.</td>
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<td>Allan &amp; Larsen, (2003), United Kingdom (UK)</td>
<td>The study explores the motivations and experiences of international recruited nurses (IRNs) working in the UK.</td>
<td>Sampling for the focus group was a two way process. After 2,200 international recruited nurses were randomly selected from the RCN database in three different regions in the UK, a letter was sent by the RCN to ask the nurses if they were interested to participate in the study and were asked to contact the researcher with a reply by phone. Those participants (n=40) who accepted to participate in the focus group and met the inclusion criteria were sent an invitation for the focus groups. The referred 40 participants were asked to invite their colleagues to participate and call the researcher accordingly if interested (snowballing). 67 overseas nurses participated in the focus groups.</td>
<td>Qualitative approach: data was generated in two stages: i) secondary data through reviewing of existing research and ii) primary data using 11 focus group interviews with 67 IRNs.</td>
<td>The experience of IRNs working in the UK were shaped by their personal characteristics and expectations such as one's professional, financial and social situation and aspirations.</td>
<td>Limitation related to the snowballing sampling technique whereas biases can be built especially in view of the fact that participants who will have certain characteristics in common will very often take advantage of their social network, thus influencing their responses.</td>
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<td>Kline (2003) - International study</td>
<td>To describe the push and pull factors of migration in relation to international recruitment and migration of nurses</td>
<td>Articles reviewed between 1993-2002. Review of the literature on nurse migration, examination of effects of donor and receiving countries and discussion on ethical concerns related to foreign nurse recruitment.</td>
<td>Review of the literature</td>
<td>The primary donor countries are Australia, Canada, the Philippines, South Africa and the United Kingdom, the primary receiving countries are Australia, Canada, Ireland, United Kingdom and the United States. The results of migration from donor countries include loss of skilled personnel and loss of economic investment. In turn, receiving countries receive skilled nurses to fill the nursing shortages and gain economically.</td>
<td>The process of how the articles for the review were chosen and any inclusion criteria were not reported by the authors in the review therefore the appraisal was very weak. Moreover articles reviewed were very old.</td>
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<tr>
<td>Allan, Larsen, Bryan &amp; Smith (2004) - United Kingdom</td>
<td>To explore the experiences of discrimination and racism among internationally recruited nurses working in the UK.</td>
<td>A purposive sample of 67 internationally recruited nurses from various countries. Participants had different backgrounds, experiences, views, nationality, ethnicity, gender and current professional status</td>
<td>Qualitative approach, using audio taped 11 focus group interviews as a data collection method</td>
<td>The key findings were that racism was experienced by various participants and that coping with racism was significantly challenging for the participants.</td>
<td>The sample was purposive. Limitations pertaining to the focus group method of data collection where some of the participants tend to dominate over others in the group, particularly because some participants were more fluent in English than others thus making it more easy for them to voice their opinion during the focus groups.</td>
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<td>Alexis &amp; Vydelingum (2004)</td>
<td>To explore, describe and develop a greater understanding of the experiences of black and minority ethnic internationally recruited nurses in the UK.</td>
<td>A purposeful sample of twelve nurses originating from Philippines, South Africa, Caribbean and sub-Saharan Africa.</td>
<td>A phenomenological approach using Heidegger’s perspective on hermeneutics. Data was collected through semi-structured interviews.</td>
<td>Participants recounted their difficulties in adjusting to their new settings. The difficulties that were encountered resulted from differences in nursing practice especially with regards to organization of care, differences in communication as English was not their first spoken language resulting in embarrassment and humiliation, lack of equal opportunities especially for promotions, and lack of organizational formal support. Some participants reported that colleagues treated them well while others noted experiences of bullying by colleagues.</td>
<td>Findings could not be generalized due to the small sample size and the different nationalities within in. Having different cultures pooled in the cohort of participants poses limitations in extending findings across the study and moreover beyond.</td>
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<tr>
<td>DiCicco-Bloom (2004) - United States</td>
<td>To describe the experience of a group of immigrant women nurses working in the US, regarding their life and work in a culture that differs from their own.</td>
<td>10 South Asian nurses all coming from India who were selected through a snowballing technique.</td>
<td>A qualitative approach, using semi-structured interviews with open ended questions</td>
<td>Dominant themes that emerged were cultural displacement and racial experiences in the work place and at home.</td>
<td>Findings are limited to contexts pertaining to participants from an Indian culture, therefore careful attention need to be taken with the applicability of the results to other contexts.</td>
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<tr>
<td>Gerrish &amp; Griffith (2004), United Kingdom</td>
<td>To evaluate an adaptation programme for overseas nurses, and identify the various meanings of success of the referred programme as defined by the stakeholders.</td>
<td>A purposive sample of 17 female nurses originating from China, the Philippines, India and sub-Saharan Africa were chosen for this study. With the exception of one nurse, all the nurses had a post registration experience of over 10 years, with the time spent in the UK varied from seven months to six years.</td>
<td>Focus groups and individual interviews with nurses, clinical mentors and ward managers, and individual interviews with Assistant Chief Nurses, Recruitment manager, promoting diversity officer and three educationalists.</td>
<td>Five ways of defining success of the programme were identified: gaining professional registration, fitness for practice, reducing the nurse vacancy factor, equality of opportunity and promoting an organisational culture that values diversity. The ease with which nurses gained Auk registration and integrated into the UK workforce was influenced by the characteristics of the work environment, level of support and organizational context.</td>
<td>Limitation is mostly related to the limitation in the generalizability of the results because this study had focused only to the British context.</td>
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<td>Veer, de, Ouden den &amp; Francke (2004) - Netherlands</td>
<td>To find out how many nurses qualified in other European countries migrated to the Netherlands and to explore why they migrate to the Netherlands, how do they prepare for work, and their experience of working in the Netherlands.</td>
<td>980 nurses working in the Netherlands and who hold an EU nationality other than Dutch, most of them coming from Belgium, Germany or the UK between 30 and 50 years of age participated.</td>
<td>Quantitative approach using a structured questionnaire as data collection method with questions covering reasons for experiences when seeking employment in the Netherlands and the experience when working in the Netherlands.</td>
<td>Primary reasons for migration to the Netherlands were personal circumstances such as marriage and spousal employment. Problems encountered were knowledge of the Dutch laws and procedures, Dutch taxes and social security, Dutch language especially for the non-Belgian nurses, lack of knowledge of the healthcare system and lack of support from employers.</td>
<td>The use of a questionnaire limited the depth and nature of the data collected.</td>
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<td>Taylor, (2005) - United Kingdom</td>
<td>To explore the experiences of nurses who have trained overseas and travelled to work in the UK.</td>
<td>A purposeful sample of eleven overseas nurses representing the Philippines, China, Finland, New Zealand, Nigeria and South Africa participated in the study.</td>
<td>A qualitative research design using a constructivist methodology, the primary method of data collection being participant observation during which the researcher worked as a care assistant working alongside overseas nurses. A second phase of the study comprised two focus groups with UK trained colleagues of the foreign nurses and three foreign nurses. A one to one interview was also conducted with two overseas nurses who could not attend the focus group which was carried out amongst the foreign nurses.</td>
<td>Six themes emerged from the combined data: i) Communication due to the language barrier that had caused overseas nurses to feel isolated and being treated differently, ii) differences in the nurse's role, iii) de-skilling of overseas nurses when their experience and clinical competence were not recognized, iv) the devalued status of overseas nurses when nurses described themselves as being treated like a child, v) racial discrimination and vi) pastoral support.</td>
<td>The multi-method approach strengthened the data of the study with respect to both confirmability and completeness of the collected data. However, the number of participants (n=3) who participated in the focus group was relatively small.</td>
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<tr>
<td>Matti &amp; Taylor, (2005) United Kingdom</td>
<td>To explore the cultural experiences of international recruited nurses (IRNs) in the UK, both from a personal and a nursing perspective</td>
<td>12 nurses from Mauritius, Philippines, India and Nigeria with a nursing experience ranging from 3-12 years and length of stay in the UK ranging from 9-12 months</td>
<td>A phenomenological approach using semi-structured interviews as data collection method</td>
<td>Findings show that migrating nurses' own culture, influenced their adaptation. Cultural facets which were influential include; preparation in their country of origin and exposure to international contexts. The quality of induction programme received in the UK, language issues and the support that they got from the host nurses also influenced one's adaptation.</td>
<td>This study was based on experiences from only a few nurses from four specific countries and was limited to one global geographical area only.</td>
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<td>Magnusdottir (2005) Iceland</td>
<td>To generate an understanding of the experience of foreign nurses working at hospitals in Iceland</td>
<td>Purposive sample of 11 registered nurses coming from 7 different countries. Initial estimation of the sample was 55 nurses.</td>
<td>Vancouver School of doing phenomenology-a hermeneutic methodology influenced by constructivism and the work of Paul Ricoeur. Unstructured interviews were used</td>
<td>Five main findings emerged: i) the initial challenges were addressed through using source of strength from their patients and colleagues, ii) the importance of a supportive manager and spouse was paramount and seeking the use of prayers and relaxation free time, and phone calls to home were main coping strategies. iii) Nurses felt they were outsiders and needed to be let in especially when participants felt they needed to be valued and trusted; iv) struggling with the language barrier and adjusting to a different work culture were very experiences and v) overcoming initial challenges resulted into significant personal and professional growth.</td>
<td>A small sample with different cultures</td>
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<tr>
<td>Winkelmann-Gleed &amp; Seeley (2005) United Kingdom</td>
<td>To examine the experiences of internationally qualified nurses who migrated to the UK</td>
<td>The recruitment of the sample was done through a refugee organization which supports migrant nurses in accessing employment in the NHS regardless of their motives for travelling to England. Majority of the migrant nurses were of Asian origin</td>
<td>Qualitative and quantitative approach using self-administered questionnaire (n=140) and in depth interviews with 22 nurses and a follow up interview after one year with only seven nurses. An interview was also carried out with key informants (26) which among others included NHS managers.</td>
<td>Most of the migrant expressed satisfaction with their work environment and the way they were treated. They spoke positively about the way they passed on their language skills when foreign patients were being cared for and how they served as translators and contributed to ease the communication between patients and doctors. On the other hand there were times when these nurses felt excluded and rejected, and some recounted experiences of unfavourable treatment by their mentors.</td>
<td>Method used in carrying out the study was not clearly explained in the published resource</td>
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<tr>
<td>Likupe (2005) United Kingdom</td>
<td>To explore the experiences of Black African nurses in the UK</td>
<td>Only articles written in English and which studied the experiences of overseas nurses were selected.</td>
<td>A literature review of 19 articles dealing directly with the experience of particular ethnic group with no limitation of year of publication</td>
<td>Six themes related to the experience of overseas nurses were identified: i) Motivation for working in the UK described in terms of push and pull factors, ii) pay and conditions iii) experience in the NHS some have reported a positive experience while for others it was a negative one resulting mostly from language barriers, unfavourable treatment stemming from racial discrimination, iv) exploitation, v) discrimination and harassment and vi) other ethical issues related to the ethics of national policies especially when countries who are struggling with their economy and cannot afford to offer better conditions for their nurses are losing skilled nurses to richer countries.</td>
<td>No limitations of year of publication, some were old dated back to 1988 and 1995.</td>
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<td>Edwards &amp; Davies (2006) States</td>
<td>To determine the learning needs of internationally educated nurses and their perceived competence in a specific set of clinical areas</td>
<td>Nurses taking the CGFNS certification examination in different countries around the world were asked to participate to determine how they felt their education prepared them for nursing practice in the United States. 90% were Asian. The CGFNS qualifying examination predicts success in the U.S. licensure examination and also meets one of the basic requirements for obtaining an occupational visa to practice nursing in the U.S.</td>
<td>Quantitative design using The Clinical Competency Survey to measure perceived proficiency in activities related to safe and effective nursing practice. These included conducting physical assessments, planning nursing care, administering medications, performing treatments, managing specific diseases conditions and using technology. Surveys were mailed to all domestic and international CGFNS sites.</td>
<td>Each dimension was analysed in relation to gender, age and educational program. There were few differences in scores for each dimension by gender or educational preparation. There was little difference in perceived proficiency by age except for those in the fifty age groups, who scored themselves lower in performing treatments, managing cardiac patients, administering medications and using the nursing process for care planning. However they scored equally high in using technology.</td>
<td>Quantitative design thus further in depth collection and analysis of data obtained was restricted. Response rate from each country was very low thus significant numbers of respondents were lost. In most countries response rate was below 50%; Philippines- 60%, India (30 %), Nigeria- 3 % and other - 7 %; thus it was unable to obtain a representative sample of CGFNS candidates across the world.</td>
</tr>
<tr>
<td>Konno, (2006) Australia</td>
<td>To summarise the best available evidence regarding the adjustment by overseas nurses to Australian nursing practice.</td>
<td>12 Qualitative and Quantitative Australian studies were included in the review. Participants in these studies had all received their basic nursing education outside Australia, English was not their first language and had worked outside Australia.</td>
<td>Literature review</td>
<td>Issues identified through the analysis of all quantitative and qualitative studies included; the need to include cultural difference issues in a transition/adaptation programme for overseas nurses and ii) the provision of formal networks for overseas nurses and support to facilitate the establishment of informal networks. It was also identified that nurses had experienced loneliness, isolation and a feeling of being an outsider resulting from the nurses' inability to communicate effectively in English. The use of preceptorship or buddy nurses was also reported to facilitate nurses' adjustment to Australian nursing culture.</td>
<td>Some articles reviewed are very old dated back to 1985-2003. Moreover, the conclusion of this review is limited by the designs of the studies.</td>
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<td>Smith, Allan, Henry, Larsen, Mackintosh (2006) UK</td>
<td>To analyse overseas trained health care professionals' experiences of working in the UK, their employment mobility and career progression, in order to inform policy development related to international recruitment</td>
<td>A total of 93 overseas trained healthcare professionals were included in the study, who had lived in the UK for varying lengths of time. Time was considered important due to the study's focus on career progression. Ethnicity was primarily black African 43% while 27% were Philippine.</td>
<td>Qualitative design. For the purpose of data collection individual semi structured interviews with overseas trained nurses were used together with interviews with national and local stakeholders and case studies involving UK health care employers in the NHS and independent sectors in different regions of the UK.</td>
<td>Overseas trained nurses' skills are not recognised resulting in under grading and deskilling. Migrants' varying motivations are poorly understood and not addressed effectively. Stereotyping across different migrants was evident which often resulted in career progression.</td>
<td>Findings were mostly influenced by the high percentage of Africans' response (43%) compared with the low Philippine response (27%)</td>
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<td>Aboderin (2007)</td>
<td>To understand how Nigerian nurses' socio economic, cultural and professional contexts and position in their home country shaped their migration motivation and influenced their experiences in the UK system.</td>
<td>Initially 46 Nigerian nurses were systematically selected among the Nigerian overseas nurses in the UK and working for an independent nursing home, using fixed selection criteria. Of the 36 participants invited to participate 11 declined, 25 accepted and were interviewed. Additionally, suitable nurses and nurse tutors in Nigeria, were opportunistically identified for the study by gate keepers of the nursing system in Nigeria.</td>
<td>A qualitative approach conducted in two phases. Phase 1: Interviews with Nigerian (n=25) nurses working in an independent nursing home, and informal conversation with care home managers and non-migrants. Phase 2: Interviews conducted in Nigeria with registered Nigerian nurses, nursing tutors=5), and returnee migrant nurses.</td>
<td>The nurses migrated to provide a better education and quality of life for their children. However, professionally the group was working in a nursing home, not utilizing their skills or making as much money as they should have been. The nurses claimed to have experienced discrimination in the work place by the white carers and by nurses of lower status.</td>
<td>Time and resource constraints acknowledged therefore limited the number of participants.</td>
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<td>Alexis, Vydelingum &amp; Robbins (2007)</td>
<td>To explore, describe and develop a greater understanding of the experiences of overseas trained black and minority ethnic nurses in the South of England</td>
<td>A purposive sample of 24 nurses originating from Africa, Asia and the Caribbean with a total of 8 different countries.</td>
<td>A qualitative phenomenological study utilising 4 focus groups as a method of data collection.</td>
<td>Six main findings were identified: lack of trust or opportunities to demonstrate leadership; Discrimination relating to lack of equal opportunities particularly as regards promotions; Concept of invisibility when participants were ignored by managers and colleagues; experiences of fear due to abusive attitudes towards them; feelings of self-blame; clear benefits of migration as it allowed the participants to support their family, while some others reported job satisfaction and reported positive experiences associated with being exposed to other cultures.</td>
<td>Limitations were largely related to using focus groups as a method of data collection.</td>
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<td>Larsen (2007)</td>
<td>In depth examination of whether discriminatory attitudes and practices are experienced by overseas trained nurses and how this discrimination may impact well being and career progression.</td>
<td>An analysis of two interviews (out of 93) conducted with two overseas nurses in Smith et al. (2006) study, purposively selected to provide in depth detail on experiences of discrimination and racism. The 2 informants were chosen out of the 93 that took part in Smith et a's study (2006) because of a range of similarities in their background and experiences.</td>
<td>Secondary phenomenological analysis of two semi structured interviews. The two participants were selected due to similarity in the participant's backgrounds and experiences, and yet differences in circumstantial experiences on migrating resulting in very different career outcomes.</td>
<td>One participant experienced persistent social undermining and helplessness profoundly affecting her personality and sense of self, making her career trajectory suffer. She was working at the same level as she was when she arrived 5 years earlier. The other participant pursued a master's in education and increased his nursing status. He denied any experience of discrimination.</td>
<td>With only two interviews analysed one cannot generalize the findings.</td>
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<td>O'Brien (2007)</td>
<td>To address the issues involved in recruiting, retaining and supporting overseas nurses in hospital trusts in England.</td>
<td>63 participants; 40 overseas (India, Philippines and Spain) recruited nurses randomly selected from respective lists, 8 managers who were purposely selected and 15 nurses who worked in nursing homes.</td>
<td>A case study approach with multiple research methods: 63 semi-structured interviews with 40 overseas trained nurses, 8 hospital managers and 15 home nurses. Most of them were mentors to the overseas nurses, periods of observation on the wards were carried out and data from internal hospital documentation, government data and national census information was analysed by the researcher.</td>
<td>Many overseas trained nurses reported issues of de-skilling which had caused frustration and the delay in full credentialing had led to employment in lower level nursing jobs. Overseas trained nurses have also reported that in their country they had more autonomy as a practicing nurse.</td>
<td>Limitations related to the selected sampling technique, the criteria was not identified in the study. Due to inadequate information about the sampling technique it is hard to verify whether the participants are truly representative of the target population.</td>
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<td>Palese, et al (2007)</td>
<td>To describe i) the Romanian nurses' reasons for migration and the difficulties experienced in the first six months, ii) their perception of the level of professional independence and competence gained in their first six months of working, and iii) the strategies that either facilitated or impeded their development of professional independence at the Udine teaching Hospital Italy</td>
<td>Seventeen Romanian nurses who had worked for at least 5-6 months. Many (58%) had obtained nursing training during secondary school unlike Italian nurses who had trained in a University.</td>
<td>A descriptive study. Bilingual interviews using anonymous questionnaires containing 28 questions, eight open and twenty closed questions. A likert type self evaluation scale was also included to describe the level of knowledge of the Italian language. To investigate the level of perceived professional independence a numerical rating scale from 0 to 10 was also used.</td>
<td>Language skills were rated as 4/5 for reading and 2.8/5 for speaking, Primary reason for coming to Italy was better financial income. Seven of 15 nurses identified their moment of crisis as having their language tested at the local nursing board, six participants said this was difficult because they had just started working on the ward and did not know the language well. Professional independence and competence ratings averaged 7/10 from the scale and 166/270 from the questionnaire.</td>
<td>A small sample; a homogenous group culturally; one area where the study was conducted.</td>
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<td>Robertson &amp; Gaggiotti - Central Asia (2007)</td>
<td>To examine the 'shocks' or disappointments faced by expatriates working in Kazakhstan.</td>
<td>Sample included 12 expatriates working within The Kazakhstan Institute of management, Economics and Strategic Research in the Republic of Kazakhstan (KIMEP). The sample size was limited to twelve to include only those new comers arriving within a specific period (September, 2005-January, 2006)</td>
<td>Qualitative exploratory design utilising semi structured interviews to investigate the key cultural shocks encountered by the participants on their arrival in their host country and any suggestions that participants might put forward as ways to minimise or reduce or adjust to these shocks and disappointments.</td>
<td>The key issue that was verbalized by several of the respondents related to the cultural shock they had initially experienced was the language barrier, as most respondents assumed that everyone or in the least most of the people would have at least an understanding of the English language. For the participants clearly communication is critical to proper adjustment. Other issues that had emerged were organisational differences, cultural adjustment related to better preparation before moving to Asia especially in what to expect which is vital as important and the importance of building their own networks of both expatriates and locals for support.</td>
<td>Although findings were relevant to some extent, study was not related to nursing</td>
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<td>Troy, Wyness &amp; McAuliffe (2007) - Ireland</td>
<td>To explore the perceptions and opinions of the persons involved in the recruitment of the foreign nurses in a Dublin Hospital, their role in recruitment and the effects recruitment has on both source and destination countries</td>
<td>A purposive sample of 12 directors of nursing from major academic teaching hospitals in Dublin and hospitals in South Africa and the Philippines. Ten overseas nurses who were from India (n=5) and from the Philippines (n=5) and had migrated to Ireland for between one and seven years, also participated in the study</td>
<td>A qualitative phenomenological approach was taken in order to describe a lived experience, utilising in depth interviews.</td>
<td>Five main findings were identified: i) Migratory intentions the major being an opportunity to work in another country leaving behind the poor conditions within the source country, ii) effects of recruitment which was mostly positive and beneficial with regards to financial and opportunities to engage in further studies, iii) work style diversity that had sometimes created difficulties for the overseas nurses, iv) there were alternatives measures to recruitment of overseas nurses proposed by the managers and v) request for compensation which had emerged mainly from the nursing directors in South Africa as they claimed they should be compensated for the loss of nursing manpower and skills.</td>
<td>Small and homogenous sample of only 5 Indians and 5 Philipines, particularly when India is a major source country for recruiting nurses in Ireland. Finding could not be generalised.</td>
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<td>Brunero, Smith &amp; Bates (2008) - Australia</td>
<td>The aim is to examine the experiences and needs of a group of overseas qualified nurses working in a major metropolitan tertiary referral hospital in Australia.</td>
<td>The survey was mailed to 150 nurses from various countries, who had been working in the hospital for at least 18 months. Only 56 (37.3%) surveys were returned from the initial survey of 150.</td>
<td>Descriptive survey utilising a questionnaire having 3 sections: a demographic information satisfaction rating, likert scale and four open ended questions that were adapted from Daniel et al. (2002) study</td>
<td>Nurses with English speaking background were more likely to secure employment in their chosen specialty. These nurses rated the hospital and orientations more positively. Three main themes emerged; career and lifestyle opportunities, differences in practice and homesickness.</td>
<td>The poor response rate is the major limitation and limited information regarding the selection of the sample.</td>
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<td>Beechinor &amp; Fitzpatrick (2008) - United States</td>
<td>To describe and compare the demand of migrant nurses from Canada and the Philippines who migrate to USA and work in Hawaii.</td>
<td>As was estimated the largest number of nurses who at the time of the study were working in Hawaii came from Philippines and Canada. Surveys were sent to 50 Canadian and 68 Philippine nurses. Participants were self selected volunteers from an accessible population of networks of migrant nurses in Hawaii who were registered nurses and being educated at a minimum level of professional nurse in Canada or Philipines.</td>
<td>Comparative descriptive design. A standardised D.I. scale was used to measure the demands experienced by the nurses. It consisted of 23 items rated on a six-point response scale, which had been previously psychometrically evaluated in four studies.</td>
<td>Canadian nurses experienced more stress than the Philippine nurses. The Canadian nurses' distress stemmed from feelings of loss, novelty, discrimination and not feeling at home in the receiving country, while the Philippine nurses' distress stemmed from the occupational and language challenges met. Moreover this can be attributed to the fact that Philippine nurses had previously experienced work in other countries more than the Canadians and therefore would have been familiar with the demands of migration.</td>
<td>Findings of the study could only be generalised to the Canadian and Philippine population working in Hawaii. In view of its quantitative approach questions might have not yielded very rich data. Data very restricted. Results could also be biased in view of the fact that in Hawaii there is a large Philippine population which could have influenced the results of the study as the Philippine nurses would have had a social and professional support system that is widely documented in the literature may decrease the level of stress and ease their adaptation.</td>
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<td>Emerson, Griffin, L'Eplattenier &amp; Fitzpatrick (2008), United States</td>
<td>Determine the i) levels of acculturation and job satisfaction, ii) relationship between acculturation and job satisfaction and iii) effects of select sociodemographic variables in predicting job satisfaction among Philippine nurses who were educated in the Philippines and work in the USA.</td>
<td>A convenience sample of 96 Philippine nurses were surveyed during a PNAA (Philippine Nurses Association of America) Eastern regional Conference in Baltimore.</td>
<td>Descriptive correlational statistics were carried out across data gathered through using a Short Acculturation Scale to measure acculturation, Part B of the Index of Work Satisfaction Scale to assess job satisfaction and a demographic questionnaire</td>
<td>A positive yet a moderate correlation between acculturation and job satisfaction emerged. Multiple linear regression statistics showed that all three independent variables (acculturation, length of US residency and age) predicted job satisfaction.</td>
<td>Data was restricted to only one ethnic group. Comparison related to similarities and differences in acculturation and perception of job satisfaction could have resulted in a broader perspective if the sample was larger and randomly chosen, or with different ethnic groups.</td>
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<td>Sherman &amp; Eggenberger (2008), United States</td>
<td>To investigate the educational and support needs of international nurses from both their own perspective and that of managers with experience in supervising internationally recruited nurses.</td>
<td>21 internationally recruited nurses participated in the study together with 10 managers with recent experience of supervising newly recruited nurses from countries outside USA. Participants were chosen through a geographically diverse purposive sampling approach. The majority of the participants were from India.</td>
<td>A qualitative design. Data was collected through telephone semi structured interviews during which notes were taken during the telephone conversation.</td>
<td>Four main findings emerged from the data gathered amongst nursing managers: Nurses who had worked in similar health care system adapted easier, ii) the nurse leaders themselves stated that they would have preferred if they were given training on how best to support the international recruited nurses, iii) the need of an extensive orientation programme for overseas nurses and iv) the perception towards migrant nurses was that they were willing to learn, they were hard workers and disciplined. Three main findings from IRNs: i) difference in nursing practice; ii) most experienced transition challenges and iii) orientation needs were most critical, especially orientation to health policies.</td>
<td>Through a telephone interview data collection can be very limited especially since data was not recorded, meaning that interviews could not be re-listened, and thus some important data could have been missed.</td>
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<td>Allan, Cowie &amp; Smith (2009) - a United Kingdom</td>
<td>To illustrate how racist bullying as discriminatory practices operates in the workplace.</td>
<td>Three of the participants from the 93 overseas trained nurses and other healthcare professionals from different backgrounds across three UK regions in Smith et al study(2006). The three interviews were selected because they illustrate in detail racist bullying practices as well as a range of emotional reactions and coping strategies in response to such negative behaviors.</td>
<td>Secondary analysis of three semi structured interviews purposely selected in which the participants had talked about their experiences of discrimination. Limited information regarding the approach to the secondary selection is provided.</td>
<td>Three themes emerged from the analysis of the three interviews: i) abusive power relationships between managers and the employee were experienced, ii) communication difficulties which according to one of the participants was part of the social exclusion these nurses experienced and from the subtle social misunderstandings because of their poor command of the English language, iii) and emotional reactions to bullying resulted in lowered self esteem.</td>
<td>Limited only to the three interviews purposely selected from the 93 interviews.</td>
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<td>Alonso-Garbayo and Maben (2009) - United Kingdom</td>
<td>To compare the different motivations of nurses who had migrated to the UK from different countries comparing the motivations and reasons of migration of those of nurses with previous migratory experience, with those of first-time migrants, as well as the different motivations of Philippine and Indian nurses.</td>
<td>Nurses recruited from India (n=6) and the Philippines (n=15). Participants were purposively selected from a National Healthcare Service (NHS) acute trust in London. London was selected because it employs the largest number of foreign nurses, more than anywhere else in the United Kingdom.</td>
<td>Qualitative interpretative approach. Data was collected by means of semi-structured interviews in 2 phases: 1: longitudinal study of six Indian nurses who were interviewed three times over eight months from the date of their arrival in the UK and 10 of their managers and mentors. 2. Cross-sectional Interview with Philippine nurses recruited from two cohorts – 6 nurses who had been in the post in the UK for 18 months and 9 nurses recruited 4 years earlier.</td>
<td>Nurses in the study reported the importance of family and friends regarding their decision to migrate, together with the influence of the cultural environment, especially for those nurses who had previously worked in Saudi Arabia before coming to the UK. For these nurses who had migrated from previous migratory destinations (e.g. Saudi Arabia) migration was also influenced by professional and social aspirations, unlike those nurses with first migratory experience who came to the UK for economical reasons.</td>
<td>Gender bias since all the participants were women. Findings could not be generalised due to its small sample although the author acknowledged that generalisation was not the objective of the study and the theories constructed from the findings can be tested in other similar contexts. Furthermore the authors also acknowledge that the recruitment of participants could be biased since it was undertaken by the Recruitment and Retention Department in the Trust and would have some organisational interests.</td>
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<td>Kawi &amp; Xu (2009) - International studies</td>
<td>To identify facilitators and barriers encountered by international recruited nurses (IRNs) while they adjust to a new health care environment.</td>
<td>Inclusion criteria included studies that were published in English and that described adjustment issues of international recruited nurses. Dissertations and thesis were included.</td>
<td>Based on Cooper's Five Stages of Integrative research Review, a systematic search of eight electronic databases was conducted through which twenty nine studies conducted in Australia, Canada, Iceland, UK and the USA were retrieved and analysed. Research designs comprised qualitative (62%), mixed methods (21%) and quantitative descriptive (3%) approaches.</td>
<td>Facilitators and barriers to the transition of IRNs in their new workplace environment were identified: Facilitators to adjustment in the new context were i) positive work ethic, ii) persistence and developing coping mechanism; iii) psychosocial and logistical support such as airport meet/greet and transitional programmes offered by employers. In most cases these were reported to be inadequate but the majority found support by fellow IRNs and social groups, iv) learning to become assertive in the new workplace v) continuous learning such on new technology, and the different culture. Barriers included: i) language and communication inadequacy, ii) differences in culture-based lifeways, iii) lack of support from staff, colleagues and supervisors in their adjustment, iv) inadequate pre- and post-arrival orientations, v) differences in nursing practice and vi) denial of opportunities for professional development and promotions.</td>
<td>The literature review appears to have been thorough and systematic</td>
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<td>Lin, (2009) - United States (U.S.)</td>
<td>To synthesize the existing literature about Asian nurses' work experiences in, and adaptation to the US health-care system</td>
<td>Four inclusion criteria were applied in the search that included: i) date of publishing 1992 or after; ii) written in English, iii) addressed issues related to Asian nurses working in the United States and iv) were research studies with either qualitative or quantitative designs. Only eight studies met the criteria, 4 quantitative; 3 qualitative and a 1 had a mixed method design</td>
<td>Literature Review based Cronin, Ryan and Coughlan's (2008) step-by-step approach to generate the results of the synthesis. The literature review process included first the review topic was selected, a search of the literature followed, literature was analysed, the review was written and presented.</td>
<td>Findings of this review were grouped into six major themes i) overcoming language barriers identified as a major obstacle for Asian nurses' adjustment to their new work environment, ii) dealing with discrimination such as inequitable working conditions; iii) adopting U.S. nursing practices with differences noted to be in the nursing routines and the overall role of nurses; iv) adjusting to the U.S. nursing practice; vi) becoming accustomed to the U.S. culture and vii) reconciling work ethics.</td>
<td>The majority of selected studies were descriptive therefore a limited depth of understanding can be generated. The work experience of Asian nurses and adaptation to working and living in the USA have not been fully explored.</td>
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<td>Okougha &amp; Tilki</td>
<td>To bridge the gap in evidence, highlighting issues met by migrant nurses that are rarely discussed but have the potential to damage relationships with clients and colleagues as well as the quality of care.</td>
<td>A purposeful sample of Ghanaian and Philippine nurses (n=13), working in various specialties and had spent 5 years in the UK</td>
<td>Qualitative methodology utilising a grounded theory approach. Two focus groups were undertaken, one comprising four men and three women from Ghana and one comprising five women and one man of Filipino origin.</td>
<td>There were few differences between the nurses from Ghana and those from the Philippines. Their experiences and problems were mostly related to communication and cultural shock that was related to respect, expectations of family and care provided by the family and approaches to death and dying.</td>
<td>The use of focus groups can create a limitation in that some of the participants tend not to participate in the discussion. The small number of participants in each group can also create a limitation as the discussion between them can be inadequate, in that the variants may be limited or under-represented.</td>
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<td>Allan (2010) - United Kingdom</td>
<td>To discuss barriers to effective and non-discriminatory mentoring in clinical placements for overseas nurses in the UK National Health Services followed by recommendations to stop discrimination and improve overseas 'nurses' experiences of mentoring.</td>
<td>Secondary analysis of interviews conducted with 93 overseas trained nurses with different backgrounds and in different circumstances across the UK by Smith et al, (2006). 24 national and 13 local managers and mentors.</td>
<td>A secondary analysis and discussion of the data related to mentoring of overseas trained nurses that had been previously collected Smith et al study (2006)</td>
<td>Analysis revealed that the main barrier to effective and non-discriminatory mentoring was the lack of preparation with regards to how cultural differences affect mentoring and learning for overseas nurses and their mentors. Mentorship should be provided in a way that it recognises that overseas trained nurses have been trained in a different system and have different learning styles. Mentoring system should also provide the necessary training for mentors, in that it should include diversity training issues, language differences and support and the emotional effects of migration.</td>
<td>Limitations are related to the secondary data analysis. In secondary data analysis the researcher cannot personally check the data so its reliability may be questioned.</td>
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<td>Nichols and Campbell (2010) - United Kingdom (UK)</td>
<td>To improve the recruitment and retention of migrant nurses in the UK by gaining insights into their working lives, the challenges they face and how they cope with them, and their views on UK nursing.</td>
<td>Inclusion criteria specified that studies had to be the lived experiences of nurses whose primary registration was obtained overseas, and published in the UK after 1994.</td>
<td>An integrative literature review of 30 primary qualitative and quantitative studies.</td>
<td>Seven themes have emerged after a process of content analysis: i) motivations for migration were largely related to career development, lack of opportunities unavailable in their home country and financial reasons, ii) cultural differences related to the different models of training, unfamiliar nursing roles and different approaches to nursing care were challenging, iii) residential care: nursing and residential care does not exist in many IRNs home country and thus working these environments was challenging, iv) Reimbursement were IRNs felt that they are not fairly reimbursed for the work that they do given their level of responsibility, v) deskilling in that their experience and knowledge are not recognised, vi) racial discrimination was experienced by some and vii) nurse's role and identity were different in that nurses felt that in their home country they are more technical.</td>
<td>The limitation of this literature review is that the nationalities of the nurses under review in the various studies are not adequately documented.</td>
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<td>Takeno (2010) -</td>
<td>To explore the perceptions of Korean and Japanese nurses about nursing in Australia</td>
<td>Five East Asian nurses - three Korean and two Japanese who had completed their basic nursing education in their home country and having work experience as an RN in their home country and Australia.</td>
<td>Qualitative exploratory research design comprising in depth semi structured interviews</td>
<td>Five themes emerged from the interviews: i) work conditions that include the workload and working style were favourable. Participants were happy with working conditions in Australia in terms of pay and work hours, and the workload ii) Support systems emerged quite positively by the participants who mentioned a well organised support team for overseas nurses, together with adequate continuing education opportunities iii) nursing values, where nurses appreciated the time they have to communicate with the patient were regarded positively however they were also struck by the differences in values and systems embedded in Australian nursing. iv) Language difficulties that resulted in anxiety and a negative experience v) cultural differences were widely reported.</td>
<td>A small sample size with a big difference in the amount of time spent by the different participants as nurses in Australia. Moreover because the researcher is Japanese and interviews with Korean nurses were conducted in English, data from the Korean nurses may not be as sound as those of the Japanese participants.</td>
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<td>Woodbridge &amp; Bland (2010) - New Zealand</td>
<td>To identify the significant factors that impact on migrating nurses becoming competent and confident registered nurses in the New Zealand practice environment</td>
<td>Search was limited to texts published in English between the period of 2002-2009, with preference given to peer-reviewed research based articles.</td>
<td>A literature review of 19 articles dealing directly with the experience of one specific ethnic group (Asian nurses).</td>
<td>The review revealed key issues related to the complexity of nurse migration: i) push factors are shaped by the poor working conditions and practice environments in their home country and the pull factors such as higher remuneration, better working conditions and greater educational opportunities; ii) educational opportunities since migrant nurses have to overcome many barriers to gain recognition of the nurses education obtained in their home country while ensuring that the host country provides a comprehensive orientation programm, iii) language competency which is one of the most critical tasks that migrant nurses in New Zealand have to face, iv) nursing skills and competence as migrant nurses face challenges when practicing in their new role and context and v) cultural competence.</td>
<td>Period of time is restricted to seven years only and this might have also restricted the data. Most of review was based on expert opinion articles and analysis of official data, rather than primary data retrieved from original studies.</td>
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<td>Newton, Pillay &amp;</td>
<td>To comprehensively review recent literature related to the migration and</td>
<td>Literature was deemed appropriate for inclusion if it was a report of</td>
<td>A comprehensive review of both quantitative and qualitative research</td>
<td>Common themes were extracted and synthesized including: (i) reasons for and</td>
<td>While the authors acknowledge that an extensive review of the literature was taken, the study is not a systematic review. Moreover, although the literature search is comprehensive, articles published in non-English languages or articles published before 2004 were not included, which may have limited the full breadth of the literature reviewed.</td>
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<td>Higginbottom</td>
<td>transitioning experiences of internationally educated nurses</td>
<td>research, rather than being a historical review, opinion or theoretical</td>
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<td>challenges with migration, (ii) include cultural displacement, (iii) language</td>
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<td>(2011)-</td>
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<td>based paper. Letters, editorials and commentaries were also excluded.</td>
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<td>and communication barriers upon arrival, (iv) feeling like an outsider.</td>
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<td>Internationally</td>
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<td>Only English literature was retrieved.</td>
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