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Health Worker Migration in Canada:

Histories, Geographies, and Ethics

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HEALTH WORKER MIGRATION IN CANADA: HISTORIES, GEOGRAPHIES, AND ETHICS

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ABSTRACT

This working paper explores issues of health worker migration through examining the history, geography, and ethics of international recruitment and migration of health workers to Canada, focusing on the experiences of registered nurses from the Philippines. During the past few decades the migration of Filipino nurses to Canada has considerably expanded, with nurses from the Philippines making up the largest group of all immigrant nurses in the Canadian workforce. Derived from presentations, discussions, and insights from an interdisciplinary workshop on health worker migration attended by academics, professionals, policymakers and health workers, we underscore the importance of further debate on the issues confronting recent migrant nurses from the Philippines to Canada. The aim of this working paper is to bring the complexity of the experiences of migrating nurses in health care explored during the workshop through various lenses of transnational historical research and biographical reflection, contextual and local geographical studies, evolving ethical norms and policies guidelines around recruitment, national and internationally, to a wider audience. We call for more in-depth academic research engaging the perspectives of policymakers and health professionals and of migrant nurses affected by their decisions. Furthermore, we bring forward recommendations and insights raised during the workshop.

INTRODUCTION

During a recent workshop on health worker migration in Canada¹, a number of issues were brought forward that warrant further discussion and exploration. Although international migration issues among several health professions were discussed, including those of physicians and physical therapists, the most prominent theme addressed was the rapidly increasing number of migrating Filipino Registered Nurses (RNs) to Canada. The workshop was designed with the view to bring together an interdisciplinary audience of students, professionals, policymakers, and academics to discuss issues of health worker migration. A number of thoughtful considerations were made during the workshop, prompting the co-authors to come together to articulate some of the key issues that figured in the discussions in order to stimulate further debate and inform policy making.² Several historical, geographical, and ethical issues raised are worthy of further reflection. In sharing them, we aim to advance the understanding of the complex context of health worker immigration among the broader community of professionals, policymakers, and academics. After providing a brief introduction to Filipino nurse migration to Canada, we will subsequently address historical, geographical, and ethical issues and findings, and share some key points for further reflection.

1 The workshop *Health Worker Migration in Canada: Histories, Geographies, Ethics*, was held at the University of British Columbia (UBC), September 30, 2010. We gratefully acknowledge the funding and support from Metropolis BC (major sponsor) as well as Health Match BC, MITACS Accelerate BC, St. John's College UBC, UBC Department of Geography, UBC School of Nursing, the Critical Research in Health and Health Care Inequities Unit, the Migration Studies Group and the Liu Scholar Program at the Liu Institute for Global Issues, the UBC Centre for Women and Gender Studies, and the Doctoral Scholarship Program of the Trudeau Foundation.

2 Co-author Catherine Ceniza Choy, author of the acclaimed book *Empire of Care: Nursing and Migration in Filipino American history*, published in 2003, delivered the keynote lecture at the workshop. Co-authors Geertje Boschma, nurse historian, and Mark Lawrence Santiago, PhD candidate and Trudeau scholar on Filipino nurse migration in Canada, organized the workshop. Co-author Charlene Ronquillo contributed to the presentations and discussions, focusing on the history of Filipino nurse immigration in her studies.

FILIPINO NURSE MIGRATION TO CANADA

During the past few decades the migration of Filipino nurses to Canada has expanded considerably, with nurses from the Philippines making up the largest group of all immigrant nurses in the Canadian workforce at about 27 per cent (Baumann et al. 2004). After the establishment of public health insurance in the 1950s and 1960s, attracting internationally educated nurses emerged as one strategy to meet the demand for qualified health personnel resulting from the rapid expansion of Canadian hospitals. The federal government of Canada approved of a new public health insurance arrangement with the provinces, passing the Hospital and Diagnostic Services Act, which came into effect in 1957, and the Canadian Medical Services Act, which was implemented in 1968 (Ostry 2009). As the demand for health services grew, staffing an expanding services system with qualified personnel was an ongoing struggle, and attracting international health workers was one of the strategies pursued as a solution (Mullally and Wright 2008).

These developments were not unique to Canada. The Philippines became the lead supplier country of nurses worldwide (Blythe and Baumann 2009) and has been identified as the largest source of Registered Nurses (RNs) working overseas (Aiken et al. 2004; Back 2003). Significantly, RNs comprise over a third of all migrant deployment in the Philippines (Burgess and Haksar 2005). Stemming from a relationship rooted in colonialism, the Philippines has a long history as a sending nation of nurses to the United States (Choy 2003). After colonizing the Philippines in 1898, the U.S. colonial government established nursing schools in the archipelago that followed a U.S. professional nursing curriculum. The U.S. colonial context created a Filipino labour force with the skills, professional credentials, and English-language ability necessary to work

in hospitals and other health care institutions in the United States during the second half of the twentieth century (Choy 2003). In recent decades, popular destinations for Filipino nurses have expanded to include Canada, the United Kingdom, and many Middle Eastern Countries (Brush and Sochalski 2007; Buchan et al. 2006; Dumont 2008; Emerson et al. 2008; Kline 2003). Many Filipino nurses no longer follow linear migration trajectories from one country to another. Their travel is interspersed with temporary work and contracts that are largely determined by temporal changes in destination countries' migration policies, recruitment practices, demand for nurses, and availability of immigration opportunities (Guevarra 2010; Ronquillo et al. 2011).

In Canada, demand for nurses from other countries, now more commonly referred to as "internationally educated nurses" (IEN's), a term which we also use in the remainder of this paper, has not diminished despite changing funding arrangements and new immigration policies. In addition to Filipino nurses migrating to Canada on their own, Canadian provincial health authorities have actively recruited nurses from the Philippines recently, and most notably, to Saskatchewan, Manitoba, and Alberta, following guidelines set in the Memoranda of Agreement between the three provinces and the Philippine government (Saskatchewan 2008). In British Columbia, while there is a pre-existing Memorandum of Agreement between the province and the government of the Philippines regarding the migration of workers, there have not been any specific recruitment drives, although some nurses with initial education and training in the Philippines are recruited through 'third countries' such as the United States and the United Kingdom.

While the migration of Filipino nurses has often been explained from an economic perspective, emphasizing the push and pull factors shaping nurses' motivations to migrate (Kline 2003), for example cultural, historical, geograph-

ical, and ethical influences are also central to the explanation of Filipino nurse migration. By 'zooming in' more closely on the experiences and motivations of immigrant Filipino nurses, we can discover broader cultural and societal influences shaping Filipino nurses' decisions not only to become nurses, but also to migrate. Motivations beyond strictly economic incentives have been cited and include, first and foremost, the overarching influence of the culture of migration in the Philippines – a culture that blossomed from a long history of foreign presence. (Abella 1993; Choy 2003; Martin 1993; Ronquillo et al. 2011; Sills 2007; Tan 2001). In a recent oral history study of Filipino migrant nurses in Alberta (AB) and British Columbia (BC), Ronquillo et al. found that this deeply ingrained culture sees immigration as an "obvious" goal for the majority of Filipino citizens, with factors such as familial, cultural, and societal pressures as additional powerful motivators for pursuing immigration. Moreover, the particular Filipino context of professional nurse education, which is closely linked to the Philippines' historical colonial relationship with the United States, underemployment, and racialization also shape individual experiences.

Several studies in the US and Canada using historical, qualitative, and survey approaches have begun to include the voices of Filipino nurses in order to gain a more in-depth understanding of the complex power dynamics and processes of racialization that affect nurse migration and subsequent work experiences of migrating nurses (Buchan et al. 2006; Choy 2010; Das Gupta 2008; Kingma 2006; Pratt 1999; Matiti and Taylor 2005); debates during the workshop illustrated these broader developments. While the importance of recent policy development around Filipino immigration in BC was an important component, the personal and professional experiences nurses and policymakers shared were no less prominent, furthering some of the key debates on health worker migration.

HISTORICAL ISSUES

Three issues stood out in the workshop discussions that allude to the importance of a historical perspective in understanding Filipino nurse immigration experiences. First, the longstanding participation of Filipino nurses in Canadian health care and their potential as a resource was highlighted. Secondly, it was argued that health care and immigration are intertwined social and historical processes that have shaped Canadian health care. Furthermore, the history of regulatory structures and legal frameworks in which recruitment, migration, and 'integration' evolve often create unanticipated inequity that may work against rather than support integration of internationally educated nurses, thus generating discriminatory effects.

Significantly, several retired Filipino nurses who had spent most of their working lives in Canada attended the workshop. One nurse shared the experience of her arrival to Winnipeg, Manitoba in 1966, with a few fellow nurses. They knew very little about Canada when they arrived. To support each other, they formed a close-knit, small community sustained through friendships and networking with new incoming fellow nurses. The group in Winnipeg gradually expanded and formed one of the earliest centers of Filipino nurse migration to Canada (Bejar 2006). It now has a large population of immigrant Filipino nurses. Their early immigrant experiences highlight how immigrant nurses have not only been active participants in the creation of services, but also how in grouping together and supporting each other they have helped facilitate the transition of next generations of Filipino nurses to Canada. More notably, the province is home to the largest organization of Philippine nurses in Canada, the Philippine Nurses Association of Manitoba (PNAM), which also supports newcomer nurses from the Philippines and other countries immigrating to

Winnipeg and other parts of Manitoba. In broad socioeconomic analyses of nurse migration, this important historical contribution is often overlooked. Contemporary analyses of the adaptation of immigrant nurses often focus on current experiences, overlooking the longstanding presence and participation of Filipino nurses in shaping health care (Whithers and Snowball 2003). While it is important to articulate transition issues in health care, including recruitment, adaptation, and integration, the fact that Filipino nurse migration is not a recent phenomenon should not be ignored. Portraying alleged problems of integration as a present-day issue, the ways in which Filipino nurses themselves have formed resourceful communities historically and presently becomes invisible. Like the Philippine Nurses Association of Manitoba, these communities could be seen and perhaps invited to help create locally oriented practical support for new immigrant nurses that are sensitive to the variegated requirements of provincial nursing regulatory colleges. From the 1960s onwards, Filipino nurses have had a crucial role in Canadian health care contributing their work and experience.

At the workshop, Filipino nurses now retired emphasized how these previous and other potential contributions should be acknowledged. To point out another example, the community of Filipino women and nurses who are organized in Philippine Women's Centres in Quebec, Ontario, and BC already form a resource for healthy migrant integration into the Canadian workforce and could become an important participant in resource development. Another retired Filipino nurse emphasized how retired Filipino nurses are an untapped resource able to play a key role in teaching new immigrant nurses 'lessons learned', for example, on viable strategies of networking and socializing to counter the pressure of isolation and vulnerability many immigrant nurses experience. She urged recent Filipino immigrant nurses not to underestimate the

power of peer help. In other words, she believed Filipino nurses themselves could assist in the current integration of migrating health professionals.

These nurses' experiences and personal immigration histories underscore ways in which health worker migration is a longstanding, if not permanent characteristic of the health care system. Health care and migration are intertwined social processes (Mullally and Wright 2008). International migration and the history of skilled workers coming to Canada must be seen in the context of broader historical developments. In fact, Canadian health care is a prime example of the ways in which health care is characterized and shaped by the work of internationally skilled and educated nurses, sisters, doctors, and other health workers for centuries. As early as the 1600s, French sisters established some of the first hospitals in Canada and have continued to shape the development of health care ever since (Paul 2005). Since the late 19th century, various ethnic groups in the Canadian province of BC established hospitals for and through their own community. Missionary hospitals included a Chinese and Japanese hospital founded by and supported through diverse ethnic groups (Vandenberg 2010). While the history of these hospitals is only beginning to receive scholarly analysis, their presence disrupts easy assumptions about national identity, IEN's, and the idea of 'being foreign.'

Current experiences and tensions of health worker mobility intersect with complex legal issues of national immigration and a longstanding history of registration and licensing issues. Filipino nurses spoke to the complexity they experienced in light of current licensing regulation for internationally educated nurses in Alberta and British Columbia. The workshop underlined the ongoing historical tension over professional licensing and registration regulations. Registration requirements frequently pose particular, often unintended or unanticipated problems for immigrant registered nurses. Recently, the College of

Registered Nurses in British Columbia (CRNBC), the body legally responsible for the registration of internationally educated nurses in BC, had stipulated that IEN's who had passed the licensing and registration exam for registered nurses in Canada require the completion of a set amount of supervised practice hours to further demonstrate their competency in the Canadian health care system before they can be employed as registered nurses in Canada (Diaz 2009; College of Registered Nurses in BC 2011). The regulation further stipulates that these supervised hours have to be completed within a certain time frame, otherwise registration exam results will become invalid, and a candidate will need to retake the registration exam. Various Filipino nurses, some of whom had started their immigration journey and transition into the nursing workforce as live-in caregivers, spoke to the difficulties they experienced in the way this regulation has affected them. Although this requirement may be intended to further facilitate integration of foreign educated nurses in the Canadian workforce and ensure safe and competent nursing practice, in reality it often generated another barrier towards integration. For a number of reasons, finding supervised employment for a limited amount of hours posed difficulties for these nurses. In practice, employers were often unfamiliar with the details of the regulation and feared that supervised practice would be difficult, if not expensive to facilitate. Also, a limited number of hours were not easy to align with complementary employment. Many nurses had to work more hours in order to sustain their families. Moreover, the concept of "supervised practice" itself created confusion. With employers unfamiliar with the regulation, and colleagues unfamiliar with the concept of supervised practice, immigrant nurses often had difficulty finding this restricted employment and ran the risk of not meeting the expected requirement in time to obtain their hard-won registration.

This complex issue is not unique to Filipino nurses recently immigrated to Canada. In the 1970s, IEN's high failure rates on the State Board Test Pool Examination in the United States led to the creation of a new non-profit U.S. nursing organization, the Commission on Graduates of Foreign Nursing Schools (CGFNS). Its major objective was to oversee the implementation and administration of a pre-screening examination that would give IEN's the opportunity to be tested for communication skills and professional preparation in their country of origin before migration to the United States (Choy 2003). Similar to the recent Canadian regulation, the intent of the CGFNS pre-screening examination was to ensure safe and competent nursing practice for patients. It was also intended to facilitate a more ethical international recruitment process by deterring potential exploitation of IEN's who might have been unprepared to practice as registered nurses in the United States. However, many Filipino nurses in the United States charged that the use of the CGFNS examination was 'anti-Filipino.' Philippine Nurses Association leaders in the United States opposed the ways U.S. nursing organizations implemented the CGFNS examination, such as the use of the examinations as a visa requirement and the requirement that even those IEN's already in the United States take the examination. They believed that that examination discriminated against Filipino nurses by charging them what they believed to be exorbitant examination fees and by restricting their migration and practice in the United States. Filipino nurses in the United States organized to protest CGFNS policies at the local, national, and international levels (Choy 2003). Their critique highlights the need for the ethical integration, as well as ethical recruitment, of internationally trained health workers.

Furthermore, anecdotes given by Filipino nurses who immigrated to Canada at the workshop, as well as those in oral histories of migrant Filipino nurses

shared in a recent study, highlight how there appears to be a historical shift in the experiences of licensing regulations depending on their time of arrival to Canada. In particular, nurses who had immigrated in the sixties commented that jobs were handed to them, they could practice right away, and that their integration to work and life in Canada was facilitated by the organizations that recruited them. In contrast, those nurses who immigrated later (1970-2000), when migration and registration had become more intensely regulated and 'institutionalized', expressed encountering difficulty in regaining their credentials and meeting requirements to register as a nurse in Canada, resulting in a delay in their ability to practice that often led to a period of deskilling (Ronquillo 2010). As a result, important work experience and preparation to practice is lost, and Filipino nurses may face undue discrimination. These historical changes in migration experiences are interconnected with the broader geography of migration and ethical recruitment, both closely linked to questions of fairness and justice in the global movement of health care personnel. At the workshop, analysis of the migration experience of Filipino nurses was closely connected to questions of ethical recruitment and fairness in the workplace.

GEOGRAPHICAL AND ETHICAL ISSUES

Migration is a broad economic, sociopolitical, and cultural phenomenon as well as a personal journey (Guevarra 2010; Choy 2010). The social geography of place and identity shapes a person's individual journey of migration and fair integration into a new workplace, as well as the broader social processes of what is perceived to be fair and just international movement and recruitment in a global labour market (Kingma 2006). Several important geographical and ethical issues figured in the debates of the workshop, we will discuss the following three: ethical recruitment and ethical integration; race and racializa-

tion in the workplace; the importance of language in light of the vulnerability IEN's experience.

As we pointed out above, since the 1950s a key influence that drove recruitment of IEN's into the rapidly expanding health care systems of affluent, western countries has been the alleged shortage of health care personnel, particularly nurses. Presumably, changing demographics and a growing number of aging citizens further complicated expanding demand. However, the fact that efforts to attract qualified health personnel often implied recruitment from developing countries, where health resources were already stretched and limited, made the practice of doing so increasingly controversial. The 'drain' of qualified personnel from developing countries moving to developed countries with more resources and services made apparent the relative inequity and detrimental impact of such migration dynamics on global health (Kingma 2001, 2006, 2009). Furthermore, the global migration of health personnel illuminated the relative nature of what became framed as a pressing 'nursing shortage' in the West (Ceci and McIntyry 2001). Recruiting nurses from resource-poor sending countries to alleviate an alleged pressing need for health personnel in western, resource-rich countries (which nevertheless have much higher nurse-to-patient ratios than the resource-poor, sending countries) depleted resources globally and enhanced global health inequity. In May 2010, to address this important issue and to pressure its member countries to improve policy towards ethical recruitment of health care personnel, the World Health Organization ratified the WHO Code for the Ethical Recruitment of International Health Personnel (Zarocostas 2010).

These developments had a rippling effect in BC, as well as in Canada more broadly. The case of Filipino nurse immigration to Canada prompted academic and policy research on the migration of IEN's and generated reviews of recruit-

ment practices at various levels of government (Parpia et al. 2010). In Canada, where health care is provincially based, several provincial governments have developed bilateral agreements with the Philippine state to coordinate recruitment of Filipino nurses (Saskatchewan 2008). Moreover, as the pressure to recruit and regulate an increasing number of immigrant Filipino nurses to BC grew, policymaking bodies and institutions in this province, including Health Match BC, the College of Registered Nurses in BC, and the Ministry of Health Services joined forces to further policy research and examine existing regulations and policies. During the workshop, representatives of these organizations emphasized how local efforts have been undertaken to bring local recruitment strategies in line with global and national developments and ethical standards. BC governing bodies have joined a larger Canadian effort to review its recruitment practices (McIntosh, Torgerson and Klassen 2007).

Participants at the workshop emphasized, however, that the tension is not only felt with regard to ethical recruitment, but also with regard to ethical integration into the health care workforce. In particular, economic interests in a global labour market are, in a sense, in tension with fair recruitment regulations, often resulting in hesitancy, both on the part of receiving and sending state governments to review and adapt their regulations (Santiago 2010). Moreover, regulation practices, such as prolonging the time necessary to meet registration requirements, complicate rather than facilitate integration. These requirements not only create loss of skill, but also generate the unintended effect that IEN's might continue their career in lower skilled care sector jobs, or see their opportunity to practice jeopardized while they are in transition and not yet licensed. Workshop panelist Geraldine Pratt shared a prime example: the complicated pathway of immigrant nurses entering Canada as a Live-in Caregiver, which severely prolongs the time it takes for registered nurses to

become licensed. In her research on this phenomenon, Pratt (1999) found that it leads to deskilling and often prolongs family reunification.

Another aspect complicating the matter of fair recruitment and integration of IEN's is Canada's status not only as a receiving, but also as a sending country when it comes to international nurse migration. At the workshop, Michelle Freeman (2010) highlighted the fact that thousands of Canadian-educated registered nurses live and work in the United States, either living there or commuting on a daily basis, particularly in Canadian border cities, such as Windsor, Ontario. Canada is a major source country for meeting US nurse shortages, Freeman noted, and these nurses' experiences mirror those of other nurse migrants. Further insight and policy research on these complex migration patterns is urgently needed (Freeman 2010; Kingma 2009).

The dynamics of race and racialization in the workplace and broader work-relationships are a second source of ethical tension that workshop participants and panelists discussed. Participants pointed out how immigration and integration are not only broad sociopolitical issues, but also reflect an often unique life course that resists easy generalization. Integration has to be understood as broader than only adjustment to a particular skill and clinical knowledge in the workplace. It also relates to issues of the broader living environment and well-being to, for example, finding proper housing, obtaining support in juggling complex bureaucratic structures, and opportunities to full participation as citizens. Fair recruitment needs to touch on all of these aspects.

Workshop participants were not unique in sharing their perspective and experience of everyday forms of racism in the workplace. In a recent survey among close to 600 Ontario Nurses Association members, Tania Das Gupta (2009) found that a significant number of nurses, non-white and white, had

witnessed occurrences of racial interaction in the workplace, such as nurses being treated differently because of their colour. During the workshop, panelist Frank Gillespie, Education and Diversity Officer of the BC Nurses Union, pointed out how, despite improvements, the transition is still difficult for many immigrant nurses, with many experiencing lack of support in their workplace.³ For example, some immigrant registered nurses found the process to become licensed so complex that they preferred to continue working as a licensed practical nurse and actively chose not to fully utilize their knowledge, training, and experiences. Gillespie further shared how, in recent years, the BC Nurses Union has begun a formal outreach to IEN's by organizing an equity caucus group led by union members of various visible minority groups in 2009. These groups provided a forum for IEN's to meet and discuss shared experiences.

Panelist Jean Carne, Operations Leader at a large general hospital, shared her perspective on the importance not only of ethical recruitment, but, particularly, of the development of fair approaches in the workplace to help new internationally recruited nurses fit in and transition into their new workplace.⁴ In her administrative role she became involved with the recruitment of IEN's and helped recruit several nurses from the United Kingdom (UK). Only part of the group was made up of British nurses, she pointed out. Many were educated in other countries, particularly the Philippines and Africa, and began a second journey of transition by immigrating to Canada, using the UK as a stepping-stone for their migration to Canada. Once the first five recruits arrived, reality hit, Carne recalled. The issues of transition and adaptation were numerous given the number of differences: language, names for medication, approaches to treatment, ways of documentation, communication, and how

³ The information from Frank Gillespie's panel presentation is included with his permission.

⁴ The information from Jean Carne's panel presentation is included with her permission.

nurses deal with death and dying, to name a few. In addition to professional challenges, there were social ones, such as finding housing, childcare, and scheduling work hours - all of which affected transition, making it a complex process for both the new recruits and the hospital staff. The hospital was not alone in seeing many of the new recruits leave again, as high turnover is one of the common challenges of recruitment in nursing generally, but also among IEN's. Carne sought new ways to 'hire for fit,' exploring how to best support new international recruits in a successful transition (Carne 2010). One of the outcomes of these efforts was the development of a Bridging Plan, a quality improvement strategy, with the participation of IEN's and their preceptors, which helped support IEN's in their practice environment. Local workplace initiatives are crucial in developing grassroots strategies to address the challenges of international recruitment, as imperative as the broader governmental policy both Carne's and Gillespie's stories illustrate.

While issues of race and racialization in the workplace are vital to address, it has become clear that nurses do not always use 'race' as a concept to address racialized experiences in their workplace. In her oral history study of immigrant Filipino nurse experiences in Western Canada, Charlene Ronquillo (2010) found that nurses may not use the concept of 'race', but rather speak in more circumvented ways about inequities they experienced. For example, many spoke of the 'need to prove yourself' when addressing experiences of inequity, suggesting that nurses may not always be willing or able to explicitly use the language of race, racialization, or discrimination, but instead described their experiences as resulting from the technicalities of being trained and educated in a foreign country (Ronquillo 2010). It seems important to explore the implications and find ways to listen to different ways of voicing racialized experiences and, also, to silence. One related aspect discussed was

that race and the ability to talk about it is not only an issue for immigrant nurses, but also for Canadian-born nurses who may be from a diverse range of ethnic communities and colour. As Carne found in her hospital's process to help support IEN's, it is a mutual learning process of finding ways to best communicate and work together for all parties involved. While there is ample literature raising awareness of diversity and equity issues in nurse-patient interaction, unfairness and processes of racialization also occur in nurse-nurse interaction and are often structurally embedded in workplace dynamics (Choy 2003; Kingma 2006; Das Gupta 2009).

This brings us to our third point in relation to geographical and ethical issues: the racialization embedded in the very language we use or, in contrast, the difficulty in addressing racialized experiences due to the difficulty in discussing and expressing them in words. Michelle Freeman (2010) pointed out how structural inequity is embedded in the many labels we use to address IEN's. Terminology such as 'overseas qualified nurses,' 'foreign nurses,' or 'foreign-educated nurses' inadvertently reflects a North American or Canadian-centered perspective. In concluding her presentation at the workshop, Freeman cautioned being careful with terms such as 'foreign,' as they might unintentionally enhance the labeling of migrating nurses as outsiders, thus influencing, if not complicating, acceptance and treatment in collegial relationships in the workplace (Freeman 2010). Indeed, the language we use also structures perceptions and may provoke racialized images and understandings.

A final point of consideration brought forward during the workshop is the risk of exploitation IEN's potentially face — exploitation that makes them vulnerable and prone to implicit, or explicit, verbal or non-verbal forms of discrimination and abuse. Often IEN's fill positions Canadian-educated nurses are less interested in taking on, working in settings considered more demanding or

more marginal (Hawkins 2010). In order to understand the everyday forms of racism IEN's experience, it seems essential to conduct research that includes the stories and experience of IEN's firsthand, both in relation to licensing processes and employment. In decision-making and policy development related to fair recruitment and integration practices, it is essential to include and represent the perspective of IEN's.

CONCLUSIONS

Discussions and debates highlighted a number of essential historical, geographical, and ethical issues in the global process of international health worker migration. Employing the strategy of recruitment of IEN's in order to alleviate demand for qualified health care personnel poses global, national, and local questions of fairness and health equity. Nurse migration is both a complex, global sociopolitical process and an individual journey, affecting the lives and health of citizens worldwide. As such, it prompts the need for academic and policy research on the migration of IEN's. Focusing in particular on the case of Filipino nurses migrating to Canada, several conclusions can be drawn.

First, we must consider the longer history of Filipino nurse migration to Canada (and other receiving countries) and how this has changed over time. New studies of migrants are important, but they need to place current migrations in historical context. Second, given that there are histories of these migrations, we should review models of what has worked regarding the recruitment, retention, and job satisfaction of Filipino nurses, and include firsthand experiences and career histories of IEN's in their national and regional contexts (Hayne, Gerhardt and Davis 2009). Third, while we should consider ethical implications of international nurse recruitment, we must also acknowledge that poverty, unemployment and underemployment, favoritism, and violent

political instability in sending countries like the Philippines continue to push nurses and other health care workers to work abroad. Receiving countries should consider bilateral agreements in order to prevent worsening disparities between North and South. For example, focusing on the Philippines and Canada, specific proposals regarding bilateral agreements have been considered (Lorenzo et al. 2007; Little 2007). Fourth, beginning research on everyday forms of racism and abuse of health care workers, such as the work Tania Das Gupta (2009) has conducted among Ontario nurses, might well serve as a model for further studies in other provinces of Canada. Also, internationally, abuse of health care workers as well as the socioeconomic gains made by them should be considered. Policymaking bodies as well as employers, nursing associations, and unions need to pay heed to 2005 recommendations by the Discrimination Research Center (Morris et al. 2005). These recommendations include: actively working to ensure that race and ethnicity is not an unspoken issue in the workplace and that all employees are treated fairly; reducing social isolation of minority nurses by developing on-site support systems; and partnering with ethnic nursing associations such as the Philippine Nurses Association of America in the United States, or pioneering networks of Filipino nurses in Canada such as the Philippine Nurses Association of Manitoba, to encourage registered nurses to continue their education and to develop minority nurse leadership. Finally, as several initiatives reported on by policymakers and nurse leaders at the workshop also indicated, we should consider institutionalized ways to acknowledge the contributions of health worker migrants and immigrants in the receiving country and find strategies to support their successful transition. Many health worker migrants in Canada, for example, are no longer newly arrived foreigners. They may have transnational ties that continue to bind them to the Philippines, but they are also Canadian health

workers who may have important resources to offer in the decision-making and development of integration practices. Most importantly, they are full-fledged members of a workforce that enhances the health of the receiving nation.

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