Understanding the experiences of Pakistani educated nurses working in the United

Kingdom: A phenomenological approach

Thesis submitted in accordance with the requirements of the University of Liverpool

for the degree of Doctor in Philosophy by

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<u>DECLARATION</u>

I declare that this thesis is the result of my original work, except where indicated, for the degree of PhD at the Faculty of Health and Life Sciences under the supervision of Dr Maria Flynn; from the School of Health Sciences, and Dr Dave Mercer; from the Directorate of Nursing, at the University of Liverpool. No part of this work is submitted for any other degree anywhere without the knowledge of the University.

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ABSTRACT

Aim: The purpose of this study was to explore the lived experience of migrant Pakistani nurses working in the United Kingdom.

Background: Pakistani educated nurses have a history of migration to Middle Eastern and developed countries, and despite severe nurse shortages the Pakistan government has no strategy to retain these professionals. Pakistan saw an unprecedented shortage of nurses during the years 2000-2007 when about 1200 nurses migrated to the United Kingdom. This nursing 'brain drain' has negatively impacted on the health system in Pakistan, leaving it depleted of experienced health workers. Nevertheless, what motivates Pakistani nurses to migrate, and post migration experiences of these nurses are not known.

Methods: This study adopted the principles of hermeneutic phenomenology to explore the lived experience of Pakistani educated nurses working in the UK. A total of twenty one Pakistani nurses working and residing in the Northwest, Yorkshire and East Midlands of England were interviewed, including eleven females and ten male participants. In-depth face to face interviews were conducted with participants, supplemented by demographic information sheets, observations, and field notes. Analysis was carried out using van Manen's thematic approach.

Findings: Findings of the study reveal the complex nature of the 'life world' of participants and both dismal as well as affirmative experiences were revealed. The three major themes which emerged from the study findings were 'Becoming a Migrant', 'Dissonance and Devaluation' and 'Outsider Identities'. The lived experience of nurses showed physical and emotional hardships in Pakistan that pushed

them to leave the country and move abroad. Once migrated to the United Kingdom, these nurses started their careers in elderly care homes and found themselves devalued and deskilled. In addition, their lived experience included feelings of being isolated and alienated in the UK.

Discussion: The meaning of study findings reveals the concept of 'otherness' as core to understanding these experiences in the socio-cultural and geo-political context of the study. The meaning of Pakistani migrant nurses' lived experience is linked to marginalization, the politics of identity and belonging. The study is one of the first to describe the notion of 'otherness' as a means of understanding nurse migration, and adds to knowledge of the phenomenon of 'otherness' as it is lived and constructed. This study has also given voice to a small group of Pakistani migrant nurses who have otherwise been marginalised by their society, their profession and their migration to the UK.

ABBREVIATIONS

NMC   Nursing and Midwifery Council

PNC   Pakistan Nursing Council

GNC   General Nursing Council

IELTS   International English Language Testing System

MDGs   Millennium Development Goals

GP   General Physician

RGN   Registered General Nurse

RN   Registered Nurse

HEC   Higher Education Commission (Pakistan)

ICN   International Council of Nurses

WHO   World Health Organization

NHS   National Health Service (UK)

ICU   Intensive Care Unit

ONP   Overseas Nurses Programme

RCN   Royal College of Nursing

PIN Number Personal Identification Number

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PART I

CHAPTER 1

INTRODUCTION

1.1. Prologue

This research study is grounded in personal and professional experiences. Having attained a twelfth grade education, I had to *migrate* from Northwest Pakistan to the port city of Karachi to pursue a healthcare career; enlisting as a nursing student in a prestigious university. At this time, the *migration* of nurses to the United Kingdom (UK) was at a peak, and the opportunity to travel overseas after graduation presented exciting possibilities. During pre-registration studies, though, this trend in UK international recruitment abated, and requirements for non-European nurses to register with the Nursing and Midwifery Council (NMC) seemed daunting; not least, an International English Language Testing System (IELTS) score of seven. Because of the shortage of available nursing posts in the United Kingdom had declined radically, even the requisite English language score could not guarantee NMC registration.

Over the course of my nursing education and career in Pakistan, I witnessed the profession transform into a gateway for migration abroad. As a qualified nurse, I worked for two years in two leading hospitals in Pakistan, in clinical and teaching-cum-clinical areas. Interactions with colleagues, during this time, revealed that a significant number of them aspired to migrate to foreign countries. The two hospitals where I was employed had major issues of retaining trained and experienced nursing staff. It was not unusual the management to travel to other cities and schools of nursing

to recruit personnel. However, once these individuals had gained a degree of clinical expertise and experience they also tended to look for jobs outside of Pakistan. Although I had an understanding of how it felt being a Pakistani nurse working in my homeland, the motivation of others to undertake a migratory career was much less certain. These curiosities eventually provided me with a foundation to undertake academic study on an important aspect of nursing, moving from introspection to intellectual engagement.

To pursue post-graduate education I had to *migrate* to the United Kingdom, as no educational institutions provide for PhD studies in nursing or healthcare research in Pakistan. This was made possible by the award of a full time scholarship funded by the Higher Education Commission (HEC) of Pakistan. The phenomenological approach which informed this study outlines an interesting, and engaging, way to understand the lived experience of *becoming*, and *being*, a migrant Pakistani nurse; of what it *feels* like as a migrant to work and to live in United Kingdom, and how those collective *feelings* are grounded in a uniquely different cultural context.

1.2.   The context of the study

Living and working in a foreign country, especially in Europe, could be caricatured as the 'life dream' of many young Pakistani nurses. To move abroad in anticipation of better future prospects requires careful planning beside financial resources. Many Pakistani nurses with the ambition to gain foreign employment seek work in the Gulf States, returning home after a few years. During the year 2005-06, the shortage of nurses in Pakistan precipitated a staffing crisis in major private sector hospitals, sometimes compelling hospital managers to utilise nursing students as a strategy to ensure that shifts on the wards were covered.

Having relocated to the UK, as a post graduate student at the University of Liverpool, I encountered a number of Pakistani nurses of my own age who worked in independent sector nursing care homes. I noticed that these individuals tended, out of preference, to live in areas with established Pakistani communities. As I spoke with them, I sensed that their social life was a compromised one. Most had to work twelve hour shifts, only returning home to sleep. I was still unaware about their experience of working-life, or how they felt about *work* and *life* in the UK. Observations, and reflections, such as these assumed great importance in articulating the research question that drove this project.

In the first half of the last decade, an acute shortage of nurses in the United Kingdom created, again, opportunities for nurses from developing countries to seek work, with many Pakistani nurses hired by recruitment agencies for employment in private care nursing homes. Around this time, 'terrorist' attacks on the twin towers of the World Trade Centre in the United States of America (USA), and emergence of a 'risk culture', changed the western world view of Islam, and those professing the Islamic faith. The 'post 9 /11' culture, and political impact of a 'war on terror', had specific implications for Pakistanis moving to western countries. Pakistan as a country was linked to fears that it 'harboured terrorists', and Pakistani people were subjected to increased levels of surveillance and monitoring (Mythen, 2012, Mythen et al., 2009). In the United Kingdom, the '7/7' incidents in London, added further fuel to anti Pakistani sentiments as two of the four attackers were identified as British Pakistanis (BBC-News, 2005). Despite great diversity in the Pakistani population, common stereotypes of the 'Muslim', as members of an untrustworthy collective who potentially posed a threat to national security, emerged during this time (Mythen et al.,

2013). It is important to note that the transition experiences of migrant Pakistani nurses included in this study happened in the wake of these two events.

Migrant Pakistani nurses have high expectations of working in first world health care systems. Initially, migrant nurses have to undergo further training to secure a licence to practice in the United Kingdom. Their adaptation posed many challenges, but the struggle for advancement continued and over time they have grown personally and professionally. Many have now brought their families to the United Kingdom. Importantly, the United Kingdom government awarded British citizenship to these nurses; a changing status from foreign workers to British citizens. Most of them have no intention of returning to Pakistan, and want to reside permanently in the United Kingdom. However, as their transition into UK culture continues, it is paralleled by recognition of their being different from the host community; a difference of identity, which plays a part in constructing them as 'the other', 'alien' or 'foreigner'.

1.3.   The phenomenon of 'otherness'

For migrants, to adapt to a country with which they are not familiar is a difficult process (Ehrkamp, 2006). One dynamic of this is the concept of 'otherness' which captures the experience of the migrant in terms of culture, roots, language, and religion; typically accompanied by feelings of marginality, discrimination or rejection (Ehrkamp, 2006). Otherness is a phenomenon through which a group is considered as different and described as 'other', and as such is a socially constructed phenomenon (Avila-Saavedra, 2011). The identity/self of the 'other' is measured against a hegemonic universal human being/psyche, constructed as white, middle aged, working class, able bodied 'men' (Brown and Theodossopoulos, 2004, Hirose and Pih, 2011). The notion of otherness is relevant to gender, sexuality, religious belief, and migration.

As migrants start their life in a new country, their situation changes from *being part of* a majority to *being one of* an ethnic minority (Birman and Trickett, 2001, Kirkham, 2003). In white majority societies, critical race scholars give voice to non-white minority experience by challenging white power and privilege (Anthony, 2012) where, in a post-colonial context, one set of people dictate an ideological construct of 'others'. This assumption holds that people of colour do not have complete control over how selfhood is conceptualized, because a substatntial part of their identity is defined for them (Anthony, 2012): "The assumption is used to support the notion that white majority is more self interested, more power hungry, and more biased toward racial others than non white minorities" (Anthony, 2012, p 262).

The relationship between migrants and host societies has drawn a great deal of attention in recent years among scholars from different disciplines (Avila-Saavedra, 2011, Elsrud, 2008, Nagel and Staeheli, 2005) and, in the UK, is the basis of considerable political rhetoric. The majority of discourse and debate is around notions of assimilation and integration of migrants into their adoptive country. Assimilation is based on the assumption that migrants discard their own culture and values in order to embrace the culture and lifestyle of the new society (Nagel, 2002). Assimilation is rooted in normative world views, uni-dimensional interpretations of culture, and parochial systems of privilege and power: "By constructing immigrants as inferior other, native majorities create a sense of superiority and stability, it is immigrants who are 'othered', need to change, and to live up to the expectations of non-immigrants majorities set forth" (Ehrkamp, 2006 , p 1677).

Extant literature on migration has focused on assimilation of migrants into the host society as one of the requirements of adjustment. In Western countries, the issue of

Muslim migrants as different, and difficult to integrate, has attracted increased research attention in recent years (Betz and Meret, 2009, Dwyer, 2000, Kunst et al., 2012). For example, in the post 9/11 world, Arab Muslims in the USA described difficulties in gaining acceptance and becoming part of American society, but believed this could be achieved over time. They likened themselves, and their experiences, to those of Irish migrants to the United States in the 1950s (Nagel and Staeheli, 2005). In Germany, Turkish people are considered as being difficult to assimilate into society, and are often concentrated in geo-spatial colonies while maintaining their own culture, religion and identity (Erten, 2005, Ehrkamp, 2006). Migration scholars have paid attention to host-immigrant interactions and the way migrant identities are formed, often by focusing otherness and sameness (McDowell, 2003, Elsrud, 2008, Pio and Essers, 2013, Nagel, 2002). Identities are socially and politically constructed through individual identification and group formation, shared experiences and narratives that groups construct about themselves (Somers, 1992).

In this context, it is important to understand the ways in which migrant Pakistani nurses construct their life experiences in the UK. Before proceeding to explore these issues, though, it is important to understand some of the background that shaped their migration.

1.4.   Pakistani migrants in foreign countries

It is estimated that in 2004/05 approximately four million Pakistanis resided outside their country of birth, having formed overseas Pakistani communities in various parts of the world (Lakha and Aziz, 2011, Siegmann, 2010). A major portion of Pakistani migrants are in the Middle East which accounts for about two million of the overall figure. In Europe the major concentration of Pakistani migrants is found in the United

Kingdom, with 0.8 million (Lakha and Aziz, 2011). Pakistan is a leader in international migration, supported through public policies (Azam, 1995, Iqbal and Sattar, 2005, Azam, 2005, Siegmann, 2010). Pakistan has experience of over three decades of managing international migration (Azam, 2005). Overseas migration from Pakistan started in the early 1950, and has steadily increased in the intervening years. There have been domestic concerns regarding the migration of physicians from Pakistan (Sheikh et al., 2012, Imran et al., 2012, Aly and Taj, 2008), but nurse migration has drawn little attention from the academic community.

1.5.   The migration of Pakistani nurses to foreign countries

Pakistan has long faced chronic 'brain drain' issues (Kaukab, 2005, Khalid and Saleem, 2011, Lakha and Aziz, 2011, Talati and Pappas, 2006) and Pakistani nurses continue migrating to Gulf countries, UK, USA, Australia, and Malaysia. Pakistan is the sixth most populous country on the globe, with a currently estimated population of 180 million (Population-Census-Organization-Government-of-Pakistan, 2013). To meet health demands of this growing population, Pakistan needs to, both, train and retain more nurses for future workforce planning. The internationally recommended nurse/doctor ratio is 4:1 (World-Health-Organization, 2011), but in Pakistan the ratio is reversed with 3/4 doctors for one nurse (Shah et al., 2008); indicating a severe imbalance in the healthcare workforce. Additionally, an estimated 25% of nurses leave the country (Sarfaraz et al., 2010). Pakistan faced a severe shortage of nurses in 2003-2006 when about 4% of the total nurse population moved to the UK. The Nursing and Midwifery Council register shows that some 1,200 Pakistani nurses have registered to practice in the UK in the years 1999-2008 (Nursing-and-Midwifery-Council, 2008). Ironically, nursing regulatory bodies in Pakistan have no reliable data on the actual

number of nurses working in Pakistan and/or leaving for employment abroad. Moreover, there is no strategy to retain, and sustain, Pakistani educated nurses.

Migration of Pakistani nurses to foreign countries is an established phenomenon, and weekly newspapers advertise vacancies for Pakistani nurses to work in Saudi Arabia, Bahrain, Oman, Abu-Dhabi, Kuwait, and other Gulf countries. These nurses are temporarily hired on a contract basis, and once the contract is completed they must return to Pakistan. However, Pakistan saw an unprecedented shortage of nurses in 2002-2005 when a large number of nurses migrated to the United Kingdom, where there was an acute shortage of qualified staff. Many Pakistani nurses have, since, tried to migrate to the United Kingdom, despite legislation curtailing employment of non-Europeans. Unlike nurses who move to Gulf countries for employment purposes, nurses migrating to the UK have an opportunity to obtain indefinite leave to remain. In this context, the opportunity to start a 'new' life abroad may represent one driver for nurse migration. However, little is known about the motivation of those who choose to leave Pakistan, or their experiences of working in the United Kingdom.

1.6. The shortage of nurses in Pakistan

The shortage of qualified nurses is a global health issue (Ineternational-Council-of-Nurses, 2006). Ever increasing globalization has resulted in the loss of healthcare professionals from developing countries (Cutcliffe and Yarbrough, 2007), where South Asian countries are the main victims of this international trend. They are also witnessing internal migration from rural to urban areas, and external migration from developing to developed countries (Khan, 2007). The loss of human resourcing, due to overseas migration, compromises the capacity of health systems to delivery care in regions where it is most needed (Stilwell et al., 2004).

Pakistan is facing an acute shortage of qualified nurses (Manzoor et al., 2010) but there is no accurately available data on the actual number of nurses employed in hospitals. Newspaper reports, though, indicate that government sector hospitals in Pakistan are particularly affected (Kundi, July 23, 2011, Iqbal., May 12, 2011). For an estimated population of 180 million, there are only 55,165 registered nurses. This means that only one nurse is available for every 2,973 people (Federal-Bureau-of-Statistics-Government-of-Pakistan, 2006). According to the estimates of the Pakistan Nursing Council (PNC) in 2009, only 27,000 nurses were employed in Pakistan, with 15,000 unfilled posts (Oulton and Hickey, 2009). Most recent statistics indicate that in relation to the total population there is an overall shortfall of about 1.3 million registered nurses in Pakistan (see Table 1).

A shortage of nurses has also affected the achievement of Millennium Development Goals (MDGs) in Pakistan. MDGs, endorsed by the UN General Assembly in September 2000, represent broad international consensus on human development targets that developing countries must strive to achieve by 2015 (Islam, 2004). There are eight MDGs, and Pakistan is struggling hard to achieve each of these. These development goals aim to improve child and maternal health, but Pakistan has the poorest health demographic indicators in South Asia. In 2006, Pakistan had an infant mortality rate (IMR) of 76 per 1000, and maternal mortality rate (MMR) of 276 deaths per 100,000 births (Shadoul et al., 2010). A significant shortfall of nurses is identified as one of the biggest obstacles in achievement of MDGs (Kirk, 2007), with great detriment to any health improvement policies in Pakistan. Moreover, the international migration of Pakistani nurses will directly impact on quantity and quality of the current nursing workforce and healthcare delivery systems.

Table 1: Health professional numbers in Pakistan

Resource	Registered	International Standard	Requirements (estimated for a population of 170 million)	Shortfall
Doctors	145,799	2 physicians per 1000 population	340,000 doctors	194,201
Dentist	10,693	1 Dentist per 1000 population	170,000 dentists	159,307
Nurses	55165	4 nurses to 1 doctor	1,360,000 nurses	1,304,835
Pharmacy	32511	1 pharmacist per 6 doctors	62,085 pharmacists	29,57

Source: (World-Health-Orgnaization, 2011). WHO Global Code of Practice on International Recruitment of Health Personnel Implementation Strategy Report 2011 – Pakistan.

1.7. The importance of nursing workforce in healthcare

Nursing staff are considered the mainstay of contemporary, high quality, health care systems around the globe (Kirk, 2007), where standards of health care performance and provision are determined by the knowledge and skills of nurses (Scott et al., 2014). Today, nurses not only play a vital role in providing clinical care in hospitals, but extend their roles into advanced practice arenas, tasks previously undertaken by doctors; in some places, this includes surgical procedures (Scott et al., 2014). Nurses also deliver counselling services, risk-manage challenging behaviours, and promote healthy and safe living in the community (Bhutta et al., 2008, Guo et al., Underwood et al., 2009).

Nurses with higher educational qualifications in diverse fields can become senior executives in hospitals, long term care facilities, community health centres, home care agencies, nursing colleges and professional associations (Bernard, 2014). In such positions, they are often responsible for managing large staff numbers and multi-million dollar budgets, establishing standards for care, or advocating public health policy. With scarce resources rapidly becoming a global reality, nurses need to be able to effectively support, through research evidence, clinical and health policy decision-making related to development of the profession (Lee et al., 2002).

Evidence suggests that a high staff to patient ratio is associated with better patient outcomes (Aiken et al., 2002, Aiken et al., 1999, Zhu et al., 2012, Brennan et al., 2013). High nurse staffing levels decreases both morbidity and mortality rates in acute care hospital settings. In addition, adequate patient ratios have a positive impact on nurse retention, increased job satisfaction, and reduced staff 'burnout' (Aiken et al., 1999). Conversely, inadequate nurse staffing levels might result in loss of important aspects of care and negative patient outcomes (Zhu et al., 2012).

In Pakistan, the government has paid little attention to developing a strategy to organise nursing workforce planning and management. As a result, a very low nurse to patient ratio is found in Pakistani hospitals. Subsequently, the quality of care provided is poor and patients are rarely satisfied with services being delivered in hospitals. In this context, migration of Pakistani nurses to foreign countries may have negative effects on an already weak healthcare system. Thus, the decision of Pakistani nurses to work abroad constitutes a 'double-edged sword', where personal development abroad conflicts with the collective development of healthcare at home.

It is therefore important to critically explore the context of living and working conditions for nurses in Pakistan.

1.8.　　The working conditions of nurses in Pakistan

The scope of nursing practice in Pakistan includes clinical nursing and education. Most nurses, after completing their education, work in tertiary care, either in public hospitals or private hospitals, which may be because of the lack of opportunities in community health services (Upvall et al., 2002). Nursing in Pakistan is in its infancy and does not yet have the status of a mainstream profession. The public image of nursing is poor in the male dominated society of Pakistan (Khowaja, 2009), and the profession faces challenges on many fronts. Pakistan has a long history of severe leadership crises in the nursing profession (Harnar et al., 1992), and nurses in Pakistan are rarely prepared to take on the role of decision-maker, risk-taker, teacher, or change-agent (Lee and Saeed, 2001).

The prevailing conditions of the nursing workforce in Pakistan are challenging (Khowaja et al., 2005). Since the health system in Pakistan consists of public and private provision, nurses have employment opportunities in each of these sectors. In government hospitals nurses are faced with low wages in the face of increasing inflation, a high workload, and lack of a system for the protection of nurses' rights. In addition, there is no proper career structure in government hospitals, and once employed on the 'basic pay scale' (BPS) the nurse has to continue on the same grade for their entire working life.

However, working in the public sector may be preferred because it ensures long-term employment benefits, and there is less chance of the job being terminated. There is no

proper mechanism for checking care provided by nurses in government hospitals, and quality is generally poor. However, government jobs may also be selected because in these settings nurses perform mostly technical skills. In the private sector, nurses are used largely for business purposes, and there is less protection of their rights. The private sector has its own issues of retaining nurses, where the approach to care is business oriented and nurses' positions are vulnerable to changing economic conditions. Thus, an overall demoralization is found among Pakistani nurses (Bahalkani et al., 2011).

Protesting for incremental salary increases in Pakistan is not a new phenomenon (Pakistan-Today, May 11, 2011). Yet, despite such campaigns there has been little effort to listen to, or address, grievances and only symptomatic measures are offered. Nurses working in Pakistan have been found to suffer from mild to moderate anxiety and depression (Khan et al., 2012), and studies have shown low levels of job satisfaction (Khowaja et al., 2005). Bahalkani et al. (2011) conducted a study at one tertiary care hospital in Islamabad and found 86% of Pakistani nurses were not satisfied, and 26% were highly dissatisfied, with their working lives. Among contributing factors for these figures were poor working environments, low salaries, lack of training opportunities, improper supervision, time pressures, and few financial rewards (Bahalkani et al., 2011). Similarly, Khowaja et al. (2005), noted that Pakistani nurses exhibited stress associated with taxing workloads and biased management, lack of appreciation or financial incentives, and authoritarian styles of leadership.

1.9.   Nursing profession: The role of gender in Pakistan society

Nursing is not perceived as a desired profession for the daughters of middle and upper-class Muslim families in Pakistan (Lee and Saeed, 2001). The decision to join the

nursing profession in Pakistan is framed by overall societal, cultural and family values that construct female gender (French et al., 1994). Women's autonomy in rural Pakistan is determined by rigid gender systems (Sattar and Kazi, 2000), where women and men working together is not viewed positively. Nurses in Pakistan are sometimes regarded by patients and their relatives as sexual commodities. Yusufzai (2006) reported an incident where a female nurse was stabbed for refusing the invitation to spend a night with one of her patients. Somani and Khowaja (2012) reported a case of sexual violence against a nurse in a tertiary care hospital.

Working in potentially violent environments is also a risk factor in Northwest Pakistan (Yusufzai., 2011) where a large segment of conservative Pashtun society does not consider mixed sexes working together to be acceptable. There is a clear need to change the public image of nursing among the Pakistani population, to gain respect from patients and their families, as well as professional colleagues such as physicians, pharmacists, dieticians, and physiotherapists (Khowaja, 2009). In this context it can be seen that there are many potential reasons for Pakistani nurses to consider migration. But, available evidence does not give any real understanding of their working and social lives once they have embraced a migratory move. The study being reported here was designed to explore these lived-experiences in a UK context.

1.10. Organization of the thesis

The personal reflections outlined above describe how my personal journey, and observations of nursing, in Pakistan generated an interest in exploring the migrant Pakistani nurses' 'life world' in the United Kingdom. The remainder of the thesis is organised into chapters which report the processes undertaken in completing the study.

Chapter two provides a discussion of the methods used to systematically search, retrieve and appraise evidence on nurse migration and the migratory experiences of nurses. In chapter three, literature pertinent to the international migration of nurses is critically reviewed. Broad issues and ideas are explored such as globalisation and a global workforce; the shortage of nurses in developed and developing countries; the production of nurses as an export strategy; international recruitment and resultant migration of nursing staff. Chapter four looks at migratory experiences of overseas nurses, drawing on global literature regarding migration motives, and experiences of nurses in developed countries. It concludes by focusing on the specific circumstances of nurses who have migrated to the United Kingdom.

Chapter five interrogates the philosophical assumptions and underpinnings of the method used to explore the lived-experience of Pakistani educated nurses working in the United Kingdom. The roots of phenomenology as a European intellectual tradition are discussed, and contributions of prominent philosophers from Husserl to van Manen are noted. Distinctive differences between descriptive and interpretive approaches within the phenomenological school are considered. Then, in chapter six, attention is given to the design of the research study as a way of exploring the lived experience of migrant Pakistani nurses in the United Kingdom. Particular emphasis is given to the work of van Manen, as this guided the scholarly and pragmatic development of the research process, data collection strategies, and analytic engagement.

The following three chapters' present the study findings. Chapter seven explores the construct of 'becoming a migrant' in the life world of migrant Pakistani nurses while working and living in Pakistan; unfolding complex issues and challenges faced by participants. Narrative accounts of these nurses revealed economic and emotional

struggles, aspirations for a better future and escape from the privation and hardship of daily life in Pakistan; all of which contributed to the phenomenology of *becoming a migrant*.

Chapter eight explores the concepts of 'dissonance' and 'devaluation' as central themes of the lived experience of the nurse respondents. The low status jobs and the routine care provided by these migrant nurses in care homes conflicted with their previous experiences and challenged their expectations of first-world nursing. The constructs of *dissonance* and *devaluation* are discussed in terms of loss of professional identity, loss of professional skills, unmet expectations, and cultural challenges.

Chapter nine focused on lived-experience in relation to the social world of migrant Pakistani nurses in the UK, and challenges that might not be faced by other groups of migrant nurses working in the same health system. The foremost of these was the feelings of *fear* and *vulnerability*. Moreover, migrant Pakistani nurses had an acute sense of being isolated and adopted strategies to cope with feelings of exclusion. Most nurse respondents claimed to have experienced direct and indirect racism during interactions with clients and care workers.

Finally, chapter ten draws out and synthesises key themes which are presented as a critical discussion centred on the construct of 'otherness' in nurse migration, providing a unique knowledge contribution in the thesis. The socially, culturally, and economically constructed attributes of migration are identified in terms of time and context; embodied as 'social otherness' in Pakistan, and 'ethnic otherness' in the United Kingdom.

1.11. Summary

Pakistan has heavily relied on foreign reserves by encouraging human export and such endeavours are promoted through the formation of public policies. People migrate from Pakistan to other countries in search of jobs and quality of life. In the health sector, despite an acute domestic nursing shortage there are few efforts to retain the nursing workforce; evidenced by deteriorating working conditions. Among multiple challenges, international migration of nurses is an important factor.

CHAPTER 2

LITERATURE SEARCH

2.1. Introduction

This chapter discusses methods used to systematically search, retrieve and appraise evidence on nurse migration. Studies included in the review are presented in a tabular format. The chapter presents comprehensive evidence on nurse migration and then narrows the scope of the review down to the migration motives and migration experiences of nurses in the United Kingdom.

2.2. Review method

A narrative review was conducted to address the objectives of literature search, as one way of critiquing and summarising previous literature. This body of knowledge encompasses relevant publications and other textual sources of information in relation

to the subject area (Green et al., 2006, Cronin et al., 2008, Gasparyan et al., 2011). The narrative review provides a thorough background of what is already known about a topic, and also furnishes a robust foundation for new types of research. Additionally, narrative reviews help identify gaps in the current literature, of import in generating an original research question or selecting an appropriate study design (Cronin et al., 2008). Narrative synthesis is regarded as a method of collating findings from multiple studies and presenting them in a story-telling form. A good narrative synthesis clearly conveys why something needs to be adopted, or abandoned, based on evidence (Popay et al., 2006). There is increasing emphasis on following a systematic process in conducting a narrative review (Popay et al., 2006, Snilstveit et al., 2012) and such was adhered to in the current review of issues around migration.

The main objectives of the literature review were:

1. To search global literature on issues in the international migration of nurses.
2. To search literature on migration motives and experiences of overseas nurses in developed countries like Australia, United States of America and United Kingdom.
3. To discuss up-to date evidence on issues in nurse migration and the migratory intentions and experiences of nurses.

2.3. Search Strategy

The search comprised of two phases. The first one encompassed broad themes such as nurse migration, international migration of nurses, globalization and nurse migration, nursing shortage and migration, and nurse migration to the United Kingdom. Online electronic databases including Medline (Ovid), Scopus, CINHAL, University of

Liverpool search-engines Discover and Discover (Health Sciences) were accessed. In addition, Google Scholar and Google search-engines were used to retrieve literature from nursing bodies such as the Nursing and Midwifery Council (NMC) and Royal College of Nursing (RCN) and international organisations like the International Organization Migration (IOM), International Council of Nurses (ICN) and World Health Organization (WHO). In this way, broad evidence on international migration of nurses was retrieved (Appendix I).

In the second stage, the search focus was narrowed to retrieve empirical evidence on migratory experiences of nurses. Studies published between the years 2000 and 2014 were included in the review. This time span was chosen because during the last decade an upsurge in nurse migration had been noted (Buchan, 2007, Aiken et al., 2004, Buchan and Sochalski, 2004, Kingma, 2001, Buchan et al., 2006). For the period 2001/02, in the United Kingdom, more overseas nurses were enrolled onto the NMC register than native nurses (Bach, 2007). Firstly, evidence was retrieved on the migration motives of nurses. Secondly, the process was repeated regarding the experiences of migrant nurses in the United Kingdom. Search terms were established following a preliminary search of the databases. Search terms (1) included key words such as 'intentions', 'motivations', 'aspirations' and 'migration motives' combined with 'nurses', 'nurse migration', and 'international nurse migration'. Search terms (2), used key words 'overseas nurses', 'foreign educated nurses', 'overseas qualified nurses', 'international nurses', 'internationally educated nurses', 'migrant nurses', 'experiences', 'perspectives', 'adaptation', 'adjustment' and 'work experiences', combined with 'United Kingdom', 'UK', 'NHS', 'Britain', and 'Great Britain'. An example of search in step two is provided in Table 2.

Electronic databases including CINHAL Plus, Scopus, Medline, ISI Web of Knowledge and Google Scholar were searched. Search step one generated 241 articles, and search step two produced 1,759 articles. Article titles and abstracts were initially scrutinized for their suitability for inclusion. The reference lists of the articles were hand searched for additional articles that might have been missed in the original searches. A total number of 21 studies (see Appendix II) were deemed relevant to be included in the first step of the review. Regarding the migration experiences of nurses in the UK in the second step a total number of 28 studies (see Appendix III) were found to be relevant for the final review.

Key subject headings in search step one and two were combined with 'Pakistan', 'Pakistani nurses', 'Pakistani educated nurses' to retrieve any information regarding migration motives and/or experiences of migrant Pakistani nurses working overseas. This did not produce any 'hits', suggesting that the area of investigation is under-researched from the perspective of Pakistan.

Table 2: Example of Search Strategy (Scopus)

Google produced only one study conducted in the Punjab province in Pakistan: '*Induction and retention of nurses: Resolving the planning mismatch*'(Sarfaraz et al., 2010). Though not directly relevant to the migration of Pakistani nurses, it provided information regarding the key retention issues of nurses in the Punjab province.

2.4. Inclusion and Exclusion Criteria

	Searches	**Results**
1	overseas nurses OR migrant nurses OR foreign educated nurses OR international nurses OR internationally recruited nurses AND experiences OR perceptions OR adaptation	1,759
2	overseas nurses OR migrant nurses OR foreign educated nurses OR international nurses OR internationally recruited nurses AND experiences OR perceptions OR adaptation (United Kingdom)	240
3	migrant nurses OR overseas nurses AND experiences OR perceptions	102
4	Migrant nurses AND experiences	94
5	Overseas nurses AND experiences	79
6	internationally educated nurses AND experiences	23
7	migrant nurses OR overseas nurses AND experiences OR perceptions (United Kingdom)	22
8	internationally recruited nurses AND experiences	17

The search strategy identified a large number of articles, but the use of inclusion and exclusion criteria enabled this figure to be reduced to those most appropriate to address the aims of the current review (see Table 3). It was essential that the focus of the studies should explore migration experiences of nurses. Research on international

nurses that did not focus on their migration experiences was not included. In this way, only empirical studies exploring the experiences of nurses that were published in indexed journals were included. Similarly, only articles published in the English language were included in the review.

To assess the rigour and quality of the studies, critical appraisal tools (CASP, 2015) were applied to retrieved literature. Key information was extracted from each study (see Appendix II and III) rating factors such as the focus of the study, participants, study design and main findings. Since most literature retrieved used qualitative designs to investigate the experiences of participants, textual descriptions of their accounts were extracted. Following the review process, two main themes were derived, this consisted of discursive literature on nurse migration and the empirical evidence on the experience of nurse.

Table 3: Review Criteria

Criteria	Inclusion criteria	Exclusion criteria
Year of publication	Articles published between 2000 and 2014	Published before 2000.
Search 1: focus of study	Migration motives, intentions, motivations	Not related to migration motives
		Other cadres of healthcare professionals
Participants	Nurses	

Search 2: focus of the study	Experiences of overseas nurse	Experiences of native nurses
Participants	Nurses who obtained registration overseas	Nurses who obtained their pre-registration education in UK
Type of research	Primary research	Reviews, documents, concept papers, reports, commentaries, editorials
Language	Articles written in English language	Articles published in languages other than English
Publication type	Articles published in indexed journals	Web Pages, organizational surveys, market based research.

2.5.   Summary

There is a scarcity of literature on the migration experiences of nurses. A small number of research studies undertaken to date have attempted to sensitize the various adversities faced by overseas nurses in foreign countries. Much of this empirical evidence has been generated only in the last decade. The following two chapters will address facts and figures regarding the international migration of nurses, and the empirical evidence about the migratory experiences of nurses.

CHAPTER 3

THE INTERNATIONAL MIGRATION OF NURSES

3.1.   Introduction

This chapter covers broad issues around international migration of nurses such as globalisation, the shortage of nurses in developed and developing countries, production of nurses as an export strategy, international recruitment of nurses and resultant international migration of nurses. A brief history of the nursing labour market in the United Kingdom regarding international recruitment is described, and the United Kingdom Nursing and Midwifery registration process is discussed. The chapter completes by highlighting the significance of the study.

3.2.   International migration- some facts

Migration is not a new phenomenon and is defined as the movement of people between areas or countries (Haour-Knipe and Davies, 2008). People have migrated since ancient time, and globally around 3.4 billion people live outside their country of birth. Half of the world migrants are characterized as 'working migrants' whereas the other half migrates for other purposes such as education and/or accompanying a partner (Haour-Knipe and Davies, 2008). Each year between 5 and 10 million people worldwide cross an international border to migrate to a country different from their county of birth. In 2005, some 191 million individuals, or approximately 3% of the world population, were international immigrants (Haour-Knipe and Davies, 2008).

About 40% of global migration takes place in industrialised countries and 60% between developing countries (Haour-Knipe and Davies, 2008).

Although there have been concerns over nurse migration (Sparacio, 2005) no one can deny the nurses right to migrate under the free human movement, enshrined in the Universal Declaration of Human Rights 1948. Article 13 of the declaration states that, 'every one has the right to leave any country including his own and return to his country' (United-Nations, 1948). The International Council of Nurses (ICN) supports nurses right to migrate regardless of their motivation. Thus, migration is a human right that is characterized by dynamic movement and a continuum of freedom of choice, not only guided by individual motivation but also determined by external barriers and facilitators (Freeman et al., 2012b).

However, as a result of rising concerns regarding the unethical recruitment of nurses from developing countries, by developed countries (Cutcliffe and Yarbrough, 2007, Kingma, 2001, Pittman et al., 2007, Wellard and Stockhausen, 2010), the International Council of Nurses has issued a position statement on international recruitment of nurses. The position statement condemns the practice of recruiting nurses from other countries where countries have failed to adequately plan human resources (International-Council-of-Nurses, 2007). The position statement further condemns the practice of recruiting nurses by misguiding and recruiting them into working conditions and job responsibilities that are incompatible with their skills, expertise and qualifications (International-Council-of-Nurses, 2007). The ICN further argues for regulation in recruitment processes based on informed decision making, good employment policies on the part of government, employers and nurses (International-Council-of-Nurses, 2007).

Globalisation and multiculturalism represent a fundamental challenge to how health-care practice is understood and designed (Graham and Norman, 2008). It is believed that skilled and educated migrants do not realize their full potential in new countries, therefore policies are necessary to facilitate 'brain gain' (Baumann et al., 2006). Diallo (2004) suggested that statistical data on the migration of health professionals is incomplete, underused, and limited. Moreover, in international health care, nurses are discussed as commodities in the current global labour market (Campbell, 2006). However, nurse migration will affect nursing practice and healthcare throughout the world (Kingma, 2001). The issue of nurse migrants and migration is of interest nationally and internationally (Freeman et al., 2012b).

3.3.   Globalisation: A driver in nurse migration

The international flow of physicians and nurses has been a major political and social concern for many nations, and this has continued for many years (Mejia, 2004). Globalization has made it easier for health professionals to move, to the destination of choice, across borders. Globalization can be defined as international economic expansion, as well as interdependent economic, political, and social processes that accompany the flow of people, capital, goods, information, concepts, images, ideas, and values across increasingly diffuse borders and boundaries (Hurrel and Woods, 1995). With the advent of technology and science the world has become a 'global village' and with a growing recognition of international social, political, economic, environmental, and cultural issues affecting health and health care around the world, the concept of global health is evolving (Carlton et al., 2007). South Asian countries are a focus of globalization and are witnessing internal migration; from rural to urban

areas, as well as external migration from developing to developed countries (Khan, 2007).

Three distinct perspectives are used to explain human movement (Bach, 2007). The first is the equilibrium approach which is based on neoclassical economic analysis where individual economic differences are assumed to affect migration. This approach recognises that geographical wage difference exists across the world, so workers migrate from areas of low wage and high labour supply to areas of high wage and low labour supply. The theory is based on the 'law of supply and demand', and assumes that migration would cease at the point when equilibrium is achieved (Bach, 2007). The concept of equilibrium also underpins the 'push-pull' thesis. Push factors are those that result in individuals to leave the country of origin for a variety of reasons, such as poor wages, bad working conditions, or economic and political instability (Kline, 2003). Pull factors, that motivates migrants in the resource countries, are improved working environments, higher wages, economic and political stability, and improved quality of life (Kline, 2003). This approach to understanding migration also includes recognition of household and family networks (Bach, 2007). The 'push-pull' argument accounts for migrant behaviour in the family and wider community perspectives, suggesting that families assign roles to different individuals for different tasks; a decision regarding migration as a collective decision. Family networks and acquaintances are used to seek support, and usually the network is built on loose connections with other relatives or known people (Bach, 2007).

A third explanation, that of globalization, is the current and most widely accepted explanation of migratory behaviours. It postulates that the insertion of new countries

into the global labour market provides a cheap source of supply for employers in developed countries (Bach, 2007). Usually, economic liberalisation, privatisation and marketisation exacerbate poor working conditions in source countries. However, more nations are entering global labour markets and people in developing countries have more incentives to migrate to a place where they can earn better wages (Bach, 2007). Globalization can be seen to facilitate nurse migration, with the global shortage of qualified nurses providing oppurtunities for nurses to move to their choice of destination.

3.4. The shortage of nurses

According to a World Health Organization report on the shortage of healthcare professionals there is an estimated global shortage of 4.3 million physicians, nurses, midwives, and support workers (World-Health-Organization, 2006). The shortage of nurses is experienced in, both, the developed world and developing countries (Kingma, 2007). The shortage is worse in developing countries, and uneven distribution of health workers across the world shows that in Europe the ratio of nurses to the population is ten times that of Africa and South East Asia (Kaelin, 2011). The universal shortage of nurses may have severe consequences for the health system of a country because nurses form the largest group of healthcare workers and deliver the highest percentage of care to the patients as compared to other health professionals. There are multiple causes of the shortage of nurses which are complex and far reaching (Oulton and Hickey, 2009), including both demand and supply factors. The demand factors include an ageing population, growing globalization, and increasing public demand for services nurses provide in the healthcare sector. The supply factors include

undesirable working conditions, wage disparities and less autonomy in decision making, and change in the approach to human health resources (Oulton, 2006).

3.4.1. The shortage of nurses in developed countries

Developed countries affected by the chronic shortage of nurses have relied on international nurse recruitment. For example, the United States has the largest nursing workforce of about three million, and has been importing around 15,000 nurses annually (American-Nurses-Association, 2008). However, there is a predicted shortfall of more than 800,000 nurses in the United Status by the year 2020, more than any other profession, according to the statistics of US Department of Labour. (Aiken et al., 2004, American-Nurses-Association, 2008, Chandra and Willis, 2005, Beechinor and Fitzpatrick, 2008, Aiken, 2007). Canada is another example where nurses are recruited from international sources, and it is estimated that by 2016 Canada will have a shortage of 113,000 nurses. Denmark is one of the countries with the highest nurse to population ratio, but it is estimated that by 2015 the country will have a shortage of 22,000 nurses (Oulton, 2006).

Other developed countries such as Australia, New-Zealand, and Ireland have a history of recruiting overseas nurses into the health system, and the United Kingdom has also relied on international nurse recruitment to manage a shortage of nurses in the recent past. In this context, developed countries have the capability to attract nurses from developing countries, and as developed countries have high nurse to population ratios, even minor shortages of nurses can stimulate major recruitment drives (Aiken et al., 2004).

3.4.2. The shortage of nurses in developing countries

The shortage of nurses is worse in developing countries, which is evidenced by the low nurse to population ratio in these countries (Anderson and Isaacs, 2007). For example, in Asian countries the nurse to population ratio is 1 per 1000 people as compared to 1 per 100 in developed countries. African countries are reported to have the most severe shortage in developing countries. In Africa there is an estimated overall shortage of 600,000 nurses (Ineternational-Council-of-Nurses, 2006). For instance, in Ghana total nurses numbered 4,000 where 10,000 nurses were needed. Similarly, in Malawi there are typically 30 nurses in a 1,000 bed hospital (Oulton, 2006) and in the South American country of Guyana there is scarcity of nurses and midwives to the extent that they are simply unable to deliver public health programmes because of migration or retirement. The migration of nurses from developing countries to developed countries severly impacts on global and local public health initivates in the origin countries (Perrin et al., 2007) and in developing countries chronic nursing shortages are exacerbated by out-migration of nurses in search of better working conditions and an improved quality of life.

As ever increasing globalization results in the loss of healthcare professionals in developing countries the capacity of health care system delivery in developing countries is further compromised (Stilwell et al., 2004). However, the labour export strategy of some developing countries also plays a part in the international migration of nurses. In this context, the international migration of nurses adds to a deterioration of health care systems in developing countries.

3.5.   Production of nurses as labour export strategy

Some labour export countries have adopted strategies to produce a surplus of nurses specifically to export them to foreign countries. Such endeavours are targeted at increasing foreign economic exchange, through migrant nurses transferring money directly to their families in their country of origin. For example, the Philippines and India have openly adopted an approach to encourage nurses' migration and thereby increase the input of foreign capital into the economy (Masselink and Lee, 2010, Yeates, 2009, Adhikari, 2010).

The Philippines is the leader in international nurse export, and has the most advanced bureaucracy to assist in the migration of nurses (Yeates, 2009). In the Philippines 354,154 nurses graduated between 1970 and 2004 and only 27,150 were actually employed at home. More than 300,000 nurses trained in the Philippines have either left the profession or left the country (Yeates, 2009). An estimated 85% of employed Filipino Registered Nurses (RNs) work internationally. Of the 100,000 overseas trained nurses working in the USA in 2000, 32.6% were from the Philippines (Perrin et al., 2007).

Likewise, despite very low nurse to population ratios, health authorities in India are not overly concerned about the emigration of nurses to other countries, and have actively promoted nurse migration. It is estimated that the cost of training a nurse in India is around US$ 4,700-7,000, yet these nurses can earn as much as US $47,000 once placed abroad (Khadria, 2007). The Indian government encouraged considerable benefit in nurse migration through alleviating under employment and securing foreign remittances (Yeates, 2009). The province of Kerala was the main producer of nurses for export, where an estimated 40,000-60,000 nurses were exported to gulf countries

(Percot, 2006). Similarly, China has a severe shortage of nurses, with only one nurse per 1,000 population, compared to 1 nurse per 100 population in the US. Despite this ratio many Chinese nurses are unemployed, or underemployed, and do not rescive equitable salaries compared to ther professioal groups. Chinese nurses are, thus, prepared to invest money in being recruited abroad for employment, yet have to work many years to return those costs(Yeates, 2009).

In the last decade, Pakistan has encouraged nurse migration as an economic benefit to the wider economy. There has been substantial growth in new nursing schools, both publicly funded and in the private sector. More men are encouraged to join the nursing profession, emphasising the scope for overseas employement as a qualified nurse. However, concerns have been raised by nursing leaders in Pakistan over the poor quality of education provided in some of these schools, and more regulations have been implemented to monitor the quality of education, particularly by new private nursing schools. It would appear that the growing commercialization of nurse education is another factor in the international migration of nurses.

3.6.   International nurse recruitment and the United Kingdom

The United Kingdom is a multi-ethnic and multicultural society with people from diverse backgrounds (Mehta and Saggar, 2005). This population diversity is also represented in the health workforce. The NHS in the UK has the largest number of workers from black and minority ethnic groups and is also the largest employer in Britain (Kalra et al., 2009).

The British nursing market can be dated at 1896, when the Colonial Nursing Association (CNA) was formed to recruit nurses for employment in colonies across

the British empire (Solano and Rafferty, 2007). The CNA initially recruited some 8,400 British nurses to serve in private and government hospitals throughout the British Empire. The imperial nursing labour market was established with British nurses working in leadership positions across the empire to train nurses in territorial regions (Solano and Rafferty, 2007). Initially, Irish nurses were the main recruits to UK hospitals, and overseas recruitment on a substantial scale started in 1941 with recruitment from 16 British colonies sought to fill vacancies following the Second World War. Until this time overseas nurses were only eligible to apply for auxiliary positions in the UK. When the NHS was established in 1948, the Nurses Act (1949) changed the basis on which recognition for overseas nurses could be granted by the General Nursing Council (GNC) (Solano and Rafferty, 2007). The new Act offered entry onto the register for many overseas nurses, by their undergoing through further qualifications deemed necessary by the Council. This opened the way for many overseas nurses to seek work in the UK. Overseas recruitment continued well into the 1970s when more than 10,000 nurses were recruited from the Caribbean, Malaysia, Philippines, and Mauritius (Solano and Rafferty, 2007).

The recent wave of overseas nurse recruitment started in 1990s, and was largely stimulated by NHS workforce planning which saw reductions in training placements, from 37,000 to 8000 between 1983 and 1998 (Withers and Snowball, 2003). Overseas nurses have arrived to the UK from many destinations, including Pakistan, and between 1995 and 2005 approximately 100,000 international nurses were recruited to the UK nursing register (Nichols and Campbell, 2010, Buchan., 2007). In 2001/02, for the first time, more overseas nurses were entered onto the professional register than UK trained nurses. However, an important consideration has been whether these

overseas nurses will stay in the UK or are likely to move to another country (Buchan et al., 2006).

The latest trends in the UK nursing labour markets and the international flow of nurses' show that more nurses are now going to other developed countries than are coming to the UK. Their destinations include Australia, Canada, New Zealand, and the USA (Buchan and Seccombe, 2012).

3.7. Overseas nurses NMC registration process

Nurses who gain their pre-registration qualification in a country other than the UK are normally required to undergo additional preparation before being allowed to practice in the United Kingdom (Daniel et al., 2001). Upon successful completion of the programme nurses are allowed to practice in the UK. Nurses from Europe, and some other countries whose qualification is recognized as an equivalent, can register directly with Nursing and Midwifery Council (Gerrish and Griffith, 2004). However, nurses from outside the European Union have to undergo further training before they are allowed to practice in the United Kingdom (Gerrish and Griffith, 2004).

The amount of supervised practice hours which need to be completed by migrant nurses varies significantly, depending upon the country of training. Almost all nurses from the USA, Australia, Canada and South Africa are not required to undertake an adaptation programme (Buchan et al., 2005). However, it is normally the case that nurses from India, Pakistan, Mauritius, the Philippines and sub Saharan Africa have to undertake adaptation programmes in the UK (Buchan et al., 2005). In this context, migrant nurses from the developing world may be at a considerable disadvantage in re-locating to the UK. Despite the recognised need for nurses in the UK health system,

there is also an acute shortage of supervised practice placement opportunities (Winkelmann-Gleed, 2005). In 2005, there were 37,000 overseas nurses in the UK waiting for a place on the supervised practice adaptation programme (Parish and Pickergill, 2005). Research reports that nurses on adaptation programmes were not valued and their skillls were not recongnized, which led to feelings of resentment (Allen and Larsen, 2003).

Up until 2004, there was no specifically set programme prescribed by the NMC, and a mentor was assigned to the overseas nurse. The mentor was usually a qualified nurse who would assess the overseas nurse, and upon completion of the programme would submit a competence form to NMC (Gandhi and French, 2004). The programme was called 'adaptation programme', and depending upon the country of qualification and the post professional experience the duration of the programme ranged from 12 weeks to 24 weeks (Horner, 2004).

However, in 2005 new guidelines were issued, and from September 2005 an English language programme was made compulsory for overseas nurses, and a protected 20 days learning introduced for all foreign educated nurses. This was in addition to the supervised practice hours (Jordan and Brown, 2011). The new programme is called the Overseas Nursing programme (ONP) and can be taken at approved higher education institutions. The practice placements for the supervised practice hours are also accredited, and audited, by the NMC. The duration of ONP programme is three to nine months depending on the need of individual nurse training requirements (Nursing-and-Midwifery-Council, 2005).

Since October 2014, the NMC has introduced new guidelines for registration of non-European nurses, which are internationally recognized; an assessment process which

requires aspirant candidates to go through numerous steps. When the candidate is eligible for registration they have to take an objective structured test of competence which can be done on-line through established test centres located throughout the world. However, the second part, the objective-structured clinical examination, (OSCE) can only be taken in the United Kingdom at the University of Northampton (Nursing-and-Midwifery-Council, 2014).

In this context all the nurses who migrated from Pakistan to the United Kingdom were required to undergo through adaptation programme and the participants in this study have undergone their adaptation programme in private nursing home settings.

3.8.   The migration of Pakistani educated nurses

Rapid globalization and shortage of nurses have provided opportunities for Pakistani nurses to migrate to foreign countries. Pakistan has also adopted strategies to promote nurse migration, as new nursing schools are allowed to open in the private sector. Many Pakistani educated nurses who left their home country have settled in the UK, working in the NHS and independent care home sectors. Many of these nurses have, subsequently, brought their families to the UK and now live with them in their adopted home country. NMC statistics (NMC 2008) show that during 1998-2008 Pakistan was the second largest supplier from South Asia after India (see Table 4). Pakistan is lacking any policy to reatain its nursing human health resource, and despite a severe chronic shortage of nurses in Pakistan, there is currently no strategy. Labour migration from Pakistan is a constant phenomenon, and the nursing profession is no exception in this regard. However, this begs the questions of what challenges face nurses in foreign countries? And, are they adequately prepared to tackle them? There is a paucity of research in this area, suggesting an understanding

Table 4: Initial admissions to the NMC register by overseas country 1998-2008

Country	1198/99	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
India	30	96	289	994	1,830	3,073	3,690	3,551	2,436	1020
Philippines	52	1,052	3,396	7,235	5,593	4,338	2,521	1,541	673	249
Australia	1,335	1,209	1,046	1,342	920	1,326	981	751	299	262
Nigeria	179	208	347	432	509	511	466	381	258	154
South Africa	599	1,460	1,086	2,114	1,368	1,689	933	378	39	32
New Zealand	527	461	393	443	282	348	289	215	74	62
Pakistan	3	13	44	207	172	140	205	200	154	42
Zimbabwe	52	221	382	473	485	391	311	161	90	49

of Pakistani migrant nurses lives would make an important contribution to knowledge about nurse migration in a global health economy. This study was designed to investigate the experiences of Pakistani educated nurses working in the United Kingdom.

3.9.   Significance of the study

Nurse migration is a problem faced by nations from around the globe, and countries have adopted different strategies to address it. A small number of studies conducted so far, by both developed and developing countries, have contributed to a growing body of literature on nurse migration. However, there is no evidence on this issue from the perspective of Pakistan. It has also been noted that Pakistan, as a country, has grossly failed to address nursing workforce issues, and foreign migration of nurses has further added to the current chronic shortage of nurses in Pakistan. In the context of globalization, and current economic climate of Pakistan, it is imperative that Pakistani nurses continue to migrate abroad in search of better jobs and life opportunities. The current study is the first to sensitize this issue, and it is anticipated that the findings will provide a foundation for further research in area. It is expected that the study will specifically achieve the following goals:

- The study will explore the reasons that participants considered while making a decision to migrate from Pakistan to another country.
- The study will identify challenges faced by Pakistani educated nurses in foreign countries.

- The study will help inform nurse educators, and policy makers, in Pakistan to understand the issue and consider appropriate steps to facilitate nurses in the process of migration.

- The study will capture the lived-experience of nurses who worked Pakistan and the realities of their daily life prior to migration

- This study will help understanding the challenges these nurses face in the United Kingdom.

3.10. Summary

The global shortage of nurses has provided nurses the opportunities to travel to their choice of workplace destination. Both developed and developing countries have failed to manage their nursing workforce, and developed countries have relied on foreign nurses to cope with nursing shortages. The United Kingdom has a long history of recruiting overseas nurses, and in recent years NMC has tightened its rules for registration of overseas nurses. Pakistani nurses have their shared role in global nurse migration. However, little is known regarding their migration, and migratory, experiences. The current study is an attempt to redress this imbalance. It is anticipated that this study will provide a base for further investigations in this area from the perspective of Pakistani educated nursing staff.

CHAPTER 4

LITERARTURE ON MIGRATION EXPERIENCES OF NURSES

4.1.   Introduction

In the previous chapter different push and pull factors playing a role in international migration of nurses were discussed. This chapter, however, focuses on literature surrounding the migration experiences of nurses. The chapter first focuses on migration motives of nurses such as economic, social/professional and personal factors. It proceeds to focus on the experiences of overseas nurses in developed countries. A general picture of migration experiences of internationally recruited nurses in developed countries is given, and then experiences of internationally recruited nurses in the United Kingdom are explored. The chapter notes a dearth of literature on the experience of South Asian nurses, with a specific lack of evidence on the experiences of Pakistani educated nurses.

4.2.   Motives for migration

Three types of migration are generally common, that is migration among developing countries, migration from developing to developed countries, and migration among developed countries. However, migration motives of nurses are complex and no single theory has yet explained all the factors as to why nurses migrate (Kumpikaite and Zickute, 2012, Piché and Dutreuilh, 2013). Motivation to migrate is the key

characteristic in nurse migration, and can be both intrinsic and extrinsic. Many theories have been used to explain motivation for migration such as equity theory, Maslow's hierarchy of needs, expectancy theory, and social and network theories (Winklemann-Gleed, 2006). There follows, below, a discussion of scholarly articles included in the study (see Appendix II).

4.2.1. Financial motivation

Most studies included in the review identified financial motives as the main factor behind migration (Aboderin, 2007, Chikanda, 2005, Perrin et al., 2007, Freeman et al., 2012a, El-Jardali et al., 2011, Grigulis et al., 2009, Larsen et al., 2005, Palese et al., 2007, Palese et al., 2010, Likupe, 2013, Mejia, 2004, McGillis Hall et al., 2009, Thomas, 2006, Buchan et al., 2006). Financial motives are mainly linked to push and pull factors (Kline, 2003). For nurses in developing countries, push factors that play a role in migration include poor wages, economic instability, and poorly funded healthcare systems (Kline, 2003). Pull factors are higher wages, better working conditions and professional growth opportunities (Perrin et al., 2007).

For example, Freeman et al. (2012a) conducted a mixed method study on the migratory intentions of Canadian nurses in a border city near to USA, and concluded that nurses preferred to migrate only because they thought they could improve financially and professionally. Similarly, dissatisfaction with rewards and incentives is one of the factors that play a role as proposed by El-Jardali et al. (2011) in a cross-sectional survey exploring reasons why Lebanese nurses chose to migrate. In addition, economic pressure from the family could also be another factor prompting migration Grigulis et al. (2009). Here, it was noted that the chief reason given for migration of Malawian nurses to the UK was to send remittances back home to support relatives.

Similarly, Aboderin (2007) undertook a study on Nigerian nurses in the UK, and returnee nurses in Nigeria, to understand the context and motives of their migration. It was found migration intentions were initiated by worsening working conditions in the home country. Nigerian nurses attributed their 'de-facto global migration' primarily to economic reasons (Aboderin, 2007).

Palese et al. (2007), conducted a descriptive study with seventeen Moldavian nurses who had migrated to Italy, suggesting it to be job opportunities and financial security. Likewise, Chikanda (2005), reported on a questionnaire survey (n=231) the migration intentions of Zimbabwean nurses, finding that 55% of nurses wanted to migrate for economic reasons such as better remuneration. Future prospects in terms of higher wages and better quality of life are also incentives for migration (Chikanda, 2005, Thomas, 2006). The findings of all these studies are consistent with a World Health Organization study (YEAR) on statistical reports from 137 countries which found that for many nurses, the main motivating factor was a desire to send remittances back home to support families, and that other factors were secondary to economic factors (Mejia, 2004).

In the United Kingdom, Larsen et al. (2005), conducted a study to assess migration motives of overseas nurses with 67 participants in 11 focus groups. They noted the diverse motivations of nurses to migrate, but the major driver reported was improved finances. Similarly, Likupe (2013) roported on a study conducted in the NHS on migration intentions of nurses from Sub-Saharan Africa, with 30 nurse participants. The authors discussed five factors that African nurses considrered in migration, that is poor wages, lack of professional development at home, poor health care systems, language and education similarities, and ease of obtaining a visa and position. It is

important to note the migration motives of nurses for economic reasons could be very different, and economic reasons may represent a desire to change overall life conditions.

4.2.2. Life change strategy

Economic factors are not the sole objectives of nurse migrants, and literature reports reasons other than economic (Salami et al., 2014, Alonso-Garbayo and Maben, 2009, El-Jardali et al., 2009, Thomas, 2006, Hendel and Kagan, 2011, Troy et al., 2007). Both push and pull factors are recognised in this domain, where destination countries are viewed as having better social prospects (Kline, 2003). Other research suggests that when economic motives were met by migration, nurses would migrate to a second destination for better future prospects. For example, Salami et al. (2014) reported that fifteen Philipino nurses in Canada had followed multi-step process in their migratory journey; first they migrated to Saudi Arabia for financial gain, and later to Canada in search of citizenship for themselves and families. These findings replicate previous work by Garbayo and Maben (2009) in the UK based on interviews with Filipino and Indian nurses.

Whilst enhanced social status acts as a pull factor, social factors also contribute to the push for migration, (Chikanda, 2005, Aboderin, 2007, Thomas, 2006, El-Jardali et al., 2009). Thomas (2006) reported Indian nurses were not happy with attitudes towards them, wanting to move abroad in the hope of receiving greater rescpect. However, Hendel and Kagan (2011), in a cross-sectional survey of Israeli nurses found no association between nursing images and intentions to migrate.

Research has also shown the prime motivation to become a nurse could be to migrate abroad and this could be again socially motivated. Troy et al. (2007), conducted a phenomenological study to understand the migration intentions and experiences of overseas nurses. A total twelve nursing directors, six from Ireland, three from South Africa and three from Philippines were interviewed in addition to ten overseas nurses. The study found that for overseas nurses the primary motivation for becoming a nurse was to move eventually abroad and their families encouraged them to become a nurse as it offered employment opportunities abroad.

4.2.3. Professional adavncement

In addition to economic and social factors, some studies report factors related to a lack of job and career advancement opportunities in their home countries as motivation factors (Chikanda, 2005, Beaton and Walsh, 2010, Alonso-Garbayo and Maben, 2009, Smith et al., 2008, El-Jardali et al., 2011, El-Jardali et al., 2008, Likupe, 2013). Similarly, the lack of security and safety of nurses is another important motivational factor (Kline, 2003). Smith et al. (2008) in a cross-sectional discriptive survey with overseas nurses in Australia found professional and career related motives were an important driver for these nurses to migrate to Australia beside other motives. Chikanda (2005) reported that Zimbabwean nurses had intentions to migrate abroad because of poor working conditions in Zimbabweian hospitals, high workloads and inadequate equipment for performing nursing duties. Lack of personal protective equipments was also reported to motivate nurses to think of migrating to a place where they can practice safely. El-Jardali et al. (2008) reported on a mixed method study on the intentions of Lebanese nurses to migrate abroad. A questionaire survey and stuctured interviews were conducted with nursing schools, recruitments agencies and migrant nurses. The study found a link between job dissatisfaction of Lebanese nurses

and their intentions to migrate. Percieved lack of value and a 'blame' culture, job stress and inadequate opportunities for professional enhancement were the main motivating factors for nurses to migrate abroad. It can b noted here that Lebanese nurses intentions to migrate abroad are multifaceted but overall career related motives are more evident. Similarly, Thomas (2006) reported a questionaire survey on the migtration motives of Indian nurses to migrate abroad. A total of 448 questionaires were included in the study and found that Indian nurses migrated abroad because of poor working conditions in their home country, and nurses working in the private sector were more likely to go abroad than those who worked in the government sector.

However, Palese et al. (2007) reported that none of the participants in their study mentioned professional aspirations as the determinants of migration rather the overarching motivation was job oppurtunities and ecnomic reasons.

4.2.4. Safety and Security

Some studies reported political factors as determinants of migration, where nurses felt dissatisfaction with the prevailing political situation in origin countries and had a desire to move to a place where they will have equal opportunities and their children can get good education (Thomas, 2006, Chikanda, 2005, El-Jardali et al., 2008). For example, El-Jardali et al. (2008) found that Lebanese nurses wanted to migrate because of the high level of violence and crime in their country and their desire to raise their children in a secure environment. Zimbabwean nurses also had migration motives based on a desire to secure the future of their children and themselves (Chikanda, 2005). Nurses have also been found to be dissatisfied with organizational hierarchies in hospitals and not being involved in decision making processes. Thomas (2006) also reported that Indian nurses were dissatisfied with unequal treatment in promotion

based on social class or caste and intended to migrate to a place which offered equal opportunities for everyone.

4.2.5. Adventure stragey

Nurses who migrate within the developed world are often described as 'backpacker nurses' who do not intend to stay for long time (Buchan et al., 2005, Beaton and Walsh, 2010, de Veer et al., 2004). Personal motivating factors reported by these nurses include a wish for adventure or a holiday strategy. They also identify a wish to be exposed to the high standard of care and to seek oppurtunities of professional advancement (Larsen et al., 2005). A study conducted by Beaton and Walsh (2010), on overseas nurses who migrated mainly from UK to Newfoundland and Labrador in Canada, reported that most nurses were motivated by an opportunity to travel. de Veer et al. (2004) concluded results from a survey on Europrean nurses reasosns for migration to Netherland and found that 60% of respondents reported personal reasons for migration such as marriage or the to see the challenge of working abroad. Hendel and Kagan (2011) had also reported one of the reaosns for Israeli nurses to migrate was to join spouse in another country.

4.3. Global literature on migration experiences of nurses

This section gives a brief account of the literature on the experiences of overseas nurses in developed countries such as United States of America and Australia. Studies conducted on the experiences of overseas nurses in developed countries have generated a wide body of knowledge which encompass both social and practice related issues of migrant nurses in host countries. The social issues described are mainly racial experiences in the new environment, whereas practice issues are related to the differences in nursing practice in the host and origin countries of migrant nurses.

4.3.1. Adjustment to a new culture

Literature from developed countries report the difficulties experienced by overseas nurses in getting adjustment to a new culture. For example, Yi and Jezewski (2000), conducted a grounded theory research study on the psychosocial adaptation experiences of Korean nurses to US hospitals. The adjustment process included 'relieving psychological stress' 'overcoming the language barrier', "accepting American nursing practice," "adapting to American problem-solving strategies," and "adapting to the American style of interpersonal relationships" (Yi and Jezewski, 2000). Of the five categories, the first three basically characterize the initial 2-3 years experiences after arrival in the USA, and the final two categories may take an additional five to ten years (Yi and Jezewski, 2000). A cross sectional questionnaire survey by Beechinor and Fitzpatrick (2008), in the American State of Hawaii noted that Filipino nurses were less distressed and more successfully adapted to acculurtaion than immigrant nurses from Canada. It was suggested that the low level of stress in Filipino nurses might be due to the more collegial and social support they have than nurses from Canada (Beechinor and Fitzpatrick, 2008).

Similarly, Kishi et al. (2014) reported a qualitative study on the adaptation experience of 14 Japanese educated nurses in Austraila with the aim to generate discrirptive knowldgle of their adaptation. The study proposed a model comprised of three phases to adapt to Australian culture that is; seeking, acclaimazting and settling (SAS). Likewise, Zhou (2014) reported a constructivist grounded theory study on the experienecs of 28 China educated nurses in Australia. The study proposed the core category of 'reconcilling different realities'. The main themes emerged from the study findings were realzing, strugglinhg and reflecting. China educated nurses upon migration realized the difference between home country and the new way of living in

Australia, they struggled to get adjustement to this new society, however, refelecting on this whole experience they had to weigh the benifs and losses as result of migration and it was not easy for them to go back to home country.

These studies have provided some useful information on overseas nurses adaptation experience in USA and Australia. It is evident from these studies that adaptation to new country is a stressful journey for overseas nurses.

4.3.2. The difference of practice

Studies from developed countries have also focused the difference of practice overseas nurses reported between the host country and their home country (Deegan and Simkin, 2010, Jose, 2011, Xiao et al., 2014).

For instance, Jose (2011) reported on a phenomenological study conducted on 15 overseas nurses working in the US hospitals, and the study highlighted the trajectories of internationally educated nurses working in the United states and found that internationally educated nurses have high expectaions of working in the USA and although they initially feel devalued, they are able to adjust over time. Smith et al. (2008) reported on a survey from a hospital in Australia found that difference of practice in Australia and the home country was frustrating for overseas nurses. Partcipants reported requirements for performing skills as stressful, for example where they needed to complete training courses for intravenous cannulation, a procedure which they would routinely perform in their home countries. In addition, overseas nnurses from culturally and linguistically diverse backgrounds reported not being employed in their chosen speciality, but were more satisfied with hospital experience as compared to migrant nurses with English speaking backgrounds. In another qualitative study by Deegan and Simkin (2010) conducted with 13 non English

speaking overseas nurses in Australia, the nurses felt they had been 'demoted' from an expert to a novice in the new health system and also expressed difficulty with English language, specially the accent.

However, a phenomenolgical study conducted by Smith. et al. (2011) in Australia, reported that overseas nurses found themselves 'rediscovering' nursing. Particpants experiences were more focused on nursing practice than in their home counries. Participants reported that nursing was different in many ways to their training but the basics of nursing were same. Moreover, it was the patient centred approach to work in Western Australia which was new to them, where the ratio of nurse to patient was ten times higher than in their countries of origin. These migrant nurses felt also valued because of the wages and the amount of annual leave avialbale to them.

4.3.3. Racial discrimination

One of the central aspects of overseas nurses' experience in developed countries is the grievance of racial discrimination. For example, Dicicco-Bloom (2004), conducted a qualitative descriptive study in the USA with ten female migrant nurses from the Indian state of Kerala. The racial and gendered experiences of nurses were reported in terms of discrimination based on colour, the tension in their daily lives being here (US) and there (India) (Dicicco-Bloom, 2004). Participants faced the challenges of living in the US, simultaneously balancing their cultural role as Indian women of colour. They also faced profound experiences of racism at work placements where they were not promoted to higher positions due to their colour (Dicicco-Bloom, 2004).

Deegan and Simkin (2010) in their study with overseas nurses in Australia had also noted that these nurses struggled with their professional identity and perceived discrimination from colleagues. Overseas nurses also reported feelings of

disempowerment caused by discriminatory practices, professional isolation, and unrealistic expectation by their local counterparts (Deegan and Simkin, 2010). A more recent study by Wheeler et al. (2014) found that internationally educated nurses experienced more explicit discrimintaion from patients, families and other colleagues at workplacments in the US as compared to their native counterparts. Likewise, a quantitative questionaire surrney by Pitman et al. (2014) with overseas nurses on their perceptions of employement based discrimiantion found that approxiamtely half of the respondents had experiences job related discrimation in the United States of America. The survey recruited particpants from different countries and found that those participants who are recruited by employement agancies and from low income countries experience more discrimnantion as compared to nurses from United States (Pitman et al., 2014). In this context, it is also important to note that that nurses who migrated from Pakistran to United Kingdom either traveled on their own or were hired through recruitment agencies, however so far there is no available evidence on the experiences of migrant Pakistani nurses.

The findings of studies discussed above provide an insight to some of the difficulties faced by internationally educated nurses working in the United States and Austraia. It is noted that majoriy of the studies have used qualitative approach to explore the expience of overseas nurses while one study included here has used surevy method to investigate the perception of overseas nurses.

4.4.   Experiences of overseas nurses in the United Kingdom

Studies on the migration experiences of nurses in the United Kingdom (appendix III) have focused different aspects of nurses' experiences in the UK such as adaptation experience, the expectations of performing skills and discrimination experiences.

Whilst most of the studies have included participants from more than one country some of the studies have solely focused participants from single country. Such as (Adhikari, 2010, Adhikari and Melia, 2013) focused on the experience of Nepalese nurses in the UK, a total of twenty one nurses were interviewed and the study found deskilling as the main aspect of their experiences. Grigulis et al. (2009), studied the experiences of Malawi nurses in the United Kingdom and focused their migration experience. Aboderin (2007), studied the migration experience of Nigerian nurses in the United Kingdom and found their main raison for migration was deteriorating working condition back home and economic reasons to migrate to the UK. Henry (2007), studied the experiences of Ghanaian nurses in the UK.

From the available evidence following themes were extracted regarding the migration experiences of nurses in the UK.

4.4.1. Acclimatization experiences

Studies have found migrant nurses entering the UK need to address many challenges in adapting past training and skills to UK settings. One of the biggest challenges is completing supervised practice placements necessary for NMC registration (Daniel et al., 2001, Withers and Snowball, 2003, Gerrish and Griffith, 2004, Smith, 2004, Parry and Lipp, 2006, Allan, 2010). Though the majority of migrant nurses coming to the UK originate from English speaking Commonwealth countries (Parish and Pickergill, 2005) they still find the adaptation programme stressful.

Daniel et al. (2001) conducted a study on the experiences of newly recruited Filipino nurses, using two focus groups. Focus group one consisted of 15 Filipino nurses (14 females and one male) who had been in the UK for three months, while focus group two consisted of 9 Filipino nurses with clinical experience. Findings revealed British

nurses were supportive and helpful, but this did not preclude experiencing racism and discrimination. Withers and Snowball (2003) undertook similar research using questionnaires and interviews to collect data. Findings revealed mixed results. Affirmative experiences included the positive attitudes of hospital management but, again, discrimination by staff and patients was reported.

Gerrish and Griffith (2004), reported on a study used to evaluate adaptation of foreign educated nurses working in the United Kingdom, based on a sample of 17 female nurses recruited from India, Philippines, China and Sub-Saharan Africa. Focus group and individual interviews with participants, clinical mentors, managers, educationists and diversity officers were undertaken. Findings suggested five ways for adaptation programmes to succeed, including getting professional registration, fitness for practice, reducing nurse vacancies, promoting equal opportunities and an organizational culture that valued diversity. Similarly, Smith (2004), explored the training of nurses during adaptation using a qualitative approach. Key themes, identified with stress, emerged from this work; communication issues, role definition, and cultural factors.

In a larger, comparative, study by Smith et al. (2006) to explore overseas nurses experiences in NHS and independent sectors, semistructured interviews were undertaken with 93 respondents across three sites. It was reported nurses who took adaptation programmes at private nursing homes expressed poor levels of teaching, support and supervision; with limited opportunities to practice skills, they were utilized as 'a pair of extra hands'. A major hindrance in overseas nurses adjustment is communication difficulties, and Okougha and Tilki (2010), looked at this from the perspective of Ghanaian and Pilipino nurses in the UK using grounded theory.

4.4.2. The experience of being deskilled

In addition to difficulties experienced by overseas nurses in adapting to life in the UK, studies also report they often report feeling devalued and deskilled in the British healthcare system (O'Brien, 2007, Aboderin, 2007, Adhikari, 2010, Adhikari and Melia, 2013, Grigulis et al., 2009). Hardill and MacDonald (2000) conducted a qualitative study with sixteen overseas nurses recruited to an NHS hospital in the East Midlands, finding that, despite downward mobility, these individuals valued positive aspects of migration.

Alexis et al. (2007), report on a phenomenological study into the experiences of overseas nurses in the UK, base on focus group data with 24 NHS nurses from Asia, Africa and the Caribbean. Thematic findings included devaluation, self-blame, discrimination/lack of equal opportunities, and a feeling of living under constant scrutiny. Alongside this, again, was the benefit of being in the United Kingdom.

In terms of deskilling, studies report overseas nurses are not afforded an environment to practice technical skills previously performed at home. O'Brien (2007) undertook a case-study approach at three NHS hospitals in North West of England. Migrant nurses found themselves technically deskilled in a caring culture emphasising humanistic, 'hands on', approaches.

Aboderin (2007) reports a qualitative investigation into the experiences of Nigerian nurses working in UK care homes, where high expectations had informed the decision to migrate. Though devaluation was commonly spoken about, financial incentives provided some degree of compensation. Almost identical findings are provided by Grigulis et al. (2009) in relation to Malawian nurses, and Adhikari and Melia (2013) regarding staff from Nepal.

4.4.3. The experiences of racial discrimination

Discrimination is defined as showing partiality or prejudice in treatment, action or policies directed against the welfare of a minority (Pager and Shepherd, 2008). It has been reported minority ethnic nurses occupy lower nursing grades, often working in the least popular nursing disciplines. It has also a concern that in the NHS black nurses are five years behind in career progression compared to white colleagues (Kingma, 1999). Many UK studies have found overseas nurses experience racial discrimination (Allan. et al., 2004, Alexis, 2009, Alexis and Vydelingum, 2005, Alexis and Vydelingum, 2007, Alexis and Vydelingum, 2009, Alexis et al., 2006, Winklelmann-Gleed and Seeley, 2005, Larsen, 2007, Henry, 2007, Hellen et al., 2009, Likupe and Archibong, 2013, O'Brien and Ackroyd, 2012). Overseas nurses, working in the UK, have reported experiencing racism from colleagues, other staff, patients, relatives and other migrant nurses. There are reports of black and minority ethnic staff being disadvantaged in terms of equal opportunities in the health system. Two RCN commissioned surveys (Ball and Pike, 2005, Ball and Pike, 2007), found many overseas nurses employed at basic grades, this increasing over time as the proportion of UK qualified nurses on lower grades declines. Allen and Larsen (2003) note international nurses' professional skills to be poorly recognized, producing talk about isolation and bullying.

Despite attempts by some employers to recognize diversity, gaining acceptance and respect is difficult for migrant nurses. Research indicates that their identities as migrants, rather than men or women, were central to the experience. Allan et al. (2004) claim that racism, discrimination and negative stereotyping are central to the experience of overseas nurses (Allan. et al., 2004). Alexis and Vydelingum (2005) discuss eight over-arching themes which encapsulate this collective experience: not

feeling appreciated, feeling inadequate or unwelcome, inequity of opportunity for skills and training, and unfairness in practice and performance reviews. The findings of this study are reinforced by similar work undertaken by Winklelmann-Gleed and Seeley (2005) on the experiences of internationally recruited nurses in the United Kingdom.

Racism may also be manifested through bullying, and Hellen et al. (2009) report, from a larger qualitative data set, three cases of racist bullying of overseas nurses. Participants spoke about their experiences of being socially excluded, labelled as not proficient in English, being 'picked on' and reported to a manager, and termination of employment. Larsen (2007) from existential-phenomenological analysis, suggests overseas nurses with profound experiences of racial discrimination and exploitation internalize experiences as a part of adaptation; embodied discrimination that leads to reduced levels of self-confidence, professional competence, and a poorer quality of life.

Studies have also shown that negative experiences in the workplace hinder the career progression of overseas nurses. For example, Henry (2007) reported findings from a qualitative study of Ghanaian nurses in the United Kingdom, where demoralization was associated with institutionalized practice and the patronage of managers. Similarly,O'Brien and Ackroyd (2012), reported a realist case study conducted with three cohorts of nurses from the Philippines, India and Spain employed by the NHS which identified 'everyday racism' as a barrier to advancement. In a recent study, by Likupe and Archibong (2013), conducted a study on thirty Black African nurses from sub-Saharan countries working in North East England in four NHS Trusts. Black African nurses, it was posited, experience discrimination from both white nurses and

other migrant ethnic groups. Further, this was seen to be reflected at more senior organisational levels.

It is suggested that lack of opportunity for migrant nurses is based on racial features rather than professional quality and merit (Harris et al., 2013). Out of 400 directors of nursing in England only three black nurses held this rank minority, illustrating the under-representation of ethnic nurses in senior positions (Harrison, 2003). Two empirical studies report the ineffectiveness of equal opportunities policies in NHS (Alexis and Vydelingum (2009), Alexis et al. 2006) in terms of career progression and skills development/training.

4.5.   Summary

The emperical evidence narrated in this chapter suggests that the migratory motives and experiences of nurses, though multifacted, are contextual in nature. Much of the literature on the migration motives has used cross-sectional surveys approach. Majority of the studies are descriptive in nature having used self-administered questionnaires. However, to use such questionnaires participants should first share their own experience in their own words. Therefore, there is a need to conduct phenomenological studies on the participant motives to migrate to foreign countries. Such literature may also help in designing and testing the surveys on migration motives of nurses. Similarly, most of the studies undertaken on migration experiences of nurses so far are descriptive in nature and none of the studies have emphasised the experiences of overseas nurses in geo-political context. Majority of the studies conducted in the UK have focused on the experience of Filipino nurses or nurses from African countries, but there is a scarcity of literature on experience of South Asian nurses. It is also suggested that most of the studies conducted so far are based on the

experiences of nurses in NHS in the UK. No single study has been conducted to explore the migration intentions and or experience of Pakistani nurses in an overseas country and the literature from other contexts may not be precisely applicable. In this context this study will focus on the experience of Pakistani educated nurses working in the United Kingdom.

PART II

CHAPTER 5

PHILOSOPHICAL ASSUMPTIONS AND UNDERPINNINGS

5.1.   Introduction

This chapter describes the philosophical assumptions and underpinnings of the method used to explore the lived experience of Pakistani educated nurses working in the United Kingdom and shows why phenomenological assumptions were adopted as the foundation for the study. The chapter first outlines the aims and objectives of the study, and then contextualizes the design used to investigate the lived experience of Pakistani educated nurses working in the United Kingdom. The philosophical roots of phenomenology as an alternative approach to understand human phenomena are discussed as well as the contributions of prominent philosophers from Husserl to van Manen. Descriptive and Interpretive approaches are considered as distinctive approaches in phenomenology. The chapter then goes on to critically discuss the use of phenomenology in nursing research, including the rationale for the approach in this study.

5.2.   Aim of the study

The overarching aim of the study was to explore the experiences of Pakistani educated nurses living and working in the United Kingdom in the North West and East Midlands of England.

5.3.   Objectives of the study

The main objectives of the study were:

1. To elicit the lived experience of migrant Pakistani nurses in making a decision to migrate to another country.

2. To explore the lived experience of Pakistani nurses while they are working and living in the United Kingdom.

3. To interpret these experiences in socio-cultural and geo-political context of nurse migration.

5.4.   Research Question

What is the lived experience of migrant Pakistani nurses working and living in the United Kingdom?

5.5.   Rationale for using a phenomenological approach

The primary purpose of the study was to understand the 'lived experience' of migration of Pakistani nurses to the United Kingdom. A qualitative approach was deemed best to explore the experiences of study participants, and all the approaches in qualitative tradition were considered for their suitability to answer the research question.

A grounded theory approach was not considered suitable because the research question did not aim to generate a theoretical explanation of the basic social processes (Charmaz, 2006). It was not the main aim of the study to develop a theory grounded in the data from the field (Strauss and Corbin, 1998) rather the primary purpose was to explore the essence of lived experience of participants. Similarly, an ethnographic

approach was not relevant as the research question was not seeking to observe the culture of Pakistani nurses in the UK (Green and Thorogood, 2004). Ethnography primarily describes and interprets a culture sharing group and looks for shared patterns of culture of a group (Creswell, 2007).

A narrative approach focuses to tell stories of individual experiences (Creswell, 2007). Qualitative case study primarily focuses an in-depth description and analysis of a case or multiple cases (Creswell, 2007). Other qualitative approaches such as discourse analysis (Starks and Trinidad, 2007) and critical theory (Creswell, 2007) were not considered as their epistemologies were not congruent with the aim of the study. A phenomenological approach was deemed most suitable to explore the lived experience of participants because phenomenology focuses the lived experience of participants. In addition the study was looking for the essence of lived experience or the shared experience of participants; hence phenomenology was the option of choice in this study (Speziale and Carpenter, 2007).

The choice of an interpretive phenomenological approach was based on the underlying research question and the aim of the study (Starks and Trinidad, 2007). The phenomenon under investigation was the 'experience of becoming and being a migrant Pakistani nurse in the UK'. As the question aimed to explore the essence of experiences of Pakistani educated nurses in the UK, phenomenology serves best to address this question.

Before going into the details of how I used the principles of phenomenology in collecting and analysing the data, in this chapter I will first cover its foundations.

5.6.   Emergence of phenomenological method

The adoption of an alternative approach to inquiry into human phenomena is mainly attributed to the Neo-Kantian school of German social philosophers at the beginning of the nineteenth century (Benner, 1985). Around this time there was growing recognition that human sciences were different to the natural sciences. One of the first philosophers of human sciences was Wilhem-Dilethy, who is thought to be the principle engineer who coined the term 'giesteswisseenschanften' (McEwen and Wills, 2002). It is suggested that psychology makes a foundations of such approaches that explore" historico-social reality" (Holmes, 1990, p 188). Dilethy differentiated the natural sciences from human sciences and conceived the idea that the proper subject matter of 'Giesteswissenschaften' is the human word characterized by 'Giest', mind, thoughts, consciousness, values, feelings, emotions, actions and purposes, which find their objectifications in language, beliefs, arts and institutions (van Manen, 1997).

 The concept of phenomenology was first expressed by Kant and Hagel in the early 19th century (Dowling, 2007) and phenomenology was adopted as an approach to study 'human science' that rejected the traditional empirical science or positivist approach to understanding human experience. As it evolved, phenomenology became both a philosophical movement and a research method (Wojnar and Swanson, 2007, Connelly, 2010, Earle, 2010). The word phenomenology is derived from Greek word 'phainomenon', meaning appearance. As a research approach, phenomenology is rooted in philosophy and psychology that focuses on the lived experience of humans (Polit and Beck, 2008). Phenomenology seeks to describe particular phenomena or the appearance of things as lived experience (Speziale and Carpenter, 2007, Starks and

Trinidad, 2007). Phenomenon are the world of experience and occur only when a person experiences them, and the experience is considered unique to that individual, such as in the current study Pakistani nurses have their own experiences of migration and the experience of migration they have undergone in unique to them (Burns et al., 2011). Phenomenology investigates the 'lived experience, and according to van Manen (1997), "lived experience involves our immediate pre reflective consciousness of life" (p 35), it means lived experience is the first-hand account of experiences. Phenomenology helps in giving meaning to everyday lived experience that may be otherwise ignored (Starks and Trinidad, 2007). Hermeneutics, or interpretive phenomenology, uses lived experiences as tools for better understanding of the social, cultural, political, and historical context in which those experiences occur (Polit and Beck, 2008). In this study, I have attempted to explore the phenomenon of becoming and being a migrant Pakistani nurse working and living in the United Kingdom.

5.7. Contributions of prominent Philosophers to the development of phenomenology

The major premises of philosophical contributions come from Husserl, Heidegger, Merleau-Ponty, Gadamer (Struthers and Peden-McAlpine, 2005) and van Manen (1997). For the purpose of this thesis I will highlight the work of prominent philosophers from Husserl to van Manen. These philosophers are briefly discussed here because van Manen's action sensitive approach is influenced by the work of these philosophers.

Phenomenology was originally proposed as a philosophical approach by German philosopher and mathematician Edmund Husserl (1859-1938) (Giorgi, 2000a). Husserl was mainly influenced by the work of Franz Brentano (1838-1917) who used

the term 'intentionality'. This means that consciousess is always conscious of something. Brenato was a psycholgist who used the term 'descriptive psychology' or 'descriptive phenomenology', but the credit for introducing the concept of the 'lived experience' is given to Husserl (McConnell-Henry et al., 2009).

Husserl's philosophical contributions led to descriptive phenomenological inquiry (Flood, 2010, Simpson, 2007). Husserl's main stance was that a 'scientific approach' was required to understand the essential structures of lived experience specific to a group of people (Lopez and Willis, 2004). To understand the embodied experience, two important concepts must be employed by a phenomenological researcher, the phenomenological attitude and intentionality. Husserl believed that in pursuit of knowledge one should step back from the phenomena to take a 'fresh' look at it. The concept of bracketing, that is suspension of foreknowledge to take a fresh insight to the study, is central to Husserlian phenomenology.

Heidegger (1889-1976), a student of Husserl, challenged Husserl's thoughts by proposing that the reality of any description without interpretation is not possible (Mackey, 2005). The main perspective of Heidegger's phenomenology is that the understanding of individuals is not possible without recognition of the culture, social context or historical period in which they live (Wojnar and Swanson, 2007). Heidegger produced a book 'Being and Time' in which he outlined the main tenets for understanding human beings. Heidegger's phenomenology is based on concepts of 'being-in-the-world', 'fore structures' , 'time' and 'space' (Mackey, 2005).

One of the key philosophers in the development of phenomenological approaches was Merleau-Ponty (1905-1980). Building on the work of Husserl and Heidegger, he

described the 'Phenomenology of perception' in which he proposed that the goal of phenomenology is to explore the first-hand experience (Merleau-Ponty, 1962). Merleau-Ponty stressed that phenomenological reduction is vital for exploring the essential structure of the lived experience (Dowling, 2007). In relation to health, he also proposed that the experiences of illness are unique to the individual and there can be no universal explanation or prediction to describe the course of any particular disease process (Benner, 1985), thus emphasizing the uniqueness of individual experience. These philosophical prospects give rise to four existential concepts that he considered fundamental to the structure of the life world. These are 'lived body', 'lived space', 'lived time' and 'lived human relation' (McDonald and McIntyre, 2001, McNamara, 2005, Merleau-Ponty, 1962, Thomas, 2005).

Another notable philosopher who contributed to theoretical understandings of phenomenology was Hans-Georg Gadamer (1900-1996). He suggested that the Heideggerian concept of 'knowing' was better described as 'understanding' (Fleming et al., 2003). Gadamer posited that understanding occurs through history because we are all part of history and it is not possible to step outside history. He took the position that one is embedded in the social, cultural, and historical world, and that this situatedness needs to be considered when interpreting the writer's text. He further emphasizes that consciousness is determined by the fusion of individual horizons with the prejudices of the history (Fleming et al., 2003). This means the view point of the researcher and participants mingle with each other during dialogue in conversation or text. Gadamer also developed the concept of a hermeneutic circle, which is the process of movement between details of a text and the interpreter of that text. In this movement the preconceptions of the interpreter are incorporated into the process and shifted from pre-conceptions to new understandings (Converse, 2012).

None of these philosophers developed research methods, however their philosophies are used to underpin qualitative research designs (Dowling, 2007). Phenomenology originated and was developed in Europe and has been adopted in health sciences, psychology and nursing to guide inquiries into understanding human behaviour and experience (Speziale and Carpenter, 2007). As a Euro-centric philosophy, phenomenology has applications in a specific cultural and historico-social context, but this study applied this philosophy to exploring and understanding the lived experience of participants with a very different cultural and historical frame of reference. However, whilst Husserlian phenomenology seeks universal essence, the Heideggerian approach stresses understanding of the individual, with reference to the context (Wojnar and Swanson, 2007), this mode of inquiry was therefore deemed relevant to investigating the lived experience of Pakistani educated nurses working and living in United Kingdom.

5.8.   Approaches to conducting a phenomenological inquiry

Canadian educationist and philosopher van Manen (1997) offers a pragmatic way to undertake a phenomenological inquiry. van Manen blended both phenomenological and hermeneutical traditions into one research methodology. According to van Manen, phenomenology aims to describe the lived experience as it appears and hermeneutics interprets the lived experience (van Manen 1997). However, van Manen further mentions that "(phenomenological) 'facts' of lived experience are always already meaningfully (hermeneutically) experienced. Moreover, even the 'facts' of lived experience need to be captured in language (the human science text) and this is inevitably an interpretive process" (pp. 180-181). Thus, hermeneutic phenomenology

uncovers the meaning of the description of lived experience written in text from the perspective of study participants (van Manen, 1990).

Two distinct approaches to conducting phenomenological inquiry are briefly discussed here because the current pragmatic method of van Manen is based on these two approaches. I first describe the descriptive tradition and explain why it was not used in this study.

5.8.1. Descriptive Phenomenology

Descriptive phenomenology, "calls for exploration of phenomena through direct interaction between the researcher and the objects of study. It calls on investigators to set aside preconceptions through the procedures involved in bracketing" (Wojnar and Swanson, 2007, p174). Koch (1995) opined that the genuineness of a pure phenomenological inquiry is that its job is 'a matter of describing' (p 828) . In this way, the researcher is bound to discard his own assumptions and describe the phenomenon in its 'pure' form. Husserl believed that a 'special different attitude' is required for a phenomenological project. The 'phenomenological attitude' is an approach in which the researcher strives to suspend their presuppositions and go beyond the natural attitude of taking for granted understanding (Finlay, 2008, p 2) it means as a researcher one has to take a fresh insight into the experience and ignore his pre-understanding of the subject. The phenomenological attitude requires the researcher to reduce all assumptions about the phenomenon. 'Phenomenological reduction', is a return to original awareness regarding the phenomenon under investigation (Speziale and Carpenter, 2007). The researcher deliberately attempts to understand the phenomenon as free as possible from the cultural context (Dowling, 2007). 'Phenomenological reduction' is achieved by the process of 'bracketing'

(Beech, 1999), which requires the researcher to hold in abeyance all the previous knowledge about the phenomenon and to look at it with fresh insights (Wall et al., 2004).

Another feature central to phenomenology is 'intentionality' and this refers to being conscious of something (Earle, 2010). One of the concepts of descriptive phenomenology is that, there are features to any lived experience that are common to all persons, called 'universal essences or 'eidetic structures' (Lopez and Willis, 2004, Dahlberg, 2006). Essence, according to van Manen is "what something is and without which it would be no longer what it is" (van Manen, 1997, p15). This study explores the essence of experience of 'being a Pakistani migrant nurse in the UK' and its meaning to participants in this study. I have therefore based this study on the assumption that phenomenological description has an interpretive component (van Manen, 1997). However, I have not adopted descriptive phenomenology as in seeking universal essences as it considers context peripheral to the phenomenon. In the case of nurse migration context is known to be important.

5.8.2. Interpretive Phenomenology

Interpretive phenomenology, or hermeneutics, focuses on the meaning of being in context. An interpretive approach is considered more likely to reveal the depth and diversity of knowledge, because an interpretive approach focuses on understanding rather than explaining the phenomenon (Mackey, 2005). In this study, I have followed the philosophical assumptions of Heidegger's interpretive phenomenology. I have adopted this approach because, I am of the opinion that the researcher cannot put aside or bracket their own knowledge of the phenomenon under investigation. However, I do acknowledge that freeing previous knowledge is mandatory in order to investigate

the phenomenon, in as much as possible, in an unbiased way (van Manen, 1997). "Heideggerian approach is appealing to nurse researchers who seek not only to describe lived experiences related to health and illness, but to understand the meaning of those experiences within the context of everyday lives of those whom they teach or for whom they provide nursing care" (Draucker, 1999, p 371). This study is informed by the principles of interpretive phenomenology or 'hermeneutics'. The word hermeneutics is derived from Greek word 'Hermes', a Greek god, who is responsible for understanding and interpreting the messages between gods (Lopez and Willis, 2004). This approach allows in-depth understanding of a phenomenon in a human and holistic manner, with adherence to methodological and scientific rigour. Koch (1999), described the important concept of interpretive phenomenology as, human beings are capable of interpreting and their interpretation connotes their self which is influenced by the context where they live.

The fundamental concept of Heidegger's phenomenology is emphasis on what it means to be, which he termed '*being-in-the world*' (McConnell-Henry et al., 2009). Heidegger proposed that object and subject are inseparable and that we cannot abstract ourselves from the world. In the same way, Heidegger also asserted that we already exist in a world and we cannot separate ourselves from this world (Heidegger, 1962). One of the assumptions of interpretive phenomenology is the concept that as humans we exist in the world as being aware of our own being; that is we are capable of reflecting upon our own existence. Heidegger termed it '*Dasein'* (Mackey, 2005, p 182). Hence, it is not the content of pure subjectivity that is the focus of inquiry, rather what individual narratives imply about what he or she says (Mackey, 2005). The focus of interpretive phenomenological inquiry is therefore not the individual but the

relation of the process. In line with a Heideggerian approach, in this study I considered myself as 'being in the world of participants' (McConnell-Henry et al., 2009).

Another key feature of Heidegger's phenomenology, that is important to this study, is '*fore structures'*. It means that in a research study both the participants and researcher bring their own knowledge to the research process. Gadamer suggested that the researcher pre-understanding is mixed with the data shared by participants and called it 'co-constitution' of data (Fleming et al., 2003). According to Mackey (2005) "fore structure is what is understood or known in advance of interpretation. It is prior awareness and the anticipation of meaning" (p 182). Unlike Husserl, Heidegger premised that 'fore knowledge' is necessary and it is the 'fore knowledge' that sparked the researcher's interest in the phenomenon. Gadamer called it, 'fusion of horizons' when the view point of researcher and participants mingle with each other during the dialogue in conversation or text (Fleming et al., 2003, Koch, 1996). This is described as context dependent knowledge, opinions, and experiences which the researcher and participant bring to the research study. It means the researcher's expert knowledge or presuppositions are valuable to the inquiry and in fact make the inquiry a meaningful undertaking. The technique of bracketing is not consistent, but rather questionable within an interpretive phenomenological approach. Central to this notion is the term called 'situated freedom', it means that as "human beings are embedded in the world to such an extent that subjective experiences of the world are linked to social, cultural, and political contexts" (Lopez and Willis, 2004, p 729). In this study, I have the fore knowledge of Pakistani nursing education and healthcare system as I am also a Pakistani educated nurse. I also understand that the meaning in this study is co-constituted by the knowledge that participants have shared and the attempt I have made to unfold that knowledge.

One more basic tenant of interpretive phenomenology, which is followed in this study, is the emphasis on all human experiences being grounded in time and space. Being in the world means being *temporal and spatial* (McConnell-Henry et al., 2009). Time is one of the fundamental structures of human existence and has been conceptualized in many forms (Mackey, 2005). *Temporality* refers to the awareness of time through the experience of being in time. The meaning of being is considered in context. The context of this study is the participants' experiences of working and living in the UK. Moreover, in the current study, the time of investigating the lived experience of migrant Pakistan nurses is also considered important, as within interpretive phenomenology experiences are time bounded. Interpretive phenomenology is considered as circular, moving back and forth between the whole and its parts and between the investigators fore-structure of understanding and what was learned through the investigation. Heidegger referred this as process as entering into a 'hermeneutic circle' of understanding that reveals a blending of meaning as articulated by the researcher and participants (Wojnar and Swanson, 2007).

In nursing and health sciences research the utility of hermeneutics can be seen in the way both health and illness are lived experiences and are experienced through perception, belief, skills, practices and expectations (Koch, 1999). The hermeneutic approach also overcomes the issue of extremes of subjectivity or objectivity as it considers situation important to understanding human experience (Koch, 1999).

5.9.   Phenomenology in nursing and Health research

Phenomenology is extensively used by nurse researchers. The care of an individual in a holistic 'bio-psychosocial' manner is an important tenet of nursing philosophy (Wojnar and Swanson, 2007). Nursing science is concerned with human beings and

human experience is the focus of concern in nursing practice, therefore a means of describing lived experience in nursing situations is relevant and important to the discipline (Racher and Robinson, 2002, Austgard, 2012, Van der Zalm and Bergum, 2000). The same principle also underpins the philosophy of phenomenological inquiry; hence phenomenology can be seen to have practical applications for experiential fields such as nursing. Phenomenology invites researchers to discover knowledge that is compatible with holistic nursing by studying human experiences in health and illness and identifying the caring needs of health workers and patients (Wojnar and Swanson, 2007).

Phenomenology has become a dominant philosophy that guides knowledge generation in nursing and healthcare (Norlyk and Harder, 2010, Caelli, 2000). Nurse researchers believe that phenomenology allows for doing research that is consist with nursing philosophy and theoretical concepts (Mackey, 2005).

In nursing, phenomenology was championed as a research technique by prominent nurse researchers of the late twentieth century, such as Patricia Benner and Cheryl Tetano Beck (Beck, 1992, Burns et al., 2011, Benner, 1984). However, phenomenological nurse researchers have utilized phenomenology in a variety of ways (Mackey, 2005), and this had led to scientific debate and criticism (Barkway, 2001, Paley, 2005, Paley, 1998). Wojnar and Swonson pointed out that although there are at least seven different type of phenomenology, the descriptive and interpretive approaches dominate (Wojnar and Swanson, 2007). It has also been reported, that rather than using phenomenology in a rigorous way, some nurse researchers have only adopted a phenomenological orientation (Rapport and Wainwright, 2006). Growing debate around the application of phenomenological principles in nursing research have

differentiated American and European (traditional) phenomenological approaches (Caelli, 2000). It has been suggested that American phenomenology does not focus on pre-reflective experience but rather includes thoughts and interpretations of the experience in the data collection and analysis. It has even been argued that nurse researchers have used phenomenology in their own way, which is a hybrid phenomenology, lacking philosophical or methodological 'purity' (Dowling, 2007).

5.10. Critique of phenomenology in nursing

In nursing research there is an increasing need to explicitly describe the assumptions in designing research studies, and this is particularly important in phenomenology because of variation in approaches to conducting a phenomenological inquiry. In addition, some research studies are critiqued for not adequately addressing philosophical underpinning and scholarship requires nurse researchers to have good knowledge of philosophical assumptions and appraise the philosophical underpinnings of the methodologies. However, this should not restrict nurses in their efforts to address challenges that nursing research faces (Racher and Robinson, 2002).

Nursing's use of phenomenology by some scholars such as Crotty (1996) and Paley (1997, 1998), have created awareness among nurse researchers in using phenomenology rigorously (Paley, 1998, Paley, 1997). Crotty (1996), argued that nurse researchers have developed their own phenomenology by adopting a modified form of phenomenology which serves their purpose. He termed this kind of phenomenology as descriptive, subjective and without critique (Dowling, 2007). Crotty (1996) conducted a review of 30 nursing research articles and he argued that nursing researchers focused on experience but they were not following the original philosophical principles. He stressed phenomenological reduction for exploring the

essence of experience. Similarly, Paley (1997, 1998), argued that nurse researchers have misunderstood the three tenets of phenomenology, phenomenological reduction, phenomena and essence. He further says that nurse researchers use of phenomenology bears little resemblance to the original philosophy (Paley, 1997). In regard to Heideggerian phenomenology he pointed out that the way nurse researchers refer to Heideggerian philosophy suggests that nurse researchers are misreading Heidegger. In a similar manner, Thomas (2005) also suggested that nurse researchers who use phenomenology are focusing more on method rather than philosophical assumptions (Thomas, 2005). Porter (2008) argues further that nursing researchers are conducting research with the method but without having strong knowledge of its philosophical foundations (Porter, 2008).

Oritz (2009) critiqued the work of key nurse phenomenologists such as Benner who refer to their work as hermeneutics, but suggests they adopt an epistemology that is inconsistent with Heidegger's ontology (Ortiz, 2009). The critique of these scholars has raised awareness among nurse scholars who use phenomenology. However, scholars have responded to Crotty's critique of nursing scholarship as misunderstanding Heidegger' by suggesting that "Crotty's understanding of Heidegger's work was often both narrow and misguided and this work is assuredly incapable of being read as any definitive pronouncement of what Heidegger really meant" (Darbyshire et al., 1999, p 23). Giorgi (2000b), refuted Paley's arguments and asserted that he does not distinguish scientific phenomenology from philosophical phenomenology. This has led to further debate as Caelli (2000) responded that nursing researchers use phenomenology for research and not purely for philosophical purposes and therefore modifications need to be made to this approach (Caelli, 2000). Earle (2010), posited that nurse researchers need to address philosophical assumptions

properly, however in journals there is an emphasis on presenting research findings rather than methods, so assuming that nurse researchers lack knowledge of philosophy and methodology is wrong.

The current debate highlights that nurse researchers using phenomenology do not always adequately address the philosophical assumptions of the study (Lopez and Willis, 2004). However, there is also a view that engaging too much in methodological discussion may hinder the progress of research projects (Pringle et al., 2011). To address this, I have attempted to make my method more explicit and I have adopted the increasingly pragmatic method in phenomenology proposed by van Manen (1997). van Manen's method is further discussed in chapter 4, where I describe the application of this method to the study of the lived experience of Pakistani educated nurses working and living in United Kingdom.

5.11. Summary

Through consideration of the philosophy and principles of phenomenological enquiry, and discussion of the utility of phenomenological inquiry in nursing research, I have presented a justification for the research method employed in this study. Phenomenological method allows the necessary depth of inquiry into the life world of migrant Pakistani nurses which no other exploratory approach can offer. Interpretive phenomenology also allows the exploration of the phenomenon with reference to social context, culture, and time. Hence, an interpretive phenomenological approach can facilitate achievement of study aims and purpose.

In the next chapter I discuss the practical application of phenomenological method in gathering and analysing study data.

CHAPTER 6

METHOD

6.1. Introduction

This chapter discusses the method used to explore the lived experience of migrant

Pakistani nurses living and working in the United Kingdom. Particular emphasis is

given to the application of van Manen's approach to conducting a phenomenological

inquiry. The chapter also describes the data gathering strategies and the protection of human subjects. The application of van Manen's "six steps" analytical process and its utility in achieving trustworthiness in particular is considered.

6.2.   van Manen's method of phenomenological inquiry

Max van Manen is a Professor of education at the University of Alberta in Canada. He proposes that phenomenology is relevant to fields such as education, health sciences, nursing and psychology. An important concept that van Manen emphasises is that the distinction of human science from natural science is a fundamental concept in understanding lived experience (van Manen, 1997). Unlike other social sciences research traditions which may use experimental designs, human science is interested in human beings where they are naturally engaged in their worlds (van Manen, 1997). "Phenomenology is not an empirical human analytical science and so it is not a science of empirical facts and scientific generalizations" (van Manen, 1997 , p 21). However, phenomenology is not mere speculative inquiry and takes its point of departure from lived experience or empirical data (van Manen, 1997 , p22). According to van Manen, "human science is the study of meaning of the descriptive-interpretive study of patterns, structures, and level of experiential and/or textual meaning" (p.181). van Manen acknowledges the contributions of Husserl, Heidegger, Dilethy, Gadamer, Merleau-Ponty (van Manen, 1997), but does not prescribe a mechanistic set of procedures to undertake a phenomenological inquiry. Rather he argues that the method of hermeneutic phenomenological human science is "scholarship". The researcher is a scholar who is a sensitive observer of the subtleties of everyday life, so there is no method rigorously described as a set of investigative procedures. "Indeed it has been said that the method of phenomenology and hermeneutics is that there is no method"

(van Manen, 1997, p 29-30). However, he further points out that phenomenology has its own tradition, a body of knowledge and scholars who contributed the methodological grounds for phenomenological research practice. Thus, from a phenomenological point of view, to 'do' research is always to question the way we experience the world and to be curious to know the world in which we live as human beings (van Manen, 1997).

Lived experience, according to van Manen (1997), is the immediate experience of the participants without any presuppositions and without any reflections. van Manen has been influenced by hermeneutic phenomenological traditions of Germany (from 1900-1965) and the Netherlands (1945-1970) (van Manen, 1997), as well as North America (Dowling, 2007). In these traditions there is not much emphasis on epistemology of method, rather phenomenology is supposed to be learned by *doing*. van Manen extended Husserl's concept of 'life world', the notion of essence of experience, as well as emphasising exploring the phenomenon in an unbiased manner. However, at the same time he argued that one comes to research with a prior background such as being a teacher, a nurse or psychologist, therefore, abstracting oneself from the research is not completely possible. In addition, he proposed engagement in a dialogical way with the text of research. Similarly, van Manen emphasised Heidegger's hermeneutic interpretation. van Manen (1997) suggested that every descriptive component has an interpretive component to it and thus his approach is located in the Utrecht school, and is a combination of both phenomenological and hermeneutical traditions (Polit and Beck, 2008). Interpretive phenomenology helps the researcher to understand the *meaning* of the description of lived experience, as it is written in the text, from the perspective of the study participants (van Manen, 1997, Zhu et al., 2012), and van

Manen proposed six steps that provide a comprehensive approach to conducting a phenomenological inquiry.

6.2.1. Six Steps of van Manen's phenomenology

The first guiding principle of van Manen is '*turning to the nature of lived experience'*. This includes knowing the nature of experience, orienting oneself to the phenomenon, formulating the phenomenological question, explication of assumptions, and pre-understanding. The lived experience in this study was the 'experience of becoming and being a migrant Pakistani nurse in the UK'. In line with the aim of the study, I turned to the lived experience by reading articles, books, and literature. A full study protocol was made and all the necessary arrangements were made to embark on this piece of research. The research question was proposed, developed, defined, and refined. This allowed me to start investigating the lived experience of becoming and being a migrant Pakistani nurse in the UK. The lived experience of migrant Pakistani nurses included their experience, from the point of first thinking to move abroad to the time the study was undertaken.

The second guiding principle of van Manen's method, is *investigating the experience as we live it*. This included interviewing, observing, keeping field notes and consulting the phenomenological literature. In this study, I investigated the experience of migrant Pakistani nurses by conducting interviews with participants. The life stories of migrant Pakistani nurses in the United Kingdom were captured. The means of data collection used were demographic sheets, audio-recorded interviews, observations and field notes. I immersed myself in the data.

The third guiding principle of van Manen' is *reflecting on the essential themes*. All the themes that were important were uncovered from the interview transcripts. The three approaches adopted to analyse the data were, holistic or sententious approach, the selective approach and the detailed approach. This is further elaborated in the process of data analysis. I carried out a thematic analysis of the interview transcripts during the process of analysis. In this I extracted all the essential themes that characterized the lived experience of Pakistani educated nurses in the UK. This reflected the shared experiences or the essence of the phenomena.

The fourth principle is *the art of writing and re-writing*. During the data analysis I wrote and re-wrote all the themes, defined and refined them. I also included anecdotes in the text to supplement the data. In this way I exercised the art of writing and re-writing during the process of describing the results and findings.

The fifth guiding principle of van Manen method is *maintaining a strong and oriented relation.* Here the emphasis is on the text that is oriented, strong, rich and deep. I was aware of the demanding nature of the study and the method being employed and fully committed to maintain a very strong orientation to the study under investigation. The phenomena were explored in depth and superficialities were not relied upon.

The sixth guiding principle of van Manen's method is *balancing the research context by considering parts and whole*. van Manen suggested that human science research should be presented in a narrative form. I presented the study findings in a narrative form to make sense of the findings. I also gave proper evaluation to the total study design and text and evaluated individual parts for their own significance throughout the study process as recommended by van Manen (1997).

6.3.   Data collection

This section examines the data collection process in detail and discusses the study settings, pilot interviews, population and sample of the study, approaching the participants and data collection according to the principles of phenomenology.

6.3.1.   Study settings

I conducted this study in the Northwest, Yorkshire, and East Midlands of England. The United Kingdom hosts Pakistani communities, in larger cities, including Manchester, Nottingham, Birmingham, Bradford, and Glasgow. Seventeen participants were recruited from Northern cities and four participants were recruited from the East Midlands. I contacted participants through a snowball sampling technique. Options were given to participants to choose a suitable venue for the interviews, and the majority of the participants opted to be interviewed in their private quarters, when they were off-duty. Therefore, nineteen interviews were conducted with participants at their homes. This gave participants the sense of being able to share their feelings without any external pressure. Only two interviews were conducted at places of work during working hours.

6.3.2.   Pilot interviews

As part of the study, initially pilot interviews were conducted with four participants. The purpose of the pilot interviews were to get a sense of the appropriateness of the recruitment strategy, practice and refine the interview technique and to anticipate any issues likely to arise in conducting the study. The pilot interviews also helped test the questions that I was planning to use in the main study. Although pilot studies are more commonly associated with positivist approaches, there is an increasing emphasis on

conducting pilot studies in qualitative inquiries (Sampson, 2004). Conducting pilot interviews are recommended, especially for novice researchers, to ensure that the questions are properly understood by the participants and to help researcher to self-evaluate their skills, readiness, and commitment to the study. Pilot studies can also increase the overall credibility of qualitative research (Vivar et al., 2007, Turner Iii, 2010), and can help in defining and refining the research question (Kim, 2011).

All the four participants that were recruited to the pilot interviews were informed that they were part of the full project. The study information was shared with them through participant information sheets and informed written consent was taken. The pilot interviews were only conducted when ethics approval had been secured from the University ethics committee (see Appendix IV). The interview schedule was used to frame discussion around the area of interest, but the emphasis in the interview was on encouraging participants to share their feelings and describe their experiences in their own way. When the pilot interviews ended, feedback was sought from the participants on the interview questions and process.

All the four pilot interviews were transcribed soon after the interviews were recorded. Interview transcripts were shared with supervisors and feedback was sought. After these interviews the interview schedule was revisited and new areas of interest were added. The pilot interviews helped in focusing the research on the main topic and some new areas were identified. I also found during the pilot interviews that migrant nurses were ready to share their accounts and there was a lot to be explored in the migrant Pakistani nurses' experiences in the UK. This helped in designing the interview topic guide for the semi-structured interviews used further in the study.

6.3.3. Study population and sample

The target population of this study was all Pakistani educated male and female nurses working and living in the United Kingdom. I recruited participants using a purposive sample, and a snowball technique. This kind of sampling is based on the premise that researcher's knowledge can be used to select participants who have knowledge about the issue under the study (Polit and Beck, 2008). In purposive sampling, cases are carefully considered and those participants who can most benefit the study are recruited.

 Snow ball sampling technique is employed where participants are difficult to locate, or hard to reach (Sargeant and Faugier, 1997). Snowball sampling is claimed to be a well adopted method in qualitative research (Noy, 2008). In this study I employed snowball sampling technique because participants were scattered throughout the UK. Moreover, only a few potential participants were known to me before I embarked on this project. Pakistani migrant nurses who were known to me were asked to suggest other potential participants from their networks.

The sample size in qualitative studies tends to be small, and Morse (2000) discussed that sample size in qualitative research is determined by a number of factors including, the scope of the study, the nature of the topic, the amount of useful information obtained from each participant, the number of interviews per participant, the use of shadowed data, and the qualitative method and study design used. In his study Mason (2010) analysed five hundred and sixty PhD theses of qualitative studies for sampling size and out of 57 phenomenological studies, the range of sample sizes was between 7 and 89 with a mean of 25. The guiding principle for sample size determination in qualitative studies is data saturation (Polit and Beck, 2008). Before this study was

conducted, it was anticipated that up to thirty participants would need to be recruited to achieve the aim of the study. However, theoretical saturation was achieved after twenty one interviews and there was no new knowledge coming out of the later interviews. This was checked with supervisors and no further interviews were arranged. The final sample therefore consisted of twenty one participants including eleven female participants and ten male participants.

6.3.4. Characteristic of study participants

The sample size comprised of 21 participants including both males (n=10) and females (n=11). The age of participants ranged from 30 to 46 years. Ethnic distribution of the sample were Pathan (n=8), Punjabi (n=10), Mohajir (n=1), and Hindhko speaking (n=2). The qualifications of participants were BSc Nursing (n=4) and diploma in general nursing (n=17). All the female participants had also an additional qualification of diploma in midwifery as it has been the requirement of Pakistan Nursing Council for female nurses to hold an additional midwifery qualification. Four participants had post basic qualifications such as diploma in cardiac nursing, diploma in mental health nursing etc. Their job experience ranged from 2 to 14 years in Pakistan health system where they had worked in general wards, intensive care, gynaecology, medical/surgical areas and cardiac care. Majority had worked in public sector hospitals (n=13) and only few (n=8) in private sector hospitals.

Out of the total 21 participants 17 were married and at the time of recruitment to the study 15 were living with their families in the UK and the rest of participants had the intentions to bring their spouses to the UK.

For majority of the participants coming to the UK was the first migration experience (n=13), whereas few (n=8) participants (all females) had travelled before to Gulf countries such as Saudi Arabia and Kuwait. All these participants were hired by private agencies for independent care nursing homes sector in the UK and at the time of recruitment all participants were actively working as Registered general nurses in nursing homes (n=14) and NHS (n=6), and agency nurse (n=1). Their work experience in UK ranged from 5 years to 11 years.

Now I will briefly highlight the history and life journey of each participant to the UK.

Participant 1: Participant one is a male migrant Pakistani nurse who graduated in 2004 and worked in Pakistan in intensive care for two years and then migrated to the UK in 2006 where he started working in a nursing care home. At the time of recruitment to the study, participant one was working as registered general nurse in care homes, however he had an inspiration to move to new role as researcher/ academic and had earned a Master degree from a prestigious UK university.

Participant 2: Participant two is a male migrant Pakistani nurse working as registered general nurse in care home in United Kingdom. He completed his education in Pakistan in 2005 and worked there in oncology wards and as an instructor in nursing school before moving to the United Kingdom in 2007. He is residing with his immediate family in the UK.

Participant 3: Participant three received his nursing diploma in Pakistan during the year 2002 and worked there for 2 years in intensive care units. He described economic motivations as the primary reason for him to migrate and, in 2004; he moved to the UK and started working in independent care nursing homes. Having ambitions to work

in NHS, he started working there as a bank nurse and at the time of recruitment he was living in a shared accommodation along with other colleagues.

Participant 4: Participant four is a female migrant Pakistani nurse who got her nursing and midwifery diplomas in Pakistan in 1991 and worked there for 5 years as a mental health nurse. Then, she moved to Kuwait where she worked in medical-surgical areas in a hospital. However, once she heard of the opportunity to travel to UK she made her arrangement to travel here for permanent settlement. At the time of interview participant four was working as a bank nurse in a care home and permanently in NHS in medical surgical units. Participant is living in United Kingdom with her husband and children.

Participant 5: Participant five is a male migrant Pakistani nurse, who has been working in a care home in United Kingdom. He received his nursing education in year 2000 and worked in Pakistan in intensive care for about a year. He described that, in 2004, the migration to the UK was at a peak when he travelled. Participant is settled with his immediate family in a rural area in the Northwest United Kingdom.

Participant 6: Participant six is a male Pakistani migrant nurse in the United Kingdom who is working as RGN in NHS in intensive care. Participant moved to United Kingdom in the year 2001. He had worked in Pakistan for eleven years at different posts such as a nurse in medical surgical areas and instructor in a nursing school. He had vast experience in Pakistan in both the government and private sector. Dissatisfied with life in Pakistan, he decided to migrate to the UK and started working here initially in care homes to the level of a deputy manager. Participant is living with his immediate family in United Kingdom.

Participant 7: Participant seven is a female migrant Pakistani nurse who got her nursing education in 1989 and worked in paediatric intensive care. She then received her post basic diploma in psychiatry and worked four years as a mental health nurse. She was hired by Saudi hospital in 1996 among a group of nurses where she worked in intensive care unit for another five years. She described the discrimination experiences in Saudi Arabia. Dissatisfied working in Saudi Arabia and the lack of any permanent settlement system there she decided to move to the UK where she started adaptation in a nursing care home. She got a job in NHS but due to her family commitments left it and at the time of interview was working in a care home.

Participant 8: Participant eight is a male migrant Pakistani nurse working in nursing home in United Kingdom. Participant is living with his immediate family in the United Kingdom. He completed his nursing education in year 2002 and worked in intensive care and emergency room for two years. Upon migration to UK, in 2004, he started job in a nursing home. In the UK, he topped up his diploma in nursing to a bachelor degree and at the time of interview was enrolled for a part time master degree in healthcare.

Participant 9: Participant nine is also living with his family in the United Kingdom. He received his education in early 1990 in Pakistan and worked in intensive care for fourteen years. He moved to the United Kingdom in year 2000 and started working as a nurse in nursing care home sector and has been working as an RGN.

Participant 10: Participant ten is a female migrant Pakistani nurse who worked in Pakistan for a year in gynaecology as a nurse midwife. She moved to the United

Kingdom and started working as nurse in a nursing home. Participant ten is also living with her family in the Northwest UK.

Participant 11: Participant eleven is a female migrant Pakistani nurse who has been working in NHS and living with her family in North West UK. Prior to her moving here she worked in Pakistan in medical-surgical areas for ten years. She worked initially for few years in Nursing homes but soon got a position in NHS and has been working in medical surgical units in NHS.

Participant 12: Participant twelve is also a registered nurse working in NHS in United Kingdom. She got her nursing education in Pakistan and worked for four years in Pakistan before moving to Kuwait where she worked for four years. She moved the UK in 2000 and worked for two years in nursing homes. She got in a job in NHS and has been working in NHS since then. Participant twelve is living and working in a Northwest city in a Pakistani settled community.

Participant 13: Participant thirteen is a registered nurse working in NHS in United Kingdom. Participant thirteen got his education in Pakistan in 1999 and worked there for three years in a renal dialysis unit. He moved to the United Kingdom in 2002 and started his adaptation and work in a private care nursing home. After working for about three years in nursing homes he moved to NHS and started working in a renal dialysis unit. He is living with his family in Northwest in UK.

Participant 14: Participant fourteen is a male migrant Pakistani nurse who received his nursing education in Pakistan in 1991 and started working there as registered nurse. He worked in Pakistan in both private and public sector tertiary care set ups. He received a post basic diploma in teaching and ward administration in Pakistan. He

moved to the United Kingdom in the beginning of 2000 and described himself one of the few first Pakistani nurses to come here. During the time of interview participant was working in NHS in operation room and was living with his family in a settled Pakistani community in one of the cities in Northwest England.

Participant 15: Participant fifteen is a female migrant Pakistani nurse who is working in care homes since 2005. Participant received her nursing education in 1980 and worked there for about fifteen years at different positions in public sector and NGOs. She moved to the Saudi Arabia and worked there for five years in medical surgical areas. Upon hearing the opportunity she came to the UK in 2005 and is living in Pakistani community in Northwest.

Participant 16: Participant sixteen is female migrant Pakistani nurse who has been working in a nursing home in the United Kingdom. She received her nurse training from in mid 1990s and worked five years in intensive care units before moving to Saudi Arabia where she continued working in intensive care. She moved to the United Kingdom in 2005 and made many attempts to work in NHS. Participant number sixteen is living in East Midlands of England in a Pakistani community.

Participant 17: Participant seventeen is a female migrant Pakistani nurse who is working in nursing care home in the United Kingdom. Participant received her nursing education in Pakistan in year 1990 and worked for nine years and then moved to Saudi Arabia where she worked for eight years. She moved to UK in 2005 and is living in a Pakistani community in East Midlands of England.

Participant 18: Participant eighteen is a female migrant Pakistani nurse who received her nursing education in Pakistan in early 1980s. She has vast experience of working

in Pakistan at prestigious positions. She also has ten years of experience of working in care homes in the United Kingdom and at the time of interview was working as an agency nurse in different care home/NHS setups.

Participant 19: Participant nineteen is a male migrant Pakistani nurse who has recently secured job in NHS in dialysis unit. Participant received his nursing education in Pakistan in year 2001 and worked in Pakistan for 2 years. He moved to United Kingdom in year 2004 and started working in nursing home as a registered nurse. He tried to secure a job in NHS and was recently successful after multiple attempts. He was living with his family in one of the rural areas in Northwest UK.

Participant 20: Participant twenty is a female migrant Pakistani nurse who is living with her family in East Midlands of England. Participant received her nurse training in 1996 and worked for three years before moving to Saudi Arabia. In Pakistan and Saudi Arabia she worked in tertiary care hospitals in gynaecology and labour rooms. Upon migration to the United Kingdom she started working as registered nurse in nursing care homes and despite many attempts to get a job in NHS she couldn't succeed.

Participant 21: Participant twenty one is female migrant Pakistani nurse who completed her nurse training in Pakistan in 1987. She has worked as nurse in Pakistan for 11 years before moving to Saudi Arabia in 2000 where she worked for five years at different positions. After that, she moved to the UK and at the time the study was conducted she was working in a nursing home in East Midlands of England.

6.3.5.   Inclusion and exclusion criteria

An explicit inclusion and exclusion criteria was made to recruit participants as per the study objectives (Table 5). The inclusion criteria were Pakistani nurses who obtained their pre-registration nursing education in Pakistan and had worked in Pakistan as a nurse with first-hand experience of Pakistani health system. It was also necessary that Pakistani nurses had immigrated to the United Kingdom for the purpose of working here as registered nurses, and were currently working as nurses in the United Kingdom. Other categories of participants such as Pakistani nurses who were in the UK for studying and were not having NMC registration were not included because they had no experience of working as registered nurses in the UK. Pakistani nurses who were working as care assistants in the UK without having NMC registration were also excluded from the study because they were not falling under inclusion criteria. British Pakistani nurses whose parents migrated to the UK got their nursing training in the UK and had no experience of working as registered nurses in Pakistan neither did they migrate to the UK were also excluded from the study.

Table 5: Inclusion and exclusion criteria

S	Inclusion Criteria	Exclusion criteria
1.	Being a Pakistani trained nurse who immigrated to the UK as a nurse	Pakistani origin nurses who have got their pre-registration nursing education in United Kingdom.
2.	Being a Pakistani trained nurse practicing as a nurse in the UK	Pakistani educated nurses with NMC registration who is not working as nurses in the United Kingdom.

3.	Have current registration with UK Nursing and Midwifery council and working in independent health sector in care home settings or National Health Service (NHS).	Pakistani trained nurses in UK not having UK NMC registration in other categories such as university students etc.

6.3.6. Recruitment to the study

Participants were accessed through Pakistani educated nurses, known to the researcher, who were also working as nurses in the UK. The information packs containing participant invitation letters, participant information sheets and reply slips (see Appendixes V, VI, VII), enclosed in envelops, were distributed among these nurses. They were asked to introduce the study to other Pakistani educated nurses who were working in UK as Registered General Nurses (RGNs) and pass the invitations to them. A great deal of care was exercised to avoid intrusion and maintain privacy of participants. Volunteers interested in participation were asked to contact me directly. Interview date, time and location were arranged with all eligible nurses who contacted me. The majority of participants opted to be interviewed in their homes, and two nurses arranged to be interviewed at their place of work. Before proceeding with the interview, participants were encouraged to ask any questions they had and clarify that they understood what was being asked of them. Prior to the interview, the interview process was thoroughly explained to the participants. It was explained that the interview was to be tape recorded and data transcribed verbatim. Informed voluntary written consent was taken from all the participants prior to interview.

A society called All Pakistani Nurses Association (APNA) was found on the internet and accessed through email and information related to study was sent to them.

Contacts made through the APNA were recruited by email. Some of these were Pakistani nurses who had completed their pre-registration nurse education in the UK. They were excluded as they were not eligible to take part in the study because they did not migrate to the UK as nurses, rather their parents migrated long ago and they were born and raised in the UK. However, some further contacts provided by them were migrant nurses, who were subsequently interviewed.

I found that accessing the participants, and recruiting these participants was not an easy endeavour. Not all contacts were willing to be interviewed and it took about six months of field work to recruit the sample. Some of the potential participants shared their concerns about being "spied upon", and although all potential participants were assured of the privacy and confidentiality of the data, some chose not to be interviewed. The reluctance of some of the participants to be interviewed may be due to the current global political situation. The two terrorist incidents that happened in the September 2001 attack on the 'twin towers' in New York, and the July 2005 bombings of London buses and underground trains were linked to Muslim fundamentalism and led to increased and widespread surveillance of Muslims in the Western world.

In this study participants were recruited from both the NHS and nursing homes and some demographic information about participants was collected before the commencement of the interview. Table 6 shows the basic demographic information of the nurses who participated in the study:

Table 6: Demographic details of participants

S No	Gender	Age	Academic education	Professional education	Experience in UK	Experience in Pakistan	Experience in other country	Work sector
1	M	33	A level	BScN	7 years	1 year	Nil	Nursing home
2	M	29	A level	BScN	4 years	2 years	Nil	Nursing home
3	M	30	Master in Science	Diploma in general nursing	7 years	2 years	Nil	Nursing home + NHS (bank)
4	F	46	Matric (O level)	Diploma in general nursing + midwifery	11 years	5 years	Kuwait 4 years	NHS +Nursing home (bank)
5	M	34	Bachelor in Arts	Diploma in general nursing	7 years and 6 months	2 years	Nil	Nursing home+ NHS (bank)
6	M	44	Bachelor in arts	BScN+ Diploma in Cardiac Nursing	11 years and 6 months	10 years and 3months	Nil	NHS
7	F	43	Matric	Diploma in general nursing + midwifery+ diploma in psychiatry	8 years	5 years	4 years Saudi Arabia	Nursing home(current)

								NHS (previous)
8	M	31	BSc	Diploma in general nursing BSc honours in professional practice + PG diploma in occupational health	7 years	2 years	Nil	Nursing home
9	M	43 years	Intermediate	Diploma in general nursing+ diploma in cardiac nursing	8 years	14 years	Nil	Nursing home
10	F	37 years	Intermediate	Diploma in general nursing + midwifery	11 years	$1^{1/2}$ years	Nil	Nursing home
11	F	44	Matric	Diploma in nursing + diploma in midwifery	9 years 8 months	13 years	Nil	NHS
12	F	41 years	Matric	Diploma in nursing + diploma in midwifery	12 years	4 years	Kuwait 4 years	NHS
13	M	36	BA	Diploma in general nursing	10 years	3 years	Nil	NHS
14	M	41	Masters	Diploma in general nursing	12 years	6 years	Nil	NHS
15	F	55	Matric	Diploma in nursing + diploma in midwifery	5 years 6 months	15 years	Saudi Arabia 5 years	Nursing home

16	F	36 years	Matric	Diploma in nursing + diploma in midwifery	6 years	5 years	Saudi Arabia 4 years	Nursing home
17	F	40	FA	Diploma in nursing + diploma in midwifery	8 years	$7^{1/2}$ years	Saudi Arabia 5 years	Nursing home
18	F	41	FSc	Diploma in nursing + diploma in midwifery	10 years	20 years	Nil	Agency nurse/ Nursing homes
19	M	32	FSc	Diploma in nursing	8 years	2 years	Nil	NHS
20	F	34	FA	Diploma in nursing + diploma in midwifery	5 years	3 years	Saudi Arabia 4 years	Nursing home
21	F	42	Intermediate	Diploma in nursing + diploma in midwifery	7 years	11 years	Saudi Arabia 5 years	Nursing home

6.3.7. Data collection as per the principles of phenomenolgy

The data was collected according to the principles of interpretive phenomenology. The lived experience of migration of Pakistani nurses was explored in the context. It was the focus that how participants tell their stories in their own words and what does their experience mean to them. Interview questions were asked in such a way so that participants tell about their life world of migration, and as per the principles of phenomenology their experiences of becoming and being a migrant is influenced by social and political circumstances.

Data collection tools in this study were a demographic information sheet, an interview topic guide, an audio-recorder, and field journals. Interviews were the main source of data and were conducted according to the philosophical foundations of phenomenology. In phenomenological interviewing there is a reflective relation between the interviewer and the participant with the researcher acting as an instrument (Kvale, 1996, Wimpenny and Gass, 2000). I maintained a reflective relationship with participants by adopting a broad and open ended approach when asking questions (Vandermause and Fleming, 2011). Interviewing skills employed reflection, clarifications, requests for examples and descriptions, and conveyance of interest through attentive listening (Wimpenny and Gass, 2000). I also conveyed an empathetic relationship by listening attentively and showing an interest in the stories of the participants (Wimpenny and Gass, 2000). This was based on a trust and respect for the participants and the information they shared (Dicicco-Bloom and Crabtree, 2006).

The interview topic guide format is flexible enough to allow participants to share their stories but also helped me to focus on the topic (Whiting, 2008, Dicicco-Bloom and Crabtree, 2006, Gill et al., 2008).

In the beginning of the interview I built rapport by being less formal (Walker, 2011), however I maintained professional boundaries. The interview context ensured privacy and minimum interruption (Dicicco-Bloom and Crabtree, 2006). I conducted the majority of interviews in participants' homes and whilst I acknowledge I may have less control over the environment, familiarity may have helped the participants to relax, resulting in a more productive interview (Gill et al., 2008).

I conducted interviews in English and started with a 'grand tour' open ended question (Walker, 2011); "please describe in detail your experience of being a Pakistani educated nurse working in the UK" What does it mean to you?" I asked participants for examples to illustrate their experiences or life events (Wimpenny and Gass, 2000). I framed the interview questions broad and open ended to avoid influencing participants answers in any way (Baker et al., 1992). Participants were encouraged to share their experiences, feelings and emotions in a free manner. When the participant stories were finished and I had no more questions, participants were asked to share anything else that they might feel important. This was done to make sure the interview did not finish abruptly. Once the interview was concluded, I wrote field notes.

6.3.8. Positionality

In qualitative studies the researcher's positioning to those researched is critical while collecting and interpreting the data. This positioning of the researcher as in insider/ outsider has been important primarily in ethnographic studies, observations and field

research, however, recently in all forms of qualitative studies researchers are encouraged to discuss their positioning (Dwyer and Buckle, 2009). The researchers' positioning comprise of personal attributes, such as race, gender, age, migration status, personal experiences, language, beliefs', biases, personal preferences, theoretical, political, ontological and emotional responses to the participants (Berger, 2013).

An inter-related concept is reflexivity and it is one of the main features of interpretive phenomenology (Berger, 2013). Reflexivity is generally important in qualitative research because it enhances the overall credibility of the study (Dowling, 2006, Jootun et al., 2009). Reflexivity asks the researcher to be aware of the self in the research process and includes methods of examining our attitudes, thoughts, reactions and habitual actions (Bulpitt and Martin, 2010, Walker, 2011, Clancy, 2013). According to Parahoo (2006), 'reflexivity is the on-going process of reflection by the researchers on their values, preconceptions, behaviour or presence and those of the participants, that may affect the interpretation of responses. I engaged myself in a continuous self-reflection process. Throughout the study no attempt was made to influence the participants' stories. I also used field notes to write down personal reflections and observations throughout the data collection process.

The study focus is also a politically sensitive area and so it is important to clarify my positioning to the study participants (Khawaja and Morck, 2009). During the interview many participants related their experience to me thinking that I had similar experience placing me and themselves in the same position as social other in Pakistani society like the following extract is taken from an interview with participant: "Our government is not providing enough staff for the hospitals...not medicines" participant is referring here me as part of the system where nurses are 'othered' or marginalized

in Pakistani health system. One of the similarities with participants was that I also had an aspiration to migrate abroad when I was working in Pakistan. However, I had an opportunity to avail a scholarship to study further and moved to the UK for further studies. In the study I was both an interviewer and researcher with prior experience and knowledge as a nurse working in Pakistan. However, I do not have a registration with the Nursing and Midwifery Council, nor do I have experience of working as a nurse in the United Kingdom. I also found that my role in this study, primarily as a researcher and interviewer with my background being a Pakistani educated nurse helped me to understand the background of participants. My own background helped participants to share their experiences freely on the basis of common experience (Berger, 2013), but it is recognized that in this study I am neither fully an outsider nor insider.

In a study like phenomenology it is also essential to gain the trust of the participants as phenomenology focuses the feelings of participants. It was therefore important for participants to know that I had received my nursing education from a prestigious University in Pakistan. Upon graduation, I worked two years in two different leading hospitals in Pakistan as a staff nurse and as nursing instructor. It is also imperative to note that the researcher pre-understanding or foreknowledge mix with what participants share in a 'hermeneutic circle' (Fleming et al., 2003) and therefore the study is an attempt to understand the participant experiences with an acknowledgement that I also have the prior knowledge and experience as Pakistani nurse working in Pakistan.

6.4.   Data analysis approaches in phenomenology

This section describes the data analysis approaches in phenomenological studies. I first briefly outline data analysis in phenomenology in general terms, then cover some practicalities of doing 'thematic analysis'. Later in this section I focus on van Manen's (1997) pragmatic steps to analyse the data and illustrate the process by which I arrived at the main themes and sub-themes in the data.

Broadly speaking, there are three distinct approaches to qualitative data; content analysis, grounded theory and narrative analysis (Silverman, 2011). There are crossovers and overlaps between different types of approaches to analysing qualitative data. In every form of qualitative data analysis findings are presented in written format and presented to produce analytic categories and theoretical explanations (Pope et al., 2000). Grounded theory analysis is an inductive method with the aim to generate theory from the data and is applied in the grounded theory method (Vaismoradi et al., 2013). A content analysis can be used to analyse qualitative data however it is more associated towards quantitative approaches as it counts the data and thus provide more descriptive account (Vaismoradi et al., 2013). However, a thematic analysis is a full scale approach that is purely qualitative and nuanced (Braun and Clarke, 2006). Thematic analysis should be informed by the epistemology of the method and in the current study the principles of interpretive phenomenology were applied in analysing the data.

A number of approaches have been suggested to analyse data in the descriptive phenomenological tradition, such as those described by Colaizzi (1978), Giorgi (1985), Paterson and Zderad (1976), Van Kaam (1966) Moustakas (1994), (Holloway and Wheeler, 2010, Phillips-Pula et al., 2011, Polit and Beck, 2008, Creswell, 2007).

Similarly, several approaches are utilised in carrying out data analysis in hermeneutic phenomenology such as Gadamer (1975), Riceour (1981), Diekelman, Allen and Tanner (1989) and Benner (1994) (Polit and Beck, 2008). Phenomenology requires researchers to become immersed in the data (Speziale and Carpenter, 2007). van Manen (1990) uses a combination of a descriptive-interpretive approach to data analysis in his six steps approach to phenomenological inquiry. van Manen emphasises a reflection on the nature of lived experience, a thematic analytic approach, and the art of writing and rewriting (van Manen, 1997, Van Manen, 2002, Van Manen, 2006).

Thematic analysis is the most extensively used approach in qualitative data analysis yet is considered not well defined (Roulston, 2001, Aguinaldo, 2012). However, it should be carried carefully and pitfalls avoided in the process make it more meaningful. Thematic analysis is an approach to identify, analyse, and report patterns (themes) within data. (Braun and Clarke, 2006). The basic purpose of thematic analysis is to paraphrase and summarize the dataset as a whole or in part in relation to particular research questions (Aguinaldo, 2012). Thematic analysis includes to identify the content of the data, reduce redundancy, and group data into representative categories that articulate or describe a particular social phenomenon (Aguinaldo, 2012).

6.4.1. Data analysis process

The process of data analysis involved determining subthemes, main themes and the essence from the participants' descriptions (Braun and Clarke, 2006). Interpretation began during the first interview (Liamputtg, 2009). Analysis of the data was carried out using van Manen's thematic analytic approach (van Manen, 1997), and analysis was not a linear process. The steps of van Manen (1997) that structured data analysis

were hermeneutic reflection, hermeneutic writing, maintaining a strong and orientated relation, and balancing the research context by considering parts and the whole. I will now discuss how each step was carried out practically.

In hermeneutic reflection a thematic analysis was carried out of all the interview transcripts. First, in the process of reflection, I gave enough time to ponder over the data. Here, I considered three steps suggested by van Manen. First I transcribed verbatim all the interviews. After this, I read and re-read all the transcripts several times to make a sense of what was happening in the data. In this way I explored the overall meaning of the text. I attended the text of transcripts as a whole to make sense of what was conveyed in the text. At this stage, I didn't formulate any meaning units, rather I used overall approach to know what each transcript meant as a whole. In the selective approach, I read and re-read the text several times and asked questions, such as 'what are the statements that reveal the phenomenon being investigated?' in this case   the experience of migrant Pakistani nurses. In this way, I examined all the sentences of interview transcript and separated sentences that seemed thematic out and thus formulated meaning units. I interrogated each meaning unit about its meanings to know what it conveyed. In this way, I made initial themes from the meaning units and during the whole process I took notes. After this, sentences, phrases and anecdotes that seemed to be thematic for each transcript were marked as meaning units. In the detailed approach, the sentence was read separately line by line, to understand what the text in that sentence means. Thus themes were derived from the sentences that were relevant to the experience of migrant Pakistani nurses. Several themes emerged during this process and they are presented in the findings chapters.

As the majority of the work of hermeneutic phenomenology is reflecting, writing and rewriting, this was done throughout the process until an essence of experience of Pakistani educated nurses was achieved (Nay and Fetherstonhaugh, 2012). An important concept that van Manen (1997) pointed out is that interpretive phenomenological research and theorizing cannot be separated from the textual practice of writing. In accordance with van Manen's method, meaning units and preliminary themes were read and re-read, combined and reduced, written and re-written until a basic structure was obtained. At this stage I also used free imaginative variation to differentiate and verify 'essential' and 'incidental' themes.

I immersed myself in the data to understand fully what the lived experience of becoming and being a migrant Pakistani nurse working in the UK meant. Finally, the research was balanced by looking at overall meaning and each individual part was considered. I stepped back several times to see the whole and the context given to each part and whether it matched the general theme and overall story.

In this way three main themes were arrived at and a general structure was made. The three main themes were labelled

1. Becoming a migrant
2. Dissonance and devaluation
3. Outsider Identities

These themes are discussed in detail in Chapters 7, 8 and 9. Table 7 gives an example to illustrate the data analysis process by which themes were derived.

Table 7: The process of arriving at subthemes and main themes

←——→

Transcription   Analysis

Theme 1: Becoming a Migrant

Main theme	Subtheme	Category	Code	Data extract
Becoming a Migrant	Exploitation of nurses in Pakistani health system	Workload	High staff to patient ratio Difficulty to cope High staff to patient ration	"some time was in a urology ward was sixty or seventy patients…. only two staff nurses (.) and it's really hard to cope" "forty patients' one staff nurse in the morning (.) third year students second year students first year students (.) staff nurse is only one"
		Working in resource constrained settings as a frustrating experience	terrible feelings asking family members to brings medicines for patients doing job without adequate resources Lack of care of employee	"Always felt terrible time at the whole world when I was doing you know when anybody is on antibiotics or pain killers…. and I used to write on the paper give to the relative (.) *"bring it"* now relatives would some of them would literally cry from where(?)……*"we don't have money this is only fifty rupees this medicine is about two hundred pounds erm rupees so from where we will then puttar(used for child) we have got these ten rupees some time for this nan channa(nan and chickpeas.) to buy and to eat"* "I used to cry…when people I couldn't help them (.) when people couldn't do the things (.) couldn't bring them… couldn't afford them (.) and they were in pain"

Oppression from management in Pakistan	Forceful obligation to do job	Forcing employee to do job regardless of circumstances	"in a Pakistan no body consider if you are ill (.) you need to come for work if you have children in hospital no body care… they said they are your children you need to come for work"
			"I used to have in Pakistan I was very bad (.) diarrhoea but once in a while …because I was when it was really bad" I went to the doctors and doctor give me and he said you need I/V drip..I was admitted… and she told me *"you need to do the evening shift if you are ill or not I do not have any arrangement"*
	Different treatment for doctors and nurses	Was refused vaccination based on status as a nurse	"once I am pricked with one of patient's…he was hepatitis A positive (.) and I got pricked (.)erm when I complained… I mean I was entitled to get injection… the vaccination (.) I applied for it (.) and the administrator the MS you know after.. but the doctor …he went put his own name and he got that vaccine (.) and after he gave it to me (.) but he refused it"
Social Non-recognition of nurses work	Nurses are not highly regarded in society	Discouragement of family to join nursing	"My family impression wasn't good… everyone was really angry *"why she is going in nursing (?)" "why she is going in nursing (?)"* (Female nurse: 10).
	Lack of respect	Discouragement of family to join nursing	"when I become nurse… and when erm I asked my dad…father.."*I want to become nurse"*…and my dad actually my dad he loved me…because I was only one daughter…and he said *"that's fine (.)then you can go for the nursing"* (.) so when I did FA… and I went for the… my dad went with me for the interview…. I select (.) and I interviewed (.) and when I went to Islamabad… my brother they don't like (.) they said you have to stop (.) you have to go for the further study… don't go for the nursing… because nursing is…erm you know… bad name people is talking negative about nurses… so don't go (.) we will not allow"
		Feeling of being treated as servant	

				"in Pakistan they call nurse…*" nurse come here do this job*" like erm(.) it's not nurse (.) your servant …and that's why ..like you..but the nurse sorry to say… but I feel this is my feelings" (Female nurse: 10).

Theme 2: Dissonance and Devaluation

Main Theme	Subtheme	Category	Code	Data extract
Dissonance and Devaluation	Loss of professional identity	Feeling of not working in a professional role	Working like care assistant	"I really feel I lost myself...I lost my...everything...we have carer...erm care assistants there in Saudi Arabia...they was doing that job"
			Low category job	"its just like continence care and all that...you know nursing home is just like giving them continence care and all that"
			Feeling working in a hotel	"In nursing home there is no anything (sic) there is old peoples just putting them to bed...giving them medicines this...like we are working in hotel and people is coming we are...look after them"
	Loss of professional skills	Non-clinical environment	Losing skills	"I am just feeling I am earning money...I am losing my skills...yeah really"
			No exposure to skills	"over here you do not have that exposure as I told you that I have even forgot if I can say I have more than I have forgot very important (.) erm knowledge which nurses should have….like I will say that I had a very good knowledge of angiography angioplasty erm ventilators ECG machine erm you know the erm interpretate(sic) the...what we called those ECGs and things like that (.) I even cannot think of that how to operate it so interpretating(sic) and now I even do not know how to operate it (.) so these are the things I am losing here"
			Forgetting skills	"back home we were we could ahm read like ABGs you know…you know this person is going acidosis (.) alkalosis something you know…read the ECG you know… some changes but we are not able to do it now… because I have forgotten

				if I don't use the knowledge I had you know… back home so most of the things I have forgotten"
	Cultural Challenges	Shocking experience	Surprising environment and unexpected skills	"when I started over there I cry so much as well because I did not see old people living separate...leaving families...living alone and nurses are coming and carers are coming to giving them support and feed...what is this...washing dressing everything"
			Surprising experience	"I was just thinking...and then I kept thinking...I thought several time that why there are so many old people living in here is this the hospital and then they go...and then they discharge or whatever"
			No previous knowledge of nursing home	"Ah nursing home...I never heard of nursing home in Pakistan (.) it was totally different because we used to work...as I told you that I worked in critical care areas (.) it was totally different experience for me"

Theme 3: Outsider Identities

Main theme	Subtheme	Category	Code	Data Extract
Fear, Isolation and Racism	Feeling fear	Stereotyping	Getting a negative image	"there was English lady she was carer with me (.) and she said "we don't like Pakistanis because erm they all the time fighting they all the time killing other persons"
			Being scared	"if you remember when we came (.) may be you were not there in 2005 (.) in February or March there was bomb blast in London (.) you know (.) and they were they were thinking you know (.) they were thinking (.) the Pakistani people they did this one (.) and that's not our fault you know (.) the finger is not equal you know (.) what I mean (.) and they were thinking there is Pakistani and they were hating because of that terrorism (.) erm you know (.) they were thinking we are the one as well (.) and that's why some time they were hating us as well"
	Isolation and homesickness	Social Isolation	Compromised social life	"I will say that even after seven years (.) erm... my social life (expressions) is not as it used to be in Pakistan (.) it was more...erm what you call it... erm I was more in action more and more in motion erm whereas over here I mostly concentrate on job and if I do much more(.) so I just go to gym so gym job and my bed so no more social life although I know that I get on well with the things you know ...erm but my social life seems to be a bit compromised"
			Homesickness and social sickness	"but what I am lacking here is my family… first of all like my moms and my sisters and brothers… and by the time you get back to home from work in Pakistan you know you are in a family (.) and erm you relatives can come and you can go to the relatives yeah… you know it's all the social life and you know your blood relations are missing a lot (.) you know like several time I tried I could go back to home this is what I tried I aimed for that and at the same time because the law and order situation in Pakistan (.) the socioeconomic

	Racism	Rejection	Racial comments	prices in Pakistan (.) the energy crisis in Pakistan (.) there are many things going on so you know like I couldn't go these are the things like I must admit that"
				"some of them which are late 60s you know they were really racist like...you know they said no we don't want this black girl we want white so that time I feel...what you have to say...discrimination dishurted(sic) and I say no this is not and then slowly I said you are my mom you are my grandma"
			Racial comments	"specially patients…patients confused and I heard the patient calling a staff nurse Paki Paki Paki yeah so that means there is still racist there"

6.5. Ethical considerations and protection of human subjects

For the protection of human subjects, I sought ethics approval from the University of Liverpool research ethics committee. I started data collection only after ethics approval had been secured (see Appendix IV). Ethical considerations pertaining to this study are the participant's right to informed consent, autonomy, privacy, anonymity, and confidentiality.

6.5.1. Informed consent

I obtained informed voluntary written consent from all participants. I provided participants participant information sheets and addressed any questions that participants were having before the interview. Initially, I provided a consent form (Appendix VIII) to participants and asked participants to sign the consent form. I only started interview after participants were satisfied and they understood the purpose of the study and what was expected of them, and had given written consent.

6.5.2. Autonomy

I explained participants that their participation in the research was entirely voluntary and that their decision about whether to participate or not would not affect them in any way. I also assured them that they were free to withdraw at any time if they wished to do so.

6.5.3. Privacy and confidentiality

I kept confidential all the information that participants provided. I recorded personal details on demographic data sheets collected during this study (see Appendix IX). Data recorded in field notes and audio-taped interview transcripts were kept in a locked

cabinet at the University of Liverpool and the computer where data are stored is password protected.

6.6. Maintaining rigour

An important issue in qualitative research is to maintain rigour in the research process (Koch, 2006, Rolfe, 2006), however there is no consensus to establish a quality criteria and the notion of having such a criteria is still controversial (Rolfe, 2006). Nevertheless, the credibility of the study is linked to faithful descriptions, and when readers are able to recognize the experiences (Koch, 2006). Rigour, in qualitative studies, aims to make sure that participants' accounts are portrayed in an accurate manner. According to Sandelowski (1993) "in naturalistic interpretive paradigm, reality is assumed to be multiple and constructed rather than singular and tangible"(p.4). Rigour in this study was maintained through credibility, transferability, and dependability.

6.6.1. Credibility

I maintained credibility by describing my own experiences and by keeping a journal in which I noted the content and process of interactions (Koch, 2006). I recorded all interactions with participants from recruitment until the interview was finished, and also wrote post-interview discussions in field notes. Moreover, I also clarified my position and shared this with the participants.

6.6.2. Transferability

Koch (1996) suggested that transferability is dependent upon the degree of similarity between two contexts and it has also been suggested that the researcher should describe the context sufficiently. In this study, I have described in detail the context

of the current study in chapters one and two. Moreover, transferability is addressed by providing a complete description of the context of the study, all the assumptions regarding the study, and an accurate description of participant's accounts. In the finding sections, within each of the themes, I have discussed the context of the study to supplement the data.

6.6.3. Dependability

Dependability is viewed as the process of research being auditable. "A study and its findings are auditable when another researcher can clearly follow the 'decision trail' used by the investigator in the study" (Sandelowski, 1986 p 33). I achieved dependability by iterative reviewing of the study finding with research supervisors**.**

The criteria mentioned above were met to ensure the trustworthiness of the study. Participants' accounts were described in an accurate manner and study findings were discussed in context.

6.7. Summary

This chapter has detailed the method utilised in this study. The chapter outlined the aim of the study, described van Manen's phenomenology, and the six steps that he proposes to analyse phenomenological data. In addition, the chapter examined the practicalities of applying a phenomenological approach, through all stages of the process, from recruiting participants to collecting and recording data. It has also discussed the data analysis procedures and illustrated this through a table. The three key themes of 'becoming a migrant', 'dissonance and devaluation' and 'outsider identities' are discussed in detail in chapters 7, 8 and 9 of this thesis.

PART III

CHAPTER 7

BECOMING A MIGRANT

7.1. Introduction

The overall aim of the study was to explore the lived experience of becoming and being a migrant Pakistani nurse working and living in the United Kingdom. The first objective of the study was to illicit the lived experience of participants in regard to moving to the United Kingdom. The second objective of the study was to explore the lived experience of Pakistani nurses working and living in the United Kingdom. The third objective was to interpret these experiences in socio-cultural and geo-political context of the study. The study findings and discussion are presented according to the sequence of these three objectives.

7.2. An overview of study findings

As per the objectives of the study the data was analysed and three major themes were derived from participant interviews. These were becoming a migrant, dissonance and devaluation and outsider identities (Fig 1). The study findings discussed in chapter seven focuses on the first objective of the study. The chapter describes the lived experience of participant in regard to making a decision to move abroad. Five inter-related themes are discussed in the chapter that is the feelings of exploitation by the health system in Pakistan, financial difficulties of nurses in Pakistan, oppression by the management and authorities in Pakistan, the social non-recognition and the lack of respect from physicians (Fig 2). The feelings of these nurses revealed one kind of

social otherness that felt by these nurses in Pakistan. The concept of this social otherness will be discussed in the discussion chapter.

Chapter eight and nine focus on the second objective of the study and describe the lived experience of Pakistani nurses in the United Kingdom. Chapter eight discusses the arrival of these nurses to United Kingdom and their adjustment and adaptation to new health system. Six inter-related themes discussed in the chapter are loss of professional identity, feelings of initial demotion, loss of professional skills, unmet expectations, difficulty accessing NHS jobs and cultural challenges (Fig 3). While getting adaptation to a new system these nurses had the feelings of devalued otherness in the United Kingdom which will be discussed in the next chapter.

Chapter nine discusses the experiences of participants regarding living in the United Kingdom. The long term struggle of participants to get acceptance in the new country is discussed under the main theme of outsider identities. Sub themes in the chapter include 'feeling fear', 'Isolation and home sickness', feelings of isolation at work placements, 'acculturation into a new society' and the feelings of rejection and racism (Fig 4). These experiences represent one kind of ethnic otherness in the lived experience of migrant Pakistani nurses working and living in the United Kingdom.

All the three finding chapters are pulled together and discussed in the final chapter.
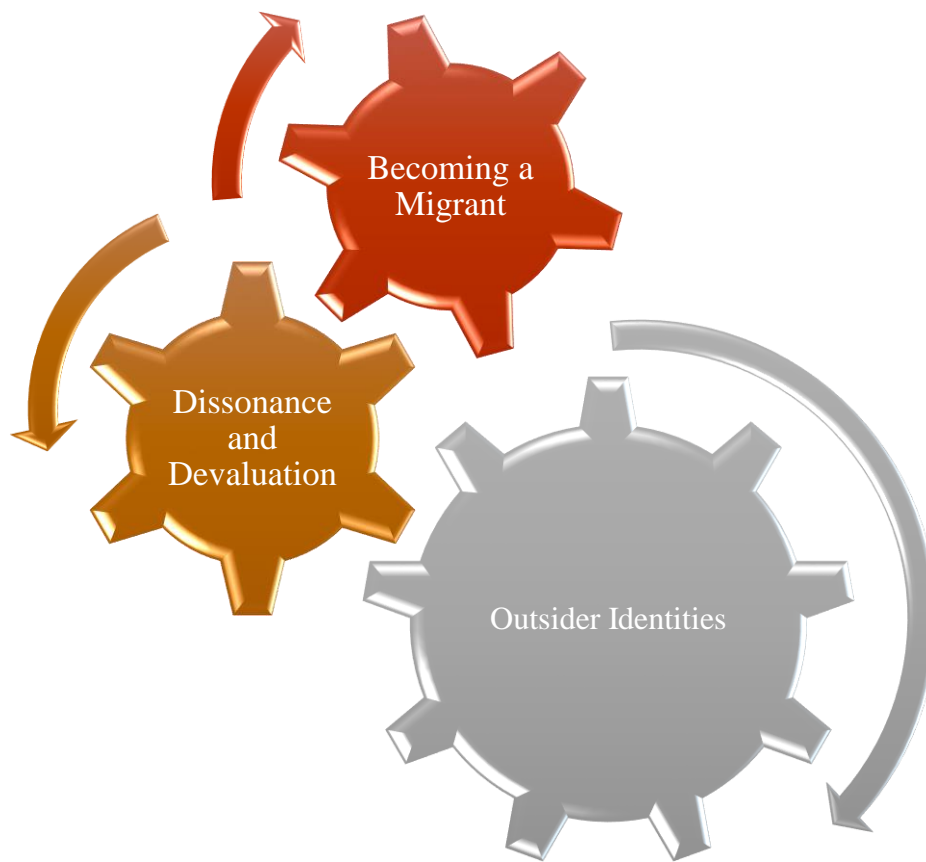
Figure 1: The lived experience of Migrant Pakistani nurses working in the United Kingdom

7.3. Becoming a migrant-participants feelings

This chapter explores the construct of 'becoming a migrant' in the life-world of migrant Pakistani nurses while working, and living, in Pakistan. It focuses on the retrospective experiences of participants in regard to leaving their homes to move abroad, reflecting on the complex issues and challenges that individuals faced in making this decision. The accounts of participants revealed a 'struggle' for a better future by escaping from the hardships of life in Pakistan. Participant narratives constructed the social process of 'becoming a migrant' as the resultant outcome of interwoven discourses that combined material and economic motivation with emotional costs.

Recalling living and working in Pakistan, participants talked about psychological stresses that derived from impoverished conditions, framed by an overwhelming sense of oppression and discrimination. Most participants shared a feeling of low self-esteem in Pakistan that was mainly attributed to the poor social image and lack of respect accorded to the nursing profession. This combined with the hard work of the job itself and less than adequate financial remuneration. In this context, relocating overseas was constructed in terms of financial incentive. A few of the participants suggested that a lack of educational opportunities in Pakistan had 'pushed' them into thinking of moving abroad. Others, though, commented that the aspiration to work outside of Pakistan was prominent from the beginning of their careers, influenced by a societal norm that equated wealth acquisition with geographic mobility. For this reason, some nurse participants had moved to Middle Eastern countries as first destination employment. However, these same individuals also spoke about a shared experience

of discrimination and inequality in Arabic countries like Kuwait. Here, moving to the UK was discussed in terms of relief and optimism.

Given the 'brain-drain' issues in Pakistan, the decision of Pakistani educated nurses to migrate was influenced by multiple social and economic factors. The lived experience of participants showed that, for some nurses the decision to move out of the country is a phenomenon that starts as early as thinking about joining the nursing profession. Although many nurses put their plan into action, to move abroad, after getting their licence to practice, the process started earlier for many of them. Beside financial motives, many other factors shaped the nurses' decision to move abroad. Social atmosphere influenced many nurses, as migrant nurses disclosed that living in a country where other people routinely emigrate to earn a livelihood provoked their thinking. Lack of domestic professional development also encouraged nurses to go abroad to countries which offered greater opportunities. Similarly, living away from ones hometown, in other cities of the country, was described as a factor that prompted nurses to go overseas. In this sense, becoming aware of a shortage of nurses in the UK was described in terms of escape and the chance to 'fulfil their dreams'.

Figure 2: Becoming a Migrant

Participant experiences revealed a critical social stance over the status quo of the nursing profession while they were part of the healthcare labour force in Pakistan. Their lived experience connoted a sense of powerlessness, combined with an oppressive management system, and social non-recognition. Migration, for participants in this study, emerged not as a choice but as an important decision to change life and work conditions. For participants, migration reflected a failure of the Pakistan government to retain its nursing staff. The underlying issues of a diminished professional identity resonated in the lived experience of nurses who felt that they had little control over their lives or careers. In addition, in Pakistan they were accustomed to a culture of deference and obedience with little redress to employment law or rights. The job done by nurses does not seem recognized in the patriarchal, male-dominated society of Pakistan where nursing is largely viewed as 'women's work' and accorded a low status. The essence of five inter-related themes constructed a 'lived-experience' of marginalization for these Pakistan nurses, prompting them to make a decision to migrate.

7.4. Exploitation of nurses in Pakistani health system

A major theme derived from participant stories was a sense of exploitation, derived from poor work and life conditions, and embedded in the nature of job, and less than adequate financial rewards. Nurse accounts of working in the Pakistani health system were constructed around an overwhelming sense of 'hopelessness', where migration seemed the only option to restore some control into their lives and resist the strictures of powerlessness. The stress of nursing in a resource-constrained environment like Pakistan, compounded by negative public perceptions, generated both frustration and

dissatisfaction. Most, mentioned 'moving abroad' as an 'escape strategy' to overcome exacting working conditions and poor quality of life in Pakistan.

One nurse described her emotional feelings during the time she worked in a government hospital in Pakistan. She reminisced about the intensely painful experience of putting prescription slips into the hands of poor people, who then needed to purchase medicines from a local pharmacy. Further, the nurse opined that most of these individuals could not afford the cost of the preparations. In Pakistani government hospitals patients' family members have to bear all expenses for medical and nursing treatment. As part of this system, the nurse is required to ask family members to buy medicines and bring them onto the ward in order for them to be administered. Most people who use these services are from economically disadvantaged backgrounds. Participant talked about how, both, patients and staff had little social value in Pakistan. Each group were screamed and shouted at by the management and medical staff. Similarly, this nurse described her monthly salary as hardly enough to survive on, given that she also had to support the studies of her siblings:

> "I used to cry…when people I couldn't help them...when people couldn't do the things...couldn't bring them…couldn't afford them [pause] and they were in pain...I really couldn't help them [pause] but I was just feeling about them and I thought maybe one day this country will change or maybe people will get more valued…that we will get better treatment [pause] or maybe these attitudes will change…well…there are no resources...then how you can make the things right" (female nurse 12).

Additionally, most nurses mentioned the way in which ambivalent attitudes in the Pakistan workplace disturbed them at an emotional level; a lived-experience of distress which mirrored the suffering, lack of care, and inadequate funding and

facilities that constructed the lives of those for whom they cared. Similar experiences were recalled by other nurses who had worked in government hospitals in Pakistan. They described an emotional trauma when very sick patients were ill-treated by doctors and healthcare staff; the poverty of the people compounded by the greed of those charged with a duty to care:

"when people were keep...like you know…devaluing people...shouting screaming...and the third thing was you know when patient was in pain they wouldn't treat them quickly…and as much as possible [pause] that they can prevent that pain and that agony…and that was one thing that I was thinking... that why they can't be free of pain…but then they are not being treated after major surgeries well…they are crying they are screaming….is there no medication to control when they gone through like such all these things (?) [pause]…you know…just I was really really very very disturbed in Pakistan" (female nurse 12).

"I got very hurt you know that time [pause] and they were dealing the patient [pause] if they have no money ten...even they have no ten rupees to pay for the admission fees…we nurses we pay for the admission fee for them…ten or twenty rupees [pause] but if when we are asked the doctors they said…'send them back to home if they have no twenty rupees…don't admit them'…so this thing is really disappointing as well" (female nurse 18).

"poverty...one was the poverty of people [pause] people were so poor to afford the treatment…and the other was doctors and nurses attitude towards patients….when people are you know...when we become ill we become very sensitive…feel very much hurt…we need more attention than our normal days…and I always felt people were keeping shouting at patients...treating like you know terribly" (female nurse 21).

Just as female nurse participants had shared the emotional pain of those they attempted to care for, their personal and professional lives merged, also, as a result of their shared life circumstances. For someone who had an ill family member, affording treatment

on the salary of a nurse was not easy. One woman described the misery of her life in Pakistan. She spoke about her daughter who had been diagnosed with haemophilia and was very sick, and the way this had impacted on the immediate, and extended, family group:

> "my daughter was not very well in Pakistan [pause] she has haemophilia…and was very expensive treatment you know in Pakistan…and we need to go Fatimid you know where children can get blood transfusion and plasma [pause] you know white blood cells…was really really hard to get a blood…my husband given blood several times [pause] I given blood several times...and any other relatives [pause] it was a very very hard life in Pakistan" (female nurse 11).

7.5. Financial difficulties of nurses in Pakistan

Besides working in deprived and under-resourced settings, the heavy workload was also a demoralizing experience for many of the participants, where financial remuneration was minimal. The data extracts below illustrate how low staff-patient ratios compromised the quality of care on one hand, and resulted in psychological frustrations to nurses on the other:

> "it was really really hard work…for some time I was in a urology ward for sixty or seventy patients…only two staff nurses [pause] and it's really hard to cope…and also good care...we are not only giving a good care…there we just give a medication" (female nurse 11).

> "forty patients'...one staff nurse in the morning...third year students...second year students first year students...staff nurse is only one ok...nurses...two nurses were giving medications [pause] even first year students give medications but even if others were there then third year student would give the medications…and first second year will do rest of the care for the patients….but imagine...one staff nurse or one student for the forty patients [pause] is not enough" (female nurse 12).

"our government is not providing enough staff for the hospitals...not medicines [pause] I am always feeling...and it's hurting me because they are entitled to have medicine from the hospital but always people they are just writing oh go and buy from outside...so this is always dislike about Pakistan" (female nurse 4).

A vital aspect of the life-world of Pakistani nurses was the financial constraints that contributed to the lived-experience of powerlessness. Barely existing on the wages in Pakistan, most nurses described inadequate salaries as the main factor that compelled them to think of moving abroad. In addition, with extended family systems, for most nurses, it was made more difficult to manage economically and socially. In the following extracts nurses spoke about their income in terms of a 'hand-to-mouth' existence where it was not possible to buy a house or live a good life:

"you can't run your family...you can't run your life...you can't enjoy yourself...you can't buy a house... you can't buy anything…so that's [pause] it's these...are more things to push me to come here" (female nurse 10).

"it was only may be four or five thousands rupees…that time it was enough…but not more than enough [pause] you can say hand to mouth (laughs) yeah… so being a female and Pakistani...if you are from the middle class families…you know the females...they thought if we are going to get married we should have everything so all those things…has decided ok we will see…if we can make some money…so that is what…we left" (female nurse 7).

Surviving on the salary was harder if someone had a sick member in the family. One of the nurses shared that if you have a sick member in your family you have to pay for expensive medical treatment, as people have no trust in the government health system. Even doctors in government hospitals will recommend for investigations to be carried out at private medical centres. In such cases, for a nurse who is being employed in government sector, affording the treatment of the family member is not possible at all:

"suppose if my family is back home...if anybody gets ill they have very difficult time because they go and they spend all the money in hospital [pause] and the hospital system is still same what it was twenty years back…even more worse... even it's worse [pause] whatever they tell me…so I know the investigation we used to do…like blood test and all we were relying on that...nowadays...whatever do government hospitals...doctors don't rely them" (female nurse 12).

One nurse described the multitude of problems that would affect the future lives of herself and her children in Pakistan that resulted in her making a decision to migrate abroad. A lived-experience of powerlessness, caused by the complex interrelated issues embedded in the health system of Pakistan where as a nurse she felt little control over her situation. The nurse described many issues that pushed her to make a decision to move abroad. These included poor salary and onerous workloads in a hierarchically ordered system predicated on exploitation and punishment. The emphasis given to the need for children to be educated places hope in the future, and promises a better world than that which initially framed, and limited, their lives. The experience of this participant signalled a need to leave the sufferings of life in Pakistan, where emigration was much more than just a metaphor for escape:

"the problems one was you know the children education...the less salary of staff nurses...and very   hard work [pause] in Pakistan it's so much different...senior and junior…if you have got little bit mistake everybody is shouting to you" (female nurse 11).

"surviving on that salary...to be honest you know our salary was not that much good...that much you know...so that we can survive [pause] but some people…you know were saying…if they have a got a big family or they were supporting some other members... so they were facing problems" (male nurse 19).

If on one hand wages are not enough and on the other hand you are a part of an extended family system, where you have a duty to support other family members, life become harder. One male nurse described this aspect of Pakistani culture as a powerful motivator for people to consider leaving their homeland, and becoming an 'economic migrant':

"in Pakistan…is a different culture [pause] you have to look after...not only you have to be...look after your family [pause] so the opportunity...although the job was there...everything was there...but there was far much opportunity in for my future prospects [pause] so the very simple reason is that economical migrants [pause] so I believe I can earn more money than you know...with a best living style in this country rather than living in Pakistan which [pause] they don't care why I am going you know...nobody stopped me to provide services over there" (male nurse 14).

"there was one thing also you know...if I will go out of the country I can support my family and my brothers and sisters because they were all younger than me [pause] so one thing was this" (female nurse 4).

"that's the reason only to leave Pakistan because of the...you know the salary was not really very good…which was not enough for my family...erm because of that I just left Pakistan" (female nurse 21).

One nurse reflected on his overall experience of working in Pakistan in terms of a lack of empowerment. But this was one more component of an abstracted despair, where 'power' could not be 'given', but nor could it be 'taken'. The narrative, again, is based on individual choice rather than collective action:

"Nurses (in Pakistan) need to be given power...nurses need to take power" (male nurse: 2).

For someone who had worked in the system for many years, and faced the adversities of life, hopelessness was at its peak, and the only option to resist the status quo was to search for opportunities abroad. One female nurse recalled how quickly anxieties could be relieved after being informed by the Kuwait Ministry of Health that she was selected for a position. In a life-world constructed around financial hardship and family suffering, the invisibility of the individual finds expression in the greater workings of divine intervention:

> "and that my prayers were heard...for some...you know *Allah Taalah* (God) just heard it…and there was one more thing I had three nieces who had haemophilia…they are still there...one is here…I brought them after I got here [pause] my sister...my two nieces are still there…and you know the blood problems in Pakistan…to collect and to give so that was they needed every now and then blood…they were collapsing there was no blood...now…*Alhamdulillah* (thanks God) now because they were my sister's children...and when they used to come to the hospital I had to help them as well…so when I was helping them I was running out of my pocket money" (female nurse 12).

The lived-experience of exploitation being a nurse in the Pakistani health system has been described. Nurses had aspirations to change their material and professional life conditions, but realised that the cultural status quo offered no way of achieving this in Pakistan. For these nurses, migration abroad presented an option to bring about change in their lives and 'realise their dreams'.

7.6.   Oppression from management in Pakistan

Alongside the physical, emotional, and financial impediments of life in Pakistan, participant accounts revealed they felt oppressed, and discriminated against, by those responsible for managing hospital services. Participants felt that management

exploited nursing staff, and gave scant consideration to personal factors which impacted on their lives and families. Oppression was experienced where Pakistani nurses thought their rights were not properly protected by employing organizations, but where they were required to execute their responsibilities and duties without challenging authority. Here, oppression is inter-related with the first theme in this chapter, powerlessness, and helps to understand some underlying problems at the forefront of the nursing profession in Pakistan.

The staff-management relations in Pakistani hospitals, as described by participants, were not that of collegial type but, rather, were based on hierarchical power structures, rank, and status In this context, challenging hospital authorities was not appreciated. Nurses were expected to act in a submissive, rather than assertive, manner. Asking for your rights to be respected was described in the language of confrontation and struggle, where the consequences could be costly; this was not considered a good thing to do, particularly when dismissal could be the outcome:

> "I find one thing Pakistan...they [the management] sorry [to say this]…in Pakistan they persist you to stop...do not say anything…in Pakistan if you fight for yourself you will be fired you will...I think you wouldn't be there" (female nurse 10).

Not understanding staff concerns led to conflict between nursing staff and management of the hospitals. In the data extract below, a nurse who had worked in Pakistan in various capacities (staff nurse, head nurse, and nursing supervisor) recalled her experience regarding tensions between the nursing staff and hospital management as part of the daily routine in her work place. The nurse observed that there were constant 'clashes' between nurses and the matron as a figurehead of management. If there was a degree of sympathy for those given responsibility for organising care in a

chaotic setting, nursing staff were equally trapped but lacked any resources to change things:

> "there is always clashes in Pakistan between matron and nurses…they all have fight with each other [pause] you know the matron it's her responsibility…obviously she is not...it's not her fault because she has to cover the shifts you know" (female nurse: 18).

Although nurses were well aware of the management responsibilities, they felt that they were being coerced to cover duties, even if they had genuine and unavoidable reasons which meant they were unable to attend for work. The participant discussed her experience of careless, or callous, attitudes of the hospital management towards employees where family sickness was discounted. This generated a sense of resentment about management:

> "In Pakistan nobody consider if you are ill [pause] you need to come for work if you have children in hospital...nobody care [pause] they said they are your children you need to come for work" (female nurse 11).

Participants discussed how management treatment of staff was experienced as oppressive and threatening to the extent that even serious sickness was not considered a valid reason to be excused from working. In the following data extract one nurse shared her lived experience of oppression when she was sick, and had diarrhoea, and was admitted to the same hospital in which she worked. However, when the management came to know that she was unwell, the matron visited the ward and instructed (forced) her to come on duty after intravenous hydration was finished:

> "in Pakistan I was very bad [pause] diarrhoea and these symptoms always stomach upset for some reasons…when it was really bad I used to be...like if I was off…fair enough…I went to

the doctors and doctor give me...and he said you need I/V drip [pause] I was called to the ward and I was admitted in the ward and I told the sister...I said sister I am admitted in this ward because I had diarrhoea and the doctor put me on IV fluids and I wouldn't be able to do the evening shift…and she told me *'you need to do the evening shift if you are ill or not...I do not have any arrangement'*" (female nurse 12).

Another nurse shared similar experiences about the way she was poorly dealt with by management. Her daughter was critically ill and had been admitted to a nearby hospital in a metropolitan city of Pakistan. The nurse herself used to work at another hospital. Despite her daughter requiring inpatient treatment she was asked to come on duty and do her job. The account was emotive and distressing, but offered visceral imagery of a healthcare system that lacked any of the qualities associated with human, and professional, caring. She complained that the management would not care whether her daughter was sick or not, but would rather ensure that shift duties were covered:

"my daughter she was very little…she was one and half year…she was very very poorly...and she was [pause] so I worked very hard and nobody consider at all…they were just only asking to come to work…she was in like gasping condition…she had a blood transfusion and she was one and half year old [pause] she got blood reaction and then she got septicaemia…and was blister in the body and she had lots of blood transfusions during that and nobody considered that at all…they said I was going every day for work to hospital" (female nurse 11).

Another nurse who previously held a managerial post in a Pakistan hospital reiterated this, drawing on personal experience to portray 'management' as a faceless, monolithic, industrial bureaucracy insensitive to those factotums who keep the wheels of the machine turning:

"even if you are genuine [pause] probably will be genuine...they don't listen to you [pause] that's why they get so frustrated you know they have no cooperation with the family...they

have no cooperation with management…and obviously they need to look after their family as well…too much oppression on nurses in Pakistan…they can't...they are not working in a relaxed environment so how can they update their knowledge" (female nurse 18).

In the following data extract a nurse shared her lived experience of oppression while working in a resource-constrained environment in Pakistan, shared an event from her experience how she felt oppressed from her nursing matron when she tried to borrow plaster of Paris (POP) to help a poor patient. When the senior manager saw her doing this, for a patient from another ward, the dressing was taken out of her hands in a humiliating ritual that took any concept of 'care' out of 'healthcare'. Re-living events revealed how powerless, helpless, and socially disadvantaged she had felt at the time. Moreover, these experiences reflected lack of care of management for the employees, and lack of trust between employees and management in the Pakistan public health system:

"I borrowed you know...once like dressings from the theatre because you know I had a patient who was having P.O.P…and then I saw the...not the manager...the above manager…of the unit I was working on and then she said what is this (?) I said these are crape bandages sister I took you know the patient she needs it…and she is very poor...I got from my friend you know…and then she said 'oh who gave you...give it to give it to me' and then she took…and she came to the dresser the who just the dressing for the patients we used to have that...and she came to him and she said 'did she take these bandages from you (?)' and then she took bandages off me..and she said 'no you can't have it'...imagine how would you feel (?)" (female nurse 12).

The following two extracts are taken from an interview with a female nurse who had extensive experience of working in Pakistan, at senior levels in the government sector. She shared her lived-experience of being a nursing supervisor in Pakistan, sitting in the office of a matron. The ward staff used to come to this participant to book holidays

and she would grant the annual leave requested. The matron, though, told her not to grant holidays like that:

> "once I was the supervisor in the matron office [pause] that time the girls have so many problems...I was in the office and they were coming to me ask for holidays or for some leave so I was assigning them…the matron she will say '[name] don't give it to them' [pause] I was really soft with them...they have to consider like the nurses home...back home problems you know...instead of being strict with them…and abusing each other and putting in a bad manner…you know...sometimes they deal with the nurses in very bad manner " (female nurse 18).

It was also perceived by participants that management themselves failed to follow rules they had implemented, considering themselves immune from any regulatory practices:

> "If you have got...especially if you have got a high position in Pakistan yeah…then they thinking they're everything...you don't need any rules and regulations" (male nurse 13).

The accounts of migrant Pakistani nurses strongly suggest that the feeling of oppression from management was an important part of decision-making about migration. Another component of this was talked about as favouritism being prevalent in the work environment, where merit was not considered as the standard guideline:

> "Pakistan is totally different…even if you are right [pause] still if they have somebody good relation there they will support…they will not listen you." (female nurse 16).

Another participant described an experience of discrimination that she had felt in the work place. The nurse related how she had once received a needle-stick injury when working with a patient blood sample that was contaminated with hepatitis A virus. The

nurse claimed that although she was officially entitled to have a vaccine she was not given the vaccine, and then she requested a doctor on her unit to get her the vaccine. The doctor got the vaccine and gave it to the nurse. The lived experience of the nurse is captured in her own words:

> "one thing that's happened to me once I am pricked with one of patient's…he was hepatitis A positive and I got pricked [pause] when I complained…I mean I was entitled to get injection…the vaccination...I applied for it...and the administrator…it was 1000 rupees…injection you know …vaccine for hepatitis…but he refused it…but once he did…after he went [name of doctor] his own name and he got that vaccine and after he gave it to me...so this is discrimination" (female nurse 18).

Participant stories revealed a critical stance toward the Pakistan health system, where nurses felt marginalised and robbed of dignity. These issues should be seen in the larger picture of the nursing profession in Pakistan, where an embryonic profession has yet to gain recognition and status.

7.7. Social non-recognition of nurses work in Pakistan

In addition to powerlessness and oppression, the lived experience of Pakistani educated nurses working in the UK revealed social non-recognition while working in Pakistan. The stories of participants revealed a poor public image and social status in Pakistan which manifested in accounts of diminished identities and low self-esteem. Participants shared unpleasant experiences as nurses in Pakistan. There was a general consensus among the participants that the image of nurses and nursing was not good in Pakistan. The experience of women participants suggested social class and gendered ideologies in a male dominated Pakistani society were central to the professional pariah status of nursing.

Families were the first to give an impression about the image of the nurses. It was revealed by participants that families showed their reservations when participants were making a decision to pursue careers in the field of nursing. In the data extract below, one female nurse shared her lived-experience of the social non-recognition of nursing when she was joining the profession:

"My family impression wasn't good…everyone was really angry...'why she is going in nursing (?) 'why she is going in nursing (?)'" (female nurse 10).

In a similar manner, another nurse shared her experience of entering the nursing profession. The lived experience of social non-recognition was revealed in the difficulty of getting approval from her brothers to become a nurse. She explained that her male siblings were not happy with her as they thought the image of nurses was not a good one in society. Her brothers wanted her to continue in further education instead, preparing for a good career as opposed to joining one with a 'bad name':

"there's no respect for the nurse as well…so which one you know…when I become nurse…and when I asked my dad…'father I want to become nurse'…and my dad actually... my dad he loved me…because I was only one daughter…and he said 'that's fine...then you can go for the nursing' so when I did FA (pre-university course)…and I went for the…my dad went with me for the interview…and I interviewed...and when I went to Islamabad my brother they don't like...they said you have to stop...you have to go for the further study…don't go for the nursing…because nursing is…you know… bad name...people is talking negative about nurses…so don't go...we will not allow" (female nurse 20).

Another participant shared her experience of being treated with a lack of respect as a nurse in Pakistan, which was beyond her understanding. Though, arguably, nursing is viewed as a noble, or valued, profession around the world, there was a stark contrast

with the perception of nursing in Pakistan. The extent of this was sometimes so extreme that it was suggested families of nurses felt too ashamed, or embarrassed, to introduce their daughter to other people as a 'nurse':

> "they don't respect you know...they really don't respect like…the nurses you know…so you know family they don't want to introduce them [break] I don't know because people doesn't like the nurses or anything…I am always thinking we never get that respect in Pakistan" (female nurse 16)

Beside the first impressions, at the time of joining the profession, most nurses felt that even later in their careers they experienced lack of respect from others. One nurse shared her experience of being a nurse in Pakistan, noting the negative construction of the profession:

> "Actually the first thing is also you know in Pakistan…nurses there's no respect…it's the big thing also…you know whatever people is thinking they are very negative...very negative points" (female nurse 20).

One female participant articulated her experience in terms of gender bias in the male dominated society of Pakistan, where a general conservatism is inclined toward intolerance of men and women working together:

> "in Pakistan you didn't get much respect for the nurses you know…specially for the female nurses…people in Pakistan not very broad minded…you know to accept the nurses...because they work with the men you know" (female nurse 18).

It was also reported by one of the participants that during her career in Pakistan she was told many times that being a nurse she would not be able to make a good relationship. The nurse described her lived-experience in the way she was constructed

by other people. If nursing in the western world has been disadvantaged by a long-association with caring values associated with a 'feminine' psyche, and accorded a second class/sex status, the dynamic seems very different in Pakistan. Indeed, it is closer to the Victorian idea of nursing being a morally improper pursuit for young 'gentlewomen', given their dealings with men, particularly soldiers from the lower social classes. Nursing here is connoted with the body as unclean, where intimacy and exposure to sexual characteristics are taboo outside of marital relations:

> "always listening that one...'oh she will not get good relation with anything…not get nice thing anything if she's a nurse' [pause] the people never thinking respect...a way...if they are thinking she is a nurse she's in hospital dealing with the men's or things...this one cannot clean their minds...that's in Pakistani people mostly" (female nurse16).

In the male dominant society of Pakistan, some female nurses talked about the expectation that they ought to leave the nursing profession if they enter into a spousal relationship. In the following example one woman claimed that she had seen nurses having difficulty getting into relationships as people did not want nurses to be included within their kinship group; a loss of familial dignity, where chastity is compromised by a social pollutant:

> "in Pakistan my one friend she was nurse and she wasn't married…because she was engaged to her uncle's son…real uncle's son [pause] and they said 'why she is not leaving the nursing (?)' [pause] she said 'I will not leave the nursing because I am training only one year is left to complete this course and after this if you don't want I will not do the job...but I will complete my course' you know what I mean...training I will complete the training [pause] but her uncle he said 'no if you will not leave this training we will leave this relation'" (female nurse 17).

This participant hinted that the negative perception about nurses was due to low literacy levels in Pakistan, and lack of awareness in a traditional society where oral history shapes the present. Here, nursing not only takes women out of the home, it takes them away from a commonly constructed, and confining, sexual division of labour:

> "they don't have concept…they don't have experience…but they are listening to others...what the other people they are saying...and just they are following the others [pause] they don't have experience they just follow the people…what they are saying...and they will say same things and they think as a woman she shouldn't go outside...'why we can't go (?)'"" (female nurse 17).

> "but when the things…of you know respect thing… you know..they say 'she's a nurse...oh she's a nurse she works in hospital' it's really the lack of education...you know...the people don't know" (female nurse 18).

Others, though, posited that even 'educated' people would not 'accept' the nurse. This 'issue of acceptance' emerged as a theme that was closely associated with the 'issue of image' in the Pakistan society. The low status of nursing profession was reflected in participant experiences. However, medicine was regarded as a prestigious profession in Pakistan. This was perceived by nurses while they were doing their job on the wards where patients and families give doctors a great deal of respect. In contrast, the nursing role seemed invisible to them:

> "when I was back home you know that our culture is that they more respect the doctors...and the nurses are not much involved [pause] like my case was exceptional because…the university teaching hospital where I studied in...they were like the hospital was being run mostly by the doctors…but still the families and the patients were not aware of our importance

[pause] some of them were good…but they would have been the exceptional cases...like…they would order…you...like...'oh do this...and do this ...and do this'" (male nurse 1).

7.8.   Lack of respect from physicians

Beside the issue of poor public image, the workplace experience of nurses in Pakistan revealed a lack of respect from doctors. Most nurses had experienced being treated as subservient by doctors. In the data extracts below, participants shared their feelings of the lack of respect while doing their job in Pakistan. One of the nurses evoked the sense of servitude by using the term 'servant' to denote the nature of relations between the physician (master) and the nurse:

> "I was feeling very much very bad from the doctors behaviours…they were so bad…they were just...they never showed any respect to the nurses [pause] hardly they showed any respect to the nurses" (female nurse 12).

> "everybody they are thinking like they will just put you very down...you know [pause] like you are really belonging to very low category...yeah [pause] I feel there the doctors will be so bossy that they can shout at you" (female nurse 21).

> "in Pakistan they call 'nurse...nurse come here...do this job' like it's not nurse...your servant" (female nurse 10).

> "the doctors they are ordering there you know 'nurse you do that one... nurse you do that one' they will give all responsibility they will throw on nurse…you know I mean…they will say nurse please can you please pass the I/V cannula can you maintain the I/V line...can you do this one...can you do that one… mostly they are not doing a lot of things you know...but all they are expect from the nurses they will do" (female nurse 17).

One of the nurses shared her lived experience of working in Pakistan and the lack of trust. The nurse described that most of the physicians were very strict with medications and didn't trust the nurses:

> "like you know like we were in few wards…few kinds of doctors [pause] like registrars or assistant professors or any consultant kind of…and they were very very strict to the medication has been given in time and been signed…well fare enough…medication is been given and signed properly…but they were you know...the thing is in Pakistan I felt that they erm never trusted nurses [pause] they don't trusts nurses…I don't know at that time [pause] they were thinking that maybe they didn't give medications…and they signed and may be they gave it…and they didn't give in time and...but that was there" (female nurse 12).

Some of the nurses also complained that the doctors would hardly give any importance to the job nurses were doing. In the following extract one of the nurses articulated her experience of working in Pakistan. The nurse felt that being a nurse she was considered the right hand of the doctors and was perceived as just writing the files only. One of the nurses shared his experience of the attitude of consultants with nurses. The nurse complained that the attitude of consultants was such that they would not treat nurses with respect like 'human' beings. It was a humiliation borne in silence, of being unheard. If the consultant thought he was 'everything', the account of the nurse depicted feeling like 'nothing':

> "but there doctor doesn't listen you… I don't know even when I was there…I got good experience but doctors [pause] always say 'what you doing here…you just writing the files' [pause] always takes obs...I always take history...when I was in Pakistan and doctors always say 'she is our assistant' and something like that…and they are not giving you chance to speak...to say anything...they don't treat you well" (female nurse: 10).

"as I said...if consultant come on the ward round [pause] as I said he's thinking he's everything…he's you know…and then he wouldn't treat you…on the same way it should be as human…in some cases as well…you know" (male nurse: 13).

During the interviews two female nurses described their lived experience by suggesting that although they had gone through such experiences they would urge Pakistani people to give respect to nurses. They suggested that nurses' work needs recognition in Pakistan, because they are doing important jobs and having an impact on the lives of those for whom they provide care. The extracts below are taken from interviews with these women, where they reflected on the lived experience of social non-recognition, and the cost to the nursing profession as well as the human actors. Again, it is a shared story, a plea, from those who felt compelled to leave to the next generation of nurses in Pakistan; painful anecdotal evidence presented as hope for the future:

"I just I just want to say…if you are going…when you finish your study…from here [pause] this is really message from my side…to my home-made…I mean my Pakistani made…I want to tell them please...please do better things…change their minds about the nurses because we are human beings [pause] and if they are not having…I mean good and they don't have the knowledge...don't think about the nurses…they are wrong…and they are bad…nobody can become bad you know everybody is you know…same…if you will not give respect to somebody they will not give you respect" (female nurse: 17).

"I just want to request Pakistani people…they should respect nurses...they should give good reward to nurses...see when nurses is coming to you…have operation…like I have operation…so I feel angel is coming…when she will hold your hand...with nice cute smile...your pain is you know relieving you know [pause] you don't need any pain killer [pause] but see if nurse is coming and she is treating you…but in Pakistan they are not giving respect" (female nurse: 10).

The lived experience of social non-recognition as reflected from participants' interviews depicts the status of the nursing profession in Pakistan. Poor public image and lack of respect emerged as two of the reasons that qualified nurses felt not 'the need to leave', but the 'impossibility of staying' as edging them toward the prospect of employment abroad. It is important to mention here that the themes which emerged in this section should not be viewed as exclusive, and that rather other factors shaping the experience of nursing in Pakistan need to be considered in conjunction.

7.9.   Summary

The master-status narrative of migration as economically driven is challenged by the experiences of these nurses. From a feminist perspective (Chafetz, 1997), the empowerment of women, the right to be autonomous in decision-making about life choices, and the struggle for professional recognition in a patriarchal society need to be taken into account. Pakistan is a male dominated society, women have little freedom regarding their lives, and oppression is a taken-for-granted part of the female condition. Female nurses were more critical of working and living conditions in Pakistan. Men, though, had aspirations to go abroad in order to support families at home.

CHAPTER 8

DISSONANCE AND DEVALUATION

8.1. Introduction

This chapter looks at dissonance and devaluation as a central theme in the lived-experiences of migrant Pakistani nurses working in the United Kingdom. The narratives of participants in this study unveiled the life-world of Pakistani educated nurses, and reflected the challenge of making their place in the new healthcare system. The low status jobs and routine care provided by these migrant nurses in care homes conflicted with their previous experiences and compromised their expectations about first-world nursing. They also revealed that the migrant nurse experience was characterised by a loss of skills and a sense professional identity. The construct of dissonance and devaluation is explored here in terms of a struggle for identity, initial demotion, loss of professional skills, unmet expectations, difficulty securing NHS jobs, and facing realities of a new work environment.

In terms of understanding the migrant Pakistani nurses' experience in the UK it is important to note the statutory registration process they are required to complete before being allowed to practice as registered nurses. Prior to migration, all participants in this study had worked in prestigious positions in Pakistan hospital settings, but on arrival in the UK they had to familiarise themselves with a very different healthcare system. Before they could practice as a registered nurse (RN) they also had to apply to the UK regulatory body, the Nursing and Midwifery
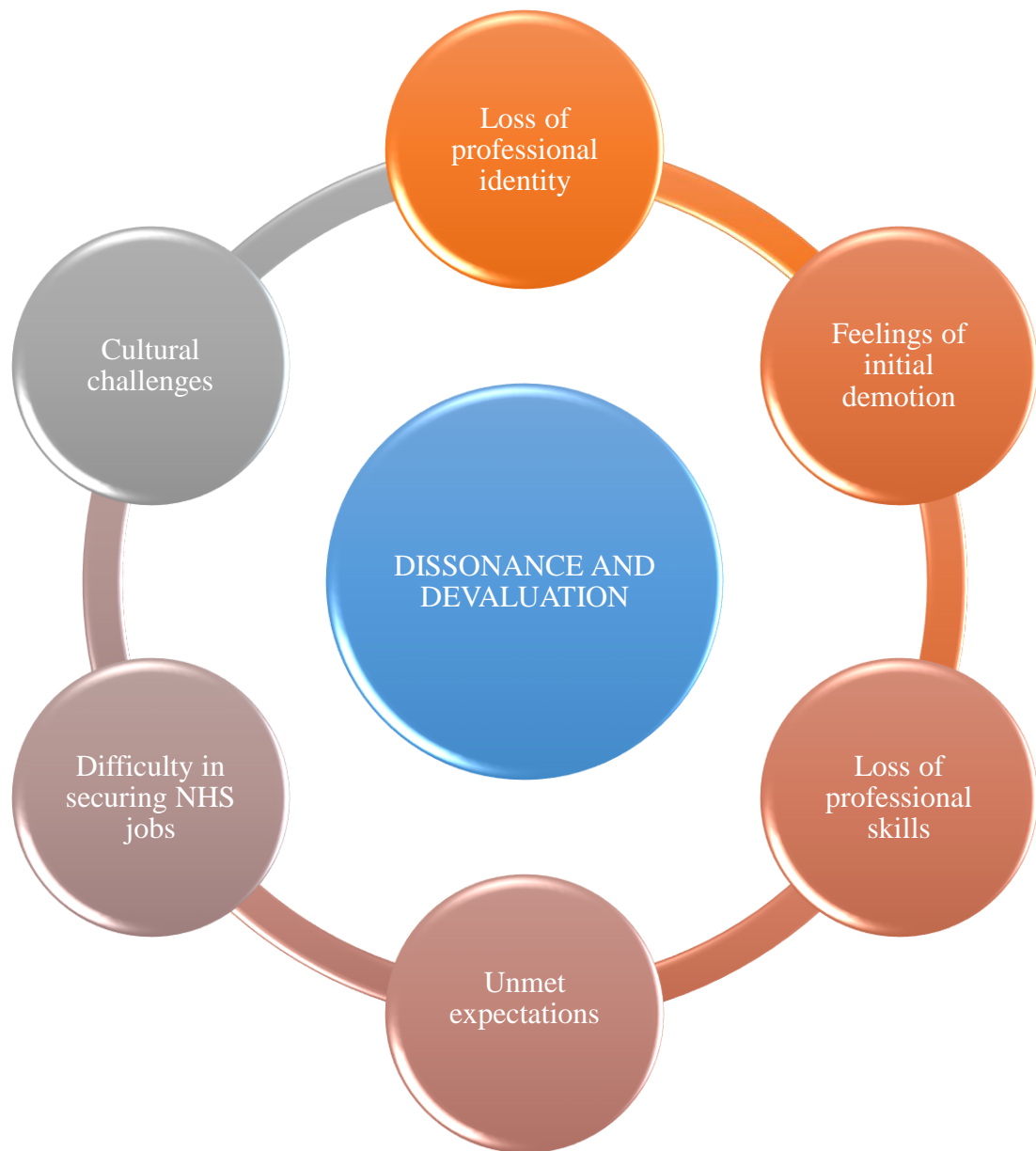
Figure 3: Dissonance and Devaluation

Council (NMC), to complete the Overseas Nursing Programme. This is commonly referred to as the 'adaptation programme' and is designed for overseas nurses to demonstrate competence in nursing practice and theory before being awarded a

licence. The programme involves completion of supervised 'practice hours' and assessment of nursing skills in recognised and accredited clinical placement areas. This means that Pakistani qualified nurses will often have to work as unqualified care assistants, in some cases for up to two years, before finding a suitable placement to complete their adaptation course and gain UK registration.

As a result, many of the migrant nurses start their new UK careers working as healthcare assistants in homes for the elderly. These are normally low paid, low status jobs, involving duties for which migrant nurses are neither prepared nor trained by their nursing education in Pakistan. However, despite employment in devalued positions the financial rewards are substantial. Due to currency exchange values, the salary that migrant nurses can earn is fifteen to twenty times the salary which they received as a qualified nurse in Pakistan. These factors are reflected in the accounts of the migrant nurses, and the experience of dissonance and devaluation emerged as a central aspect of the life-world of Pakistani educated nurses working and living in the United Kingdom. In this chapter, these negative experiences are explored and discussed under six themes derived from interviews: loss of professional identity, initial demotion, loss of professional skills, unmet expectations, difficulty getting NHS jobs, and facing the new reality.

8.2.   Loss of professional identity

The lived-experience of Pakistani nurses reflected that they were puzzled by the kind of work they were expected to carry out as professional nurses. Migrant Pakistani nurses found themselves 'lost' in the new health care environment and unable to see,

or feel, themselves as professional nurses. The inability to retain a professional identity, as a result of exposure to new professional role requirements, was partly attributed to the nature of work they had to carry out in the new nursing role. The concept of care in elderly care homes, to some extent, conflicted with previous work experience, and the nursing-education philosophy of migrant Pakistani participants. Consequently, while working in care homes, participants shared their feelings of loss in the new work environment:

> "I really feel I lost myself...I lost my...everything...we have carer...erm care assistants there in Saudi Arabia...they was doing that job" (female nurse 16).

The profound impact of nurse education and previous work experience was evident where the meaning of 'nurse' was perceived differently, and the new role of a nurse in care homes was not constructed in terms of nursing duties. The job components of Pakistani nurses in these settings were described as vastly different from previous work experience in technologically sophisticated hospital settings. The new role was generic, embracing a range of exacting and undemanding tasks, to the extent that one participant ceased to see, or call herself, a 'nurse'. Similarly, the complexity of a professional role in the new workplace could be attributed to the different meaning of a nurse and the new care environment. In the following lines, one of the nurses expressed her feeling of being lost, as she had never expected to work in a nursing home, and that the meaning of being a nurse was gone:

> "It's different...yeah it's different...nursing home nursing is different...I don't call myself nurse in nursing home...I am everything here…and in a nursing home you are everything (laughs) nursing home is heavier...I will say heavier than hospitals" (female nurse 7).

"I was thinking what is going on here...we are here meant to be nurses...working as nurses and that...I never thought I will work in nursing home" (female nurse 10).

One male participant, who had previously worked in Pakistan for fourteen years as an intensive care nurse, found that without being given any training or preparation for his new role, he was supposed to carry out the job. This was described as 'surprising' for him, and he questioned the 'kind of nursing' that he was introduced to, and expected to undertake, as a professional nurse:

"when I went to the nursing home they straight away put me on the floor without any training without anything you know...they said ok these are the residents...you have to give them supper and you have to put them onto bed...and it was surprising what kind of...this nursing" (male nurse 9).

Likewise, it was disclosed by some participants that by working in care homes, they did not see themselves as being professionals. As they described it, 'anybody' could perform what was asked of them. In the following extract, one nurse articulated his experience of working in a nursing home as equal, or identical to that of a senior carer, undifferentiated from the role of care assistants in residential facilities:

"and a nursing home there is no...I think anybody can do...I think even as a senior carer you don't need to be have a nurse...even senior carers or residential areas they are doing it [pause] the same medicines...they are giving the medicines as well...they are managing as well" (male nurse 3).

Another female participant who had previously worked for ten years in Saudi Arabia shared her feelings about the work she was doing in nursing homes, choosing to compare herself to a domestic labourer working in a 'hotel'; connoting a servile and second class status:

"In nursing home there is no anything...there is old peoples just putting them to bed...giving them medicines this...like we are working in hotel and people is coming we are...look after them" (female nurse 16).

Participants in the study talked about their work environment and the types of tasks they were doing. The loss of professional identity is, to an extent, also linked to low-status labour being carried out by Pakistani migrant nurses. Participants articulated their experiences in terms of carrying out the tasks as generic, menial and low-profile in the healthcare settings. In the following extract, the participant articulated the kind of work that she was doing as low status and task-focused. She talked about practice in terms of menial jobs, as routines, that were demarcated by gender; for instance 'laundry lady', 'kitchen lady', and 'cleaner'. Here, her identity as a 'nurse' was sacrificed to the most mundane aspects of health care provision. Her experience was recounted as a narrative of loss and regret; a loss of status, and loss of skills. To illustrate this, she talked about the frustrations of having been a 'charge nurse' in Saudi Arabia and Pakistan, yet now expected to undertake the role of a 'care assistant'. The language of the participant captured her experience in terms of 'difficulty' and 'horror':

"but here nurse is cleaner…nurse is a laundry lady…nurse a kitchen lady...yeah so many things we do [pause] so the care settings were very different…so first we regret oh where we came...why we came... why we left [pause] it was better we were been there [pause] always missing that ICU settings and CCU (laughs) no so that was really horrible experience...that time [pause] and if that our English it is not very brilliant so English understanding as well the accent was bit difficult in that as well…so when you have worked like a charge nurse and suddenly you will work as assistant care assistant...that is how it feels" (female nurse 7).

Similarly, another male nurse shared similar kinds of feelings while doing his job in nursing homes. He mentioned his tasks that were routinized, labour-intensive and demanding, typically enacted in isolation:

> "you are the only nurse in the building like certain times you will be two [pause] you've got to manage the laundry...you've got to manage the housekeeping...you've got to manage the kitchen...you've got to manage the administration" (male nurse 1).

Another participant who had worked in nursing homes for the last seven years as an RN shared almost identical feelings, focusing on a cultural regime that centred on a repetitive cycle dictated by the bodily functions of an elderly client group. The new role requirement in care homes was seen as just 'serving' the older people and not as a 'profession' undertaken in a clinical setting defined by the descriptor of 'hospital':

> "hospitals you enjoy your work because that is your real profession [pause] here what is it that I am (?) a nurse as well….but serving to the older people it is more...more…like erm I should say that…serving them as like with the motions…they are older...they need that help [pause] so it's little bit difficult" (female nurse 7).

> "its just like continence care and all that...you know nursing home is just like giving them continence care and all that" (male nurse 3).

'Moving and handling' was not, typically, part of previous experience, but this became a defining feature of the new the job requirements:

> "in Pakistan and Kuwait we never had any...I never had any experience to nurse elderly people where we needed lifting...we were always...like I nursed them when they were bed ridden and we just turned them...cleaned them...changed them...but we were never used to sit them on chairs because they were such a poorly...in poorly states" (female nurse 12).

Participants in this study constructed their experiences as part of a devaluation process they were undergoing. The nurses were not satisfied with their current roles and wanted to achieve higher, or more responsible, positions. Participants spoke about knowledge and skills which, in their current jobs they were not getting the opportunity to use; a situation where they were unable to realize their potential. Here, the discourse shifted to one of exploitation where they represented little more than a source of 'cheap labour', to undertake the least rewarding, and most demanding, aspects of basic care:

> "although we all experienced nurses came into this country even being a student you are in a first year you will be able to manage the whole bit of you know [pause] basic nursing skills but there wasn't anything like that in this country...just simple you know wash and clean bums and just keep changing the pads...so basically you just work here as a cheap labour that's all" (male nurse 14).

Subsequently, it created frustration for some of the nurses to discover the new concept of care or the kind of work to carry out as nurses, who inherited by nursing education and previous experiences in hospital setting, the meaning of nursing as 'totally different'. In the following two data extracts nurses disclosed feeling 'down' because of limited opportunities which the nursing homes symbolised. The narrative is one rooted in cultural conflicts and contradictions about the 'meaning' of nursing; where feeling 'down' acts as a metaphor for being 'sent down' to a place of little status or value:

> "I was really like erm...my feeling was very down because I was thinking that I came here to training as a nurse [pause] but this nursing is totally different which I brought with my mind here [pause] and I thought oh what I am doing...is it nursing (?)" (male nurse 3).

"I was little bit you know…I was little bit down...little bit down…like when you are coming from like I work mostly I said to you I worked in the theatres and emergency units…and then suddenly when I get down to the nursing homes...so of course I really...you know I was feeling like what is this (?)" (female nurse 21).

8.3. Feelings of initial demotion

A crucial phase in this perceived devaluation of migrant Pakistani nurses arriving in the United Kingdom was the initial adaptation period; described as 'demotion' from experienced professional to care assistant, or the equivalent of a student nurse. Achieving registration with the Nursing and Midwifery Council (NMC) was a harsh experience, and all participants had to undertake intensive training. The adaptation placement for each of the participants was in the independent health sector, in elderly care settings. All the nurses in this study previously held prestigious positions in Pakistan and Middle Eastern countries, often at senior levels in hospitals, before coming to the United Kingdom. One nurse expressed feeling 'demoted' during his early days in the country. When the interview was finishing, the interviewer asked this man what he would like to mention as his most important experience:

"only thing I would say that we get we get we have two time when we come we are nurses as a student and then we just work as nurses so you can consider that you know…asking somebody when you came and you were a student and you were doing your placement you know how did you feel about it you know being a staff nurse in Pakistan and then demoted to a student nurse and…. then becoming a nurse again right so what is this you know what do you feel about it....I mean that question it's something like demotion probably...you see because you are qualified aren't you (?)" (male nurse 5).

For some nurses who had previously held valued positions in Pakistan, it mattered a lot to experience displacement to a position where they had to work at a lower level.

BPS (Basic Pay Scale) 17, is the rank awarded to gazetted (commissioned) officers of the public sector in Pakistan, and such positions enjoy a good salary, great respect, and major responsibilities. Participants spoke about their new world as having been turned 'upside down', a complete reversal of what they knew, what they had done, and what they had expected to be doing:

"when I left my last job I was working as erm you know like nursing instructor [pause] that was BPS seventeen grade...scale seventeen scale job and it meant like status was you know like from higher level to lower level you know...like this is upside down...so that kind of feelings I had" (male nurse 6).

"I started working in bone marrow transplant unit of oncology [pause] worked over there for around eight months...then left that place and moved onto [hospital name and city name] [pause] I was doing two roles one was working as an instructor...college of nursing [hospital name] and then I was overlooking the lab laboratory kind of thing as well in the [hospital name] [pause] when I landed here I started working in a nursing home...and I started working in here as a care assistant" (Male nurse 2).

Additionally, some nurses expressed frustrations that when working as care assistants they were not allowed to carry out the tasks a nurse is equipped, and entitled, to do. The jobs they had to undertake were more akin to support work, described as restrictive. Others ventured to suggest that the adaptation course did not represent a proper teaching and learning process, but allowed them to be used as full-time carers under the guise of professional education:

"I was working in first as a care assistant I couldn't do...I couldn't do anything because I was not allowed to do anything" (male nurse 3).

"during adaptation we done basically...we done as a carer work...they were taking full job of a carer we didn't do like adaptation... like we stood beside the nurse...and we will know" (female nurse 4).

"I was working as a care assistant you know they used to call it...I was a student nurse...student visa so I was working as a student nurse but I was doing work as a carer" (male nurse 9).

Although the period of adaptation to become registered with the NMC, and acquire the essential Personal Identification Number (PIN), is normally six months, it was difficult for some of the nurses to find an adaptation placement immediately, and they had to work for up to two years as care assistants in a nursing home before getting registered. Initial demotion from the experienced professional nurse was a frustrating experience for migrant Pakistani nurses, as on one hand they had to go through additional mandatory training to secure NMC registration, but on the other hand had to work in the capacity of care assistants. Loss of professional identity was frustrating, but central to their lived-experience of 'feeling lost' in UK health care settings.

8.4. Loss of professional skills

Migrant Pakistani nurses talked about caring in nursing homes as a de-skilling experience, in terms of forgetting previous skills, not acquiring new skills, and the drudgery of simple and repetitive routines. Skills they had learned in Pakistan were described as 'fading from their minds'. Routinized work was described as prescriptive and restrictive, with few, or no, learning opportunities:

"I am just feeling I am earning money...I am losing my skills...yeah really" (female nurse 16).

"the skills which I did back home I was about to forget [pause] because like erm...like within one year I was...the half of things which I learned in Pakistan I have forgotten [pause] it was really major procedures which I was doing...but in a nursing [home] you cannot do anything like that [pause] that is why all the skills which I...you know gained in Pakistan when I came here it was just erm fading away from my mind" (male nurse 3).

Other nurses who had been working in nursing homes since arriving in the UK articulated shared experiences by providing examples of the clinical environments in Pakistan where they had the opportunity to perform advanced clinical skills. Participants expressed sadness, and loss, when recalling the knowledge and skills that had been 'forgotten' in the cumulative attrition of deskilling:

"Unfortunately the way over here you do not have that exposure...as I told you that I have even forgot if I can say I have more than I have forgot very important [pause] erm knowledge which nurses should have….like I will say that I had a very good knowledge of angiography...angioplasty erm ventilators ECG machine and things like that [pause] I now...I do not even know how to operate it [pause] so these are the things I am losing here" (male nurse 1).

"back home we were we could ahm read like ABGs you know…you know this person is going acidosis...alkalosis something you know…read the ECG you know…some changes but we are not able to do it now…because I have forgotten if I don't use the knowledge I had you know…back home [pause] so most of the things I have forgotten" (male nurse 8).

In addition, participants articulated their new experiences in comparison to their previous work in more technologically sophisticated settings, such as critical care wards, in Pakistani hospitals; another illustration of the deep emotional feelings that contributed to their sense of dissatisfaction, dislocation, and devaluation. In the following extract of data, one participant recalled his experience back home, where he

was employed in a high-tech intensive care environment. He spoke about working alongside physicians, as a partner, in caring for, or curing, the sick:

"like I was using these different kinds of latest monitors in…erm intensive care [pause] and the ventilators...and different procedures…and as compared to home there was nothing in the home [pause] and every single day in intensive care we…we were doing different procedures or assisting doctors erm…with different procedures [pause] but in a home so we haven't seen any...so in a way that...so we lose our I/V cannulation the main thing…like we were doing in intensive care I/V cannulation…we lose that skill [pause] since I was in the home so we never touched the I/V cannulation or peripheral cannulation and the different procedures…like we used to do these assisting doctors these central...they were passing central lines and the chest tubes and sterilized environment or the sterilization room over there…and LPS lumber puncture and ETT tube insertion...these NG tubes and parental feeding [pause] parental feeding it was here as well you know…some patients but different I/V fluid different kind of drugs…and the side effects and different kind of disease information [pause] so we were in terms of these we were losing like basic information...about the acute and medical diseases" (male nurse 19).

Nurses contrasted learning back home in the clinical environment to the lack of learning in UK nursing homes. The work environment in Pakistani hospitals was described as offering more learning opportunities as compared to the new environment with little 'exposure' to learning or 'experience' of involvement. It is a relationship with medicine that is described as 'passive', of being on the outside of things, of being unseen and unheard:

"over there with every passing day we were learning things [pause] erm in the nursing homes like you are mostly dependent on GPs and you do not have much exposure to the things to be honest…while whereas back home I was the one with the doctors and surgeons…I was involved in everything so I was in good position to take decisions and that was when I learnt

a lot [pause] so that I would say that in nursing home environment it is a bit passive" (male nurse 1).

The 'forgetting' of previous skills in care homes was associated with a diminished position in the context of multi-professional working in the UK. When in Pakistan, these participants had operated with an extended, and to some degree autonomous, role. The nature of their work had been based on responsibility, independent decision-making, and clinical expertise. In contrast, the nursing home relegated them to repetitive, mundane, and routinized caring, experienced as a form of professional impotence. Higher levels of intervention were the province of the general practitioner described as remote figures who were tangential to the everyday rituals of the care home. If they symbolised status and power, it was in stark contrast to the daily drudgery of the lives of nursing staff:

"in nursing home it just...it's simple routine [pause] you have to do the same medicines...same routine...you have to go through the routine...you can't change any of them…like this time you can't do even any procedure [pause you can't do like I mentioned before if you have certificate you can do catheterization...not even if you have got certificate you would not be catheterizing anybody [pause] and not doing any procedure which I used to do in Pakistan [pause] that is why I was about to forget everything [pause] like same routine and that's what I did not like it because you can't learn much in a nursing home...you can't learn much [pause] you will be doing the same things...same routine...you will be going the same day if anything happen you can't do anything because you are sending them to hospitals or just treat them simple erm thing in nursing home that's why I don't like it" (male nurse 3).

"you have got the same routine every next morning…in nursing homes you always every other morning you have the same routine [pause] for every advanced intervention you've got to call the GP you've got to send the resident in the hospital...so you don't get much exposure to do things on your own you know the multidisciplinary team is much involved" (male nurse 1).

"it's different and in a nursing home you are not able to do anything…like you have not got all the machinery and everything...equipment and everything…that is why you will just send the patients to hospital" (male nurse 3).

The nursing home work was recognised by Pakistan nurses as not only being different to their practice at home, but also to the work of nursing staff in UK hospitals. But this was spoken about as another world, rather than part of a larger healthcare system. It was described as something of which they had very little understanding – perhaps a glimpse from the side-lines of looking after the elderly – who needed frequent in-patient admissions. Like the people they tended for, their lives were marginal to mainstream society, and their language about 'simple', 'basic' tasks, 'difference', 'struggle' and 'lost confidence' captured well the lived experience of being an *outsider*, (an)*other*:

"I don't compare the nursing homes with hospitals over here [pause] maybe the hospital people they learning more...but in nursing home I still had the understanding that I need to have very good hands on the theory on the practice...and I need to know a good physiology...pathophysiology [pause] but I think it was much needed back home...but I over here in nursing home I think they have quite basic things" (male nurse 1).

"it is really simple to work in a nursing home [pause] if you go to hospital here it's totally different from nursing home" (male nurse 3).

"very difficult always struggling as a working...working in nursing home [pause] actually I don't have that much experience to learn more and more…and more but I think people working in the hospitals doing NHS jobs…they have more experience...more knowledge...more confidence...and they learn more than people working in nursing home…right (?) the life is very hard here" (female nurse 16).

8.5. Unmet expectations

Dissonance was a dominant theme characterized in all the participant interviews, with a range of different dynamics. In this section, though, dissonance is explored in the context of unmet expectations. The expectations of developed-world nursing were viewed in terms of advanced hospital settings, new technologies and equipment, and sophisticated nursing procedures. In the data extract below, one participant talked about how, in Pakistan, she had imagined that the healthcare system in the United Kingdom would be more 'advanced' than other places that she had worked. In contrast, she described being shocked by clinical practices she considered outdated which were still in use on the UK wards. Similarly, the intensive care unit (ICU) 'technology' was more dated than equipment in both Pakistan and Saudi Arabia:

> "I was thinking this country will have very advanced...will see the new things but like paraffin or these eusol dressings...these things were finished...but when we came here it was still being in use...honey dressing and papaya dressing...all we have left behind [pause] but here still they using...honey is still being used for the sores and things...so we were been thinking's new machinery new...so the ventilators which I have seen here in UK...more advanced ventilators I have seen in Saudi so it was not very new...for me it was old [break] trainings they have given us infection control feedings and infusions pumps trainings…so even those pumps were been not advanced than pumps which we have seen in ICU back home [pause] and even Saudi Arabia" (female nurse 7).

> "We heard we are coming here to learn more techniques...like more study" (female nurse 10).

> "when I was in Pakistan you know I was thinking you know when I was...I will go to England I will get more knowledge...I will get more chance to improve my knowledge and as well as I will get some more techniques...you know modern techniques...you know modern technology" (male nurse 9).

"it was in my mind I can come here...I can learn more modern techniques and more update myself to get more knowledge [pause] so I decided to come here to improve myself you know...so I can participate you know so because you know I am working you know so it was intensive care unit" (male nurse 14).

The ambition to work in technologically advanced hospital settings and to learn advanced procedures were unmet. Moreover, some of the nurses discussed how they had 'worked very hard' to acquire expertise before coming to the UK, as they anticipated working with the latest technology in UK hospitals. In contrast, the experience was described in terms of shock and disbelief, and distress. As discussed above, following 'adaptation', itself a spurious myth, these new arrivals to the UK did not secure positions in a hospital setting, advanced or otherwise:

"because I used to work very hard there handling ventilators everything...then I was thinking when I will go that country after my adaptation I will get job straight away in hospital...I never ever have thought there is nursing home or anything...the nurses...no idea...nobody told me when I came there... oh my God" (female nurse 16).

"my thought was totally that I will be working in the hospital because when I was working in Pakistan really in the serious department [pause] and the same thing I done when I went to Saudi Arabia I worked in the labour department you know...the obstetric unit and that was also the same thing you know [pause] and of course Saudi Arabia practice and experience and facilities many thing of course it was totally different from Pakistan…but I can say that it was really a bit better than Pakistan you know [pause] so that's why I was thinking if I am going to UK…UK is more…erm...you know than Saudi Arabia…a good country [pause] so I think I will be again working in the hospital that was my thought...I will be working in the hospital as a nurse you know…but when I came here and then when I got this...that I am going to the nursing home or you know we are facing this problem here…so I was a bit upset" (female nurse 21).

Most nurses were, initially, hopeful of learning new things and new procedures in the UK in terms of knowledge and skills acquisition, as a strategy to enhance their professional careers. Aspirations to become 'international nurses', were short-lived, and instead of a foundation for universal development, their world was suddenly circumscribed and limiting; described as the 'opposite' of opportunities once hoped for:

> "I wanted to become an international nurse you know...so that's why I left Pakistan to came to UK to work in hospitals [pause] unfortunately I didn't get a chance to work in hospital since that it was totally change experience here for me when I came here [pause] so I did my adaptation in nursing home and it's totally change environment for me because first time struggle you know....because I was used to working in hospitals not in nursing homes and in Pakistan there is no concept for nursing homes" (male nurse 9).

> "when I came in this country I will tell you I was thinking that one the study will be more difficult I will be more qualified and I will learn more...but when I get the job in nursing home I said oh my God I finished my everything what I learn so anyway that's totally different really [pause] but I think it's opposite" (female 16).

8.6. Difficulty in securing NHS jobs

So far in this section, dissonance and devaluation has been explored in the context of unmet expectation and lack of access to NHS jobs. Shifting the focus from entrapment in nursing homes, one needs to consider the ways in which migrant Pakistani nurses tried to get NHS jobs in the UK. All the nurses in this study had tried to find jobs in the NHS, and some were successful. However, those who did not get a chance to work in the NHS, and continued working in nursing homes, did so for a variety of reasons. In the following data extract one female nurse explains this as a product of her priority to 'settle down'. The story is familiar, and resonant with ideas, discussed in chapter

five, about 'becoming a migrant'. Though not an exclusive argument, the discourse cannot be easily disentangled from the gendered experience of Pakistani women. It is a narrative of surrender and sacrifice, of maternal responsibilities, financial commitments, and familial obligations:

"I start working as a nurse RGN and because I didn't go into the NHS that time...because I want to settle down myself first...because I left my kid behind I said ok let me settle down first and then I will think about NHS...then I start working as a nurse and then I tried to save some money as well and then I buy my house...mortgage that time [pause] I didn't know what is mortgage and what is this kind of things...so some of my family members they helped me...so I said ok...then I moved to that house...during that process there were people also they helped me then when I buy my house and brought my kids here in England and then because of family...then again I have to stay at nursing home...that's why again I didn't go to NHS" (female nurse 10).

Male nurses had different experiences, though the outcome was the same. One man who worked in Pakistan, in intensive care, for fifteen years talked about numerous attempts to obtain a permanent position in the NHS but, due to his residency status, he was not able to do this. He has now been working in nursing homes for the last eight years. Other male participants spoke about their experiences, and how they were unable to take up the positions because of changed policies and the constraints of requiring a 'work permit'. Simply stated, 'the door was closed':

"I wanted to go but because I was...work permit...and the door was closed...I mean I had no opportunity because they clearly mentioned about that this you know...that opportunity wasn't for hospital you know NHS they mentioned clearly they can't give that job if somebody needs work permit...so I had to stay for that job for three years" (male nurse 6).

"I did try for so many times...so many times...so mean like first I started you know...first I applied in [name of NHS hospital] and that time I was on work permit and interview was successful because I am intensive…you know so I have got fourteen years' experience in intensive care unit...it was...interview was fantastic but the problems is that time it was in 2006 you know...so the NHS changed the policy [pause] before that they were issuing the work permit...so nowadays they are not issuing any work permit or anything like" (male nurse 9).

Securing a job in the NHS was not easy and one nurse described his experience of getting a job; a struggle that was disappointing for him but he continued his efforts and ultimately got a job in NHS only recently. The nurse mentioned that he had applied more than a hundred times to get a job in the NHS, and got interviewed more than twenty times:

"I have checked my NHS application...it was more than hundred applications I have sent but fortunately I have been interviewed more than twenty times...I have given interviews but I couldn't be successful but they said to me in interview some of the interview was really really good...and the interviewer they were really happy and they were say you interview is quite ok we are quite satisfied...but the thing is that we have got another experienced nurse so that's why we offered job to the experience person in that speciality" (male nurse 19).

Whereas some of the nurses tried to test their luck to get a job in the NHS, and failed in their endeavours, others lost hope from the beginning because they had the feeling that, based on their immigration status, they could not succeed in securing a position. The 'work permit' emerged as a powerful symbolic representation of the status of 'outsider'; it, figuratively, and literally, 'permitted' one to 'work' or not. In the following lines one of the nurses who had been working for the last seven years in nursing homes disclosed her feelings:

"I didn't try to for the NHS not yet…I was...I liked to try before but it was the same problem…like they said if you are going to apply to the NHS…and I tried with one of my friends she was going for the interview and I went with her so when my friend was been interviewed…there on the front of me the first answer the first question was they was asking did you got a work permit (?) no…oh it's difficult for we to give you the work permit…so if you are applying here you have to really wait for long...but of course you can't stay in this country without work permit…so the nursing home is easily you can get the work permit because the nursing home they need more nurses as well so that's why we just went to the nursing homes so because of that work permit" (female nurse 21).

Migrant Pakistani nurses who were not able to secure a full-time job in the NHS, on permanent contract, started to work initially on a part-time basis, hoping it would help them toward permanent positions. However, one of the female nurses shared her frustrations that, when applying to the NHS, she was asked to provide three years' work experience in the UK. In mentioning that she was advised to go to a nursing home and work there for a specified period of time, she disclosed feelings of resentment toward a system that offered so few opportunities:

"they want UK three years' experience…that time [pause] twice I even I applied as a nurse agency they said you need to have three years' experience…I said if you will not give me job how will I get the experience from...where will I get the experience...just tell me (?) [pause] they said you can go to the nursing home…this one...that one [pause] so there is no option to move anywhere" (female nurse 16).

Most nurses mentioned that, competition to get employment in NHS was intense, and priority was not given to nurses who were working in care home settings. Their talk about the care home sector began to sound like a lament; of an interminable sentence, measured in *temporal terms*, but experienced in *human terms*. In the following extract

one of the nurses described the problem as lack of competence, but it echoed feelings of lost confidence and lost hope:

> "I did try you know...when I was when I got my pin number I tried [pause] but I didn't get you know the job…because all the time they are mostly they are asking for experience to work in…if there is a job I would we would like we were qualified here as a nurse you know the competition there is always more competition you know...like that's the experienced person...worked in NHS before you know [pause] then that person gets job you know…most of the time you know…and working in a nursing going to NHS they are just thinking that we don't have a lot of knowledge you know…to cope with the NHS so that's the only thing [pause] I have ahm…attend five or six interviews and then I got fed up" (male nurse 8).

One female nurse recounted a similar narrative. But here, the perception and construction of otherness connected with ideas about ethnicity and exclusion; where the defining feature of her search for better opportunities collapsed into a self-deprecatory identification of herself as 'the foreigner'. With few options she had accepted work in a care home:

> "the hospital was also doing adaptation [pause] but mostly for the foreigners the opportunities was only for the care home…because in the hospitals they was giving more you know chance to the people the locals" (female nurse 21).

8.7. Cultural challenges

This section, presents the theme of 'facing the new reality' in the context of dissonance and devaluation. All the nurses who were interviewed worked in nursing homes for their adaptation. They did not get a chance to complete adaptation programmes in the NHS because they came to the UK through private agencies who hired them to work in the independent sector. Although some of them later managed to obtain NHS jobs,

for most it was an unfulfilled promise. They experienced the new environment in terms of 'shock' and 'surprise'. In the following extracts of the data, participants articulated the experience of working in nursing homes as a culture-shock, caring for old people who are seen as helpless, living apart, and rejected by their families. The sadness in this account moves beyond 'self', to contemplate the lives of client groups demarcated, also, by the stigmata of 'otherness', the elderly and mentally ill; individuals without economic or social capital, hidden away, and relegated to the fringes of a social world inhabited by the young and the productive:

"when I started over there I cry so much as well because I did not see old people living separate...leaving families...living alone and nurses are coming and carers are coming to give them support and feed...what is this...washing dressing everything [break] because I think we are all soft hearted but I am little bit more because sometimes I cry and the old people they say why did you cry (?) I said we are not this type because we look after our people at home...here I feel strange like what's going on over here" (female nurse 10).

"I was just thinking...and then I kept thinking...I thought several time that why there are so many old people living in here is this the hospital and then they go...and then they discharge or whatever" (male nurse 6).

"sometimes I was really feel sorry about these old…especially these elderly people you know [pause] and the way we look after them they really...give us a hug and you know and they start crying…and sometimes you feel oh how lonely these people are you know…and this way we think you know is a good thing aspect in Pakistan [pause] if your parents are you know... is become elderly you must look after at home rather than you know just leave them in nursing home…to you know keep waiting…one day their daughters or sons will come and visit them…for all their life…and they suddenly just die" (male nurse 14).

If these migrant nurses found working in care homes for the elderly conflicted with their cultural values, besides the new experience being shocking and surprising, some nurses found the new care set-up different in terms of working in a different branch of the profession - mental health care. Most participants had experience of general adult nursing in hospital settings:

> "you know I mean you know I never worked with the people who have got mental illness and it was...I could say first three months you know all I could say...I was a bit upset you know" (male nurse 9).

> "first I heard about the dementia…first time I heard about the Alzheimer…this kind of thing because I never worked in the mental health side you know…how they are working you know [pause] physical side on the general nursing side you know…but since I am been working in nursing home you know so different" (male nurse 9).

> "second thing for me to get surprised was I didn't see that many people who had dementia [in Pakistan] or if anybody had dementia because the condition is not so much investigated...we call them some other names you know such patients" (male nurse 5).

Another cultural aspect of these participants lived experiences was rooted in the legal-professional domain of nursing practice in the UK. Unlike shared concerns about work permits, anxiety here - bordering on fear – was focused on the personal cost of errors in clinical judgement in a highly regulated system. Participants were aware that there was no place for making a mistake, and that failings in competence could result in questioning of their 'fitness to practice' by the statutory, regulatory, body (NMC) governing professional conduct. The overall stress of being seen to fail in new care environments led to intense feelings of vulnerability. Though the Code of Conduct applies equally to all nurses in the UK, here the language used by participants connoted

a surveillance culture in caring, where individuals feared scrutiny, being 'pulled out', and facing the 'horrible experience' of 'disciplinary action':

"like for example in our country if you are doing...everybody can do the mistake being human…there can be an error…but in our country people wouldn't take that much you know to very high…if you will try to explain you can say they will just forgive you…you know…they will understand whatever [pause] but here they will pull you out you know…if you are doing something wrong...no way they will forgive you if there is like something like that mistake" (female nurse 4).

"but it was not that we will make a mistake and nobody will correct you and they will just put you straight away to the disciplinary or something like that….but here it's different means if you made a mistake you are suspended (laughs)…yeah suspended straight away…and then sometime it's a horrible experience [break] so it is very sensitive still we are here since eight years still we are scared" (female nurse 7).

"they have sent us for two days trainings which were for the legislation in medical services so that when we have taken that class not only me...it was so many foreigners as well so when we have take that class [pause] so I came back to [name of female] and I said [name of female] it is making me scared as a nurse UK [pause] she said no need to be scared only you have to know the law how... it works here" (female nurse 7).

8.8. Summary

The findings discussed above reflect dissonance and devaluation as an integral part of the lived world of migrant Pakistani nurses working in the United Kingdom. Migrant Pakistani nurses felt they had lost their professional identity in the new care environment, and undergone a de-skilling process. Migrant nurses had expectations of working in technologically advanced hospital settings, which were unmet. Instead they experienced a feeling of demotion by having to work as care assistants before

achieving NMC registration. Securing positions in the NHS proved difficult for most migrant nurses who participated in the study. Migrant Pakistani nurses talked about coming to the UK in a way that was not only the opposite of their ambitions, but also to their past experience and nursing education. This chapter has explored the work, and workplace, experiences of migrant nurses. In the next chapter, the lived social world of migrant Pakistani nurses will become the focus.

CHAPTER 9

OUTSIDER IDENTITIES

9.1. Introduction

This chapter explores the lived social world of migrant Pakistani nurses working and living in the United Kingdom. The narratives of participants revealed exclusive challenges in the life world of migrant Pakistani nurses that might not be faced by other groups of migrant nurses. The foremost challenge was living under a shadow of fear. This was so profound that some nurses refused to participate in the study or to give an interview because they were afraid of being under surveillance. Similarly,

some participants spoke about being stereotyped. Migrant Pakistani nurses had strong feelings of isolation in the UK, and adopted strategies to cope with the challenge of exclusion. Most nurses had experienced racism in the UK in terms of their interactions with patients, care workers, patients' families and management.

9.2. Feeling fear

During recruitment to the study, I contacted many Pakistani nurses shared with them information regarding the through contacts known tome. Some migrant Pakistani nurses expressed fear about being to be involved in the study and declined to be interviewed. I faced a great deal of difficulty recruiting participants due to these reservations. Some potential participants refused to take part, and informed me that

Figure 4: Outsider Identities

they were suspicious of being 'spied on'. In the field notes I recorded a clear picture of fear among nurses.

I had understanding of the contemporary global situation and the media might have an impact on participants in making decision to participate in the study. Some questioned my interest, or motivation, in exploring the experiences of Pakistani educated nurses instead of any other group of migrant nurses. Not unusually, I was asked about any hidden agenda behind the study. Participants were of the view that I had been tasked to interview Pakistani nurses. In the following extracts from field notes, participants (whose identities are protected) shared their suspicions over the study:

"Why are you asking Pakistani nurses and who is going to listen to the interview tapes"

"Why have they given you this topic to ask Pakistani nurses about their experiences in the UK"

Despite the information sheets explicitly describing the purpose of the study, some individuals still questioned me why would I travel great distances to interview them. References to the 'Home Office', as an agent of *security*, captured powerfully the sense of *insecurity* in this group of people:

"He is going to tell the Home Office about your experiences so better be careful"

"Who is going to listen to the audio tapes is the Home Office going to listen the audio tapes"

I also observed that some of those who agreed to participate were guarded during the interview process. These nurses were, typically, reluctant to talk about negative experiences and were suspicious about the nature of the questioning. As a result, they asked me what I wanted or meant. Although I fully briefed all participants during the

consent process, and gave them n the opportunity to seek clarification, but this did little to assuage their anxieties about speaking candidly:

"We should not share any negative experiences"

"I don't want to share any negative experience"

Some participants sought reassurance from me during pauses in the interview, or once it had been completed, by asking if they had said anything 'wrong':

"Have I said anything wrong"

I was told by one participant that they were scared to be part of the study because they had suspicions about why the study being conducted. Later in this chapter the larger political backdrop of this 'climate of fear', as an adjunct of global political and economic unrest will be critically interrogated

"of course people are thinking that they are doing PhD on us so what they are going to do with our information and may be they want to stop nurses moving to other countries because now some of the nurses have moved to other countries as well"

Although participants were reluctant to express feelings of fear during interview, the field notes provided sufficient clues to the problems that migrant nurses faced in the UK. It became evident that nurses were reluctant to speak, and many asked for 'tick box' questionnaires as an alternative to verbalising salient issues. Beside feelings of fear, though interwoven, were experiences of being stereotyped. In the following interview extract one female participant articulated her experience of working in the UK, in terms of stereotyping, when she was working in a care home. Comments by basic grade care assistants were described as a 'joke', or 'teasing', but there is little

humour to be found in the crude and ill-informed association between Pakistani people and terrorism:

> P: "This country...people they have bad you know experience about the Pakistani people...everything... but I still proud of that"
>
> I: "Have you felt anything like this? Somebody has said or?"
>
> P: "Yes some time the people will tease us...oh she is Pakistani she will shoot...they just tease only as a joke"
>
> I: "How? Could you just tell me?"
>
> P: "Just some time...like a male...especially male carers...senior carers...something will happen they will [pause] oh don't talk anything...there will be bomb blast...erm there will be anything [pause] they just making a joke and still there is something true yeah even that's joke so that's erm...sometimes I feel bad because if we get anything good or anything people will not even joke to us....bad way" (female nurse 16).

Similarly, another female participant shared her feelings of being stereotyped. She shared her experience of the terrorist bombing event that happened in London in July 2007, during her initial years of arrival in the UK. The nurse recalled the incident and mentioned that, as a consequence of this attack, she had a bad time in the UK. The nurse revealed the feeling of being caricatured as emblematic of distaste and distrust, by a colleague, on the basis of her ethnic origins. The account painfully illustrates the casualties of uncritical public and mediated messages :

> P: "Maybe if you remember when we came [pause] maybe you were not there [pause] in February or March there was bomb blast in London...you know...and they were they were thinking...you know they were thinking the Pakistani people they did this one [pause] and that's not our fault you know...the finger is not equal you know what I mean [pause]and they were thinking there is Pakistani and they were hating because of that terrorism...erm you know

[pause] they were thinking we are the one as well...and that's why some time they were hating us as well"

I: "So did anybody tell you that?"

P: "Yeah many"

I: "Could you just tell me one?"

P: "There was English lady...she was carer with me...and she said 'we don't like Pakistanis because they all the time fighting...they all the time killing other persons' and you know I said 'who told you like that nobody is equal' you know [pause] I gave her example 'your country many people they are different' you know...nature different behaviour and you can't say like that [pause] she said 'no all Pakistanis are same' and they are terrorists'" (female nurse 17).

Participants disclosed that working with the identity of a Pakistani nurse was a challenging task. In the data extract below a male nurse spoke about the global situation and role of the media in portraying an image of Pakistanis. However, when I adopted probing questions he refused to share any negative experiences and provided a more positive interpretation:

"I have to take all my political background with me [pause] and even I wasn't interested I…firstly my background was Pakistan [pause] when you go somewhere else you take all your background with you [pause] basically looking into the global situation you shouldn't be ignoring you are a part of it right (?) well if you face a patient they certainly will ask you...and many has asked me where I am from...and they just want to know your identity" (male nurse 5).

Part of the coping strategy was to adopt a Goffmanesque (Goffman, 1986) attempt to manage a 'spoiled identity'; not easily accomplished in the face of entrenched prejudicial and discriminatory attitudes. He reflected that even if he was not interested in talking about his 'identity', and defined himself in terms of nursing, those in his

care were less circumspect; feeling 'depressed' was a consequence, 'ignoring it' the only solution:

> "like I have come here to care for you...not my background...but my patients wouldn't agree with me [pause] they still ask me these questions [pause] so it's not that you are a nurse…you have got your own identity...so I came with my identity [pause] which is quite challenging...and sometimes you see people and you get quite happy but some other time you get quite depressed...about people's opinion and stereotyping and things which happen [pause] you just ignore it" (male nurse 5).

In the following extract, a female nurse disclosed her interaction with a patient in her care. The nurse revealed one resident asked her about her place of origin, of which she was not comfortable speaking. In another example of attempting to 'pass' (Goffman, 1986), the nurse chose to identify herself with a northern British town, but *geographical location* was eclipsed by *geographical origin*, where 'belonging' mattered more than 'being':

> "one of residents she was...she used to be a nurse...she was 86 but the guys told me already when I went to give her medication [pause] and she said which country you belong (?) so when they ask me I say I am from Burnley [pause] she said no...no which country you belong (?) I don't want to mention...I didn't want to mention myself [pause] but no...which country you belong from backside (?) I said I am from Pakistan" (female nurse18).

Another nurse spoke about the experience of being constructed as 'different' on the basis of religious belief. Observing the Islamic faith, prayers (namaz) were offered to Allah, during 'break times', in accordance with traditional teachings. The response of those working alongside this man were described in terms of novelty. In terms of physical space the rituals could be easily accommodated, but distance was measured,

and experienced, as relational. Despite explanation, and superficial acceptance, was an awareness of being 'other' – the object of clandestine observations, where the unspoken was palpable:

"like some time you know they were getting some information or they were asking like in home [pause] personally I was doing like our faith on Allah [pause] so I am Muslim...so I was praying because it was erm I don't know...it was new to these people or whatever…but I was performing my *namaz*…my prayers [pause] so I explained them...so it is our prayer...so we will doing these time so it is our break times....so we will take our break...so [pause] which was acceptable to them...but some staff members they were...you know it was a new thing to them...like in separate room we were doing or performing our prayers [pause] so they were just coming looking at us performing prayers…so they were not used to it [pause] but after some time you know they used to with us...so these are Muslims or they were just getting some information about the Muslim people or how many times you know they performing their prayers and what's you know our belief like [pause] I explained it to them...then they were a bit you know different...they said yeah it's ok so you can do your...perform your *namaz* so in separate room...we just make it erm...not make it...it was already there [pause] but it was activity room you can say...or separate room...empty room performing and still watching...like I am saying...so what we were doing is a new thing to them but can't you know directly they can't you know they didn't say anything directly... but indirectly watching" (male nurse 20).

Similarly, a female nurse talked about the discomfort of being in the company of others when televised images of violence in Afghanistan were being broadcast. Again, it is the tacit rather than the explicit which defined the moment, and *identity* was shaped by *identification*. The account conveys, powerfully, a sense of silent stigma marked by the absence of speech or interaction:

"you do feel a bit...I feel myself a bit low when anything on BBC...anything comes on the telly you know you feel yourself very low [pause] like I was with English carer sitting in the lounge

on my night shift…so on BBC they were showing in Afghanistan the movie...you know about fighting and terrorism and there is some movie about which is...they showing very bad things…very bad things about Muslims you know which is...I was myself not comfortable...I was not feeling myself very much comfortable...we don't talk on this matter on the job like...but we don't say anything" (female nurse 18).

These feelings of otherness expressed by migrant Pakistani nurses should be seen in the current global political situation post the 9/11 attack in New York and the 7/7 incident in London. Studies have found that British born Pakistanis experienced increased levels of fear after these events, so it is unsurprising that migrant Pakistani nurses had an elevated sense of ill-ease. This feeling of being an outsider was coupled with one of isolation, which is discussed below.

9.3.   Isolation and home sickness

In the section above, the lived experience of migrant nurses in terms of feelings of fear and stereotyping was discussed. This section examines alienation as one of the central themes of the lived experience of migrant Pakistani nurses working in the UK. The stories of participants revealed isolation as one of the main challenges of their life-world. Migrant Pakistani nurses had strong ties with families back home, and shared strong emotional bonds with kinship networks they had left behind. Most migrant Pakistani nurses shared feelings of isolation in the UK in terms of homesickness, broken families and cultural fractures. It emerged that migrant Pakistani nurses adopted different strategies to cope with feelings of isolation in their new places of residence. One of the ways to cope with this, and make long-term settlement possible, was to find jobs in areas with established Asian communities. Short-term strategies, adopted by migrant Pakistani nurses, to cope with this sense of separation were to

maintain strong ties with people back home. This was done by making visits and regularly calling loved ones in Pakistan.

Although, many nurses had achieved British citizenship and regarded it highly, they still had feelings of being 'abroad', working in an alien country. In the following lines one nurse articulated the lived experience of his social world in terms that characterised the features of alienation. He had been living, and working, in the UK for the last eleven years as a British citizen but still felt distant from that which defined him as a person, and as a Pakistani:

> "I miss my culture and my people and so many things…I feel like I am still abroad and working with the strange like...community [pause] and my colleagues as well...and at the same time I am living in the UK I still feel like I am living abroad [pause] so I really miss you know my working environment in Pakistan...and my living environment in Pakistan as well [pause] so this is what...you know I am lacking" (male nurse 6).

Another nurse who had been working in care homes for the last seven years described his social life as a 'compromise'. His previous life in Pakistan was talked about in words that connoted vitality, fluidity, and purpose. In contrast, the daily rituals of living in the UK were less about life than existence. As with the repetitive routines of work, his (un)social life was punctuated by a comparable set of predetermined activities – cyclical, repetitive and unfulfilling; from 'job' to 'gym' to 'bed':

> "I will say that even after seven years erm...my social life (facial expressions) is not as it used to be in Pakistan [pause] it was more...erm what you call it...erm I was more in action more and more in motion erm whereas over here I mostly concentrate on job and if I do much more...so I just go to gym [pause] so gym...job and my bed [pause] so no more social life

although I know that I get on well with the things you know...erm but my social life seems to be a bit compromised" (male nurse 1).

Other nurses shared this experience of being and feeling 'alone' in the UK. The words 'alone' and 'lonely' convey a sense of distance that cannot be measured in miles. There are stories here about helpless isolation; of missing family in Pakistan, homesickness, and the fear of being unable to care for loved ones far away in times of crisis:

> "first one or two years it was really difficult for me because it was erm...everything was totally different...my family was not there for me and I was feeling alone...lonely and everything then [pause] but I adjusted myself in this environment…like being lone alone here and one thing is just being alone without the family that is the main thing...just being alone...that was the main stress for me [pause] that is why I am here...and I am too far if something happen and I would not be able to go straight away...that was the main thing" (male nurse: 3).

> "there are negative things as well you are away from home...and specially there is emergency back home...and you feel if you want like living here family as well...you have to take everything...you don't have that support you know [pause] back home we have support in your family you know like parents and brothers and sisters and other relatives always there...so you have...here if there is any like erm that's somebody passed away in the family and you feel you can't go...some time you know it's just that's really difficult" (male nurse 8).

9.4   Feelings of isolation at workplaces

Besides the feeling of isolation in the community, most migrant Pakistani nurses also revealed the feeling of isolation in work placements. In the following lines one nurse described the hardships of work in terms of an emotional rather than a physical challenge. This is not the discourse of drudgery and demotion discussed previously, but of long and lonely hours punctuated only by an artificial attempt to belong. Nor is it about discrimination as overt, or offensive. Indeed, the talk about being part of a

'team',' friendship', and 'integration' mask the 'overwhelming' sense of isolation and loneliness:

> "you know what I feel...I feel at times like...at times I don't enjoy my job to be honest…because while working in a team and you are the only one who is like from the other background [pause] it seems like you are not able to mingle very easily with them...with the staff…though they are nice...try to integrate as part of team but eventually because you can't make with them because friendship or something they are friendly and friendly as well…or I try to be friendly and they tried to be friendly with me but still you know there is cultural differences…there is a cultural obstacles [pause] differences as well…so I mean I feel at times that something missing...I mean the word missing would be an appropriate instead of saying anything [pause] something missing...so if you working...if you are working with the similar cultural backgrounds and staff you enjoy more because you know like you are more friendly you understand others and the others understand you as well…and then while you working you are enjoying...you are talking you are talking and you are discussing you know what has happened and you are sharing few things and you are listening others as well...so this is what I miss [pause] you know I miss a lot…I think this is as a Pakistani nurse this is what I am lacking at work…and then you have got twelve hours shift for the night or day so if looks like just working and working…so I am feeling overwhelmed at times because you are not sharing your feelings with someone…and if I have got another from the same background I am feeling like I am more happy…because if any problem or anything if you need like...if you need help I can go to that person very easily and I approach him and then say 'oh I need help' and would come and give you assistance if he can I mean this is a big...this is a big thing" (male nurse: 6).

For others, the sense of isolation in the workplace lacked any pretence of comradeship, and was spoken about as an informal, and unspoken, apartheid. The world is described, and demarcated, in terms of categoric difference; of 'white' and 'colour', of 'English' and foreigners', where any positive construct of a team is replaced by the pejorative

terminology of a 'mix'. Identity, here, conflates ethnicity, skin colour, and status in multiple layers of difference that play out as inequitable and inegalitarian :

"for example I am a nurse in charge and I got Asian staff and English staff…so English staff they prefer to work with English staff you know they don't...they keep...they put you...they tried to put you the Asian staff with the Asian…even they don't like to work with them as well [pause] they put too much burden...they expect the Asian staff to work…to give bath to the residents...to do all personal care for them [pause] so they try to put more burden on the carers...the Asians whether the Pilipino the Indians whether they are from Pakistan…they tend to you know put more work on them" (female nurse 18).

"yeah under the foreigners...like I can say in hundred per cent...twenty five per cent or twenty per cent don't like as well…the colour [pause] the care staff like you know when I seen some of them if there's a mix...white and colour they will choose...they will...the white will work with the white and the colour will work separate you know [pause] some of them but mostly they work very rare there is few people they just don't like…and they just don't like to work under foreigners as well" (female nurse 21).

The feeling of isolation was intense for one participant who had worked abroad for over twelve years and shared the intense feeling of desolate homesickness. She had moved initially to Saudi Arabia and then came to the UK in 2004. The account is punctuated by temporal markers of a past life that is 'always in front of her eyes'. Ramadan and Eid festivals, siblings and parents, define an emotional chasm that cannot be filled with material benefits. Time, which is almost infinite in the real world, is spoken about in seconds and minutes of the life world:

"I am always thinking I miss my country...sometimes specially when I telling this Ramadan or Eid or anything...this days is coming…always but always missing I never helped my parents if they are old age anything [pause] they need my support they need my help but I am so far

from them I can...money is not everything but some…they need us every time that's the main thing I always missed and I tried it really if I will get better life or anything I want to go back to live with them...that's my wish...so that's the main thing...my family my brother and sister we are missing...but parents is more important for me…that's the thing I am always missing [pause] and every second...minute I miss when I am working in nursing home giving care to the old people…I always miss my parents and they are always in front of my eyes…and I always thought I don't want to live this... I want to go…I want to go and want to live with them…I can do everything what they want [pause] so why I am here helping the other people…money is not everything [pause] but money is need for life...everything...so many things [pause] but if you think without money we cannot do anything...but sometime money is not everything... with the relationship" (female nurse 16).

Other participants echoed these sentiments, outlining a struggle between *emotional* needs and the *economic* cost of survival:

"but what I am lacking here is my family…first of all like my moms and my sisters and brothers…and by the time you get back to home from work in Pakistan you know you are in a family and your relatives can come and you can go to the relatives yeah…you know it's all the social life and you know your blood relations are missing a lot [pause] you know like several time I tried I could go back to home...this is what I tried...I aimed for that and at the same time because of the law and order situation in Pakistan...the socioeconomic prices in Pakistan...the energy crisis in Pakistan...there are many things going on so you know like I couldn't go...these are the things like [pause] I must admit that" (male nurse 6).

"what I have lost...I have lost my parents you know like I mean I lost my mom and I am still missing her so that's the thing you know" (male nurse 9).

Migrant Pakistani nurses were well aware of the challenge of isolation in the UK and had developed coping strategies. In the following quotes, participants talked about managing the pain of separation by using technology to keep in touch with family in

Pakistan; the emotional need for physical contact replaced by a virtual surrogacy of 'seeing' and 'speaking':

> "actually I call every single day to my parents...specially my mom every single day talking half an hour...even three four times a day…I want to speak then [pause] this is the good thing because phone is very cheap here to contact with them…and sometime I will set through the internet you know the Skype... I can speak...I can see them…so I am helping to support you know sending money to help them to get whatever they want but still they want some time they miss always like we are missing you know" (female nurse 16).

> "I just cope with phoning my family and visiting my family every year...for one month" (male nurse 3).

One of the primary ways to prevent, or live, with isolation was to find placements in established Asian or Pakistani communities in the UK, and many participants had found jobs in areas with a high density of immigrant settlers. To onlookers, and cultural critics, the account might be interpreted as a vivid description the ghettoization of 'outsiders', but in this narrative it spoke of community and a sense of belonging. Rather than a *world apart*, it connoted a *world within*, a place of safety and security; somewhere that one chose to be, not a place that one was forced to be:

> "I feel more comfortable in here [pause] like if you are...even if like you are in Liverpool...I did not want to go there in Liverpool [pause] I feel like if in Manchester there are more Pakistani people yeah in Sheffield there are more Pakistani people…in London there are more Pakistani people [pause] but then I did not want to go to London because London is very you know economically it's not really really you know that much of you know good for me...so I just want to be here because you know it's my comfort area and there are so many Masjids (mosques) any place where I live in Manchester I can access a masjid maybe within a distance of two or three or four miles maximum...and I can see my friends [pause] all of my friends are

here [pause] whenever I have a problem I can just you know access them and I do not have to go and look for somebody" (male nurse: 2)

"I worked actually I came in South down Gloucestershire 2001 to 2005 I done work there so actually I wanted to move here because of my friends my families and then I got from same company to this nursing home" (female nurse: 4).

9.5.   Acculturation into an new society

Previously, the lived social world of migrant Pakistani nurses in terms of missing families and culture was discussed. This section presents the lived experience of participants in terms of 'acculturation', and the stress associated with it. The lived experience of migrant Pakistani nurses revealed that adjusting to a new culture was not an easy experience for many of them. Migrant Pakistani nurses mentioned different cultural values and resultant cultural conflicts. Nurses had, to an extent, to compromise their values and dress in adapting to a new culture. However, despite all the adjustments in lifestyle, and possessing British citizenship, some participants still felt like 'foreigners' in the UK.

Perhaps, one of the major barriers for participants, in adjusting to a new culture was the difference of culture in Pakistan and the United Kingdom, and most nurses mentioned that adjusting to the new culture had been a stressful experience for them. It was observed that nurses, at times, got caught between adopting a new culture and preserving their original values. In the extract below a male nurse articulated his experience in terms of 'difference' or 'otherness' the way social values and practices are socially constructed. Here the lived experience of 'being other' emerged where the nurse had a 'sense of belonging' to a different way of living, which was a pole apart:

"the third thing that was challenging was that we had (.) I was grown up in family and there are quite norms taken you know very if you think in the UK and our society there's a big difference (.) because it's very open society so sometime you think that it's disrespectful but then other time you think no it's something that they practice…. I would say like we would use to give a lot of respect to our teacher we had some students from local universities who wouldn't behave in a way we taught we were taught so and also because and also English people they live quite openly and these things wouldn't be accepting your mind that how would they be living this way (.) but at the end of the day it's their culture we would think but regarding acceptance or if they talk about it then you just get conflicted in mind that how would I be just be a part of all this so these were some of the" (male nurse 5).

Similarly, another nurse disclosed his story to demonstrate that cultural values are socially constructed, where belonging is based on the 'basis of origin' and the ultimate resolution is, perhaps, to accept the 'difference' of cultures. Here, the dialogue revealed the tension that exists in the life world of migrant nurses, the difference of cultures, values, and expectations between the origin and host countries and the struggle to adapt it. The differences of cultures, at times lead to a cultural conflict. The experience revealed the notion of 'difference' or 'otherness' as an acknowledged reality and therefore the ultimate resolution was to adapt it:

"but there are certain things when it comes to your family so we erm we need to have good knowledge of things we need to understand that their culture is totally different from ours" (male nurse 1).

"I recently had an experience [pause] my sister was not feeling well...she was sick you know and there were so many other things like my brother in law could not go with her because of her two young children...you know he had to stay back with the children because he did not want to show the children's mother to the children (.) you know because otherwise they will be very upset (.) so he had to stay back home and (.) there was not much thing it was really a

tough time for me like my brother who was looking after my sister his own son was in critical condition in hospital (.) and then I was trying to explain these things to my manager and I am very much attached to my sisters and brothers (.) and she would not understand it she would say that oh if she is married then why you going for her and then eventually I decided to I said ok I was just talking to her over the phone and said ok within next two hours I am coming to you with my resignation (.) and then all sudden she changed she said Abdul I am really sorry I did not mean that and things like that bla bla bla erm because I am not saying that I am not all in all for her but you know I am the one who take much of the load for the home then she changed her mind and she allowed me to go for the holidays you know there are quite few things you need to make them understand it is not that I am generalizing they have different culture and we have totally different culture so you know there are these challenges as well"(male nurse 1).

One of the biggest challenges that migrant nurses faced was to fulfil a role that was opposite to their original culture and social values. Part of getting adjustment to a new culture also demanded nurses to compromise on values but despite seeking adjustment in the new role, difference as 'white' and as 'coloured' couldn't be concealed. Here the experience revealed an attempt to 'assimilate' to the expectation and culture of the host community. Example below shared by a participant reveals an attempt to seek acceptance and adjustment while becoming a Santa Claus during his initial days in the UK and the response of one of the resident to seeing a 'brown' Santa Claus. The lived experience of the nurse is mentioned in his own words:

"when I was a student you know and my ahm it was first Christmas… and I don't know about anything you know so that time you know it was family gathering in the nursing home you know (.) so one of my manager she told me you are going to be Santa clause you know and I don't know anything about the Santa…Santa clause you know is the because the can see you know is the father so he come on 25th so he will distribute the toys and gifts to the people children you know (.) and on the 25th of night you know it is like stories you know…and my

other friends you know we become a Santa Claus you know [pause] so it was really embarrassing when   I was distributing the gifts to the one of the residents he shouted at me and he said to me oh bloody hell he is I never seen brown Santa Claus in my life (laughs)… it was too embarrassing (.) but it was ok you know so I mean like so they were always thinking Santa clause is white you know (.) but I was you it was my colour you know but he was the resident he was mentally ill (.) but he knew that all family members all were there like you know but he were in shock you know what he told but it was not his fault you know… it was my first experience so that's kind of you know…you can imagine so but now I am used to these things you know" (male nurse 9).

In the following extract a female participant shared her experience of adjusting to the new culture in the UK. Here the dialogue focused on an emotional experience of loss and guilt as something akin to losing 'honour' while taking off the hijab. However, over the time adaptation to the new dress values took place, which was seen perhaps, the better option:

 "we used to wear *hijab*(veil) in Kuwait seven years (.) we never inside or outside at work and outside we used to wear *hijab*(veil) (.) and that Pilipino agent said first thing we embarrassed really that she said take you *hijab* out …off [pause] because and then we really really you know when taking that off we thought never mind we get all the worldly things but even if you know that erm *izza*t (honour) gone the things gone religiously (.) then what is left behind you know (.) that was too much for us at that time [pause] although over the years we came used to we became used to…but at that time we were really me cried but she didn't feel anything I don't know from where she got all that idea …although I think if we would get scarf that time they wouldn't mind because in Manchester there is lot of Asians community and they are used to of it… they don't bother any when that was one embarrassment [pause] but when went into nursing home to work elderly patients who will look at you…so even though only carers all the carers were female all the nurses were female and there wasn't anybody to look really…there wasn't any male any young male or anybody like (.) that so we thought even we

were having *hijab*(veil) we will keep one side here because it was home it was really like so we we got embarrassed but we were ok then we thought" (female nurse: 12).

Participants experience revealed that they had an understanding of the difference between the culture of origin and the host culture and therefore their option was to adapt to this new culture. Nurses tried to adapt the new culture by changing the way they dressed and changing behaviours to be consistent with the values of the new country. Migrant nurses felt that without making changes in their life world, long term settlement would not be possible:

> "when you go to new culture you do not know how to dress how to speak you know there are certain things that is erm like that is your sense of humour is even different you know we joke different ways they joke that can offend them over here if you just use them jokes erm (.) communication and erm (.) yes there quite few challenges but I do not think that were those big too…because we are here and in this country we need to say that when in Rome do as Romans do we try to do much of the things which is the practice over here (.) and if you wanna adjust yourself to this environment you have got to change you certain ways because we are not in Pakistan and we have this understanding and I understand it" (male nurse 1).

> "but erm sometime some people they will sound on your back (.) some people (.) I am sorry to say (.) but like a racist you know (.) some people all the one they will say if you are covered with the scarf or you are Paki… like that you know (.) so like that some time you will hear that sound from the people otherwise on the duty between friends like that I didn't have anything like that happened you know (.) according to the culture you know I am not wearing *shalwarkameez* you know [pause] to be honest you know because in our culture you know to wear this one I am wearing like a trouser and covering my head when I am going out so erm you have everything right to do your own so nobody is saying you know what you are wearing even people they are walking around nobody care so this is depends on you how you manage (.) or how you go through but there is no restrictions from any people but some people everywhere you will go in the world everywhere some people they are bad" (female nurse: 4).

While most of the nurses were coping with the challenge of alienation and acculturation, even for some who had lived abroad for many years the feeling of missing home was intense. The extract below is taken from an interview with a female migrant Pakistani nurse who has been living abroad for fourteen years. The nurse described her feelings of being exhausted in foreign countries and disclosed her intense feelings of the tension she was suffering.

> "this is not our own country or anything so off course we like you will be fed-up one day same thing (.) will not get I have always missed Saudi Arabia that's more like our culture being a Muslim everything you will get it there…so here totally different you have to make sure because our religion is not allowing to blindly you can get anything or anything we have to make sure to get food or anything is halal or this one that one these things some time we are missing and are really fed up I was thinking better go home" (female nurse 16).

The profound feelings of alienation led some of the nurses to associate themselves with the country of origin and be a 'foreigner' or 'other' despite holding a UK passport. Here the dialogue revealed the feeling of belonging based on origin rather than geographic mobility and a sense that the ultimate resolution was an abstracted notion of acceptance of 'otherness' based on the status as immigrants rather than native citizens:

> "but one thing I conclude wherever you will go [pause] out of your country they will treat you as a foreigner [pause] even you have British passport as well so some people they wouldn't respect you know being one of a....but so many people they are very good and they know we have some problem here like assault with my husband" (female nurse: 4).

> "we are ok we do not feel we were feeling in the beginning but still some time is some area or somewhere if you go for application or apply and you are been ignored so then we feel oh

we are still foreigners even you got the British passport doesn't make difference" (female nurse 7).

9.6.   Rejection and racism

Working in an environment where participants had experienced rejection and racism emerged as one of the main themes that described the experiences of Pakistani educated nurses working in the United Kingdom. While describing these unpleasant experiences, participants mentioned that these experiences were not always common and happened in some of the cases. Rejection was experienced in different ways, from clients and their families, as well as colleagues - often from unqualified care assistants. There was a shared discourse that these experiences emerged because of the status of these nurses as 'migrants' and were common to other migrant nurses as well.

Migrant Pakistani nurses in this study recognized, and to a degree tolerated, the rejection they faced, as 'foreigners' in the work environment. The compensatory mechanism, adopted by Pakistani nurses, was to try and prove to be more skilful, competent, and co-operative while carrying out their duties. However, this strategy over overcompensation in the professional role could also serve to increase alienation and rejection.

One of the participants expressed her feelings that it was because of their background that she was not accepted at workplace. This negative response in the work place meant that the service provided often went unrecognized. In the following extract a nurse expressed her feelings of anguish and the discourse revealed the lived experience of 'invisibility' that was attributed to the status being 'other' or 'outsider':

"because we are foreigner they don't accept us...even...they knows we are the one caring...whole night only nobody is there us…and some time you know clients even they are old...but they don't trust us you know...compared with their own nurses even if they saw the carer she is British or she is white so they will share this...their problem and their things with them you know instead of us" (female nurse 15).

When asked to exemplify what 'racism' and 'rejection' means to them one of the participants articulated her experience through two anecdotes about her workplace. The first revealed overt verbal insults by a visiting family member in a nursing care home.

 "one my resident her daughter came (.) and my one colleague she is a South African (.) South American so she was on duty I was there also taking handover from her…then one lady yeah that her daughter came then she said to both of us…you people supposed to be not this country you are not able to do this job is need English people like here like we said why what happened(?) My mom is abused (.) she didn't get proper care (.) this one because you people doesn't know how kind of feed she needed what kind she has a choice (.) like so that time we feel really bad why the people is thinking that one even the cook they will come and ask their choice…and everything but still you cannot change people's nature so still people is like this she said you people came only to earn money… we are not paying you are nothing here…so that was nothing but she make us both of us upset like we feel we are abused here" (Female nurse 16).

The second anecdote, shared by the same participant, also shows overt rejection based on her status as 'outsider'. The experience revealed 'immigrant identity' as unacceptable to a client who would rather prefer to be cared by a native person:

 "you know we have one resident it's not only we have lot of different nationality people India Pilipino anybody is going she will make issue…something this person abused me (.) he severing me he is physically abuse whatever she don't want to be actually to see any foreigner

there…so that is racist (.) also so whenever we are going we make sure the British person should be there (.) but sometime that's not available that person or something so we are always going two person as a witness something… this is racist and she will tell that one that I don't want to eat… she refuse to eat and she will hate she will swear so this kind of even the staff also racist they are making discrimination" (female nurse 16).

Similar experiences of rejection were shared by two other participants who revealed that clients preferred to be cared by the native English care staff rather than by immigrant nurses. However, their shared discourse revealed that the challenge of gaining acceptance in the workplace was the same for all immigrant nurses, irrespective of country or background:

"and the other thing was there (.) because some time many residents they don't like the Asian people and as a black colour and some time they are saying clear from the first (.) we don't like black people we don't like Pakistani we don't like Indians like that and we wouldn't hurting but just were thinking why they are feeling about us like this you know… and we can call there was racism" (female nurse 17).

"we arrange for them you know like mostly when I done my practice I worked in few nursing homes because I am just doing my part time job as well…so I noticed there like one of the nursing home I see that they have got mostly the colour people you know… from Africa and there was a resident and she said….well I don't accept this one and everybody is black here (.) so what the manger done she arranged to hire some few white people there (.) so that they can just go to that resident and they can communicate that resident (.) so they do really arrange if the resident will say well I don't like this person then we arrange to go the other person" (female nurse 21).

A similar kind of experience was disclosed by another participant where the emotional pain of rejection was evident. . Here, the story connoted the lived experience of

'otherness' that was conveyed to the nurse by client, where the labour of providing care went unrecognised and the experience of being rejected was felt:

> "recently in one nursing home at night one of the resident she had a fall and we attend everything her…. and she was she can you know like she was residential like this client yeah…she can say anything to anybody about her life history she remember everything about her address about everything [pause] so we deal with her I just bring I just give the pain killer I just put her on the bed everything…but when I call the ambulance for her and when we on that shift the even my own country you know like the foreigners are on the shift with me my other staff the fellows as well so that women when she saw the ambulance people they are white...her own...so she changed her statement and straight away she told them I don't trust this woman...I don't trust on these people...even...she don't want to take the glass of water from our hand even...I gave her the glass of water she gave to the ambulance...you know this paramedics and told him you throw this water and give...just you bring because I don't trust on these people...this is the thing you know" (female nurse 15).

Belonging on the basis of country of origin was a dominant discourse that was conveyed by most of these nurses. In the following extract the nurse describes how rejection was directly conveyed to her while she was providing care in an elderly care nursing home. She expressed feelings of not getting acceptance, due to the colour of her skin, leading her to feel hurt and 'discriminated' against. She further emphasized that she felt she had to convince the clients that she was there to care and help them. Moreover, the feeling of rejection was also perceived by some nurses as not being considered akin to the native citizens of England and being viewed as 'servants' in the United Kingdom. One female Pakistani nurse shared her feelings of how she had difficulty in getting acceptance from clients, because she was told that she 'did not belong' in England and was considered a 'servant' by the residents:

"some of them which are late 60s you know they were really racist like...you know they said no we don't want this black girl we want white so that time I feel...what you have to say...discrimination dishurted (sic) and I say no this is not and then slowly I said you are my mom you are my grandma" (female nurse 10).

"they treated us like a shit...they said you go away you doesn't belong to England...you have to go back to your country...you people are servants here...we are paying you...so I just think no these are old people we are here to help them" (female nurse 10).

While participants expressed a view that the issue of lack of acceptance was based on their status as migrants, some concluded that the racial comments were based on ethnicity and skin colour:

"specially patients…patients confused and I heard the patient calling a staff nurse Paki Paki Paki yeah so that means there is still racist there" (male nurse 13).

"one of the residents she said oh that she was saying to the nurse oh which country you came she said I am English (.) she said no you are not bloody English you are Paki…so mean erm she was 96 but really she was saying to her I said I was saying ABC do you know that what you said to her she said I know what I am talking to her (.) and she understand why I am saying to her I said why you saying to her and you abuse her you know that's not very good you are good lady (.) and descent lady and this word is not suiting for you so you have to respect people… and she is trying to help you and she is look after you she said I just asked she's bloody Pakistani" (female nurse 20).

"the skin its racism is everywhere favouritism (.) but I feel I have find that the people those are old very old they do expect that may be the British people has to care them and help them when they see us they think where are their generation are (?)…and the coming generation is I think they are used to the multicultural more than the older people… so some time the patients they does not like us they do not like us they do accept the treatments they do accept tablets they do accept the care …but still their mind is that they do not… at you in the nice way… but

we can't blame them because in their time may be there were not much immigrants (.) but now if you see the nurses Pakistani Indians Pilipino and all the care staff is English so when the care staff see us working supervising them their generation being immigrants they don't like us… it's their country off course it's their country we do accept that (.) so it's my country as well now (.) but still we are being seen by the colour" (female nurse 7).

"Like when you go to the residents if you are very nice with them or whatever...and what they are doing they are focusing your colour and they are focusing your face...so if you are going talk to them they will say 'I do not understand what you are talking' because they are not listening us what we are talking even we are talking English...of course we are talking English [pause] we can't talk our language with them [pause] but them… all concentration is our face our colour so when we will talk to them they will say 'well I did not understand what you are talking'...we understand this person don't like us" (female nurse 21).

Besides coping with the challenge of rejection from patients and clients, participants also faced the difficulty of working with care staff where rejection was overt. Migrant nurses disclosed that some care assistants were uncooperative and rude.

"Actually some people these in my (.) one lady she was very jealous and I heard she was 'oh bloody they are Paki they came here' and that but she didn't say to me but I heard that while she was saying that" (female nurse 20).

Most of the nurses felt that when care assistants were uncooperative, it was not easy to exert any professional authority. The feeling of non- cooperation was manifest in support workers continuing to work in their own way, with disregard for the qualified nurses' authority:

"unfortunately most of the time the carers over here they do not take the responsibility...you keep on telling them the same thing every morning...they will still repeat the same mistake the next morning because they are not listening to you" (male nurse 1).

"and you know and there are certain things (.) then there are certain things you know like if the carers causes problems and then you have got to bear it because you know nobody has been looked after the residents is left in a mess so the next morning the manager is not gonna go to call they will be definitely ask the carers but you are the first one to answer (.) so there are quite few things you know but I cannot say I cannot think of anything particular really" (male nurse 1).

"erm may be it's wrong but this how I feel that there are some people...some local people they think that erm they we shouldn't be really you know (.) erm telling them what to do" (male nurse 2).

One nurse reported his observations of behaviour of support workers with foreign nurses in a hospital ward. The nurse complained that the standard of discipline was different for immigrant nurses and English staff. In the following two extracts one of the nurses described her experience of working with care assistants in the West of England during her initial days. The experience connoted a lack of cooperation and understanding, between care assistants and participants:

"the carers were really bad they were really rude like treating us so we came after one month in Manchester (.) we went to Gloucester and *Ramadan*(the holy month of fasting for Muslims) came and we asked them we used to ask them this is *Ramadan* we are fasting now those people in Gloucester it's very little Asian community and if there is they weren't working anywhere in nursing home or hospitals nursing home (.) I don't know hospitals…. so they weren't used to of Asian life style at all (.) so whenever we were telling them we are fasting and we need break at that time so can we have our break at that time they were getting very irritate to give us break at that time" (female nurse 12).

"like if you know if I say can we go on this break because it's breakfast time and then we can eat and drink it's not our business if you are fasting no this is the tea time it's just finished toileting time… how could and if we have drink like on you know on the hall where the patients

were sittings the residents were sitting and they wouldn't like (.) they were just making the faces and they were just like bit of backbiting (.) see what they are doing criticising (.) and then we felt like we were just like two there (.) and we were just isolated and bit of you know we what do and what to say and we were keeping quite also being new and also because it was adaptation and we were thinking if we will say something it will go against us… and they might delay our PIN number and may be they will put complain or you know all these worries was there so we were feeling bit rough at that time" (female nurse 12).

The rift between care staff and migrant Pakistani nurses was one of the workplace challenges that most of the nurses experienced, revealing the difficulties they were facing at work. This situation pertained whilst the migrant nurses were completing their adaptation programmes and were operating at the same grade as the care assistants, but was exacerbated by the gaining of registration with the Nursing and Midwifery Council (NMC):

"when I get PIN number yeah I started my day...so they informed the carers like she is your boss that day I was really happy so...but that day I think those British carers was not happy because they think we were working with them and how come we are coming over to them...and rule to them I think they didn't like that" (female nurse 10).

"they are jealous especially I don't know why they feel jealous I can't say why… but they are because you cannot you can feel they are jealous that's why they are saying like this (.) for example the carers they are saying oh if she is nurse if she is nurse what we will do you know job is job if she is nurse or whatever we are not bothering if she is senior or junior you know… like very bad words they were using for us and erm" (female nurse 17).

Participants had their own understanding of 'racism' and the way they experienced or observed it in their workplace settings. These experiences are thought to be located in the identity as immigrant or native. Some suggested that racism is grounded in a lack

of knowledge and education, and since care workers were not qualified nurses their education was different and they therefore behave in different ways. One participant compared the behaviour of the care staff with other 'educated' people and the difference observed in the behaviour:

"I will say that that it happens in some extent yeah some of the support worker you know that's something natural racism which is still exists and even on the ward…. that thing you will see quite among nurses as well support workers as well yeah support workers may thinking that I am a British and you are foreigner and I am working under you and you know" (male nurse 13).

"some time they are thinking because we are British even they are not qualified that's everything so this is the thing we are sometime facing people is thinking… we don't know anything even we are qualified whatever and even they are unqualified they are carer and they never been to the school like we have our language Urdu or Punjabi we can speak…. so we so many time we faces that one even we can understand we can speak but not like them it's totally different you can imagine that so this is the point" (female nurse 16).

 "so one thing I though at that time the carers may be they are less education (.) they are less educated (.) and they behave like rough but the educated people in England they behave good that concept came in my head and I think it's this fact here people are bit of like good educated people really know you know how to treat people they are good…. but bit like up to the benefits level and up to the not properly educated or maybe they have their own problems some time (.) they are even have got problems they don't all the time they treat…but in hospital they are they are good in care homes I thought they were very much senior carers were like matrons but in hospital they are ok since I came in hospital I felt" (female nurse 12).

 In addition, some nurses revealed their experience of being physically 'left behind' in the workplace and being expected to complete tasks alone. For someone who had previously worked in speciality areas in Pakistani hospital, the conditions of work she

described were demoralizing and punishing. She spoke about having to work long hours, having little support from, or social interaction with, colleagues. It appears that the co-workers maintained distance from her, which was justified as her being expected to know what to do as a qualified nurse:

> "once I am in uniform I don't know if I am standing in ten hours some time there no break...even will be thirsty and no time to drink a water and I was been left alone...if I am asking something they say if you are a qualified nurse you should know so that is because of the attitude that was not good" (female nurse 7).

Another participant shared a similar experience:

> "the other challenges were about the staff you know few staff I would say the staff member they tried to erm you know don't teach you all the time and they tried to use you in the in the bad manner I would say bad manner (.) I mean like erm they just try to impose things on you… these are the challenges and these challenges being and not with me but I mean I am not sure that if you ask different people they will say the same thing I mean that was a big challenge for everyone… who did the adaptation and anywhere in UK yeah that was a big challenge as well" (male nurse 6).

Besides experiencing overt racism from patients and care workers, migrant Pakistani nurses had also suffered from discrimination inherent in the organisation systems and structures.

> "there was one British manager and she was really racist because ahm like when ....sometime she was doing very big mistake and she was hiding their people like British and she was hiding don't tell to somebody even if we would we will not do any mistake and she was applying thing on us you know… I mean she says she will make error there and she will say oh this thing previous night they did because I was doing mostly night shifts… and all the time she was blaming us and she was telling all the time lie and sometime she was making me cry…

and really I leaved that place because of these things because of she was all the time she was telling lie and she was not cooperative" (female 17).

"some of the nursing homes I have seen that they will send the chosen people and if you are asking since long time one training may be they will be ignoring you" (female nurse 7).

In order to cope with the challenge of individual and systemic racism, and rejection in the workplace, migrant Pakistani nurses adopted their own coping strategies. There was a shared understanding that to compensate for the outsider identity, migrant nurses need to be more professionally competent. This meant increased sensitivity to patient care needs, cooperativeness and understanding the culture and values of patients and families.

"I said that you have to be more competent that no anybody say anything to you yeah…and more aware yeah that nobody can pick finger on you..that you and just do more cooperation" (male nurse 13).

"if it is a family you know erm you know family review (.) if they have got a family issue clients family issue erm many times ermits that you have to really prove that you are competent the families where I have proved that yes I am there to take care of your loved ones" (male nurse 2).

"you have to be really strong character nurse if being immigrant if you are a strong character person they you would not feel any difficulty yeah…you have to be good team player and we have to understand them since we are here since long time now so we do understand the culture and hard work it was bit difficult in the beginning" (female nurse 7).

However, as a means to live with racism and rejection, even these coping strategies were not always successful. In a working environment with an established order and

culture, the challenge of a migrant nurse who appeared more professionally competent could be seen as a factor which would only serve to highlight their difference. In this case the very strategies which migrant nurses employed to facilitate acceptance and integration could become factors which only served to compound their status as 'outsiders'.

9.7. Summary

Living and working with rejection and racism can be seen as a key characteristic in the daily lives of migrant Pakistani nurses working in the United Kingdom. It is clearly evident from the above data extracts that the migrant nurses had difficulty in gaining acceptance in the new care environment; in terms of rejection from both clients and care staff. Migrant Pakistani nurses have adopted coping strategies and are trying to compensate for the rejection they experience by demonstrating their professional expertise and showing high levels of cooperation with other staff and clients in the care environment. However, some argued that getting acceptance was rather a complicated phenomenon and was common to all foreign nurses working in the UK.

Within these experiences there lies embedded notions of difference, identity, and belonging as part of the lived experience of 'otherness' that will be elaborated on in the discussion chapter.

CHAPTER 10

DISCUSSION

10.1. Introduction

The overarching aim of this study was to understand the lived experience of becoming, and being, a migrant Pakistani nurse in the UK, and interpret these experiences in a wider socio-cultural and geo-political context. Although there were some impediments in executing the research, this did not impact negatively on the outcomes of the study. At the outset of fieldwork, recruitment to the study proved to be a challenging task, as some of those approached refused to participate because of suspicions about the research agenda. Others had serious reservations about taking part, but when assured of the anonymity and confidentiality of data, subsequently agreed to be interviewed. Despite these obstacles, the study addressed its aims and purpose, furnishing new

knowledge of the experiences of Pakistani migrant nurses living, and working, in the United Kingdom.

This study is one of the first to explore nurse migration experiences in the current geo-political context. Findings reveal how this group of migrant nurses constructed their feelings and emotions as Pakistani nurses struggling to escape life hardships in Pakistan in pursuit of a 'new life' in the United Kingdom. Their experience in Pakistan revealed dissatisfaction over the quality of life, where they felt exploited, oppressed, and socially unrecognized. A poorly regulated health system failed to meet daily survival needs of these nurses, and ultimately retain them in the Pakistani nursing workforce. On their arrival in the United Kingdom all these nurses, at the outset, started working in the independent nursing home sector. Their experiences revealed, they had little experience of working in elderly care environments, and this kind of work precipitated a loss of professional identity and skills. Expectations of employment in a technologically advanced and sophisticated first world health system were not fulfilled and, despite continuous struggle, only a few succeeded in securing a job in the National Health Service. As their transition to life in the United Kingdom continued these nurses had to face and live with the 'reality' of being a foreigner, or outsider, in the new host country. These challenges can be summarised as learning to adapt to a new and different culture, and gaining both professional and personal acceptance in the United Kingdom. Pakistani migrant nurses who participated in this study continue to adapt to the host society, and none expressed any desire to move back to Pakistan to live or work. If considered in terms of a cost-benefit analysis, positive aspects of migration may outweigh the negative aspects discussed in this study.

The lived experiences of these nurses revealed a struggle for acceptance, identity, and sense of belonging throughout their life trajectories. The host country provided citizenship, social security, and many things they aspired to. However, over time they felt their status as an immigrant to be defined by 'difference'. The findings of the study revealed experiences of 'social difference' in terms of social class, gender, ethnicity and migrant status. The lived experience of these nurses can be best understood within the concept of 'otherness'.

10.2.   The concept of 'otherness'

Constructions of the 'other', the 'alien', 'the stranger', and their implications, are discussed within diverse contexts (Ajzenstadt and Shapira, 2012). Feelings of difference can emerge in relation to social class, gender, ethnicity, age, migrant status, sexual orientation and disability. The notion of otherness has been studied and discussed in ethnic/migration and gender/sexuality studies (Lilja and Hellzén, 2007, Herakova, 2012, Naue and Kroll, 2009, Trice, 2007, Lucie, 2006, Torres, 2006). In sociology, 'otherness' is a phenomenon that occurs in inter-cultural interactions and, as such, is a socially constructed process. The self is recognized in relation to other; female considered 'other' to male, and migrant as the 'other' of native. Groups which share the same values, beliefs and culture are represented as the same, whereas those who hold different values are demarcated as 'other'. Often, minority groups in the community are considered to be other and excluded from the main social networks. In migration and ethnic inquiry, the notion of otherness is usually studied in relation to majority and minority groups (Mclntosh et al., 2004, Davis and Sosnovskaya, 2009). For example, Burmese people in Thailand describe feelings of otherness (Faucher,

2010), and English people in Scotland experience constant reminders of their difference (Mclntosh et al., 2004).

The social identity of a minority group is always constructed in relation to a majority group (Camara et al., 2009, Morgan, 2012), and the 'other' is set up against the hegemonic 'universal human being'; that is, white, middle class, heterosexual, able-bodied men. The process through which those thought to be different are marked and named as 'others' is the 'othering' process (Canales, 2000).

Postmodernism emphasizes cultural diversity and difference, and an intellectual movement has emerged to discuss the inevitability of the experience of difference. In post-modern thinking there are increasing demands that difference be acknowledged and protected (Ploesser & Mecheril, 2012). Three prominent approaches to 'otherness' are described as neglect of otherness, recognition of otherness, and deconstruction of difference between other and the non-other (Ploesser & Mecheril, 2012). Work ignoring differences produces inequalities if it fails to recognize them. On the other hand, recognition of difference reproduces power relations because this classifies, and confirms, the 'other' as a consequence of the dominant hegemonic order (Ploesser and Mecheril, 2012). The recognition of differences may lead to exclusion. An important approach to this notion is deconstruction of otherness which emphasises a need to understand the negative impact of, both, recognition and neglect of otherness.

Different social and legal process are involved in constructing the notion of otherness and its cultural and social meanings. The essence of exclusion is internalized by the object of definition as well as the definer (Ajzenstadt & Shapira, 2012). Scholars agree that the construction of 'other' as a distinct group, and public policies of community

exclusion, mark normative boundaries of society (Ajzenstadt and Shapira, 2012). The othering mechanics are directed against those considered threatening to social order because of race, sexual conduct, gender or social and politictal attributes (Ajzenstadt & Shapira, 2012). In this way, marking the 'other' as an outsider, violating social and cultural boundaries, is a symbolic cultural code (Ajzenstadt & Shapira, 2012) and the 'other' is marginalized or set aside in favour of the preferred ones (Kirkham, 2003). Recognition that one is 'other' can cause feelings of shame, which in some cases lead to marginalisation and invisibility. In other cases, recognition of one's 'otherness' can induce feelings of indifference or pride about being different, so that one declines assimilation into the dominant culture (Ploesser and Mecheril, 2012). A third possibility exists whereby individuals who are separate, and distinctly different from one another, live peacefully side by side, with neither one being dominant over the 'other'. In this case, neither feel 'othered' but instead experience being apart but equal (Ploesser and Mecheril, 2012).

In this context, the concept of 'otherness' is used to gain deeper understanding of the meaning of the lived experience of becoming and being a migrant Pakistani nurse in the UK socio-political context. Two main concepts based on study findings are the experience of *social otherness* in Pakistan and *ethnic otherness* in the United Kingdom.

10.3. Social otherness in Pakistan

Study findings underscore that in Pakistan this group of nurses experienced social otherness, as being different from mainstream society, because of professional and gender roles expectations. Social otherness is discussed, here, in terms of nursing as an 'othered' profession, confounded by gender role stereotypes.

10.3.1. Social otherness and nursing in Pakistan

The study findings underscore the construction of the nursing profession as 'other' in Pakistan. The lived experience of becoming a migrant, of Pakistani educated nurses, revealed that they were prompted to take a decision to migrate due to realization of the feeling of otherness. The status of the nursing profession was constructed as 'other' in comparison to the respect enjoyed by other professions such as medicine. This feeling of otherness was grounded in marginalization, and compounded by the way authorities in the health system in Pakistan dealt with them, where concerns raised were not addressed. The experiences of these nurses revealed complex factors at play in constructing the status of the Pakistan nursing profession as 'other', as a part of the status quo of the system.

The study found that in Pakistan this group of nurses were working in a system where they felt their rights were not protected. This suggests that in the Pakistani government sector nurses do not have the resources to carry out their jobs, nor do they have optimum wages to fulfil daily life needs. This can lead to frustration, reduced job satisfaction and low morale (Bahalkani et al., 2011). The situation in Pakistan is further complicated by social class divisions, where only the rich can afford healthcare and education facilities for their children. In a system where one is unable to afford treatment for an ill family member, and occupational status as a nurse cannot meet the needs of children, or family members, migration was viewed as the only way to improve living conditions. The nurses had diminished confidence in the social hierarchy and healthcare service. A decision to migrate was, in this context, less about voluntary choice than a by-product of wider social injustices in Pakistani society.

In Pakistan nursing is striving to gain respect from society, but the profession is not socially valued. Participants reported that their families discouraged them from becoming a nurse, and their decision to enter the profession was not appreciated. In addition, amongst the general public, the image of nursing is not well understood or regarded. Nursing in Pakistan is struggling for social acceptance and professional identity, and there are limited opportunities for nurses to pursue further education or advance their careers. The job nurses do in Pakistan does not receive recognition from authorities and, despite 67 years of independence, the nursing profession does not enjoy the reputation of a 'noble profession'. There is a need to change the image of nursing so the profession is valued, both by other health professionals and the general public. A primary concern that emerges from this research is a lack of empowerment amongst nurses in the Pakistani health system, implying that nurses in Pakistan have little, if any, influence with policy makers.

In addition, the broader picture of Pakistan as economically dependent and exporting its human resource to generate revenue is a contributing factor in shaping migration motives of nurses. In Pakistan, migration is encouraged at a government level, and remittances 'sent home' by migrants are viewed as positive benefits to the economy.

It emerged that participants felt the Pakistan authorities were unconcerned with making any effort to retain them as professionals. If one's voice is not heard, concerns are not listened to, employment rights are not protected, and sick leave is not granted, it is easy to see how feelings of otherness originate. They experienced a hierarchy where they felt alien to health authorities; and institutions such as the Pakistan Nursing Council and Pakistan Nurses Federation appear to have little influence in protecting nurses' rights, or championing the profession.

10.3.2. Social otherness and gendered roles in Pakistan

An important tenet of the interpretive phenomenological approach is to understand participant experiences with reference to socio-cultural context, as these are bounded by time and place. The construction of the nursing profession as 'other' can be further understood in the socio-cultural context of patriarchal Pakistani society, where gender roles and stereotypes apply to both males and females.

In a patriarchal society, where males are expected to be in a position of authority, a typically feminised profession such as nursing is unlikely to be appreciated by potential recruits. Based on future job prospects in domestic and foreign markets the nursing profession has attracted increased numbers of males in recent years. A mushrooming of new male nursing schools in Karachi and other cities is illustrative of this phenomenon. The enrolment of more men to a traditionally female dominated profession in a sexually-divided society conflicts with long-standing male/gender roles. Hence, male nurses may also feel this social othering in Pakistani society. However, within culturally defined expectations for males to assume economic responsibility, they may have fewer restrictions in joining the profession. More research is needed to know the male nurses experience in a typical patriarchal male dominated society where nursing is seen as 'women's work'.

Conversely, women have little autonomy regarding life and career choices in Pakistan. Although, in Islam, women have rights to education and employment, in Pakistan such teachings are masked by powerful cultural norms and expectations. Women working with men are not regarded well by a large segment of the society, and this is especially relevant where the role of the nurse appears to transgress rigidly gendered sex role constructions.

Working in patriarchal culture may perpetuate oppression and incite aggression and violence against women. The experiences of discrimination shared by women participants in this research reflected a broader picture of the social construction of everyday life. At the level of the family unit, objections from male members over a woman's decision to join the nursing profession exercised serious strictures on their sense of agency. In this context the experience of exploitation and oppression in a masculine culture in Pakistani society needs to be understood as a component of the way gender and otherness are constructed at a societal level.

Historically, women have never been treated equally in Pakistan society, and have faced discrimination in education, health and other fields of life (Rani et al., 2011, Shaikh et al., 2008, Fatima, 2011). Usually, Islamic teachings are interpreted from male perspectives, and women's lives are dictated by a patriarchal value system in Pakistan. Women are expected to make sacrifices for family life. In this context, women are actively disempowered, and usually excluded from policy making. This may have an impact on the nursing profession in Pakistan, as it is still dominated by women, despite an increasing trend of more men joining the profession in recent years.

Despite significant economic and cultural developments in the recent past, large parts of Pakistani society remain tribal, feudal, and overtly patriarchal, which continues the oppression of women (Lee and Saeed, 2001). There is an abundance of literature on violence against women in Pakistan, and studies have shown that women in Pakistan are often victims of domestic violence (Aziz and Hughes, 2011, Bhatti et al., 2011, Syed et al., 2013, Karmaliani et al., 2012, Khan and Sajid, 2011, Ali and Khan, 2007). According to the Human Rights Commission of Pakistan about 900 women were

murdered in the name of so called 'honour killing' in the year 2013 (The-Guardian, May 28 2014, Sarwari, May 29 2014).

The role and status of women in Pakistani society is determined by social class structure, provincial boundaries, and rural and urban divisions. In Pakistani society economic position determines social status rather than education and/or professional background (Awan, 2012). Cultural values also have an impact on women's lives and these differ from class to class. Usually women from higher social classes have access to education. Middle class women are, to an extent, unable to raise a voice against violation of their rights. However, the worst affected women are from the lower social strata, as they are neither aware of their rights nor have resources to petition against injustice (Awan, 2012). In addition, women from urban and rural areas have very different roles. Women in rural areas occupy a subservient position, where their role is to carry out household tasks along with childrearing. In urban areas women can access education, print, and electronic media, and awareness programmes (Awan, 2012); participation in higher education enabling them to speak out against prejudicial practices (Malik and Courtney, 2011).

Great discrimination is found in the education of boys and girls in Pakistan. The number of women, and girls, in secondary and higher-secondary schools is substantially lower than men and boys (Ara and Malik, 2012). Pakistan has one of the poorest female literacy rates in the region (Ara and Malik, 2012). In 2009, Pakistan had 39.9% female literacy rate compared to a 67.7% male literacy rate. The female literacy rate in India is 54.5% and in Bangladesh 48%, placing Pakistan on the lowest rung of female literacy rates in the subcontinent (Fatima, 2011).

In this context, traditional stereotyped gendered roles in Pakistan may be seen as transgressed by both male and female nurses. For male nurses, society might not see nursing as a desired profession based on the argument that nursing is a 'womanly business'. On the other hand, for females, nursing may transgress the typical gender role as 'housewife', and working alongside men may not be appreciated by a substantial segment of society. Hence, the overall status of both male and female nurses in a patriarchal, male dominated society may be understood within the notion of otherness. Increased awareness and education is needed at a societal level regarding the nursing profession and gendered cultural scripts.

An important feature of otherness that compelled these nurses to migrate was the feeling of not being valued in Pakistan. In this context, the voices of participants captured in this study have implications for nurses working in Pakistan. Though this group fought a personal battle and moved out of the country, those left behind in Pakistan and who are unable to travel, have to survive facing complex issues at the forefront of the profession. The experiences of nurses in this study are consistent with the extant literature on migration motives of nurses, which describe the main factors influencing decision-making; economic/social, professional/educational, and personal/political factors (Dywili et al., 2013). Economic motives relating to poor wages (Aiken et al., 2004, Aboderin, 2007), better future prospects (Chikanda, 2005, Thomas, 2006), ability to send remittances back home (Mejia, 2004), and financial improvement (Larsen et al., 2005) were all found in the nurses accounts. Similarly, professional factors related to limited job/career advancement at home (Beaton and Walsh, 2010, Chikanda, 2005) lack of adequate opportunities for personal and professional achievement (Kline, 2003) featured. The narratives also identified social factors related to poor working conditions in the home country (Thomas, 2006), the

search for better quality (Chikanda, 2005, Aboderin, 2007, Thomas, 2006, El-Jardali et al., 2009) and political factors related to dissatisfaction with the prevalent political situation in Pakistan to secure the future of children (Thomas, 2006, Chikanda, 2005, El-Jardali et al., 2008). These migrant Pakistani nurses also identified personal motivating factors which included life adventure and an opportunity to contribute to high standards of care (Larsen et al., 2005, Beaton and Walsh, 2010).

In addition to these recognised factors in nurse migration this study suggests social 'otherness' as another important driver. In exploring the phenomenon of becoming a migrant from the perspective of Pakistani nurses the embodied feeling of otherness was demonstrated through exploitation, oppression and social non-recognition. This feeling of otherness mainly originated in the social inequality experienced by these nurses, in different forms, as part the system, where they were born, raised and educated. This otherness is further compounded in the lack of recognition, based on the status of nursing profession, experienced by these nurses. It suggests there are multiple factors at a societal level that need to be taken into account in understanding migration motives of Pakistani nurses; issues which may also be relevant to migrant nurses from other developing countries.

This study proposes that participants' experiences characterise the lived experience of social otherness working in Pakistani society. To cope with this, migration abroad is one strategy that many nurses adopt. The challenges these nurses experienced post migration is interpreted and discussed in the following section.

10.4.   Ethnic otherness in the United Kingdom

Once permanently migrated and starting work in a new environment, participants had the experience of 'ethnic otherness' in the United Kingdom. Ethnic otherness as it emerged from study findings means that these nurses had the feelings of being different within the host society in terms of culture and values. New job positions were seen as different, and nurses spoke about a shared sense of non-belonging.

Ethnic otherness describes the concept of belonging, or identity, of a minority that is different to the majority of the population (Hirose and Pih, 2011, Avila-Saavedra, 2011). Interpretive phenomenology understands experiences in context, so while participant experiences characterized social otherness in Pakistan, in the United Kingdom they characterized ethnic otherness. Ethnic otherness is discussed below, based on 'dissonance and devaluation' and 'outsider identities'.

10.4.1. Ethnic otherness, dissonance and devaluation

The notion of ethnic otherness can be portrayed in feelings of dissonance and devaluation in the lived experience of migrant Pakistani nurses. It is relative to previous work in Pakistan, and to the position and status enjoyed by native nurses in the UK. All the migrant Pakistani nurses who were interviewed had worked in Pakistan in speciality clinical areas but, with migration, they forfeited those positions. They had expectations of working in technologically advanced hospital settings in the UK. However, these expectations were not realized, and they had to begin their new career working in nursing homes. Their unfamiliarity with these settings added further to their frustration.

Moreover, many nurses experienced a deskilling process with fewer opportunities to practice nursing skills they had acquired before emigrating. This led to a sense of loss of professional identity, where the role of nurse was perceived as akin to that performed by care assistants or 'ward boys' in Pakistan. This engagement with a new reality became the daily life experience of these nurses. Many were shocked to see elderly clients being looked after in nursing homes, and participants maintained efforts to find positions in the NHS, but with little success. However, in order to get a nursing position in the NHS, many had to wait for six years to acquire the status of a British citizen. Thus, the lived experience of Pakistani nurses revealed them as existing at the margins of the health care system, and working in low status positions with few chances to advance their careers.

Nursing care, as constructed by these nurses, seemed to be technically and medically oriented. This is because they completed nursing training in Pakistan hospital settings, with little exposure to elderly care. The study findings also revealed that the way elderly care is constituted in Pakistan is very different to the way older people are taken care of in the United Kingdom. In Pakistan they are typically cared for by family members in their homes.

Migrant nurses are twice as likely to work in care homes than native nurses in the UK (Haour-Knipe and Davies, 2008) and migrant labour is often hired for jobs that are undesirable, or least desirable, by native people; usually called 'the three Ds', that is dirty, dangerous and degrading (Castles, 2000). The experience and qualifications of migrant nurses go unrecognized and a hierarchy is produced where white native nurses occupy managerial jobs, and migrant nurses the lower cadre jobs (Smith and Mackintosh, 2007, Omeri and Atkins, 2002).

It can be argued that migrants are often used as a cheap labour source in prosperous economies such as UAE, Brazil and the UK. This reflects a globalized world, where an increase in capitalization has relied on cheap labour from developing countries such as India, Pakistan, Bangladesh, and Philippines. However, the human cost of such labour is beyond understanding. It would appear that there is little value placed on human emotions and feelings, in a world where economies are built on human exploitation.

Previous literature has reported that overseas nurses found themselves devalued and deskilled in the British healthcare system (O'Brien, 2007). Nurses from developing countries reported the feeling of being devalued was mainly because they expected to work in a speciality area in the NHS, which was not fulfilled. This was similar for participants in this study. Most were hired by private nursing homes, with restrictive work permits that limited their opportunity for adaptation into UK healthcare and wider society. In their review, Nichols and Campbell (2010) found overseas nurses experience surprise and disappointment on arrival in the United Kingdom, which may precipitate overall dissatisfaction and reduced motivation, in turn causing poor performance.

This study is the first to note that the experience of dissonance and devaluation in the migrant nurse experience is one of the aspects of ethnic otherness. While most research has focused on deskilling as the main experience of overseas nurses, this study suggests that beside loss of professional skills, loss of professional identity is also experienced by migrant nurses. In addition, this study is the first to suggest that accompanying the experience of devaluation there may be a profound experience of dissonance. Despite working in devalued positions these nurses are able to earn

salaries up to twenty times greater than they could in their native country. Working in devalued positions contributes to a sense of 'otherness', as it sustains a hierarchy which puts migrant nurses at the fringes of the UK health system.

So far in this section, the concept of ethnic otherness has been discussed in terms of dissonance and devaluation. In the following section another aspect of ethnic otherness is discussed in terms of non-belonging.

10.4.2. Ethnic otherness and non-belonging

Ethnic otherness may be manifested in feelings of non-belonging, which is one of the unique study themes related to the current geo-political context. It was revealed during interviews with participants that gaining acceptance in the work place was one of the primary challenges that participants faced while working and living in the United Kingdom. The most profound experience shared by migrant Pakistani nurses was overt racism from patients, relatives and other health care workers. The feeling of rejection was attributed to direct remarks they heard from patients and relatives; suggesting migrant nurses could not provide the same level of care as a native nurse, as they do not understand the cultural mores of UK society. Despite some migrant nurses holding British passports they still experienced overt racism. One female respondent reported that when walking on the streets, she was shouted at by a group of men calling 'Paki Paki'. Another nurse revealed that she was called 'bloody Paki' by a patient. These examples characterize the concept of ethnic others as different to the majority based on ethnic origin.

The Pakistani Diaspora in the UK is found in large cities such as Birmingham, Glasgow, Bradford and Manchester. Many British Pakistanis have established their

businesses in the UK, for example the 'Curry Mile' in Rusholme, Manchester, is a famous food high street, with mainly Pakistani and Bangladeshi restaurants and takeaways. The integration of the Pakisani Dispora in the UK has been a focus of attention and research in recent years, and during interviews with participants it became apparent that many had initially came to the UK and stayed with friends or relatives who had settled in established Pakistani communities.

Participants in this study are first generation migrants who have travelled from Pakistan to the United Kingdom directly, or through other countries. However, these nurses are now seeking settlement with their immediate families in the United Kingdom, leaving behind extended families in Pakistan. Despite possessing the necessities of life, ethnic otherness was constructed as the core experience of these nurses. They are working in positions least desired by native nurses, often long hours and night shifts, making their position peripheral in the health care system. Further, they are socially isolated and bounded to the established Pakistani communities in the UK. Their social activities are limited, and they often suffer home sickness.

It is arguable that feelings of dislocation and vulnerability in migrant communities have been compounded by the rapid growth of Islamophobia in the Western world, and growing fears of religious fundamentalist terrorism. In September 2001, terrorist attacks on the 'twin towers' of the World trade Center, in the United States, changed the world view of Islam, and those professing Islamic faith. Since this date, there has been growing anti-Muslim sentiments among western societies which has led to fear and radicalisation among many Muslim communities in Western world (Kunst et al., 2013, Strabac and Listhaug, 2008, Kunst et al., 2012, The-Guardian, 2014). Since the attacks on New York in September 2001, commonly referred to as '9/11', Muslims in

Western world, specifically Arabs and Pakistanis, are subject to systematic scrutiny and surveillance (Zaman, 2010). This consistent portrayal in the media (Housee, 2012), law enforcement agencies and discourses have categorized racial groups as 'other', 'the deviant' or 'outsider' (Zaman, 2010). In recent years, Islamophobia has also stimulated an increased research interest (Kunst et al., 2013, Strabac and Listhaug, 2008, Kunst et al., 2012). Although religion in the West has been relatively constant over a long period of time, South-North migration in recent years has contributed to the formation of multi-religious societies (Kunst et al., 2012). This changing composition is rejected by many, and has shifted from Anti-Asian and Anti-Arab racism to Anti-Muslim racism (Poynting and Mason, 2006). The suggestion of Muslim immigrants as difficult to integrate has attracted increased political attention and debate, with right-wing political groups promoting ideas of insurmountable cultural difference which add to an atmosphere of intolerance and hostility (Betz and Meret, 2009). It is arguable that in the UK, Islamophobia has been exacerbated by the bombings of London buses and underground trains in July 2005 (commonly known as '7/7').

With an increase in migration trends, an increase in anti-migration sentiments is noted in the Western world (Van Oudenhoven et al., 2006, Ceobanu and Escandell, 2008), especially with the current global economic downturn. Studies have noted an increase in prejudice towards Muslim migrants across the Western world since 9/11 (Brown et al., 2013). For example, in Germany Turkish immigrants who are mainly Muslim, are perceived differently to Italian migrants who are predominantly Christian (Rohmann et al., 2006). Similarly, in the Netherlands, youth prejudice towards Muslims is reported because of perceived threats to national values.

Data collection for this study was carried out between the months of May and November 2012, and timescale context played an important role in interpreting the findings. During recruitment there were difficulties because some people felt they were being 'spied upon' and did not want to participate. Those who agreed to take part were sometimes reluctant to speak on the issue of anti-Muslim sentiments, and others were suspicious of the research agenda. In terms of context, respondents arrived in the UK between the years 2000-2007. More importantly, their transition experiences in the United Kingdom took place after the 7/7 incident in London, and this wider socio-political backdrop has great resonance in their lives.

According to Brah (1996, p 24) "for most white Britons, Asians represent the epitome of the 'outsider' and have often been seen as the antithesis of British culture, seen for example as 'undesirables who smelled of curry', 'wore funny clothes' 'lived packed like sardines in a room' and 'practiced a strange religion". Low status and devaluation afforded to migrants identifies culture, race and religion as markers of otherness, and justifies exclusion (Mohammad, 1999). First generation migrants bring their own values and culture from the society where they originated, and according to Mohammad (1999, p 227) "diasporic compliance with Islamic religio-culture both links local minorities with other Muslims across the globe and provides a basis for resistance to imperialism and racism that situate such communities as 'others'". In regard to the Pakistani Diaspora, 'terror' attacks in London led to greater political debate, and wider scrutiny of young British Pakistanis (Yew, 2005), consistently regarded as a potential threat to national security (Hussain and Bagguley, 2013). Subsequently, efforts have been made to explore identity and religious/cultural affiliations in British Muslims communities (Mythen, 2012, Richards, 2007).

In Britain, issues related to migration have been constant in the post-colonial period with an influx of Commonwealth migrants arriving in the 1950s and 1960s. In the 1970s, Premier Margret Thatcher raised concerns over immigration mentioning that 'the country might be swamped by people with different culture' (Brah, 1996). This issue has continued to the present, with the current government aiming to reduce net migration to less than half current levels. Strategies to manage immigration to the UK include increased border controls, restrictions on visas, setting up of detention centres, aggressive repatriation, and reductions in welfare provision. Under new UK regulations, policies are theoretically equal for all, but not in practice, which has been described as neo-racism or democratic racism (Khorana, 2014). Understanding of study findings would be incomplete without mention of the part played by the media in constructing the migrant as 'other' (Davis and Sosnovskaya, 2009, Camara et al., 2009).

The current study was conducted at a time when the changing political situation in the UK witnessed an emphasis on managing immigration, and in the European Parliamentary elections of May 2014, Eurosceptic and far-right political parties gained substantial victories in the UK and France; termed by many as a 'political earthquake'. In the United Kingdom the UK independence party (UKIP) has, for the first time, gained the largest proportion of votes in a European election. Populist themes such as 'anti-immigration' 'anti-Europe' and 'anti-globalization' have gained increasing support throughout the European community, a changing political scenario with likely long term consequences for world politics and migrant experience. This notion of ethnic otherness is directly related to the theme of 'outsider identities' as an account of the lived experience of 'otherness' for migrant nurses. Adaptation to this is

evidenced in decisions to settle in established Asian and Pakistani communities which offer a sense of belonging.

10.5. Implications of study findings

The study explored the life world of participants and complex interrelated issues that constructed their experiences in Pakistan and the United Kingdom. The main aim was to understand and explore participants lived experience. Although findings help to conceptualize and theorize participant experiences within a particular socio-cultural and geo-political context, contributing to a growing body of knowledge about nurse migration, they have important implications for policy makers, nursing leadership in Pakistan and the UK, and future nursing research. To bring a real change in the lives of nurses working in Pakistan and UK there is a need to engage with participant accounts. Shared experiences of exploitation, oppression and social non-recognition of these nurses in their home country have import for the nursing profession in Pakistan.

10.5.1. Policy and pratice implications for nursing in Pakistan

1. Nurses in Pakistan need to be recognised for the work they do, and the Pakistan government should acknowledge their professional training, according it appropriate societal status. This might be through remuneration, enabling nurses to better manage their daily lives and cater for the needs of families.

2. The Pakistani government may also need to invest more money in nursing education to provide aspirant nurses with higher education and opportunities for personal and professional development. It is arguable that investment in post-basic nurse education would have a considerable potential to enhance the delivery of care in Pakistan over the longer term.

3. It is unknown how many qualified nurses continue their working lives in Pakistan, or how many leave in search of job opportunities in overseas. An accurate record of this type of data could be an important step in monitoring and managing migration out of the country.

4. Nurse migration has benefits to the wider Pakistani economy, with people financially supporting families whilst working abroad. It may be incumbent on the Pakistani government to support nurses aspiring to move abroad, to prepare them for the challenges that migration brings, and ensure that their migration experience is positive.

5. At the hospital level, it appears strong nursing leadership is needed, and management should be responsive to genuine concerns that affect nurses' lives. Adequate nurse staffing in government hospitals is an important issue to address in order to minimize excessive workloads for staff, and improve the extremely low nurse to patient ratio.

6. Nursing organizations, like Pakistan Nurses Federation need to lobby the government regarding difficult issues nurses face in Pakistan, and strong national leadership is required to tackle multiple challenges at the forefront of nursing profession in Pakistan.

7. In both private, and government, sectors there need to be accurate, annual monitoring of the number of nurses employed in hospitals. A growing population, and related healthcare demands, requires strategic planning to better manage the nursing labour market in Pakistan.

8. The Pakistan government can utilize valuable experience gained by nurses working overseas and in United Kingdom. Talented and experienced staff might be attracted back to Pakistan by competitive salaries.

9. It is vital for nurse educators to teach core values of holistic nursing to pre-licence nurses, as participants emphasized technical/medical aspects of the profession.

10.5.2. Policy and practice implications for nursing in United Kingdom

Irrespective of any commitment to support and develop nursing in Pakistan, at national, regional or local levels, there will always be those who choose to migrate, and the UK is likely to remain a preferred destination. Migrant Pakistani nurses serve an important purpose in the wider provision of care in the UK, and in this context it is important they are supported to integrate successfully into the United Kingdom. UK studies have contributed to making the transition of nurses much smoother and findings reported here echo the need for overseas staff to receive proper adaptation training programmes. Only one nurse in this study had gone through the 'overseas nurses programme', the remainder processed through nursing home based adaptation programmes:

1. Agencies should abide by the ICN code of recruitment to foreign countries. Nurses should be given complete information regarding their employment contract to make an informed decision.

2. Overseas nurses should be provided with robust orientation programmes regarding life and career opportunities available in United Kingdom.

3. Care assistants working with nurses should be given training on equality and diversity, and team working should involve nursing staff and care workers.

4. Management should seek feedback from individual nurses regarding care and other issues that compromise workplace relations.

5. At service provision level, migrant nurses with perceived lack of fulfilment in terms of career goals may require specific 'bespoke' support mechanisms.

6. Community support is important for successful integration into a new culture, and this might benefit migrant nurses.

7. There is a mandatory legal framework to promote equality and diversity in the UK, and it is anticipated effective monitoring and implementation of policies by bodies such as the Care Quality Commission (CQC) will improve client care. This is particularly so in the private care home sector where many migrant Pakistani nurses begin their UK nursing experience.

8. From the perspective of migrant Pakistani nurses there is a need for them to understand the holistic nature of care provided to patients and clients in United Kingdom, an approach which differs from their largely technical role in Pakistan.

10.5.3. Nursing research

There is a strong need to conduct research in Pakistan on multiple issues at the forefront of nursing profession with a focus to promote awareness of these issues and bring change in the lives of nurses. In the United Kingdom research can explore how racism operates in the healthcare settings in 21st century and how can it be tackled.

1. The study highlights a need to understand and tackle multiple issues at the forefront of the nursing profession in Pakistan. These include public image and social status of nurses, horizontal oppression, discrimination and violence that nursing staff face from the management.

2. A great number of Pakistani nurses move to the Middle East to work and current research highlights the difficulties they experience. Future inquiry may explore the lived experience of nurses who migrate to Gulf countries.

3. Further research could, usefully, explore social, economic and psychological consequences of migration on immediate/extended families, communities, and their society.

4. In a global context, the concept of otherness proposed in this study is new in nurse migration literature, and future research could further explore how this relates to the experiences of other groups of migrant nurses.

10.6. Summary of the study

Pakistani educated nurses have a history of migration to foreign countries. Although there is a global literature on nurse migration, no single study has focused on the perspective of Pakistani nurses. An interpretive phenomenological design permitted exploration of the lived experience of Pakistani nurses regarding migration and post migration life in the United Kingdom. In-depth interviews were conducted with twenty one Pakistani nurses working and living in the UK. The majority of participants were working in care home settings. Three major themes derived from analysis; 'becoming a migrant', 'dissonance and devaluation' and 'outsider identities'. Study findings suggest that the phenomenon of otherness is central to the experience of participants. It is proposed that participants considered migration to result from feelings of social otherness, mainly attributed to social status in Pakistan. Once migrated, these nurses struggled to attain permanent settlement, and whilst doing so they experienced feelings of ethnic otherness. Most of these nurses now live in established Asian communities in the United Kingdom, and it is recommended that for long term settlement

community support is vital. The study findings have relevance for nursing in Pakistan and the UK.

10.7.   Reflection on the research process

This research started from personal journey and reflection on the migration of nurses. The research process, during the last four years, has contributed to my knowledge and skills as a qualitative researcher. Experiential learning enabled me to understand the pitfalls and challenges of conducting phenomenological social inquiry. As a nurse researcher, it is valuable to assimilate the philosophical concepts of humanistic research into the exploration of professional issues that understands individuals from a holistic perspective.

The research problem identified was personally relevant to me as a nurse as well as other nurses migrating from Pakistan to United Kingdom. There is hardly any research on the work and life experiences of nurses in Pakistan, or the challenges they face and their migratory intentions. Though ambitious to earn and reserve foreign exchange, this policy seems inconsistent with current nursing workforce planning as Pakistan faces an acute domestic shortfall.

Phenomenology was considered to be the most appropriate methodological design, keeping in mind the context of the research question, and specific focus on exploration of nurse experiences. The study primarily contributes to the theoretical knowledge base of the profession, but has important implications for nursing practice and research in Pakistan and the UK. From the outset, the supervisory team at the University encouraged me to focus on undertaking a rigorous inquiry that was congruent not only with academic nursing but relevant nationally and globally. It has been an honour to

be a part of such a prestigious and unique learning experience at the University of Liverpool.

For me, knowledge gained during these years is the beginning of a new journey towards developing my role as nurse researcher/educator, focusing on multiple issues at the forefront of the profession in a developing society. Pivotal to this position will be dissemination of scholarly work, and skills, among nursing students and colleagues; hopefully providing an academic foundation for practice-based curriculum development. A dearth of research in Pakistan on humanistic aspects of caring invites nurse leaders to embrace the concepts of qualitative and humanistic inquiry. This study represents the first step in that journey.

10.8. Conclusion

The study has given voice to a small group of Pakistani migrant nurses who lived through marginalisation in their native society, their profession, and their UK migration. It provides an original contribution to phenomenological understanding of the notion of otherness in nurse migration, and adds to literature exploring how this concept is politically, culturally and economically constructed.

The study is one of the first to report the lived experience of otherness in the migration of Pakistani nurses, and the impact socio-cultural and geo-political factors have on nurse migration. It proposes that the migratory experiences of nurses can be better understood through the phenomenon of 'otherness', and hoped that this contribution will open a new debate in the international nursing community. In the UK there is an abundance of literature on migrant nurse experience, mainly focused on racism, deskilling, and adaptation. This study provides a new perspective, for while otherness

is established in sociological discourse it is novel in nursing theory. As such this piece of work can, potentially, inform wider debate about global nurse migration in the 21st century.

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APPENDIXES

Appendix I: Broad evidence on nurse migration

Appendix 1: Broad evidence on nurse migration

Author	Date	Title	Publication
Nursing and Midwifery Council	2014	Registering as a nurse or midwife in the UK: For applicants trained outside the European Union and European Economic area	UK Nursing and Midwifery Council Guidelines.
Wheeler, R.M., Foster, J.W., Hepburn, K.W.	2014	The experience of discrimination by US and Internationally educated nurses in hospital practice in the USA: A qualitative study	Journal of Advanced Nursing, 70, 350-359.
Zhou, Y.	2014	The experience of china-educated nurses working in Australia: A symbolic interactionist perspective	PLoS ONE, 9, 1-10.
Pitman, P. Davis, C. Shaffer, F. Herrera, C, N. Bennett, C	2014	Perceptions of Employment- Based Discrimination Among Newly Arrived Foreign-Educated Nurses	American Journal of Nursing, 114, 26-36.
Kishi, Y.A , Inoue, K.B, Crookes, P.C Shorten, A.D	2014	A Model of Adaptation of Overseas Nurses: Exploring the Experiences of Japanese Nurses Working in Australia	Journal of Transcultural Nursing, 25, 183-191.
Harris, R., Ooms, A., Grant, R., Marshall-Lucette, S., Chu, C. S. F., Sayer, J. & Burke, L.	2013	Equality of employment opportunities for nurses at the point of qualification: An exploratory study	International Journal of Nursing Studies, 50, 303-313.
Piche, V. & Dutreuilh, C. T.	2013	Contemporary Migration Theories as Reflected in their Founding Texts	Population, English edition, 141.
Buchan, J. & Seccombe, I.	2012	Overstretched. Under-resourced. The UK nursing labour market review	Royal College of Nursing Report

Freeman, M., Baumann, A., Mlythe, J., Fisher, A. & Akhtar-Danesh, N.	2012	Migration: a concept analysis from a nursing perspective	Journal of Advanced Nursing 68(5):1176-86.
Kaelin, L.	2011	A Question of Justice: Assessing Nurse Migration from a Philosophical Perspective	Developing World Bioethics, 11, 30-39.
Jordan, G. & Brown, P.	2011	'20 days protected learning' - students' experiences of an Overseas Nurses Programme - 4 years on: A retrospective survey	BMC Nursing, 10: 7.
Jose, M. M.	2011	Lived experiences of internationally educated nurses in hospitals in the United States of America	International Nursing Review, 58, 123-129.
Masselink, l. E. & Lee, S. Y.	2010	Nurses, Inc.: expansion and commercialization of nursing education in the Philippines	Social Science & Medicine, 71, 166-172.
Yeates, N.	2010	Production for Export: The Role of the State in the Development and Operation of Global Care Chains	Population Space and Place, 15, 175-187.
Adhikari, R	2010	"The dream- trap": Brokering "Study Abroad" and nurse migration from Nepal to the UK".	European Bulletin of Himalayan Research, 122-138.
Deegan, J., Simkin, K	2010	Expert to novice: Experiences of professional adaptation reported by non-English speaking nurses in Australia	Australian Journal of Advanced Nursing, 27, 31-37.
Wellard, S. J. & Stockhausen, L. J.	2010	Overseas trained nurses working in regional and rural practice settings: do we understand the issues?	Rural & Remote Health. 10: 1458.
Kalra, V. S., Abel, P. & Esmail, A.	2009	Developing leadership interventions for black and minority ethnic staff: A case study of the National Health Service (NHS) in the UK	Journal of Health Organization & Management, 23, 103-118.

Oulton, J. & Hickey, B.	2009	Review of the nursing crisis in Bangladesh, India, Nepal and Pakistan. Barcelona Spain	Department for International Development (UNFPA) Report
Haour-knipe, M. & Davies, A.	2008	Return Migration of Nurses	International Centre on nurse Migration Report.
Graham, I. & Norman, L.	2008	A reflective discussion: Questions about globalization and multiculturalism in nursing as revealed during a student/staff exchange programme	International Journal of Nursing Practice, 14, 189-194.
Beechinor, L. A. V. & Fitzpatrick, J. J.	2008	Demands of immigration among nurses from Canada and the Philippines	International Journal of Nursing Practice, 14, 178-187.
American Nurses Association	2008	Fact Sheet Registered Nurses in the U.S. nursing workforce 1980-2008	American Nurses Association Report
Nursing and Midwifery Council	2008	Statistics about nurses and midwives	Nursing and Midwifery Council Report [Online]. Available: http://www.nmc-uk.org/About-us/Statistics/Statistics-about-nurses-and-midwives/ [A
Smith, J., Brunero, S., Bates, E.	2008	Expectations and experiences of recently recruited overseas qualified nurses in Australia	Contemporary nurse, 28, 101-110.
Pager, D. & Shepherd, H.	2008	The Sociology of Discrimination: Racial Discrimination in Employment, Housing, Credit, and Consumer Markets.	Annual Review of Sociology, 34, 181-209.
Carlton, K. H., Ryan, M., Ali, N. S. & Kelsey, B	2007	Integration of Global Health Concepts in Nursing Curricula: A National Study	Nursing Education Perspectives, 28, 124-129.
Khan, J. A.	2007	Migration of health personnel and its impact on health systems in developing countries	Journal Of Ayub Medical College, Abbottabad, 19, 1-2.

Bach, S.	2007	Going global? The regulation of nurse migration in the UK	British Journal of Industrial Relations, 45, 383-403.
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Pittman, p., Aiken, L. H. & Buchan, J.	2007	International migration of nurses: introduction	Health Services Research, 42, 1275-1280.
Aiken, L. H.	2007	US nurse labour market dynamics are key to global nurse sufficiency.	Health Services Research, 42, 1299-1320.
International Council of Nurses	2007	Position Statement Ethical Nurse Recruitment. Geneva Switzerland	International Council of Nurses.
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Solano, D. & Rafferty, A. M	2007	Can lessons be learned from history? The origins of the British imperial nurse labour market: A discussion paper.	International Journal of Nursing Studies, 44, 1055-1063.
Khadria, B.	2007	International nurse recruitment in India.	Health Services Research, 42, 1429-1436.
Anderson, B. A. & Isaacs, A. A	2007	Simply Not There: The Impact of International Migration of Nurses and Midwives-Perspectives from Guyana.	Journal of Midwifery and Women's Health, 52, 392-397.
Ball, J. & Pike, G.	2007	Black and minority ethnic and internationally recruited nurses: Results from RCN Employment working Well Surveys 2005 and 2002.	London: Royal College of Nursing. Available: http://www.rcn.org.uk/__data/assets/pdf_file/0006/78729/003104.pdf [Accessed March 05 2012].
Baumann, A., Blythe, J., Mcintosh, K. & Rheaume, A.	2006	Internationally Educated Nurses in Ontario: Maximizing the Brain Gain	Nursing Health Services Research Unit Report.

Winkleman-Gleed, A.	2006	Migrant Nurses, Motivations Integration and Contribution.	Book Oxford, Radcliffe.
Percot, M.	2006	Indian Nurses in the Gulf: Two Generations of Female Migration	South Asia Research, 26, 41-62.
International Council of Nurses	2006	The Global Nursing Shortage: Priority Areas for Intervention. Geneva Switzerland:	International Council of Nurses Report
World-Health-Organization	2006	Health Workers: a global profile	WHO report Available: http://www.who.int/whr/2006/06_chap1_en.pdf [Accessed March 02 2012]
Campbell, M. L.	2006	Nurses in international health care: migrants or commodities?	Health (London). 10, 361-7.
Oulton, J. A.	2006	The global nursing shortage: An overview of issues and actions.	Policy, Politics, and Nursing Practice, 7, 34S-39S.
Winklemann-Gleed, A	2005	Migrant Nurses, Motivations Integration and Contribution, Oxford, Radcliffe	Multicultural Nursing. 1, 4, 28-32.
Sparacio, D. C.	2005	Winged migration: international nurse recruitment -- friend or foe to the nursing crisis	Journal of Nursing Law, 10, 97-114.
Parish, C. & Pickergill, F	2005	Home Office considers special visa to support overseas nurses	Nursing Standard, 19, 12.
Buchan, J., Jobunpatra, R., Gough, P. & Hutt, R.	2005	Internationally recruited nurses in London profile and implications for policy	Kings Funds Working paper. Available: http://www.kingsfund.org.uk/sites/files/kf/field/field _publication_file/internationally-recruited-nurses-london-profile-implications-policy-working-paper-jim-buchan-kings-fund-22-september-2005.pdf [Accessed Feb 12 2012.
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			uk.org/Documents/Circulars/2005circulars/NMC%20circular%2009_2005.pdf [Accessed October 30 2014].
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Ball, J. & Pike, G.	2005	At breaking point? A survey of the wellbeing and working lives of nurses in 2005.	London: Royal college of Nursing. Available: http://www.rcn.org.uk/__data/assets/pdf_file/0003/78690/003021.pdf [Accessed April 4 2012].
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Gerrish, K. & Griffith, V.	2004	Integration of overseas Registered Nurses: evaluation of an adaptation programme	Journal of Advanced Nursing, 45, 579-587.
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Gandhi, S. & French, B	2004	Sharing what works: Adaptation programmes for overseas recruits	Nurse Education in Practice, 4, 114-119.
Dicicco-Bloom, B.	2004	The racial and gendered experiences of immigrant nurses from Kerala, India	Journal of Transcultural Nursing, 15, 26-33.
KLINE, D. S.	2003	Push and pull factors in international nurse migration	Journal of Nursing Scholarship, 35, 107-111.
Harisson, S.	2003	White nurses dominate shortlists for senior ranks.	Nursing Standard, 17, 6-6.
Allen, H. & Larsen, J	2003	'We need respect' Experiences of internationally recruited nurses in the UK: an RCN survey	Nursing Standard, 17, 14-16.
Kingma, M	2001	Nursing migration: Global treasure hunt or disaster-in-the-making?	Nursing Inquiry, 8, 205-212.
Daniel, P., Chamberlain, A. & Gordon, F	2001	Expectations and experiences of newly recruited Filipino nurses	British Journal of nursing 10, 254-256, 258.
Kingma, M.	1999	Discrimination in nursing	International Nursing Review, 46, 87-90.
Hurrel, A. & Woods, N	1995	Globalization and inequality	Millennium-Journal of International Studies, 24, 447.
United Nations	1948	Universal Declaration of Human Rights.	United Nations, 1948.

Appendix II: Studies on migration motives of nurses

Appendix 2: Studies on migration motives of nurses

Author(s)	Date	Title	Journal	Study design	Participants	Key findings
B. Salami, S. Nelson, L.Hawthorne, C. Muntaner, L. McGillis Hall	2014	Motivations of nurses who migrate to Canada as domestic workers	International Nursing Review	Qualitative case study design Individual interviews	15 Pilipino female nurses	Prime motivation to migrate is economic, however once this is achieved, nurses consider migration for citizenship and permanent settlement
G. Likupe	2013	The skills and brain drain what nurses say	Journal of Clinical Nursing	Qualitative design Focus groups and personal interviews	30 nurses from Sub-Saharan Africa	Poor remuneration, lack of professional development in the home countries, poor health care and systems, language and education similarities and easy availability of jobs and visas.
M.A. Freeman, A.B. Baumann, N, Akhtar-Danesh, J.D. Blythe, A.D. Fisher	2012	Employment goals, expectations, and migration intentions of nursing graduates in a Canadian border city: A mixed methods study	International Journal of Nursing Studies	Mixed Methods	Survey participants baccalaureate nursing students (N = 281) Interviews (N=37)	Two thirds of participants considered migration. They however preferred to work at home city but were feeling pushed to migrate to another Canadian city or across borders
T. Hendel I. Kagan	2011	Professional image and intention to emigrate among Israeli nurses and nursing students	Nurse Education Today	Cross sectional study design	132 Israeli nurses and Nursing students	Higher salary Better quality of life To join spouse in another country

F. El-Jardali, M.Alameddine, N. Dumit, H. Dimassi, D. Jamal, S. Maalouf	2011	Nurses' work environment and intent to leave in Lebanese hospitals: Implications for policy and practice	International Journal of Nursing Studies	cross-sectional survey design	1793 registered nurses in 69 Lebanese hospitals	lack of control and autonomy; concern over aspects of physical, psychological and professional work environments; need for professional development; salaries and benefits; role, achievements and shortcomings of national organizations; poor image of the nursing profession
A. Palese, E. C. Mesaglio E. Tempovscaia	2010	Italian–Moldovan international nurse migration: rendering visible the loss of human capital	International Nursing Review	Longitudinal study design.	110 participants	Participants considered migration because they had been contacted by a recruitment agency that offered work in Italy. They had decided to reach their family in Italy. They already knew the Italian language. They had experience in this country
A. I. Grigulis, A Prost, D Osrin	2009	The lives of Malawian nurses: the stories behind the statistics	Transactions of the Royal Society of Tropical Medicine and Hygiene	Qualitative biographical method	40 Malawian born nurses 20 in UK and 20 in Malawi	Economic reasons, pressure from family to earn money are the main motives behind participants migration

L. McGillis Hall G.H. Pink, C.B. Jones P. Leatt M. Gates J. Peterson6	2009	Is the grass any greener? Canada to United States of America nurse migration	International Nursing Review	Retrospective Exploratory research design	1996, 2000 and 2004 USA National Sample Survey of Registered Nurses	Fulltime job opportunities in America will be available to these nurses and currently they were part-time employed
Á. Alonso-Garbayo, J. Maben	2009	Internationally recruited nurses from India and the Philippines in the United Kingdom: the decision to emigrate	Human Resources for Health	Qualitative Interpretive approach Case Study	Internationally recruited nurses Philippines=15 India=6	Economic motives are the main reasons for migration. Professional Social issues Permanent settlement
M. Beaton, J. Walsh	2009	Overseas recruitment: experiences of nurses immigrating to Newfoundland and Labrador, 1949–2004	Nursing Inquiry	Oral history study	41 nurses	Personal reasons such as Holiday strategy
S. Brunero, J. Smith, E. Bates	2008	Expectations and experiences of recently recruited overseas qualified nurses in Australia	Contemporary Nurse	Descriptive Survey	56 nurses	Professional growth opportunities are the driver for nurse migration beside other motives

Author	Year	Title	Journal	Design	Sample	Findings
F. El-Jardali, N. Dumit, D. Jamal, G Mouro	2008	Migration of Lebanese nurses: A questionnaire survey and secondary data analysis	International Journal of Nursing Studies	Cross-sectional research design	106 migrant nurses	Financial reasons Professional reasons Other reasons.
I. Aboderin	2007	Contexts, motives and experiences of Nigerian overseas nurses: understanding links to globalization	Journal of Clinical Nursing	Qualitative Study design	25 RGNs working in UK nursing home And 7 returnee nurses in Nigeria	Nurses migrate because of a deterioration in working condition in home country primarily for economic reasons
M.E. Perrin A. Hagopian A. Sales B. Huang	2007	Nurse migration and its implications for Philippine hospitals	International Nursing Review	Self-administered survey	87 hospital chief nurses	Economic and professional motives are the main drivers for nurse migration.
P H Troy, L A Wyness, E McAuliffe	2007	Nurses' experiences of recruitment and migration from developing countries: a phenomenological approach	Human Resources for Health	Heideggerian Phenomenological approach Semi structured interviews	12 directors of nursing from Dublin, South African and Philippines And 10 overseas nurses	Main reasons to join nursing was that it offered opportunities abroad. Family factors
S. J. Ross D. Polsky J. Sochalski	2005	Nursing shortages and international nurse migration	International Nursing Review	Quantitative regression analysis	98 source countries	Economic growth is the main reasons developing countries adopt to encourage migration

P. Thomas	2006	The international migration of Indian nurses	International Nursing Review	Questionnaire	448 nurse practitioners, nurse educators and nurse administrators	Bad working conditions Professional status Social and economic conditions Equal citizenship rights Hard work Job security
J. Buchan, R. Jobanputra P. Gough, R Hutt	2006	Internationally recruited nurses in London: a survey of career paths and plans	Human Resources for Health	Postal Survey	380 respondents (from more than 30 countries)	Personal reasons Financial reasons Social reasons
A. Chikanda	2006	Skilled Health Professionals' Migration and its Impact on Health Delivery in Zimbabwe	Journal of Ethnic and Migration Studies	Questionnaire survey (face to face interview)	231 respondents	Economic like better remuneration For better living conditions Deteriorating public services Political violence Better future of children
A. Palese, M. Barba, G. B Maura, M S Brusaferro	2007	Competence of Romanian nurses after their first six months in Italy: a descriptive study	Journal of Clinical Nursing	Descriptive study	17 Romanian nurses	Economic reasons Work opportunity

J. A. Larsen, H. T. Allan, K. Bryan, P. Smith	2005	Overseas nurses' motivations for working in the UK: globalization and life politics	Work, employment and society	qualitative and explorative research design Focus group interviews	11 focus groups with 67 participants	Nurses' motivations contrasted their experience. Prime motivation to migrate is economic; however nurses may not reveal them as economic migrants
A de Veer, D Ouden A. Francke	2004	Experiences of foreign European nurses in the Netherlands	Health Policy	Questionnaire survey	987 respondents	Personal reasons including marriage Challenge of working abroad Professional reasons
A. Mejia	2004	Migration of nurses and Physicians a worldwide picture	International Journal of Epidemiology	Library search	137 countries	Main reasons for migration are economic. Other reasons are secondary to economic.

Appendix III: Studies on experiences of overseas nurses in the United Kingdom

Appendix 3: Studies on experiences of nurses in the United Kingdom

Author(s)	Date	Title	Journal	Study design	Participants	Key findings
R. Adhikari, K.M. Melia.	2013	The (mis)management of migrant nurses in the UK: a sociological study	Journal of Nursing Management	Ethnographic research	21 Nepalese Nurses	A process of devaluation and deskilling is experienced by overseas Nepalese nurses working in the UK. Migrant Nepalese nurses with many years of work experience in Nepal are trapped working in rural and remote nursing care homes in the UK.
G, Likupe, U. Archibong	2013	Black African nurses' experiences of equality, racism, and discrimination in the National Health Service	Journal of Psychological Issues in Organizational Culture	Qualitative study Semi structured interviews	30 migrant Nurses from Sub Saharan countries	Black African nurses experience discrimination and racism from White nurses, other international nurses, managers and patients. As compared to other international nurses Black African nurses experience more racism than their counterparts.
O. Alexis.	2013	Internationally educated nurses' experiences in a hospital in England: An exploratory study	Scandinavian Journal of Caring Sciences	Phenomenology	12 overseas Nurses	Six themes described are: Leaving a familiar world, Being thrown into an unfamiliar world, Encountering marginalization and experiencing inequalities in the world, Surviving in an everyday world
O.A. Alexis, A.B. Shillingford	2012	Exploring the perceptions and work experiences of internationally recruited neonatal nurses: A qualitative study	Journal of Clinical Nursing	Husserl's phenomenological approach	13 female Nurses	Support mechanisms, unfamiliarity with family centered care, feelings of being treated like a child (feelings of patronage) and coping strategies.

T O'Brien S. Ackroydb	2012	Understanding the recruitment and retention of overseas nurses: realist case study research in National Health Service Hospitals in the UK	Nursing Inquiry	Comparative Case Study approach	Seven cohorts of overseas Nurses India (3 cohorts), Philippines (2 cohorts), Spain (2 cohorts)	Every day racism hinders successful assimilation of overseas nurses into UK Nurses continue to work despite inhumane and unfavorable treatment due to strong economic motives
H. Allan.	2010	Mentoring overseas nurses: Barriers to effective and non-discriminatory mentoring practices	Nursing Ethics	Qualitative study	Interviews with 93 overseas Nurses 24 national nurses and 13 managers	Overseas nurses are discriminated against by poor mentoring practices Mentors are not adequately prepared to supervise overseas nurses from diverse backgrounds. Further trainings for mentors are recommended.
M. Okougha, M. Tilki	2010	Experience of overseas nurses: the potential for misunderstanding	British Journal of Nursing	Grounded theory approach	13 Ghanaian and Pilipino Nurses	Communication difficulties with patient and other colleagues, different way of care and the challenge of meeting the expectations of families
A.I. Grigulis, A. Prost, D. Osrin,.	2010	The lives of Malawian nurses: the stories behind the statistics	Transactions of the Royal Society of Tropical Medicine and Hygiene	Qualitative biographic method	40 Malawian-born Nurses	Nurses experience significant difficulties, in particular with communication, non-recognition of qualifications, and pressure from families to send money back home.

H. Allan, H. Cowie., P. Smith.	2009	Overseas nurses' experiences of discrimination: A case of racist bullying	Journal of Nursing Management	Qualitative study	2 overseas Nurses	racist bullying in the workplace: abusive power relationships, communication difficulties, emotional reactions to racist bullying and responses to bullying
O. Alexis, V.B. Vydelingum,	2009	Experiences in the UK National Health Service: The overseas nurses' workforce	Health Policy	Survey design	188 questionnaire	Lack of equal opportunities experiences. Differences in equal opportunities among minority ethnic and black nurses. More negative experiences
O. Alexis,	2009	Overseas trained nurses' perception of UK nurses' caring attitudes: A qualitative study	International Journal of Nursing Practice	Phenomenological study	12 overseas nurses	empathy, understanding and caring perspectives, emotional impact and lack of teamwork
O. Alexis, V. Vydelingum, I. Robbins	2007	Engaging with a new reality: Experiences of overseas minority ethnic nurses in the NHS	Journal of Clinical Nursing	Phenomenological study	24 nurses 6 focus groups discussions	Devaluation is central to the overseas nurses experience
I. Aboderin	2007	Contexts, motives and experiences of Nigerian overseas nurses: Understanding links to globalization	Journal of Clinical Nursing	Exploratory qualitative study	25 Nigerian trained nurses and 7 tutors	Migration in mainly for financial reasons Once migrated nurses found a loss in professional and social status in UK
T. O'Brien,	2007	Overseas nurses in the National Health Service: A process of deskilling	Journal of Clinical Nursing	Case study design	63 semi-structured interviews	Overseas nurses found themselves unable to practice their clinical skills in the UK

J.A. Larsen.	2007	Embodiment of discrimination and overseas nurses' career progression	Journal of Clinical Nursing	Phenomenological analysis	2 individual in-depth interviews	Institutionalized and socialized racism in health care settings. May be internalized by nurses and may impact their career progression
L Henry	2007	Institutionalized disadvantage: older Ghanaian nurses' and midwives' reflections on career progression and stagnation in the NHS	Journal of Clinical Nursing	Qualitative study	Interviews with 20 Ghanaian nurses	Ghanaian nurses may experience difficulty in career progression in UK and this may be due to the institutional hierarchies and practices in the ward
O. Alexis, V. Vydelingum,	2007	Migrating registered nurses in the UK: Black and minority ethnic overseas nurses' perspectives	International Journal of Health Care Quality Assurance	Phenomenology	12 face to face interviews with overseas nurses	building ties, reflecting on experience, moving on, reduced confidence and lack of support
O. Alexis, V. Vydelingum,, I. Robbins.	2006	Overseas nurses' experiences of equal opportunities in the NHS in England	Journal of Health, Organization and Management	Qualitative Study	12 semi structured interviews	Lack of equal opportunities in career progression and skill developments
M. Parry, A. Lipp	2006	Implementation of an adaptation programme for Filipino nurses in a UK adult cancer hospice	International Journal of Palliative Nursing	Descriptive Questionnaire	15 overseas Pilipino nurses	The programme was designed to train overseas Pilipino nurses into a UK hospital into palliative care. The progarmme was successfully implemented and all the nurses completed the progarmme in time. Nurses appreciated the programme designed for their adaptation.

A. Winklemann-Gleed, J Seeley	2005	Strangers in a British World Integration of international nurses.	British Journal of Nursing	Questionnaire and interviews	140 questionnaires 22 interviews	Perception of migration and migrants Integration to British culture and careers advancement of migrant nurses
O. Alexis. V.Vydelingum,	2005	The experiences of overseas black and minority ethnic registered nurses in an English hospital	Journal of Research in Nursing	Phenomenology	12 nurses	feeling appreciated, feeling inadequate, feeling unwelcome, lack of opportunities for skill development and training, unfairness in nursing practice, performance review, support from overseas black and minority ethnic colleagues and proving self
J A Larsen, H T.Allan, K Bryan, P Smith	2005	Overseas nurses' motivations for working in the UK: globalization and life politics	Work, employment and society	Qualitative Research design	11 focus groups with 67 participants	Nurses' motivations contrasted their experience. Prime motivation to migrate is economic; however nurses may not reveal them as economic migrants.
H.T. Allan, J.A. Larsen, K Bryan, P Smith	2004	The social reproduction of institutional racism: internationally recruited nurses' experiences of the British health services	Diversity in Health and Social Care,	Qualitative research design	11 focus groups with 67 participants	Racism and institutional l racism is manifested through interpersonal and structured relationships
S. Smith,	2004	Understanding the experience of training for overseas nurses	Nursing Times	Qualitative research design	20 overseas nurses	Communication issues, culture and role adjustment and achievement of competence

K Gerrish V. Griffith	2004	Integration of overseas Registered Nurses: evaluation of an adaptation programme	Nursing and Health Care Management and Policy	Qualitative focus groups and interviews	17 overseas nurses and managers	gaining professional registration; fitness for practice; reducing the nurse vacancy factor; equality of opportunity and promoting an organizational culture that values diversity
J Withers J Snowball	2003	Adapting to a new culture: A study of the expectations and experiences of Filipino	Nursing Times Research	Questionnaire and interviews	45 questionnaires and eight interviews	High expectations of these nurses in salaries were not realized. Some experience discrimination
I. Hardill, S. MacDonald,	2000	Skilled international migration: The experience of nurses in the UK	Regional Studies	Qualitative research design	In-depth interviews with 16 overseas nurse	Economic and non-economic motives of migration A downward mobility is observed in the career paths of overseas nurses

Appendix IV: Letter of Approval from University Ethics Committee

UNIVERSITY OF
LIVERPOOL

Institute of Psychology, Health and Society

Waterhouse Building, 2ⁿᵈ Floor Block B
1-5 Brownlow Street
Liverpool
L69 3GL

T 0151 794 55327
F 0151 794 5537
E halina@liverpool.ac.uk

To: Maria Flynn
Thomson Yates Building

Date: 17 May 2012

Dear Maria

I am pleased to inform you that the Institute of Psychology, Health and Society Research Ethics
Committee (REC) has approved your application for ethical approval. Details and conditions of the
approval can be found below;

Applicant Name : Dildar Muhammad
Ref. No : IPHS-1112-024
Supervisor : Maria Flynn
Title : Understanding the experiences of Pakistani educated nurses working in the United Kingdom:
A phenomenological approach
Date of email Approval : 17 May 2012

The application was APPROVED subject to the following conditions:

Conditions

1. **Mandatory :** all serious adverse events must be reported to the Institute REC within 24 hours
   of their occurrence, via Halina Dawson, IPHS Ethics Secretary (halina@liv.ac.uk) and the
   Research Governance Officer (ethics@liv.ac.uk).

This approval applies for the duration of the research. If it is proposed to extend the duration of the
study as specified in the application form, the Institute REC should be notified. If it is proposed to
make any amendment to the research, you should notify the Institute REC by following the
procedure found on the ethics webpages at the following link;
http://www.liv.ac.uk/researchethics/localpolicy.htm

Yours sincerely

Bill Sellwood .

Dr W Sellwood
Chair of PHS Institute Research Ethics Committee

A member of the
Russell Group

Appendix V: Participant invitation letter

UNIVERSITY OF LIVERPOOL

Participant Invitation Letter

Date_____

Dear_____

Title of study: 'Understanding the experiences of Pakistani educated nurses working in the United Kingdom: A phenomenological approach'

I am a post graduate research student at the University of Liverpool, UK, studying for a PhD in the School of Health Sciences. As part of my degree I have to collect data, and need volunteers to agree to take part in interviews.

I am hoping to interview Pakistani educated nurses who have been working in the United Kingdom. I would like you to consider being a participant in my study. I am happy to answer any questions regarding the study prior to you making a decision

Please read the attached information sheet carefully before you decide whether or not you are interested in participating.

If you would like to participate please complete the enclosed reply slip and return it to me on following address. I will then contact you to arrange an interview. At this stage, I will be happy to answer any questions regarding the study to help you make an informed decision.

If you have any questions beforehand then you can contact me at the following address.

 Thank you for taking the time to read this letter.

Yours sincerely

Dildar Muhammad
Doctoral research student
School of Health Sciences
University of Liverpool
United Kingdom.
Ph: 015179 45138
Email: dildar@livpool.ac.uk

Appendix VI: Participant Information Sheet

UNIVERSITY OF
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Participant Information Sheet

Title of Study: 'Understanding the experiences of Pakistani educated nurses working in the United Kingdom: A phenomenological approach'

You are being invited to take part in a research study. Before you decide whether or not to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

The purpose of the study

The study is designed to explore the experiences of Pakistani educated nurses working and living in the United Kingdom. Although there have been studies in the UK and other countries on international nurses from different countries no study has specifically addressed the experiences of Pakistani educated nurses. It is hoped that this study will unfold real life experiences of Pakistani educated nurses in the UK that will have implications for nursing practice, education and management.

This study is a full time project and will be completed in 2014. However the part that you are being asked to be involved in, the data collection phase, will last for five to six months. In total I will be talking to up to 30 Pakistani educated nurses practicing in the United Kingdom.

Consenting to take part

It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form. You will also be given a signed copy of the consent form to keep. If you decide to take part you are still free to withdraw at any time, and a decision not take part will not affect you in any way.

What the study will involve

The study is based on a one to one interview with the researcher. You will be asked to take part in an interview. It is anticipated that the interview will last between one and one and half hours. The interview will be recorded with a digital audio recorder and later transcribed and coded by the researcher. During the interview the researcher may also take field notes in a diary, this is to aid the analysis of the data when the study is being written up. At all times strict guidelines and procedures will be adhered to so that your identity and anything that you say will be kept confidential.

The benefits of taking part

There will be no direct benefits to you, but this information may help us to have a better understanding of the experiences of Pakistani educated nurses working in the United Kingdom.

Disadvantages of taking part

There is no disadvantage of taking part in this study; the only disadvantage is that your time will be consumed in taking part in interview.

Maintaining confidentiality

If you consent to take part in this study all of the information you give will be kept strictly confidential. Any information which will be used will have your name and address removed so that you cannot be recognized from it.

The Results of the study

This research is being undertaken to meet the requirement of a PhD programme registered in the Faculty of Health and Life Sciences, at University of Liverpool. When all the information is collected and analysed, the findings will be written up as thesis. A copy of this document will be placed in the Library at University of Liverpool. This piece of work is due for completion in 2014.

As part of the process of sharing new knowledge in the scientific and professional communities a series of shorter articles, based upon the study findings will be submitted to scholarly journals for peer review and publication. Similarly the information will form the basis for research conference presentations.

It is important to note that you will not be identified, or identifiable, in any report, publication or presentation derived from the findings of this study.

Complaints

If you have any complaints about any aspect of this study, please feel free to contact the primary supervisor Dr Maria Flynn (Tel: 0151-794-5775) or by email (m.flynn@liverpool.ac.uk). If you are still unhappy you may directly contact the research ethics committee (ethics@liv.ac.uk) where every effort will be taken to deal your complaint properly.

Review of this study

For approval to undertake this study, the research proposal and all appropriate documentation have been submitted to University of Liverpool ethics committee in accordance to guidelines at University of Liverpool ethics review committee.

If you require further information please contact the researcher at following address:

Dildar Muhammad
PhD student
School of Health Sciences
University of Liverpool
United Kingdom.Ph: 015179 45138 Email:
dildar@liverpool.ac.uk

Appendix VII: Participant reply slip

<u>Reply slip</u>

Title of study: 'Understanding the experiences of Pakistani educated nurses working in the United Kingdom: A phenomenological approach'

If you have read the enclosed participant invitation letter and would be willing to take part in an interview, please provide details of how I may contact you and when this will be most convenient.

Your contact details	
Name	
Telephone number	

Preferred place of contact	
Home	
Work	
Mobile	
Other	

Please tick the most convenient day(s) of the week for us to contact you							
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Any day

Please tick the most convenient time of the day for interview.					
Morning 9-12am	Afternoon 12-4pm	Early evening 5-7pm	Late evening 7-10pm	Any time of day	Any other time (please specify)

Dildar Muhammad

PhD Student

School of Health Sciences

Whelan building

University of Liverpool L69 3GB

Ph (office): 0151 794 5138

Email: dildar@liverpool.ac.uk

Appendix VIII: Consent Form

UNIVERSITY OF
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Consent form

Title of study: 'Understanding the experiences of Pakistani educated nurses working in the United Kingdom: A phenomenological approach'

Researchers: Dildar Muhammad, Dr Maria Flynn, Dr Dave Mercer
Please initial the box:

1. I confirm that I have read and have understood the information sheet dated _____ for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw   at any time without giving any reason, without my rights being affected.

3. I understand that, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish.

4. I agree to take part in the above study.

_____   _____   _____
Participant's Name   Date   Signature

_____   _____   _____
Researcher   Date   Signature

The contact details of lead Researcher (Principal Investigator) are:

Dildar Muhammad
Doctoral research student
School of Health Sciences
University of Liverpool
Ph No: 015179 45138
Email: dildar@livpool.ac.uk

Appendix IX: Demographic Data Sheet

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Demographic Information Sheet

Title of study: 'Understanding the experiences of Pakistani educated nurses working in the United Kingdom: A phenomenological approach'

Instructions: Please provide a response for each of the following questions:

What is your age: _____

What is your sex?   Male ☐   Female ☐

What is your marital status? Married ☐ Unmarried ☐   Separated ☐ Divorced ☐
Widowed   ☐

What is your ethnicity? Punjabi ☐ Pathan ☐   Baloch ☐ Sindhi ☐ Muhajir ☐
Other ☐ (please mention)_____

What was your academic qualification in Pakistan?_____

What was your professional qualification in Pakistan?_____

Experience in Pakistan (in years and months)_____

Where are you working? NHS hospital ☐   Nursing home   ☐   Other_____

Did you get any qualification in the UK? (Please mention)_____

Experience in the UK (in years and months)_____

What is your current work designation? _____

Work experience in any other country_____

Appendix X: Interview Topic Guide

INTERVIEW TOPIC GUIDE

Experience of being a Pakistani educated nurse working in the UK and what it means

- Please tell me your experience of being a Pakistani educated nurse working in the UK, What does it mean to you? Please describe in as much detail as possible?

- Can you tell me about your motivation for migration as a nurse to the UK?

- Can you tell me about your adjustment/adaptation to a new culture?

- Can you tell me about your work and workplace experiences in the UK?

- Could you tell me about challenges/ stressors that you might have faced and coping strategies /support system?