Migration Experiences of Jordanian Nurses Working in the UK

By

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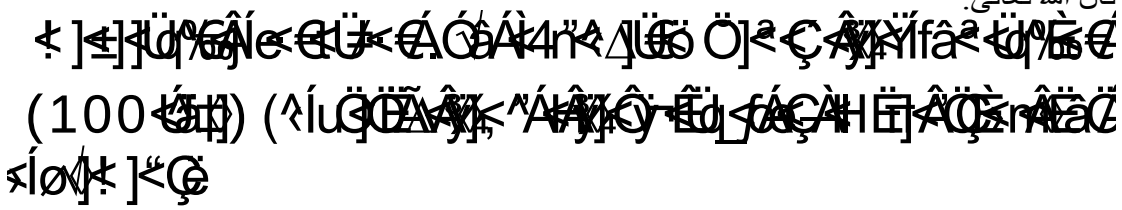
قال الله تعالى:



ALLAH almighty says, as translated in the Noble Quran:

He who emigrates (from his home) in the Cause of ALLAH, will find on earth many dwelling places and plenty to live by. And whosoever leaves his home as an emigrant unto ALLÂH and His Messenger, and death overtakes him, his reward is then surely incumbent upon ALLÂH. And ALLÂH is Ever Oft Forgiving, Most Merciful.

(Women – 100, the Noble Quran)

Abstract

Background. Many nurses have migrated to the United Kingdom (UK) as a result of workforce shortages in the health care system. This is part of worldwide shortages, which creates international mobility for professionals, in health and other sectors, a migration, which has consequences for source and host countries. Literature on migration is limited by the lack of accurate data and rigorous studies, but a range of theoretical frameworks address issues explaining push and pull factors, and consequences of migration for individuals. Few studies currently report on the experience of migrant nurses before, during, and after transition.

Aim. This study examines the personal and professional experiences of Jordanian nurses migration to the UK.

Design and methods. Using a qualitative biographic approach, data about migrant nurses was collected by survey and semi-structured interviews. The UK Nursing and Midwifery Council database was accessed to identify Jordanian migrant nurses, with the population broadened by snowball sampling. In total 52 nurses responded to demographic survey. A subsample of 13 nurses was interviewed in person and 12 were interviewed by telephone.

Findings. Three key themes were identified. First, Jordanian nurses have challenged the *'status quo'* and taken a decision to move to the UK, in response to the push or pull of work conditions, educational opportunities, career development, wages, travel and adventure. Second, 'source to host country: disconnecting and connecting' shows that Jordanian nurses disconnected many relations in Jordan or the Gulf States when they moved and established additional work and social relations in the UK. Third,

‘away from home: professional transformation and routes diversion’ reported on the shifting in Jordanian nurses’ professional and personal life in the UK.

Conclusion. This thesis argues that while migration theories focus on economic, using a case study of nursing and incorporating the professional and personal helps identify future migration movement.

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Transcript codes

Tape-recorded interview material appears in italics.

All tape-recorded materials and documents are verbatim transcriptions.

[...] words, phrases or sentences of the extract omitted.

[descriptive material added by the researcher in order to make the context and/ or meaning clear]

Data have been edited ([indicated between brackets]) in order to preserve anonymity.

All names of people and places are pseudonyms.

Abbreviations

Abbreviation	Description
AN	Associate Nurse
CCT	Cumulative Causation Theory
CNS	Clinical Nurse Specialist
GS	Gulf States
HCT	Human capital theory
HHC	High Health Council - Jordan
ICN	International Council of Nursing
IOM	International Organisation of Migration
JD	Jordan Dinar (currency)
JNC	Jordanian Nursing Council
JNMA	Jordanian Nurses and Midwifes Association
MoH	Ministry of Health
NCT	The Neo Classical Theory
NET	New Economics Theory
NGOs	None Governmental Organisations
NHS	National Health Services - UK
NMC	Nursing and Midwifery Council of the UK
PIN #	Nursing and Midwifery Council registration number
PN	Practical Nurse
RCN	Royal College of Nurses
RM	Registered Midwifes
RMS	Royal Medical Services
RN	Registered Nurse
SNT	Social Network Theory
UAE	United Arab Emirates
UK	United Kingdom
UNRWA	United Nations Relief and Welfare Agency
WHO	World Health Organization
WST	World Systems Theory

Chapter one

1 Introduction

Economic migration is an integral part of globalisation and with the latter gaining momentum, an increasing number of people are opting to migrate in search of more lucrative work opportunities. According to the International Organisation of Migration (IOM), as many as 191 million people live outside their country of birth (Omelaniuk, 2005). In terms of the labour market, there are 80 million migrant workers worldwide outside their own country. As the field of health care is labour intensive, management of health workforce migration is an important strategy for every country's health system (WHO, 2006). Since the beginning of the second millennium, researchers and policy makers have embarked upon a relentless debate regarding health workforce migration. This has resulted in extensive reporting of the issue and consequently, the topic of health workforce migration has assumed global importance (Bach, 2007; Brush, 2008).

Nurse migration is part of the common phenomenon of international migration (Kingma, 2006b; Kingma, 2006c; Troy et al., 2007). However, we are unsure of the precise number of migrant nurses currently working in each country (Stilwell et al., 2003; Stilwell et al., 2004). Whilst the total number of nurses is difficult to quantify, the World Health Organization (WHO, 2006) estimated that there were 16 million nurses, out of 60 million health professionals world wide. Despite this large number, many countries report shortages of nurses, and this trend is likely to continue. (WHO, 2006). The United States alone estimates a shortage of about 400-800,000 nurses by the year 2020 (Pittman et al., 2007).

The complexity of migration goes beyond the shortage of nurses in almost every country; since the country receiving nurses is simultaneously losing staff to other

countries. The WHO (2006) reported that one out of every ten nurses working in the UK is trained abroad. The Nursing and Midwifery Council (NMC) in the UK registered 8,862 foreign nurses during 2006, and British nurses seeking employment abroad were 7,772 (Buchan, 2007; Nursing and Midwifery Council, 2006). On the other hand, the situation of nurses in Jordan (as a source and a host country) is a reflective of the international picture. In Jordan, while there was one foreign nurse out of every fifty nurses who registered during 2003; one out of five Jordanian nurses was working abroad (Jordanian Nursing Council, 2005). Nurse migration is complex at the national level, but minimally researched at an individual level of experience and decision-making (Buchan et al 2006).

Literature on nursing migration mainly centres around examining the economic and social models that have been developed to explain the phenomenon of migration (Bach, 2003; Withers and Snowball, 2003; Larsen et al., 2005; Ross et al., 2005; Kingma, 2007). Researchers have applied economic as well as social models in order to provide policy-makers with scientific evidence for their decisions. During the last two decades, nurse migration studies have reflected on the need to develop policies for recruitment of nurses internationally.

Identification of significant patterns in nurse migration is a highly selective process, for two reasons. First, the need for research on local nursing issues has priority for logical reasons. Second, when the need for research on migration of nurses has been identified, it moves towards topics of interest for sponsors and other stakeholders; particularly, governments through their health organisations and professional registration bodies. For these reasons, many important patterns at the individual level are not reaching the level of identification and studies by scholars, and are frequently ignored due to lack of funds (Buchan et al., 2005c). Data on migrant nurses have

illustrated the professional and personal experiences of individual migrants as an important pattern and this aspect has been marginalised or ignored

This thesis proposes to fill significant gaps in nurses' migration literature, because it examines the personal and professional experiences of first-time migrants, and how they are able to cope in the new environment of the host country, that too , in the absence of any previous connections or relations.

This thesis focuses at the individual level. The study does not try to establish the number of nurses that migrated from Jordan to the UK nor to evaluate the pros and cons of nursing migration to the source or host country. Rather, this study focuses on the professional and personal migration experiences of Jordanian nurses working in the UK. Interview sessions with nurse participants were conducted to unfold the 'story' of their journey. This threw light on many of the dimensions of migrant nurse experiences - economic, psychological, social, educational, and cultural. The objectives of this thesis are threefold:

- To identify and explain the process of work-based migration from Jordan to the UK.
- To examine the predicted as well as the unanticipated outcomes of nurses' decisions and practices of migration.
- To discuss the findings' implications in the context of professional and personal adjustments made by the migrant nurse population

Chapter Structure

The thesis is structured to frame the development, starting with initial questions through to the key themes and conclusion. Seven chapters follow this first introductory chapter:

In chapter two, I pose the questions, which guide this study within the experiences of migrant nurse literature. Migration motivations, decisions and experiences are examined in the light of a critique of the labour migration theories. The literature is examined in comparison to two professions as migrants, physicians and Information Technologists. Following that, I examine the literature on international nurse mobility. Here the thesis contributes to a detailed account of the push and pull factors, blended in the context of personal and professional experiences of migrant nurses.

In chapter three, I explain how the study objectives were addressed using the qualitative research methods. I outline the principles of life history research, and justify the methods under use and the sample selection, with details of how the data were analysed and the ethical considerations of the research process.

Chapter four, is a contextual description of nursing in Jordan and explores the potential situation for the international and regional migration of nurses. The focus is on nursing education, employment, and the health system in Jordan.

The findings resulting from the data collection and analysis are presented under three major themes in chapters five, six and seven. Each chapter simultaneously reports the nurses' accounts and examines them in the light of the literature. The analysis adopted continuous questioning of the data, which revealed the three key themes. These are denoted by the titles given to the data chapters. Chapter five, 'Challenging the Status Quo', reports on the distinct and recurring themes arising out of the participants'

accounts about the push and pull factors, decision to migrate and how it was influenced by personal, professional, and financial factors. It explores the nurses' move toward the decision to migrate, to achieve stability and balance in their status. The chapter presents this in three sections; first, the 'status quo' reports and examines the nurses' work conditions before the idea of migration. Second, discussion of Jordanian nurses motivations to move abroad. Third, challenging the status quo, through a decision of moving to the UK. These three issues discuss the experience of a nurse moving from a state of no intention of migration to a state of taking a decision to go abroad.

Chapter six, 'Source to Host Country: Disconnecting and Connecting' reports on the transition of the nurses from the source to the host country. It examines the nurse's experiences of navigating through the transition phase. This has been conducted in four sections; first, the Jordanian nurses aspirations and worries during the transition. Second, how they navigated their relationships in Jordan or the Gulf GS. Third, the opportunities and challenges, as experienced by migrant nurses as they build relationships in the UK upon arrival. Finally, the experiences of excitement and shock as part of the transition.

Chapter seven, 'Away from Home: Professional Transformation and Routes Diversion', this chapter aims to identify and examine the key elements of the post-transition phase; that is six months after the nurses' arrival to the UK or getting a registration PIN number with the Nursing and Midwifery Council (NMC). It discusses this in three sections: profession transformation, life transformation and the future, UK a station or destination. 'Professional transformation' represents the outcome of shifting and adjusting migrant nurses' competencies to fit the new work place. 'Life transformation' is the changes in the personal norms and values and the adaptation to

daily routine and culture in the UK, which is different from that in Jordan. Opportunities and challenges of both professional and life transformation divert migrant nurses' future plans. There are four groups of migrant nurses in terms of future planning: those who want to stay in the UK, those who will leave for a third country, those who have not yet made up their minds and those who will return to Jordan. These are considered in the section, the UK a station or destination.

Finally, chapter eight, uses the three data chapters to show the nurses' experiences during the migration process and its social and economic complexities. Running through the three data chapters are two significant strands, which are not apparent either within the literature on migration or the three data themes. It is the personal and professional reinvention of the Jordanian nurses' experiences, which offer new insights into the migration experience. Reinvention means a new identity has been created for Jordanian nurses because of their migration experience in the UK. The chapter aims to present these two strands through four sections. First, summary and discussion of findings related to push and pull factors as experienced by Jordanian nurse. Second, discussion and summary of findings related to professional reinvention during migration. Third, discussion and summary of findings related to personal reinvention; and fourth, presentation of the study implications and limitations.

Chapter 2

2 Literature Review: Examining nurse migration pathways: an absence of personal and professional experiences.

2.1 Introduction

The International Organisation for Migration (IOM) reported that there were more than 191 million people living outside their country of origin during 2006, and of these more than 80 millions were workers (Omelaniuk, 2005; WHO, 2006). Researchers approach the subject of labour migration using several modalities, but they all address the economic dimension, because labour is a central element of any economy (Brettell and Hollifield, 2000a). Nursing, like any other profession, operates and acts in an economic, social, cultural and political environment. The migration among nurses is a part of the global labour mobility, which has primarily been triggered by an increase in the demand for health services all over the world Moreover, nurses' migration remains a significant strategy for the countries to manage imbalances in nursing workforce and financial resources (foreign currency) because both are repeatedly reported in shortage (WHO, 2006). However, there is nothing intrinsically good or bad about the flow of nurses across the borders the final impact, whether it is positive or negative depends upon who governs the flow, which in turn determines who benefits from it (Kingma, 2001). Little in literature addresses the benefit of nursing migration and this implies that positive side of migration has not been equally distributed, not only between countries but also between individuals (nurse as employee and employer) (Thomas et al., 2005; Buchan, 2007; Thupayagale-Tshweneagae, 2007). Because it is difficult to measure the benefits of migration, studying the actual experiences remains an important indicator at an individual level (Buchan et al., 2005b; Smith et al., 2006b; Walters, 2008).

In order to start answering the underlying question about the personal and professional experiences of Jordanian nurses in the UK, this chapter reviews the literature on international nurses' migration. This will include a review of issues of labour, skills, and profession. With this in mind and after the search strategy, this review discusses three main areas. First, a critique of labour migration theories. Second, a comparison of migration of nurses with that of two specific professional groups the physicians and information technologists (IT). Third, a critique of the nurses' migration literature, with particular focus on professional and personal experiences.

2.1.1 Search strategy

Different terminology and the fact that the topic of migration is related to various disciplines have made it difficult to locate the literature on nurses' migration (Stilwell et al., 2003). Although, most search systems do not keep a category specific for migration, fragments embed within many disciplines. Therefore, the search strategy covered several fields of research, and were not constrained by disciplinary boundaries. The areas covered in addition to nursing were multidisciplinary, including anthropology, geography, economy, psychology, sociology, and social policy.

The starting point of this review was the identification of literature relevant to nurses' migration. This search was conducted, using electronic databases, hand, and the internet. These identify two main sources of information concerning relevant literature: electronic sources and references of the related articles and books. Moreover, two main methods were used to find relevant research about nurse migration: electronic searching and archaeological searching.

2.1.1.1 Sources and methods of searching

The initial stage of searching was to consult the databases of CINAHL, Web of Science (ISI), EBSCO and INGENTA search engines. In addition to these, a search was carried on the University libraries, using the online search engines (see table 2-1).

Table 2-1: online search engines

CINAHL	Current Index to Nursing and Allied Health Literature
COPAC	Unified catalogues of some of the largest university research libraries in the UK and Ireland
ZETOC	British Library's Electronic Table of Contents
MEDLINE	Comprehensive source of life sciences and biomedical bibliographic information
Google scholar	Major online academic search server
SOSIG	Social Science Information Gateway
ISI	Institute for Scientific Information - Web of Science
SOCIOFILE	Database containing abstracts of the world's literature in sociology and related disciplines
INGENTA	Major online search service
EBSCO	the online database of journal articles for MasterFILE Premier, ERIC and PsycINFO
HMIC	Health Management Information Consortium

All the terms and keywords in table 2-2 were entered, with the inclusion of one of the following geographic terms: United Kingdom, Britain, England, Jordan, Arab, and International, in order to uncover as much information as possible. As expected, almost all of the search engines generated long lists, and much of the material was repetitive, or not relevant to this 'mapping'. It was important though, to use all of the listed keywords, because of the complex and multifaceted character of the topic. These terms and concepts are widely used in literature and other publications, but they are often vaguely defined. This is particularly the case with the term 'migrant', which is seldom defined with any accuracy. Hence, there was a need to search for relevant research and publications, by using five different terms (i.e. migrant, immigrant,

overseas, foreign, and international) in order to uncover as much information as possible.

Table 2-2: The search terms entered into bibliographic databases

nurse(s)	international overseas immigrant Foreign migrant brain drain
nursing	migration mobility

Given the many facets of migration, and consequently a range of disciplines addressing the issue, electronic searches also included the search for journals in the area of economics, education, training, and employment, over and above health and nursing.

A parallel search of the web used the same key words; the primary search engine used was 'Google', at www.google.com. Also it included a number of web sites hosted by academic institutions, organisations, and professionals that were active in the health field. Internet searches mainly generated resources from government or nursing professional organisations, which offered news releases and publications on the nursing shortage situation. Some of these contained reports in downloadable form, and many provided links to other sites of interest. A list of relevant web sites and addresses is also provided in the table 2-3.

Academic as well as the web databases were supplemented by archaeological searching, that is consultation by two methods (James and Clark, 2007). First, was manually searching the citations for other relevant publications, not already identified through the electronic search process. The references of the original articles were

reviewed for related literature, which had been previously missed or omitted. Second, was searching of the nursing journals, in particular for frequently cited publishing articles of the nurse migration., This involved a manual search of the table of contents of all volumes between 2001- 2007. This was carried out because of the ambiguous terminology pertaining to the topic, the possible time lag between acquisition and entry to the database, and because a physical search usually generates other useful pieces of information. Although time consuming, the archaeological technique proved to be useful as it generated a wide range of literature for this study.

Table 2-3: Nursing migration relevant organisations and websites.

International Organization for Migration (IOM)	http://www.iom.int/
World Health Organisation (WHO)	http://www.who.int/en/
International Nurses Council (ICN)	http://www.icn.ch/
The International Centre for Human Resources in Nursing (ICHRN)	http://www.ichrn.org/
The International Centre on Nurse Migration (ICNM)	http://www.intlnursemigration.org/
Researching Equal Opportunities for Health (REOH)	http://surrey.ac.uk
The Royal College of Nurses (RCN)	http://www.rcn.org.uk/

2.1.2 Selection of articles and reports for inclusion

The initial stage of the mapping process involved a careful examination of each bibliographical list generated, by looking at the title of the item, and making a judgment as to whether it was relevant to this study. Additionally, whenever it was possible, given the limitations of the physical availability of publications and the time constraint involved in conducting and completing this 'mapping' exercise, abstracts and/or full-text of items were consulted before they were included in the bibliography.

The next stage involved consideration of the sub-section of issues of migration it addressed, and consequently, a decision about the category in which the item should be included. This process was facilitated by broadly listing categories/issues of migration theories, professionals' migration, and nurse migration experience. It needs

to be noted that this list was flexible. It not only allowed for new categories to be added as they emerged during the course of this data-gathering, but also for the already defined categories to merge, in order to correspond better to the situation in this field of research.

2.2 Migration Theories

The term migrant in this review refers to a person or people from one country, locality, place of residence, and their movement to settle in another country either temporarily, or for a longer period (Perruchoud, 2004). This review identifies, discusses, and offers some critique of the major migration theories. This in turn establishes the theoretical background for an understanding of the different routes of analysis and explanations adopted to explain the migration of professionals in general, and nurses in particular.

Labour migration theories provide an analytical and theoretical framework for professionals' mobility. The main theories can be identified as the neo-classical, the human capital, the new economics, the dual labour market, the world systems, the social network, and the cumulative causation theories. These theories address the theoretical underpinning of the migration 'push and pull' factors (Isbister, 1996). Moreover, they indicate the level where migration analysis is possible (Brettell and Hollifield, 2000b). For example, the push and pull can be found at the individual, community, national and international levels.

Following Isbister (1996), Dovlo and Martineau (2004), Huston (2006) and Kingma (2006c), push factors pertain to issues in the source country, such as unemployment, low wages and/or lack of advancement or promotion opportunities in the home country, which may push the individual to move to another destination. Moreover,

the same studies argue that the pull factors, the factors which attract the flow of people, are present in the destination country, such as high wages, better working conditions, and a higher standard of living. It is worth noting that several levels of analysis are used in the theories to map the research unit and in particular, the individual, and family, national and international (Brettell and Hollifield, 2000b). For instance, the neo-classical theory and the new economics theory of migration focus on the distinction between individual decision-making and the family decision-making. Massey et al (1993) found that individuals seek to maximise income, according to the micro-level neo-classical theory. However, from perspective of the new economics theory, Arango (2000) argues that other household members apply a family strategy to minimise the risks in the individual's decision. Thus, theories operate across a range of levels of analysis that are not necessarily mutually exclusive because, the causal processes and their variables operate simultaneously on various levels.

Even though the theories emerged separately, I argue here that push and pull factors run as a common strand through all of them. Generally, scholars construct migration theories on basic variables, such as individual behaviour, the influence of the family, society, economy, and politics. Nevertheless, they complement each other, and each one contributes to understanding of the phenomenon because each theory explains the complexity of migration from a different perspective.

2.2.1 Neo-classical theory

The neo-classical theory (NCT) views migration as a sum of cost benefit decisions, undertaken by an individual, to move from one country to another in order to maximise expected outcome (Massey et al., 1998). The expected outcome is the probable increase in income an individual may gain in the destination country, relative to the source country. According to neo-classical theory, labour moves from

low income to high-income areas. Consequently, migration will not happen when there is no wage difference between two countries. Keely (2000a) reported that labour flow to a destination country increases as a result of the difference in wages, and the probability of obtaining a job. One extension to the neo-classical theory argues that the migration decision will be considered when the individual finds a gap between the expected earnings and his/her real gains in the home country (Massey et al., 1994). They added that expected earnings refer to the real earnings multiplied by the probability of employment in the prospective destination.

The neo-classical theory combines macro-perception with the micro-counterpart. At macro level, it is about the distribution of labour and wages, and the differences in these variables between the source and destination countries. It is claimed that countries with scarce labour resources tend to have high wages, and thus probably a high demand for labour. As a result, the oversupplied countries become a good source of labour, as wages tend to be low, leading to the redistribution of labour (Arango, 2000). On the other hand, migration on the micro level results from an individual rational decision, made after cost benefit calculations. Therefore, it is an individual's spontaneous and voluntary act, based on a comparison between the present situation of the person and the expected net gain of moving to another country (Massey et al., 1993).

The backbone of this theory is its sensitivity to the wage gap between the country of origin and the destination. However, wage level is not the only, or even the most important, factor in the decision to move. Massey et al. (1998) reviewed several empirical studies, which suggested that wage variable was only an occasionally significant variable, whereas employment was always significant.

The neo-classical theory is frequently used in migration analysis (Massey et al., 1994; Arango, 2000). However, several challenges stand against its generalisation. While there are huge differences across countries in income, only a few people move. Furthermore, the theory fails to explain differential migration; for example, some countries have high outward migration, and others do not, despite similarities in wages and employment. The neo-classical theory by itself does not constitute a complete explanation of the migration decision, and this suggests the presence of other factors, such as migrant experience and network connections, which may or may not be a control when used in a research model (Massey et al., 1998; Arango, 2000; Massey et al., 1993). It is clear that the neo-classical theory leaves basic questions unanswered. These are, why do some individuals migrate while others do not? How can we distinguish people who leave from those who remain in their home country? And why does return migration happen while differences in wages remain?

2.2.2 Human capital theory (HCT)

According to Chiswick (2000b) the human capital theory was developed as an extension of the micro neo-classical theory by Sjaastad (1962), and later modified by Todaro (1976). Human capital refers to the way the individuals' education, skills, and abilities are used for employment abroad, or for migration. That adds to the neo-classical theory by extending the determinants of migration.

Chiswick (2000a) mentioned that HCT treats migration as an investment decision, suggesting that individuals calculate expected returns in every destination, according to the present value in their current country of residence (Akkoyunlu and Vickerman, 2001). The expected gain from a move is a result of the higher real wage, minus the cost of migration. The costs of migration include the monetary expenses of the move, the earnings foregone during the migration, the searching and settling periods, plus

any loss of job seniority, pension plans, and other job-related benefits. In other words it is the full cost of transition from the country of origin to the destination country, including lost opportunities, which may be achieved in case migration did not happen.

Human capital theory in its explanation depends on the transferability of skills. Human capital acquired in a home country generally transfers with difficulty abroad, because when arriving at a destination, there is a need to adapt to the language, culture, and economic system, which are all added to the cost of migration. Massey and his colleagues (1998) explained the ability of the theory to predict international movement. However, they argued that the prediction of the direction and relationship between a specific individual background and migration is impossible. There is some evidence that younger people are more mobile as long as they have perceptions of gains from migration (Massey et al., 1994). Moreover, people tend to consider the cost of migration to be associated with the distance between the source country and the destination country. On the other hand, Chiswick (2000b) argues that distance can have a low importance for certain individuals, such as the educated and qualified, or those with networks in the prospective destination.

The HCT has made a contribution towards explaining the economics of migration; however, it is not without its problems and limitations. This theory does not give an explanation as to why training is needed for migrants in almost every destination country, regardless of the skills an individual has in their home country (Arango, 2000). Also, held against this theory is its focus on human capital variables, whilst excluding other variables that sometimes directly influence migration, such as the policies of acquiring a visa, or access to the destination, to name a few. Finally, the HCT adopts a highly individualist approach, neglecting wider social influences on migration decisions, such as the family, or the community roles in the decision.

2.2.3 The new economics theory

Oded Stark developed the new economics theory (NET) after his observation of many migrants, who consisted of individual family members, rather than an entire family (Arango, 2000; Stark, 1995). He noticed that some migrants remained for several years, moving between the source and destination country (Isbister, 1996). NET assumes that migration may occur when a family wants to increase its income, relative to the other families in the community, rather than just improving the absolute household income. In addition, families send members abroad, not just to maximise income, but also to diversify income resources, and insure against risk.

Unlike the neo-classical and human capital theories, which consider migration to be an individual decision, the NET approaches migration as a decision taken by the family, or sometimes by the community. However, it shares with both NCT and HCT the rational choice of the migrant, and makes use of push and pull factors. In NET, families may send members to different destinations to minimise risk, or more than one member to the same destination, to support each other. Massey et al (1998) argue that families, or the community, are in a good position to control risks to their economic well-being. NET links information gathered by the individual, with the family information, and uses it as an input for the decision to migrate.

NET incorporated the human capital theory by accounting for the influence of the individual migration cost on the family. It highlights critical interactions between individual and family variables, including the human capital of the family members, which are added to that of the migrant.

NET extended our understanding of migration over the neo-classical theory and the human capital theory, by suggesting that the wage differential is not necessarily the only, or even the main cause in the explanation of migration. Instead it highlights the

role of the family and information in the complex process of migration. However, this theory also faces many challenges. According to Arango (2000) it does not constitute a sufficiently coherent theory. The empirical evidence presented to support this theory relies on studies carried out in a small number of rural villages in Mexico (Massey et al., 1994), which only documented farm labour migration, and a long-term migration relationship with the destination country, as the causes of migration from the source. Therefore, its applicability when explaining migration of highly skilled labour, such as nurses, and their international mobility is open to question. Despite its relevance to explaining individual migration and the role of the family, it cannot be applied to family migration. This theory can predict causes of migration at the source country (push); however, it ignores the destination country (pull).

2.2.4 Social network theory (SNT)

The New Economic Theory was probably the first theory to consider family dynamics as an explanation of mobility and the empirical research associated with the NET hinted at network influence on migration. Migration networks are defined by Arango (2000 p 291) as "sets of interpersonal relations that link migrants or returned migrants with relatives, friends, or fellow countrymen." Networks require linkages between people already in the destination, and those not yet there or still in the home country.

The SNT explains migration as likely to happen when there are friends or relatives living in the destination country (Krissman, 2005). Contrary to the neo-classical theory, the SNT suggests that migration expands as groups of many people from a small number of source countries, migrate to a small number of destination countries. The existence of relatives, and other social networks make migration less costly, less uncertain and reduces the risk. Relatives and friends can provide social and cultural

support to new migrants. They convey information, provide financial assistance, facilitate accommodation, and can provide help to find jobs. This implies that once a few nurses from Jordan, for example, arrive in the UK, it might be anticipated that more Jordanian nurses will go to the UK, rather than to other places.

The SNT makes a major contribution in bridging the gap in the understanding of migration, especially taking into account the transition from micro level to macro level in terms of decision making (Arango, 2000). The SNT extended into social relations theory, when Massey and Zenteno (1999) combined networks and social capital into one theory. According to the SNT, recruitment agents and intermediary organisations are part of the networks, which usually assist migrants to overcome entry barriers after they have taken the decision to move. However, inclusion of such agents and organisations as social capital variables, lacks consistency and context. Probably at the moment, this theory does not give specific empirical evidence on the influence of returned migrants, when they experience a 'failure' on the flow of migrants from home to the destination country. While, SNT may explain the continuation of migration, it lacks an explanation of why migration stops to some destinations. Moreover, it ignores the carrying capacity of the destination country, and assumes migration to continue indefinitely (Light et al., 1993). Another limitation of this theory is that it identifies individuals and their networks as appropriate units for analysis, and excludes other factors, such as employers and recruitment agencies.

2.2.5 Dual labour market theory

The dual labour market theory was first proposed by Michael Piore (1979). It explains international migration as the result of a high demand (pull factor) in destination countries for foreign labour. Some articles refer to the theory as being about a segmented labour market, because it classifies jobs into desirable and undesirable

segments, for the local labour (Fields, 2004). Desirable jobs are stable, well paid, require skills, and often involve working with expensive capital equipment. On the other hand, undesirable jobs are unstable, insecure, low paid, dangerous, with low social prestige, with poor prospects of advancement, and lower social and professional mobility. Thus, local people would prefer not to perform them, causing a gap, which is then filled by migrant labour. The theory provides several explanations as to why migrants accept unpleasant jobs. Firstly, they accept the job as a transitionary and temporary position. Secondly, the migrants may plan to return home some day. Thirdly, even low wages are usually higher when compared to the income in the home country. Finally, the status and prestige, which counts for migrants is how it is perceived at home, and not in the destination country (Massey et al., 1998).

The dual labour market theory does not contradict rational decision-making by migrants as mentioned in the neo-classical theory, because migrants from low-income countries perceive low-wage jobs in their destination countries as employment opportunities. Recruitment by employers or agencies helps to minimise barriers to migration, as it introduces information before the decision to move, and this makes it easier to take a decision in favour of migration (Massey et al., 1998). The impact of this approach can be seen in the data for this study, where potential migrant nurses were rumoured to be required to fill jobs that the UK nurses did not want.

The dual labour theory pays attention to the receiving countries, and analyses the pull factors for foreign labour, whereas the neo-classical, human capital, and new economics theories are basically micro-decision theories, using a range of units for analysis (the individual or the family). Dual labour markets may offer an explanation at the macro level of structural determinants. The theory explains the demand by some destination workplaces for migrant labour, but is relevant only in the case of low-

skilled, low-wage labour, and not for the highly skilled and well-educated migrants (Fields, 2004). It considers that international migration is demand-driven, and excludes the push factors. According to this theory, active recruitment is the primary factor that attracts international labour to a destination, although there are many destinations adopting restrictions to control the growing flow of migrants. For example, the UK and the USA apply visa restrictions and several registration procedures, before a nurse gains official access to those countries.

2.2.6 World systems theory

The world systems theory (WST) classifies countries in terms of their power or economic domination, into core (industrial societies), and peripheral (non-industrial societies) countries. According to Massey and his colleagues (1993) the social historian Emmanual Wallerstein developed this theory by adopting historical-structural explanations of international migration.

Massey and his colleagues (1998) argue that migration tends to follow routes determined by the contemporary world systems, and that penetration of developed economic relations into less developed countries creates a population prepared to migrate to the core countries. Arango (2000) claims that migration, according to the world systems, stems from an unbalanced international order, which reinforces inequality. According to the world systems theory, international migration is a result of the structure of the world markets, rather than the difference in wages and income levels, or employment rates, between countries. Developed countries need international labour to work for low wages in certain sectors.

In the past, colonial powers formulated a world system, however, capitalism and market power currently drive the world trade, and this creates mobile labour. Neo-colonial regimes, multinational corporations, and foreign investments engender

mobility of labour. (McNeil-Walsh, 2004; Bhorat et al., 2002). The developed countries' dominance of the markets altered the socio-economic and cultural conditions in the less developed countries, which in turn motivated labour migration in the direction of the developed countries investments.

The WST explains migration as being a result of world market forces. Those forces come from the media, multinational corporations, free trade agreements, and foreign investments (McNeil-Walsh, 2004). In other words, international migration is a natural consequence of world trade and market forces. The world systems theory sheds light on the importance of past and present relations between countries at different stages of development, which cause migration.

The world systems theory is challenged by its level of analysis, as it is restricted to the international level, and in all likelihood it is not possible to make a micro version which can explain migration at the individual level. Massey and his colleagues (1994) claim that highly qualified and skilful labour is attracted to destinations as a result of economic globalisation. Globalisation generates a strong demand for expertise in different disciplines, and the highly educated labour migrates as a response to this demand. This theory assumes that all countries pass through a similar process of historical development. Furthermore, while it may provide a background for the study of specific migration relationships between countries, it is a difficult theory to test in the field.

2.2.7 Cumulative Causation Theory (CCT)

Migration is a self-nourishing trend. Regardless of the conditions that may initiate crossing of borders, it will continue, either for the same reason, or due to other factors, which may develop over time and place. International migration transforms the persons and/or their original community in the sending country – a socio-

economic shift that encourages further movement (Fussell and Massey, 2004). CCT argues that each act of migration changes the person or his/her original community attributes, thereby influencing the subsequent decisions for migration.

CCT builds on theories of social capital and social networks. It assumes that there is a change in the reasons for migration, which usually occurs after the first act of migration. The social capital attributes of the migrant change, which pushes for more migration. For example, at the individual level, the migrant acquires some personal knowledge and experiences in the destination, which may lead him/her to repeat the action, whether to the same destination, or elsewhere (Massey et al., 1994). At the community level, others may migrate from the home country because they have relations with migrants from their society in the destination country. While, the cumulative causation factors of professionals and highly skilled mobility are probably different, Massey and his colleagues (1998) pointed to several factors that contribute in the migration of the less skilled from rural areas. To mention two key factors for unskilled labour migration, the first is the expansion of network space. That is to say, migrants are access points for other members of their original society to the destination country. Secondly , the culture of migration that is the values and cultural perceptions that people in the sending community develop with the growth of migration, result in more decisions to move from members of this community. However, this requires information about the beliefs, values, and normal practices, which is difficult to collect.

In brief, CCT assumes that current migration situations and patterns determine the future projections and flow of migrants. It posits that once the level of migration in a community reaches a certain level, regardless of the presence of original causes, migration will be sustained. However, empirical research shows that the CCT is likely

to be limited to the rural contexts, and may be able to explain mass migration (Fussell and Massey, 2004), but is not applicable to the migration of professionals and less applicable at the individual level.

2.2.8 Comments on migration theories

Although scholars have developed a whole range of theories independently, no migration theory encompasses a total explanation. In spite of their strength in examining 'leavers', current empirical studies fail to give any detailed explanation about 'stayers' and they do not explain adequately the complexity of migration. The theories are criticised for their focus on the push and pull factors of migration, and the marginalisation of other aspects, such as those concerned with personal and professional issues. Each migration theory outlined above is useful in that it is able to identify and offer the theoretical and empirical evidence of key factors in labour migration. Despite the important perspectives provided by migration theories, Arango (2000) argued that they lacked epistemological rigour, and that most of them were weak in terms of logical status. Moreover, even cumulatively, they failed to capture the characteristics of every migration phenomenon.

These theories have been discussed and critiqued in order to provide a background for the interpretations of the Jordanian nurse migrants' accounts and experiences. The theories give general accounts of labour migrants, but at a level of abstraction, which does not take account of skill levels or qualifications and does not differentiate between the migration of skilled professional and unskilled labour or level of qualification. This leaves a question of whether the migration experiences of professionals and non-professionals are different. In order to examine the experiences of migrant nurses, I first focus the content of the literature to examine the migration of

other professionals. That is to highlight the possible theoretical backgrounds, against which to draw on professionals experiences.

2.3 Migration of Professionals

Khadria (2004a) classified labour migrants into four categories: professionals, skilled, semi-skilled, and unskilled labour. Nurses are included in the professional category if they have registerable qualification, but are categorised as skilled or semi-skilled labour if only technically trained (Brush and Vasupuram 2006; Huston 2006; Zulauf 2001). Much of the literature on highly skilled and professional migration has left the definition of 'profession' unclear (Raghuram and Kofman, 2002; Raghuram, 2004a; Iredale, 2001; Brooks and MacDonald, 2001). However, research on professional migration requires an absolute definition of 'profession' (Iredale, 2001). According to Brooks and MacDonald (2001 p. 41) a 'profession' in general terms is "an occupational group which provides an exclusive service involving the discretionary application of specialist knowledge". Here, 'professional' refers to group of people sharing the same career, for example, doctors, teachers, lawyers, or nurses. In the discussion below, the definition is extended to include the field which requires extensive study, specialised knowledge, and clear standards, which control the practice of the professional members.

Building on the preceding critical review of labour migration theories, this section examines the literature on the migration of two professions in order to set nursing migration within a specific context of professional migration. It examines the influence of the profession on the prospects of migration, and consequently, the experience. Physicians and Information Technologists (IT) were selected because both are included in the professional category. Alkire and Chen (2005) argue that medicine and nursing share many attributes in terms of being in the same field of

work. However, the debate whether Information Technologists are professionals or skilled labour migrants mirrors the debate on nursing (Khadria, 2004a; Khadria, 2004b). So that, IT migration literature has potential to shed a light on the profession perspective.

To address these issues, this section reviews and examines migration from the professional perspective, identifying what motivates the professionals to take a decision to migrate, in the light of the push and pull factors, which run as a common strand along the previous migration theories.

2.3.1 Factors influence the decision to migrate

In terms of professionals, economic factors may push or pull to migrate, but they are not the only factors. For example, the social dynamics of households, communities and workplaces, were also found to be significant factors in the migration process and its outcomes (Hardill, 2004; Dovlo, 2007; Fang, 2007). These are explained as family contacts, educational benefits, dislike for the previous work place or residence, and the desire to get away from the family work place or the country. Other factors are psychological patterns, which are explained by Hardill (2004) in terms of variables, such as the choices, perceptions, feelings and beliefs of the migrant.

Amongst other push factors, is the eagerness to apply the knowledge and skills they have learned, which may not be required in the vocations of the home country. After graduation, many professionals find that they have skills, which are in demand internationally, as well as locally (Oweis, 2005). The graduates from developing countries obtain qualifications based on education systems, designed for the more developed countries (Home-Office, 2002; Bhorat et al., 2002; Dovlo, 2007). Oweis (2005) argues that their education and skills do not easily fit into the local needs of the home country. Other factors which may push professionals to leave their home

countries, have been cited as declining quality of life in their areas, low wages, and lack of professional and career development opportunities (Dovlo, 2007; Fang, 2007; Bach, 2006; Eastwood et al., 2005). Bhorat et al (2002) reported that the quality of life in the home country may decline, due to safety and security reasons, taxation, cost of living, and private and public service standards.

Pull factors, sustained by a high demand for skills in the destination countries and the willingness of professionals to seek a better life, have been reported by several studies (Bhorat et al., 2002; Hardill, 2004; Dovlo, 2007; Fang, 2007). Professionals are highly educated and as such expect to be rewarded with a high standard of living and work conditions. In the absence of secure and stable positions, and a certain future , the professionals are compelled to search for these in other countries.

Disparities in technology and organisations across countries enhance the willingness of professionals to move. Bhorat et al (2002) argue that prospective professionals from around the world are now probably able to access the same information as prospective, home based applicants.

A migrant's decision to move is combined with other decisions, such as whether to stay permanently or temporally, and whether to maintain or break connections with people in the home country. There is no doubt that push and pull factors exert a significant influence on the decisions of professionals to leave their home country and employers.

Ultimately, the individual professional, who may be a nurse, translates the push factors into motivations to leave their home country, and the pull factors are motivations to move to the destination country. The following is a brief review of physicians and IT migration, before proceeding to the nurses' migration.

2.3.2 Migration of physicians

Several studies have examined the migration decisions of physicians (Dostiey and Legerz, 2005; Brown and Connell, 2004; Norcini and Mazmanian, 2005; Mullan, 2006; Ogilvie et al., 2007). These suggested that certain personal characteristics, as well as differences in potential income, may help to explain physicians' decisions on migration. However, many studies examine only the initial practice location of newly graduate medical students, and do not examine the physicians after migration, or even junior or senior physicians who stay in their home country.

Khadria (2004) reported on the intentions of Indian medical students and physicians to migrate. He found that 85% were planning to go abroad to get jobs with better training opportunities. The study reported factors such as 'rapid progress in the medical profession', better employment opportunities, and gaining medical experience in a foreign country.

Dostiey and Legerz (2005) examined whether physicians were more likely to migrate to areas where the skill reward is high. According to their study, specialists are more likely to migrate, than are general practitioners. In addition, they found that individuals were likely to select countries or regions where the returns for their skills were likely to be high. However, the study had an optimistic assumption and a non-realistic conclusion when claiming that physicians' decisions are always rational and that they face no difficulty when they decide to migrate.

Norcini and Mazmanian (2005) argue that migration may be inspired by the desire to acquire higher professional qualifications or to gain experience with new techniques , not available in the home country. Furthermore, the migration of physicians may produce benefits to the physician and the source country, through the upgrading of skills and the technological and financial transfer of human capital from the

destination country. On the other hand, if the skills which the migrants acquired during their stay abroad are too specialised, the home country may not be in a position to take advantage of them, when they decide to return. Thus, the physician migrates again, or even stays in the host country and does not think of returning home.

CCT and SNT explained how the migration of one group to a destination country encourages others to leave the home country (Massey et al., 1998; Krissman, 2005). Raghuram (2004a) argues that the migration of physicians from the home country, creates training places for other fellow physicians in the destination country. Moreover, many physicians after training in a particular place prefer to continue to stay there or come back later, because of the social networks they have built in the training institution. Such opportunities for professional training (as a pull factor) may enhance better employment opportunities with higher wages than in the home country.

The skills and qualifications of the physicians may restrict their migration, due to the incompatibility of education systems and medical practices between the source country and the destination (Raghuram and Kofman, 2002). Most countries ask the international physicians to register and gain professional license prior to practising. This registration requires passing exams and undergoing training in the new country. However, registration and licensing necessitate the physician to hold a required qualification (medical degree) from a recognised school and to complete a period of training, usually used for adaptation to the new practice setting.

In the UK, physicians who are seeking to practice need to register with the General Medical Council (GMC) (Dauphinee, 2005). International physicians need a visa to work in the UK and usually they are advised to enter the country on a visitor visa, as a

permit-free trainee, or a work permit visa (Ineson, 2005). They can obtain the GMC registration through one of three routes; either sitting for the PLAB (Professional and Linguistic Assessment Board) examination, or getting a sponsorship from an Overseas Doctors Training Scheme (ODTS), or being exempted from PLAB through the regulating specialists bodies of the Royal Colleges.

Astor et al. (2005) argue that regulations on physicians' registration restrict the access of migrant physicians to different destinations. In Canada, international physicians must take the Medical Council of Canada Evaluating Examination, and must fulfil the registration requirements of the licensing bodies. Dauphinee (2005) mentions that many international medical graduates arrive in Canada without prior arrangement for employment with the result that delay their registration. In order to practice in the USA, physicians trained abroad must pass a clinical skill assessment exam and sometimes complete graduate training and in Australia, physicians are required to pass an examination administered by the Australian Medical Council. This shows that professional registration whilst offering a passport for migration, is not directly transferable.

Several countries were concerned about the movement of highly competent physicians and international recruitment (Aluwihare, 2005). So a working group from the UK, Canada, Ireland, Australia, Pakistan, the USA, and New Zealand, a few years ago developed a 'medical passport', which would assist physicians from the member countries to move easily between them (Ineson and Seeling, 2005). Such measures might contribute to the migration of some of the best and most talented from the less developed to the more developed countries or vice versa.

With regard to the physicians' migration to a destination country, there are other factors usually shared with other professional and unskilled migrants. These factors can be described in terms of push out of the home country and pull toward the host country, beside others, which stem from the migrants themselves. Examples of push factors are similar to those identified in the first section on migration theories, such as less attractive pay, work conditions, high unemployment rates, political instability and insecurity in the home country (Aluwihare, 2005). Those factors are often combined with pull factors, such as the inability of some destination countries to produce enough physicians for their own needs (Khadria, 2004a). However, receiving countries offer the international physicians an opportunity of relocation to better themselves financially, greater job satisfaction, research and other facilities, (Ogilvie et al., 2007). Some physicians migrate for family considerations, such as a partner or family member residing in the destination country as identified in the SNT. Usually the physicians' families are educated compared to unskilled migrants' families (Martin, 2003). Furthermore, the spouse is also often a health care professional, and the children are potentially educated professionals (Hardill, 2002).

In conclusion, this brief review highlights important issues in the migration of physicians, which elucidate the main theories of the SNT, the CCT and the DLT by connecting them with the empirical evidence and that may have similarities, differences and some connections with the accounts of nurses. Firstly, governments, registration councils and unions regulate medicine as a profession; these have their role in migration and employment in any country. Secondly, physicians are likely to have similar reasons for migration as all migrants, as illustrated by the NCT, the HCT and WST, but they have specific motivations, such as rapid progress in medicine and the value of medical experience obtained from certain countries. Furthermore, each

profession has relatively different reasons and factors, which influence the members' decisions to migrate, such as the regulatory bodies and the nature of the profession. Yet nurses do not have the established sense of 'profession' that medicine does, and in order to offer insights from a more marginal profession the literature on Information Technologists is examined.

2.3.3 Migration of Information Technologists

Demand for Information Technology professionals (IT) exceeded most countries production, after the rapid growth in the information technology industry in most countries during the 1990s (Raghuram, 2004b). According to Raghuram (2004b), the industry had become more specific in its demand for skills and qualifications, although most migrants tend to hold general skills, as they are more transferable. However, employers produce detailed lists of qualifications for IT positions. For this, foreign-trained IT professionals face difficulty in matching their skills and experience with employers specific requirements (Raghuram, 2004).

Compared to physicians, information technologists' (ITs) migration is less clear in collated figures. Chakkalakal and Harvey (2001) report a difficulty in collecting data about IT due to the absence of any registration body This makes it difficult to predict how many IT migrants there are in any country, especially the less developed.

Certain specialities of the IT profession do not require movement of the employee to the work place. For example, an establishment in the UK may employ IT professionals as 'tele-workers', to perform jobs while they are in their office, or at home in India or Jordan, for example (Chakkalakal and Harvey, 2001). There is no need for an on-site presence for execution of the work which may have resonance with tele-medicine and tele-nursing. This form of IT work has developed an invisible (non-physical) migration of labour. Aneesh (2001) conducted interviews with

programmers and high-level management executives of many software firms in both India and the USA, to gain grounded, contextual and ethnographic information about on-line labour practices. The study reported that IT labour migration occurs without a visa, as they work from their home country. This is probably an implicit exclusion of those invisible migrants from having to adjust to the new culture, subject to relevant in house training, or even having to make any change in their daily life when performing the job. Contrary to this, visible migrants (such as physicians and nurses, or even IT) who physically move to the destination, require adjustments which may change the pathway of their migration.

Aneesh (2001) argues that IT migration is influenced by the IT industry flexibility and the deregulation of the labour market. Both are characterised by job mobility, and sometimes the location of the employer is distant from the employee's location (tele-working). IT organisations are characterised by executing projects for customers in a wide geographical area. Some employees might be required to move and work for a long period, at the site of the client. Aneesh (2001) reported that, in some cases, the employer requires the employee to move for a very short period to the host country work place. In this case, it is only a temporary relocation, and not migration and this may have equivalence in health when international nurses and doctors are recruited during shortages, but discontinued if there are policy changes (DH, 2007). Those IT professionals may not accrue cultural adjustment when they migrate. Moreover, they do not need even to consider all of the other issues, which accompany the physical presence of the employee in the job site for a long period.

As with physicians, information technologists are pulled to migrate by opportunities for training and to gain further experience (Raghuram, 2004). Chakkalakal and Harvey (2001). Aneesh (2001) reported that ITs are usually young, and prefer to be

mobile because of the nature of their profession. Moreover, information technologists are eager to work with the latest technology and they adapt easily to it. Therefore, they make use of the high demand for their skills, and keep moving from one firm to another. This mobility is also encouraged by the high demand on IT skills, and the high competition between technology firms for the development of services and products.

The key issue facing skilled migrants, whether physically moved or not, is knowledge of the language, which is usually required by the recruiters (Johnson et al., 1999; Hawthorne, 2001; Baumann et al., 2004). The IT positions are highly technical in nature; however, they require a certain level of communication skills. According to Raghuram (2004b), many foreign IT professionals acquire the level of language necessary to perform their jobs fully, after migration. On the other hand, the recruiters in the IT industry remarked, there is no standard language required for employment in this field, and probably across the entire sector. However, employers usually assess the language abilities needed indirectly during the recruitment interviews. While, the IT sector terminology is probably the same around the world, there is a need for terminology specific to each work place or industry. Compared to that, the nursing profession requires high communication skills (Iredale, 2001) on two levels. First, nurses on the technical level need to communicate with their colleagues, and second on the lay level, they need to converse with clients and for daily life. This is why many registration bodies for nurses in the destination countries require a language competency certificate, or apply for an assessment prior to the application for registration (Aiken, 2007; Nursing and Midwifery Council, 2007; Walters, 2008).

Iredale (2001) argues that university training is too academic, inflexible and too slow to adjust to the needs of the labour market. Specifically, some private employers have

established their own internal training systems (e.g. Microsoft), and their qualifications are widely accepted and accredited (Raghuram, 2004b). IT professionals are credited and valued for their IT training certificate from some large companies, more than for their university degrees. However, the study did not mention any details of whether the qualification is the one generally recognised, or one indicative only of certain skills which are acquired from that corporation. This issue raises the question of whether a person without any academic qualifications, but having very specific IT skills, will be recruited by employers across the borders or not.

Information Technology has an absence of national and professional control or regulations for its professionals and members (Manning and Sidorenko, 2006; Iredale, 2001). Therefore, ITs do not have the same professional accreditation requirements, which are essential for professions, such as medicine. However, ITs have fewer barriers in terms of international mobility and transferability of skills when compared to nurses, as will be explained in the next section.

I conclude from this section that there are variations in migration issues across professional groups. The attributes of physicians' migration have commonalities and differences with the characteristics of IT professionals' migration. Comparing physicians and IT literature on migration we can see, first, emphasise on family pull in physicians. Second, shared interest in personal development and improved work conditions. Third, easier mobility for ITs because members are young and profession less regulated.

Alkire and Chen (2005) argue that nurses' and physicians' migration should be treated as different from other skilled and professional migrants because their home countries

need them to fill the shortage of workforce in the health system. Alkire and Chen (2005) depend on findings related to the shortage of health professionals operating as pull factor and as this study will show, shortage plays a part in the recruitment of Jordanian nurses to the UK.

While nurses have similarities with Physicians and ITs, they have differences in terms of characteristics related to their profession, which imply different experiences. The experiences of migrant nurses and the role of regulatory bodies in nursing migration are discussed in the next section.

2.4 Experiences of Migrant Nurses

Although the labour theories provide interpretations for the migration, the professions' literature indicates the complexity of the phenomenon. The degree of complexity more likely reduced in case we deal with part of the whole such as taking nursing and excluding other professions (Kingma, 2006a). Nursing as a group of professionals has attributes which require the researcher to address it in isolation from other professionals such as the physicians and the IT. Nursing, like any migration, including professionals migration, operates and acts in an economic, social, cultural and political environment. Nurses workforce diffuse along all directions of the world, responding to the calls of the increasing demand on health services (Kingma, 2006b). On the international level, nursing workforce and financial assets (foreign currency) are repeatedly reported in shortage and as such, countries have to formulate a strategy as regards nurses' migration to balance out the situation (WHO, 2006). However, there is nothing inherently positive or negative about the flow of nurses across the borders. The outcome depends on who governs the flow, which determines who benefit from it. Little in the literature addresses the benefit of nursing migration but it does suggest that migration has not been equally distributed, with some gainers and

some losers. This may be the case both between countries and individuals (nurse as employee and employer). Because it is difficult to measure the benefits of migration, experiences remain a useful indicator.

Larsen et al. (2005) argue that the exploration of individual life perspectives, values, expectations, hopes and plans, provides an explanation for the migration of nurses. They add that nurses' life strategies under the conditions of the host country construct perspectives, which inter-relate micro to macro aspects of migration. Migrant nurses choose from a set of options, which influence their personal and professional experiences during their migration journey. These options are combinations of economic, social, and psychological factors. The nurses, during migration, decide on their career opportunities, financial security and the psychological and social costs of leaving family, friends, and their country. Apparently, deciding on any of those could influence the nurses' migration pathway, and might end with a different experience for every migrant.

Migrant nurses go through a journey full of opportunities and challenges, where they overcome barriers, adjust to the world of work and the new country and progress through numerous workplaces and positions (Buchan etal 2006; Walters 2008). Therefore, it is important to examine the migrant nurse's experience. These experiences have implications for at least three of the stakeholders. Firstly, there are implications for a nurse wanting to leave a familiar environment in the home country, to go to an unfamiliar environment in the destination country. Secondly, there are implications for the source organisation, and destination organisation. This is because the nurse leaves the first and joins the second, and this influences the quality of care, the employees' management, and planning for the health organisation. And thirdly, there are implications for the family and dependants of the nurse.

According to Moran et al (2005), the motivations, experiences and perspectives of migrant nurses have not been thoroughly explored, particularly with reference to the understanding and management of the global flow of nurses. Buchan and his colleagues (2005b) report on several issues and knowledge gaps in the international migration of nurses. According to Buchan etal (2005b) researchers have not sufficiently addressed personal and professional experiences of migrant nurses working in the destination countries. In another study in London, Buchan explicitly argued:

> *'little evidence is available on the attitudes, experiences, motivations, and career plans of international nurses in the United Kingdom'.(Buchan 2007 P.1325)*

Likupe (2006) added to Buchan and his colleagues work, noting that little research has been done on specific groups of migrant nurses. Within what is known from empirical studies, we know some about the experiences of nurses after they migrate (Withers and Snowball, 2003; Aboderin, 2007; Ryan, 2007; Troy et al., 2007; Walters, 2008), but little addressed about their experiences during the transition and before migration.

Much of the literature is anecdotal, or relatively biased on the bases of taking negative experiences only, or drawing on accounts of a small sample (Alexis et al., 2007; Allan and Larsen, 2003; Mc Gonagle et al., 2004; Taylor, 2005). Whilst there are rumours amongst people in the home country that migrant nurses have a happy experience, the media and some research focus only on unhappy experiences (Allan and Larsen, 2003; Dicicco-Bloom, 2004; George, 2005; Percot, 2005). Buchan et al. (2006) argue, it is not true that most of the nurses' experiences in the host countries are always negative, because recruitment agencies provide misleading information, or employers have exploited them.

Aboderin (2007) reported on the contexts, motives, and experiences of Nigerian nurses in the UK. She indicated that any examination of the perspectives of nurses must begin by demarcating the time and life course.

2.4.1 Pre-Transition Experiences

This phase of experiences is almost ignored in nursing literature and less addressed in the wider migration literature. Although the migration theories addressed it as push and pull factors leading to migration, researchers used proxy (substitute or indirect) measures to find these factors. What the studies consider as push and pull factors are not the actual experiences of migrant nurses, rather, it is the macro illustration of the proxy (substitute) informants. Researchers avoid the actual informants in this case, because of difficulty in reaching them and therefore proxy informants are used. If the relevant personal push and pull factors are to be identified, then appropriate informants need be approached and a study of migrant nurses experience could capture the most relevant push and pull factors. Previous research has indicated that migrant nurses have a range of push and pull factors when seeking work abroad (Kline, 2003; Padarath et al., 2003). However, further research revealed differences of reasons for migration, according to the source country. Whilst Indian nurses go abroad to better their financial life and to escape from difficult work conditions, Australian nurses go to the UK for travel and working holidays (Moran et al., 2005; Khadria, 2007; Thomas, 2006). Larsen et al. (2005) suggest that variations in motivations influence the experience of migration.

De Jong (2000 p309) argues

> *'expectations of attaining valued goals in an alternative location to the home [country] along with perceived family norms about migration behaviour are the major determinants of migration intentions. Expectations plus valued goals define motivations for migration.'*

Literature about migrant nurses rarely documents the experiences of nurses prior to migration. However, these experiences are evident in the policy research and surveys, whether related to migration or not. Researchers express the pre-transition experiences as the intention to leave and the decision to migrate (Võrk et al., 2004). Many of the intentions to leave are documented in literature, through surveys which collect data related to issues other than migration. Therefore, there is insufficient evidence in literature of how the nurses formulate their intentions to migrate.

Nurses migration is a complex and multifaceted phenomenon which is intimately intertwined with nursing education. Choy (2003) suggests that nurses' experiences in relation to migration are initiated during the education phase, but that this is under represented in the literature of migration. However, anecdotal sources and non-rigorous literature, which focus on intentions rather than experiences, provide indications that some nurses develop migration plans during their study (Button et al., 2005; Võrk et al., 2004). When the literature examined this aspect, two issues were brought to the fore as regards the student intentions to leave after study: first, the acquired skills and its transferability, and second, the nurses' status in the home country.

Student nurses realise during their study that access to any workplace is facilitated by the portability of the skills and its applicability to the setting (Marchal and Kegels, 2003). That means, their training and practice setting is not at the level of what described in their curriculum. While, they gain the nursing skills, they develop a

dream of practicing in the environment described in their textbooks (Oweis, 2005). Even after the transition from study to the first job, these nurses encounter challenges in applying what they have learnt in their local health care systems. Therefore, some develop a desire to search for organisations that will utilise their abilities and qualifications (Gerrish, 2004; Robinson, 2004; Kingma, 2006c). In this sense, models of nurses' training and education around the world can be a key factor in nurses' migration (Choy, 2003; Robinson, 2004).

Student nurses also develop intentions to move outside their home countries because their education does not endow them with the status they are looking for. Education plays a vital role in the empowerment of nurses and achieving professional status. Part of the requirements of being a professional, is the educational qualification (Petro-Nustas et al., 2001). However, sometimes all of the requirements for a regulated profession may be achieved, and yet the skilled group cannot claim a professional title. Zulauf (2001) argues that there are major debates as to whether nurses can claim full professional status; this is due to the debate on other requirements, that nursing is not fully autonomous from medicine.

New graduate nurses seek employment to earn respect, prove their self worth, and fulfil their dreams. When new graduate nurses seek employment, they search for better pay and work conditions, whether at home or abroad. The migration by nurses for positions abroad has become significant in many countries, whether developed or less developed (Schrecker and Labonte, 2004).

In a study about potential migration flows of Estonian health care professionals, more than half (56%) would like to work abroad. Võrk et al. (2004) report that their intentions were equal to the intentions of nurses in Hungary and the Czech Republic

and higher than those in Poland and Lithuania. According to Brown and Connell (2004), the nurses' intentions to migrate from the Pacific were embedded in an extended family context, where decisions to migrate and return were linked to household, as much as individual aspirations and goals which conforms with the NET of migration.

The analysis of nurses' intentions to migrate does not indicate how many nurses would go abroad. So, it becomes relevant to examine the intentions of each country's nurses, in order to draw implications specific to that country. What are the factors that influence a nurse to take the decision of going abroad?

In the absence of specific data about nurses who leave to work abroad, empirical studies remain the most trustworthy in understanding this phenomenon (Mesquita and Gordon, 2005). The nurses' intentions to go abroad may be evidenced in the studies of the internal mobility between workplaces within the country. Data about intentions to leave the work place is usually collected by surveys of nurses in the source country (Poole and Isaacs, 1997). Although this kind of survey is significant when describing the reasons for migration, it is unlikely to capture the final decisions. Moreover, the participants' answers are likely to be inaccurate, particularly when they are holding a job in the home country, and they are not sure about the consequences if their intentions become overt.

Nurses seek employment abroad when they have enough motivation to leave the home country (Winkelmann-Gleed, 2006; Larsen et al., 2005). Empirical studies mention push factors, such as poor working conditions, the lack of promotion opportunities, poor living conditions, poor wages, unemployment, and the fact that

some countries adopt a policy of exporting nurses to gain remittances (Munro, 1999; Larsen et al., 2005).

The nurses may also be motivated to leave because of a workforce shortage, which may results from poor retention, inflexible working conditions or heavy migration abroad. Nurses who are leaving to work in neighbouring countries, or elsewhere, may contribute to the crises of the shortage of nurses (Dovolo, 2007; Hongoro and McPake, 2004). Nurses also frustrated by low pay, lack of available resources, inappropriate workloads, and inefficient support systems (Kingma 2005).

On the other hand, pull factors in the destination country motivate some nurses to leave (Huston, 2006; Thomas, 2006). For example, the growth of demand on health services, changes in the conditions for visas and work permits, active employment by recruitment agents, a shortage of nurses in the destination country, the availability of employment with better working conditions, and higher wages (Kline, 2003; Buchan, 2004; Dugger, 2006; Huston, 2006; Thomas, 2006). Other pull factors are also reinforced by personal factors. Kingma (2006) states that some nurses have chosen nursing as a career in order to have the opportunity for travel and adventure. In addition, nurses could leave for a family reunion, the mobility of close relatives overseas, and, in certain cases, for marriage in a foreign country (George, 2005; Kingma, 2005). It is reported that nurses from the less developed countries leave in search of (pulled by) better working conditions, and quality of life in the destinations (Mensah et al., 2005; Muula and Maseko, 2006).

Another pulling factor is the imbalances in output of nurses' education in some destination countries (Buchan, 2002; Dovlo and Martineau, 2004; Alkire and Chen, 2005; Huston, 2006). This is reported as the primary reason for the shortage of nurses,

and the consequent migration (ICN, 2003; Buchan and Calman, 2005; Ross et al., 2005; Labonte et al., 2006; McElmurry et al., 2006). A nurse's training and education is costly because of the long duration, the high costs of teaching, and the limited resources of some countries (Muula, 2005; Loewenson, 2004; Martineau et al., 2004). Consequently, some countries save this cost by attracting and promoting international and regional mobility of ready trained and educated nurses (Dugger, 2006; Buchan et al., 2004; Buchan, 2002). The mobility of skilled nurses from countries with limited resources (developing countries) is widely considered to be a growing problem (Zulauf, 2001).

Migration, evidenced from the significant upward trend of the nurses' outflow from many countries (Bartel, 1979). For example, the number of nurses from the Philippines, who were registered in the UK, rose sharply from 3,396 in 2001 to 7,235 in 2002 (Muula et al., 2003; Singh et al., 2003).

Some countries assist their nurses to overcome the barriers to going abroad, by taking certain measures and preparing them for the journey. For example, the Philippines conducted induction programmes for the nurses which they attended before leaving for their destination (Choy, 2003). However, some measures taken at the source country may push them to migrate, whilst it was intended to retain them.

Although push and pull factors of migration analyse the reasons of the phenomena at the countries' level, they also have implications at the individual level. Just to summarise and put these factors in the context of individual nurse's intentions to go abroad, they are the same push and pull factors, which stand for the decisions. It has been reported that actual migration decisions are associated with relatively low pay, or greater relative earning differentials, and poor employment conditions in the

original country, or sometimes the workplace (Vujicic et al., 2004; Winkelmann-Gleed and Seeley, 2005; Thupayagale-Tshweneagae, 2007; Walters, 2008). Whilst this can be attributed to inadequate human resource planning, unrealistic work loads, poor infrastructure, falling service standards, declining investment in the public health sector, and limited employment opportunities (Hardill and MacDonald, 2000; JobStart-and-Skills-for-Change, 2001; Martin, 2003; Martineau et al., 2004), the issue not easily resolved. There is also significant consideration given to the impact of work-associated risks on nurses, such as AIDS, TB, and sometimes the fall of the service standards in their workplace (Dovlo, 2007; Dovlo and Martineau, 2004; Kline, 2003). For personal security, many nurses probably have no choice but to leave from areas of conflict, repressive political environments, and crime infested areas (Ogilvie et al., 2007; Pike and Ball, 2007; Pittman et al., 2007).

Although the pre-transition phase examined the literature on push and pull factors that has the potential to influence all nurses in the home country, it is difficult to explain why most nurses are not moving to the transition phase (Padarath et al 2003). It is worthwhile to try and identify the reasons to stay vis-a-vis reasons to migrate. Next, we turn to the examination of the transition experiences.

2.4.2 Transition experiences

Some nurses have intentions to go abroad and they carry it further by taking practical steps and adopting a decision to migrate. During the transition phase, the nurse experiences an interaction with the employers in the destination country or with their representatives (Withers and Snowball, 2003; Walters, 2008). This interaction shifts the nurse's decision into actual migration for the successful leavers or a complete decline for those who do not end up migrating. This section examines, literature

reports on actual decision and the experience of shifting from home country to destination country.

The actual decision to migrate in any given situation depends on a wide range of factors. De Jong (2000) found that the initial elements of migration-decision making were intentions and expectations. Kim Van Eyck (2004) talk about the economic factors, particularly those associated with quality of life issues. These factors are the theoretical basis of a new economics theory, and the human capital theory, which both were discussed early in this chapter. However, economic issues do not usually stand alone; there is impact for the social and professional aspects. Eyck stresses the importance of investigating power relations in the profession, as well as the internal family relations, to find out how the nurse embarks on the final decision to migrate.

Some nurses have plan, intend and take a decision to leave, but cannot translate it into actual migration, because they are confronted with barriers (Magnusdottir, 2005; Hawthorne, 2001). Some nurses encounter financial constraints, which may arise during the planning for travel and accommodation, before the first salary payment. Another barrier is the language and many foreign educated nurses give much time to learn the language, including the IELTS exam (Magnusdottir, 2005). The last, but not the least barrier, is the social norm and dependency level, for instance, disconnection with the family, relatives, friends and colleagues. According to Martineau et al (2002), the barriers to access nursing jobs in another country are ignorance of the vacancies, work permit, and professional registration. When, a country seeks recruitment of foreign-trained nurses, the removal of these barriers is a priority in attracting them.

Several studies provide insights into the factors, taken into account by the source country's qualified nurse, relating to where to work and live (Hardill and MacDonald, 2000; JobStart-and-Skills-for-Change, 2001; Martin, 2003; Martineau et al., 2004). Nurses are attracted to destinations and go there for various reasons and factors; most of them mirror factors in the source country. Countries recurrently mentioned in literature as primary destinations for nurses seeking employment outside their home, include the United Kingdom, the United States of America, Canada, Australia, Ireland, Norway, Switzerland, France, Saudi Arabia and The United Arab Emirates (Baumann et al., 2004a; Martin, 2003; Dovlo and Martineau, 2004; Tattolo, 2005; Buchan and Calman, 2005).

According to Human Capital Theory (HCT), nurses are attracted to destinations where there is a high demand for their skills and relatively higher payment. Destinations develop policies to offer both, when there is shortage of local skills. The shortage can be general, or in certain specialities. Thus, the health organisations may use their own direct recruitment, or achieve it through the help of a recruitment agent. Sometimes, nurses are attracted to destinations, after labour agreements between their home country and the government of the destination country, which facilitate their migration. However, until recently, sufficient empirical evidence was not available to support the fact that movements of labour and professionals is facilitated by regional unionisation, and international agreements, such as the European Union (EU) and General Agreement on Trade (GAT) (Mesquita and Gordon, 2005; Allan and Larsen, 2003).

Nurses also engage in actual transition on the basis of education offers in the destinations, where educational resources are available for wider study opportunities, and specialisation. However, most nurses gain assurance during this phase that the

destination provides higher salary in comparison with their home countries, improved pay, better conditions of employment, and sometimes an improved quality of life (Walters, 2008). Also nurses sometimes receive information from some destinations about the incentives, such as yearly return airline tickets to home locations, paid vacations, and accommodation (Percot, 2005).

Some nurses get another type of assistance to enter certain destinations, and not others, because of their close relatives and/or friends present there, who make the necessary arrangements in the destination country (Aboderin, 2007; Brush and Sochalski, 2007). This is explained by the social network theory. Some destinations encourage this kind of migration through policies and regulations, which often produce and intensify existing social, economic, and cultural characteristics of workforce, in both countries of origin and destination. According to Eyck (2004), migration policies are often gender-insensitive, and not gender-neutral, in intent or impact. However, literature gives no evidence for the changes of nurses' workforce and gender combination in the source country or even the destination country.

Host countries' registration bodies for nurses represent another access point for a group of migrant nurse. While, these registration bodies hold information about the migrants, it requests from internationally trained nurses, confirmation of registration at home country. For instance, in the UK, this confirmation is called 'verification of registration'. However, Dovlo and Martineau (2004) reported that data from verifications are not completely accurate because, their presence on a registered body list does not necessarily mean that the nurse is employed in that country. This implies that tracking migrant nurses, whether in the source country or the destination, is very difficult.

While migration of nurses documented by research and statistics as a phenomenon, it is difficult to provide precise data on how many of the nurses go outside their country. Dovlo and Martineau (2004) reported that data collection on nurse migration appears to have been a major challenge for many countries and researchers. This may be in part, due to the lack of a standard method of recording migration in general; which results in ambiguity of the situation (Stilwell et al., 2003).

To know what happens to nurses when they migrate, there is a need for a reliable and updated source of data and information about them. It is difficult to determine one source of comprehensive information, because of the discontinuity of the data. With these circumstances, the most valuable source are the nurses themselves; as they hold all the information about their own job mobility.

Martineau and his colleagues (2002) mention that no personnel record system in any organisation mentions whether the nurses who leave them are migrants or not. He added, long leave nurses are sometimes found recorded, particularly when they request documents for their employer in the destination. However, they may decline going abroad and choose somewhere else, for this, we cannot consider them to be outside the country. It is difficult to quantify accurately the nurses who leave for abroad. Data describing the migrant nurses is not readily available for the sending country. Undeniably, understanding the quality, specialities, and other characteristics of the migrant nurses, are important for policy makers.

The limited availability of information and data about nurses, working in destination countries is one of the most notable aspects of the debate on nurse employment abroad. Likewise, the source countries often have difficulty monitoring the phenomenon. Buchan (2003) claimed that many quoted sources in research reports

about international nurses have been drawn from subjective or media coverage, and are usually misleading or incorrect, with Diallo (2004) concluding that qualitative information is sometimes required.

The receiving or host countries usually activate certain barriers, to manage the inflow quality and quantity of international nurses. Some countries apply policies and procedures, requiring the migrant nurses to pass through a long process, for the validation and recognition of their knowledge, skills, and experience, prior to practice as do locally recruited nurses (Hawthorne, 2001; Hardill, 2002; Nursing and Midwifery Council, 2005; Bieski, 2007). Often, the countries request a verification of qualification apply it even on local nurses and ask them as well to go through a formal verification process, prior to practising their profession. However, there is debate whether nurses' skills are accepted globally, or international nurses' qualifications and training should be accepted as equal to the local ones (Kingma, 2006; Allan and Larsen, 2003).

While, Mesquita and Gordon (2005) reported that models of nurse training around the world are remarkably consistent, Zulauf (2001) reported that the data she collected in Germany, Spain, and the UK revealed mistrust in the foreign qualification of overseas nurses. Nurses are not allowed to practice in the UK unless they are registered with the NMC (Buchan et al., 2005a). In 2005, the NMC published new standards for overseas nurses, as requirements for registration to practise (Nursing and Midwifery Council, 2005).

While this subsection has considered the transition phase, migrant nurses engage in the actual decision and go through the process of moving and settling in the

destination. The following section reviewed and examined literature regarding what nurses do when they arrive and settle in the host country.

2.4.3 Post transition experiences

When nurses arrive to the host country they realise their presence in the alternative location to the home community, and here they start attaining their valued goals. Withers and Snowball (2003) reported that less than one third of the migrant nurses had expectations, which were achieved. Although, the study sample is limited to one NHS trust, Allan and Larsen (2003) found the same in their study of nurses recruited from the Royal College of Nurses (RCN) database. Hardill (2002) stated that nurses expect to find better job opportunities for travel and seeing the world, to gain experience, and develop a foreign language. However, probably few of the nurses expect the marginalisation and downgrading of their qualifications before they arrive.

Larsen (2007) reported on the negative experiences, and in particular, racial discrimination. According to his findings, overseas nurses who face discrimination need to move to another environment, which recognises and values their professional competencies. He commented that racial discrimination in the UK workplaces identified overseas nurses as

> *'outsiders and places them in inferior positions where their personal and professional competencies are questioned and undermined' (Larsen, 2007 P 2195).*

Similar to Larsen (2007), another study carried out by Winkelmann-Gleed and Seeley (2005) reported on negative experiences. Both reported that the 'stranger' label was used more to identify overseas nurses in the UK than the gender of the nurse. They concluded that male migrant nurses are more likely to be labelled negatively, because in addition to their migrant status, they stand out in a female-dominated profession. In spite of this perception, they indicated that male nurses were more likely to achieve

higher career positions when they aligned closer to the majority, which was often 'male' and 'white'.

When a migrant arrives at the host country such as the UK, they are likely to meet international nurses from other countries, as well as the local nurses. For example, international nurses in the UK come from countries, such as the Philippines, India, Australia, South Africa, Canada, the UK, and the Caribbean (Alexis and Vydelingum, 2004; Baumann et al., 2004b; R Loewenson, 2004; Baumann et al., 2004a), with reports of nurse from countries, such as Ghana, Nigeria, Korea, Spain, Namibia, Botswana, the Pacific island states of Fiji, and some Arab countries, such as Egypt, Lebanon, and Jordan (Kingma, 2005; WHO, 2006; Yi and Jezewski, 2000; Shukri, 2005).

Henry (2007) and Smith et al. (2006b) reported that whilst trained and registered as professional nurses at home, overseas, nurses are often downgraded and their qualifications not recognised in the destination countries. Stilwell et al(2003) claimed that many migrant nurses may work outside the health care system, and are not listed in the nurses' register. Although nurses do the job of RNs, some countries either initially or permanently give them positions much below their qualifications (Henry, 2007). This is usually justified by their inability to speak the destination language very well, and the need to adjust to the qualifications and skills, required, to practice, in the destination country.

Mesquita and Gordon (2005) found that a few migrant nurses, trained in Ghana, have successfully achieved promotion to grade G, while others spent a decade in the UK without a promotion. Many of the nurses interviewed in Mesquita and Gordon study reported receiving little support in developing their skills. Also, the study reported

that many of the migrant nurses, whose skills were not utilised by the health care labour market in the UK, were working in non-health related fields.

International nurses support the host country economy by increasing consumption, and payment of taxes for services that they may not receive (Allan and Larsen, 2003; Dicicco-Bloom, 2004). Some argue they create jobs, rather than take them; therefore, they are net contributors to the host economies (Brettell, and Hollifield 2000). This may contradict other opinions, that foreign nurses take the jobs of local ones, and weaken the national nurses' unions, to achieve better payments for their members (Eyck, 2004; Collins, 2004; PSI, 1996; PSI, 2003). However, many countries prefer to employ international nurses to decrease the cost of the high turnover of local nurses, albeit, the initial cost for recruiting an overseas nurse is higher than that of a local one (ICN, 2003).

Adjustment to living in a foreign country is also hard for those who come from conservative, or sheltered backgrounds (Eyck, 2004). Migrants' access to a culturally appropriate language or language-specific support services at home may help them to adjust easily after migration.

Literature examining Jordanian migrant nurses' experience of work abroad is not available, but, DeLuca (2005) explored experiences of Jordanian graduate students in nursing during their study in a private, mid-Atlantic University. She found that adjustment to the environment by Jordanian student nurses is '*metamorphosis of self*'. Deluca described the events leading to the *metamorphosis* and they include being selected, experiencing a great deal and looking to transfer the learned skills into Jordan. She recommended further study, because the factors, which influence the staff teaching styles, will be of help to Jordanian students.

Buchan et al. (2005b) revealed that little was known about the experiences of migrant nurses in the destination countries, in terms of their profile and career plans. When the experiences are considered in migration studies, the focus is on migrant nurses from the traditional sending countries of the Philippines, India, the Southern African countries, and the Caribbean (Collins, 2004; Daniel et al., 2001; Brush and Sochalski, 2007; Dovolo, 2007; Thomas, 2006). Hunt (2007), critiqued utilization of research results in practice saying: the discriminatory practices experienced by nurses in the REOH (Smith et al., 2006b) suggest that little, if anything, has been learned from over half a century's experience of recruiting nurses and other health professionals of different racial and cultural orientations for hard-to-fill vacancies in the UK health system" (Hunt, 2007 p 2253).

Finally, studying nurses' experiences particularly the personal and professional is required because much research has been conducted on topics such as the current international nursing shortages and a great deal written about recruitment from various countries. According to Walters (2008) the actual experiences and the stories of nurses qualified in other countries, particularly those from developing countries migrating to developed countries, is however neither well documented nor well examined.

2.5 Conclusion

Literature concerning examining the experiences of migrant nurses from developing countries is scarce, and little is also known formally about state of affairs regarding migrant nurses in the Arab region. Such literature is required to refine broader understanding of nurses' migration and how it relates to the international context (Buchan and Calman 2005; Parfitt 2006). A worldwide shortage of nurses has been acknowledged in the global workforce by WHO (WHO, 2006). Such a shortage, it

has been reported, can influence health care services, ethics of international recruitment, and workplace environment for nurses' as well as policies governing all these issues. Such issues should be taken seriously, both nationally and internationally with emphasis on strategies and policies. These strategies and policies should be evidence-based and focused on the experiences of migrant nurses.

The direct experiences of nurses who have migrated to work in a host nation not only contributes to an understanding of the context of health worker migration but also informs the global policy on health care workers (Aboderin 2007; Allan, Tschudin, and Horton 2008; Buchan et al. 2006; O'Brien 2007; Troy, Wyness, and McAuliffe 2007; Walters 2008). Research into nurses' experiences, particularly for those migrating from developing countries to developed countries, may offer strategic insights into workforce migration and international policies. It is necessary, therefore, to assess and manage a source country for (such as Jordan) nursing migration internationally and point to appropriate policies to improve employment prospects and retention for a host country (such as UK).

Literature gives no complete picture of what happens when professionals from medicine, IT and nurses migrate. Empirical studies of professions migration show that they are influenced by pay and demand on their skills due to shortage in the host countries (Iredale, 2001; Mejia, 2004; Labonte et al., 2006; Ogilvie et al., 2007; Arah et al., 2008). This is also addressed and explained by the neoclassical theory as well as indicated by other labour migration theories (Massey et al., 1993; Arango, 2000; Chiswick 2000b). However, the theories address migrants at the general level without consideration for their qualification, skills or professional group.

The literature sheds light on nurses as a workforce, which is needed to fill the gaps of shortages in the destination countries (Dovlo and Martineau, 2004; Buchan and Calman, 2005; Ross et al., 2005; Kingma, 2007). However, little addressed the individual nurse's experiences. This parallel the calls of previous studies that encourage further research, to understand the phenomenon of nurses' employment outside their home countries (Withers and Snowball, 2003; Allan and Larsen, 2003; Brooks and MacDonald, 2001). While, little in literature has explored the experiences of international nurses, less has indicated the differences among nurses of various countries. Moreover, the literature has no indications of the experiences of patients, and the host country nurses with foreign-trained nurses, although some studies remarked that the impact of the employment of foreign trained nurses on their host colleagues is not yet well understood (Smith et al., 2006; Buchan, 2007).

Although the literature indicates that nurses are pushed and / or pulled to migrate for economic, social, and educational reasons, there is little evidence regarding their achievements after their migration. There is little evidence of the personal and professional experiences of migrant nurses, whether before, during, or after migration.

The literature revealed little evidence of professional and personal issues, which is ambiguous in its status in nursing migration studies. The personal and professional issues in nurse migration are distinctive - they are not marginal, nor are they necessarily not important. Although there are no fully studied patterns within literature, it is significant in examining migration, and has implications for nurses and patients, as well as the sending and the host countries.

Currently there is inadequate comprehensive study for all the phases, which a migrant nurse would experience, from the first thought to the decision to migrate, to the phase

of achieving an adjustment to life and work in the host country. It is unlikely to find a study, which describes and explains the dropouts during the journey of migration, and why some nurses do not continue to the end.

Researchers should consider findings of the studies about the mobility of international nurses with caution. Smith and Mackintosh (2007) argue that what we know about the impact of migration is based on secondary sources (literature review). However, the studies spark some debate, and pose questions which are worthy of further investigation. While we know little about why nurses come to a host country, we know little about how they left the home country, and what happens to them during this transition in terms of life experience. Little is known about the opportunities and challenges encountered by nurses during all phases of their migration.

Finally, Jordan is an emergent country in the market of sending nurses to the UK, it is important for both home and host countries to explore and examine the personal and professional experiences of the Jordanian nurses who opt for migration. A study of Jordanian nurses would document their experiences and further shed a light on that migrant nurse's journey and consequent implications for individuals, employers and policy makers.

Chapter 3

3 Research Methodology

This chapter addresses in three parts the methodological perspectives and methods employed to examine the Jordanian migrant nurses' experiences in the UK. The first part deals with describing the relevant aspects of the research writing and design, with a brief review of the interpretative tradition. This includes a discussion of how the insights of philosophical interpretivism are formalized and translated into practical guidelines or methods for nursing migration research. , The second part articulates the methods used including survey and interview as a tool, generating a sample, data collection and ethical consideration. Finally, the third section is concerned with describing data analysis and maintaining trust and ethical integrity.

3.1 Writing as a researcher and developing the research approach

Gilgun (2005) wrote an inspiring paper on style of writing and use of the third person. The paper concluded that qualitative researchers have choices regarding how to present and represent what they come up with. She suggested a guideline for making choices that is whether the presentation is consistent with the philosophy of science on which the research is based. I believe the materials that researchers generate from an interview are co-constructions, representations of the interactive processes between the researchers and the researched. Thus, I decided not to silence my study informants, and myself, on the contrary I gave space for everyone to talk about him or her self. This was a way of acknowledging that my voice as a researcher, and the voices of those I researched were not the same, yet were interconnected because of the use of the first person and of direct quotes.

As a researcher, I have thoughts, emotions, silences, history, and multiple motivations, and my job is to represent them well, as these fit in with my theoretical assumptions, and the focus of my research. This is what I concluded, when I asked myself if my style of presentation was consistent with the philosophy underlying my enquiry and consequently the objective of this study. this in turn led to my methodological approach and the theoretical assumptions underlying the study. Methodology usually comprises two things: the theoretical assumptions, including justification for the choice of methods, and the technical aspects of the methods, including procedures and the methods for analyzing empirical material (Alvesson and Deetz 2002). Research pertaining to nurses as well as migration is most often concerned with the technical aspects of methods. However, may stand to gain from an in depth reflection over issues, such as the nature of human intentions and actions, and the relationship between the researcher's and the participant's knowledge.

My ontological position indicates that migrant nurses' knowledge, understandings, interpretations and experiences are meaningful properties of the social reality, which my research questions are designed to examine (Patton, 2002). The ontological perspectives of this study views social reality as made up of people, biographies and experiences (Roberts, 2002). These three elements rather than compete, complement each other rather, and actively engage with each other. Briefly, the data is grounded in the accounts of individuals.

These ontological properties guided me to take an interpretive position, which allowed me to generate data by talking to the nurses themselves. This ontological position is reflected in an epistemology that seeks to explore the life history of individuals (nurses) through their interpretations and their lived experiences. This conceptualises reality and admits theoretical terms, which are not accessible to

observation, that is the immediate experience of a situation or phenomenon as it is lived through, over abstract knowledge or reflection (Manen, 1990). The focus on first-hand experiences follows an interpretive tradition, where human knowledge is not seen as an objective mirror of some world 'out there'. Instead, all human knowledge is seen as relative to situations, social contexts, purposes and previous experiences. This means that a nurse's knowledge of something like the decision to migrate (in the context of migration action) were reflected in the ways that decisions were perceived and enacted in specific situations.

A qualitative approach was adopted to inform this study because, as Morse (2006) stated, qualitative research is done when "little is known" about the topic. The criterion for "little is known" is usually whether there is information in the library about the topic, including articles in different disciplines, or information hiding under different concept labels (Patton, 2002; Silverman, 2001). However, it is the scientific literature which is used as a standard for "knowing," not the folk and fiction literature, and certainly not the anecdotal literature.

3.1.1 Studying migration

Halfacree and Boyle (1993) called for a biographical approach to migration, emphasizing that migration is a reflection of the flow of everyday life. This perspective received less attention among nurse scholars (Winkelmann-Gleed, 2004; Mayor, 2002; Dyson, 2004). This is in contrast to the dominant instrumentalist view of migration as a destined event (occurring at a given moment in time), whether articulated by macro push–pull models, or at the behavioural level in terms of stimulus and response. In either case, migration tends to be treated as an isolated event, and migrants as machines, responding mechanically to forces beyond their control (Findlay and Li, 1999). Notions of human agency are not in the picture. The

story of Jordanian migrant nurses cannot be told solely in terms of the abstract push–pull factors, nor neatly separated into 'determinants' and 'consequences'. Therefore, migration is nurses' experiences of working in the health care system in Jordan, with a transition from the familiar to the unanticipated, and an adjustment to the UK work and life.

Much of the research and theory development favours large studies and positivist epistemology, where the reality of labour migration tends to be suspended in favour of 'scientific rigour'. There is, however, a growing interest amongst researchers working on the field of migration of nurses, to expand the methodological toolbox and widen the scope of inquiry. In their reports on issues and policy regarding nurses' migration, Buchan et al (2005) emphasized the need for diverse and dynamic methods to understand the phenomenon. Their calls are consistent with many others (Diallo, 2004; Stilwell et al., 2004; Siebens et al., 2006), in that they urge researchers to complement research focused on statistics and migration factors with investigation of emergence, interpretation, and intersections of various aspects of the phenomenon. Diallo (2004) went to what Larsen et al (2005) had done, they all encouraged a focus on the real-world experiences of migrant nurses, which implied the need for understanding their interpretation of the experiences and its meanings.

Interpretative research is concerned with the question of how human actors make sense of the surrounding world, and how the researcher should bracket preconceptions in an individual's vision of the world (Bryman, 2001). Meanings embedded in a nurse's migration journey could better be understood through an interpretive mode of inquiry (Hardill, 2004; Larsen et al., 2005; Omeri and Atkins, 2002). Nurses follow paths of migration which cannot be identified in clear cu terms. Instead, migrant

nurses follow pathways because of their perceptions, beliefs, values, and prejudices. This paradigm is best understood by naturalism or interpretivism.

The goal of interpretative methods is to study the peoples' understanding of the phenomenon, and their experiences in specific situations. Furthermore, it attempts to capture and communicate these understandings in empathetic and transparent ways. At the core of interpretivism is an emphasis on 'returning to the nurses themselves', and how they are living the migration experience, making sense of and enacting it in everyday life. A migration in the interpretative sense does not exist primarily in and of itself, but rather in the experiences that the nurses go through.

Holstein and Gubrium (1995) stated the interpretative perspective concerning researchers' attempts to understand participants' experiences. Usually researchers tried to study objectively how things happen (for example a decision to migrate) by recourse to neutral rules, which validate knowledge in such a way that personal opinions or pre-existing theoretical frameworks do not influence results. Such objectivity builds on ontology, and a realist epistemology, where the world can be known independent of any human interpretation. In contrast, the researcher has his/her own understandings, convictions and conceptual orientations which relate to the world of the study participants. Moreover, the cultural and socially conditioned preconceptions and interests may complicate access to the world of the research subjects. Such preconceptions constitute the basis for understanding in the first place. Preconceptions and general knowledge interests are what provide the initial understanding of a phenomenon which triggers interest, leads to the formation of tentative hypotheses, and also implies certain modes of inquiry, rather than others (Cope, 2005).

Reflexivity and the researcher's role in this study have several implications. The fact that I am of the same professional, cultural, and social background as the prospective participants would help in understanding and interpreting the account of the participant nurses. A shared language, and customs may facilitate my understanding of much of what the participant conveys (Rennie, 2000). Before the fieldwork, I was worried about the extent to which my background would influence my fellow Jordanian nurses' desire, to provide the true accounts of their experiences. However, during and after the data collection I realised the existence of a gap in terms of age and social relationship. This encouraged them to open up to me and give an accurate account of their experiences.

(Berglund, 2005) wrote:

> *The inquiry that starts with certain preconceptions and interests indicates that research is not mere speculation, which shoots randomly beyond available evidence. The results, therefore, rest on a dynamic process, involving researchers' preconceptions, observations, and reflections. These points to the importance of reflecting on why the research is undertaken, and in what way findings are produced and justified. (Berglund, 2005) p26.*

In this context, the most appropriate methodology which I identified for this research was the biographical, life history approach, rooted in social and professional history, to enable the migration process and social changes to be documented (Mason, 2002 p 56-57), and to provide a holistic approach centred on the participants knowledge, experiences and interpretations.

Roberts (2002 p5) argues:

> *"the appeal of biographical research is that it is exploring, in diverse methodological and interpretive ways, how individual accounts of life experience can be understood within the contemporary cultural and structural settings, and is thereby helping to chart the major societal changes that are under way, but not merely at some broad social level. Biographical research has the important merit of aiding the task of understanding major social shifts, by including how new experiences are interpreted by individuals within families, small groups and institutions."*

Life history study focuses on the individual migrant nurse and his/her experiences, as told to the researcher (Creswell, 1998; Roberts, 2002). Life history is defined by Denzin and Lincoln (2005) as the study, use, and collection of life documents which describe turning points in an individual's life. Life history is sometimes used under other terms in different studies, such as biography, or oral history. Life history in this study reports on migrant nurses' lives and how they reflect personal, societal institutional themes (Plummer, 2001; Manen, 1990).

In adopting a biographical study, I have assumed a pragmatic position, rather than a concrete adherence to 'realism' or 'constructionism' (Roberts, 2002). Life history of Jordanian nurses in the UK refers to 'real' events and experiences witnessed by the participants. These events and accounts are perceived, selected, and placed within the group experience of migrant nurses in the UK. The pragmatic view I followed is not trapped by the realist or constructionist imperatives, since, I relied on gaining insights into the migrant nurses' life, as reflected in the wider meaning of the Jordanian group in the UK (Roberts, 2002).

Given the theoretical assumptions of this study, I follow the steps of life history research as suggested by Denzin (1989). First, the researcher usually starts with an aim of examining experiences and life courses of the participant. Second, for concrete contextual life history, materials are collected using interviews. Third, organising the collected data around themes which are indicative of the migration phase. Fourth, examining the meaning of the participants' experiences, this provides part of the phase collective experience. Fifth and the last, constructing and reflecting on larger structures of the group experiences (migration phase), depending on the individual interaction with his or her environment and people. This is how I provide cross interpretation of the actual experiences of migrant nurses.

The next section elaborates more about the methods I used to investigate the account of the empirical work. This explains the rationale for adopting a qualitative approach in which narrative life history emerged as the central research approach, supported by the population biographical data and the literature. An integral aspect of this account is my reflection on the research process, illustrated as experiences in relation to the presentation of myself as a male, Jordanian nurse, interviewing participants of a similar background.

3.2 Methods

The life history approach is an inductive approach for data collection and it was selected, because I was exploring a relatively under-researched area. This gave me the ability to probe any issues raised in individual discussions, as and when they arose (Denzin and Lincoln, 2005). The individual nurses lived through the migration experiences and the process of transition from the home country to a destination .This experience was affected by their perceived reaction and interaction with others involved in the phenomenon (Yi and Jezewski, 2000; Omeri and Atkins, 2002; Larsen

et al., 2005). Therefore, I was interested in examining the first-hand experience of each individual Jordanian nurse in the UK. The methods used to examine the experience are included in sections pertaining to designing of study tools, generating a sample and collecting data.

3.2.1 Study tools

Two tools were used in this study, a survey and interviews. Initially a survey was conducted to supplement and generate data about the study population for the main interview. The survey was useful in describing the study population. The purpose of this survey was to build a database for the selection of the interviews purposive samples. This database ensured as wide a range as possible of reasons to migrate, skills and qualifications, recruitment types, places of current work, and experiences relevant to the Jordanian migrant nurses (see appendix 2). The survey data generated a pool from which to interview as well as supplementing interview data.

Interviewing technique is considered as the most appropriate data collection method to examine the experiences and biographies (Denzin, 1989; Roberts, 2002). It is applied in a wide variety of forms, and provided the scope required to fulfil the data collection requirements in this study. The face-to-face (personal) interview is one of the most common types of interview, however, the telephone and mailed or self-administered surveys are other widely used forms of interview (Barriball et al., 1996). I used face-to-face and telephone interviews as the main form of data collection, supplemented by the data collected by self-administered survey questionnaires.

Kahn and Cannel (1968) defined the interview as:

> *[A] two-person conversation that is initiated by the interviewer for the specific purpose of obtaining information that is relevant to research.*

The interview in this study was adopted to understand the life history and experience in a qualitative knowledge, expressed in normal language; it did not seek quantification of the phenomenon (Kvale, 1996). It was used to obtain descriptions of the experiences of the participants, with respect to their interpretations of working as Jordanian nurses in the UK.

There are many categories and types for interviews, and there is considerable debate over the merits of each type. Just to mention a few examples; there is the cultural interview, the evaluation interview, the focus group interview and the life history interview (Warren and Karner, 2005; Sturges and Hanrahan, 2004; Price, 2002; Kvale, 1996). Since I was interested in exploring and understanding the nurses' migration experiences, therefore, the life history interview was the most appropriate method for this inquiry. However, the relationship between the type of the interview and the philosophical framework is debatable (Price, 2002). The interviews, regardless of the type or the theoretical framework, are influenced in practicality by mixed experiences, issues or features.

Price (2002) discussed the power of the researcher vs. the participant to direct or shape the interview. How the questions are formulated, and how the interview is introduced will usually determine where the power would be, whether in the hands of the participant, or the researcher. For example, the participant may look for answers that he /she thinks will please the researcher.

Undheim (2003) argues that the 'interview appears to be a situation of asymmetrical exchange'. The researcher receives information, without giving the informant anything back. However, I found the participants perceived an interview as a reward for their unique experience, at least relative to other Jordanian nurses who were still in

the country. Moreover, it was interesting, since many interviews also offered opportunities for the exchange of points of view, or experiences. In particular, even now, to the moment of writing this research, many participants keep contacting me and sending me invitations to visit them.

The second issue is sustaining the interview through rapport (Denzin and Lincoln, 2005). The relationships between researchers and the study participants are viewed simultaneously as the source of many fieldwork difficulties and also the key to the successful completion of the research. A fundamental concept here is "rapport" which, according to Spradley (1979, p. 78), refers to:

> *[A] harmonious relationship between the researcher and [participant]. It means that a basic sense of trust has developed that allows for the free flow of information. Both the researcher and the [participant] have positive feelings about the interviews, perhaps even enjoy them.*

It is important to establish a rapport, particularly when the research involves sensitive topics or underprivileged participants (Russell et al., 2002; Shelton and Rianon, 2004). As I anticipated, no study participants were difficult to build trust and rapport with. All the telephone interviews were preceded by one to three phone calls, in order to initiate trust. I noticed that once the participant felt accepted, respected, and perceived some degree of similarity with me in terms of cultural background and profession, a relationship was forged. This helped me to pursue the investigation of the nurses' biographies, migration and experiences.

The third feature is openness, that is, finding out what the interviewees talk about without asking directly and threatening personal sensitivity. I achieved this by giving exclusive attention and immersing myself as a researcher in the world of the

participant. Sometimes this was necessary, to make the participants feel comfortable, and show them appreciation, in order to get the whole story. An interviewer must possess skills such as flexibility, empathy and good listening abilities to successfully conduct an individual qualitative interview (Warren and Karner, 2005; Kvale, 1996). These kinds of skills require training, particularly at the beginning, which I developed during and after piloting.

An interview is different from an everyday conversation because it is a research tool. It needs preparation of questions in advance and later analysing and reporting the findings (Rubin and Rubin, 1995). I rehearsed the interview several times to acquire the skills of practice and reflection. Several times, I considered whether I interpreted or understood correctly the participant's point of view. This also helped to find an explanation that was consistent and believable. The interview was a collaborated act between me and the participant (Rubin and Rubin, 1995). It was an attempt to obtain a description and interpretation from the participant, free of contradictions, through the consensus of interpretation between the researcher and the participant.

3.2.1.1 Interview schedule

The interview schedule (Kvale, 1996) was structured around a number of key themes. Those were personal data, study period, previous employment and preparation to pursue work overseas, arriving in the UK, current work conditions, and plans for the future (see appendix 2). The interview schedule included three main themes and several open-ended questions on each theme, designed to collect data on the three phases of nurse migration (pre-transition, transition, and post-transition) To elaborate, the pre-transition phase (exploring the possibilities of going abroad, which may cover the period from the end of nursing education to the time of securing a visa or job contract in the UK); the transition phase (translating possibilities into practice, which

covered the period from securing the visa or job contract in the UK to the end of adaptation training, or 6 months after arrival); and the post-transition phase (living in the UK, and adjusting to work and life after 6 months since arrival).

The interview schedule was designed chronologically to help the interviewee remember the ideas, and go with them systematically. Interviews that were conducted in a systematic manner went smoothly, whereas by non-systematic meandering the interviewee would sometimes find difficulty in remembering the ideas. Questions were prefaced with suitable introductory statements, and included short probe lists to ensure that all the related topics were deemed relevant to the themes under investigation. For example, the first question (see appendix 2: interview guide) "Tell me what made you think about coming to the UK?". There were three probe questions and focussed on the reasons to migrate, decision to migrate, and persons involved in that decision. If the participant did not bring up all of the listed subtopics by him/herself, I probed for information regarding them.

Although the previous discussion mainly focuses on face-to-face interviews, I considered in my plan conducting either personal or telephone interviews.

3.2.1.2 Telephone Interview

Face-to-face (personal) interviews required good planning. They involved making appointments, travelling, setting up of the environment for a comfortable interview, and special considerations for the recorder and microphone. In contrast, the telephone interview required a certain amount of preparation and considerations, but these were probably less demanding. More details and clarification about telephone interview are discussed below.

Researchers generally rely on face-to-face (personal) interviewing to conduct qualitative interviews (Sturges and Hanrahan, 2004). However, the telephone interview is recognised as the right choice for short, structured interviews, or very specific situations (Rubin and Rubin, 1995). Initially, I thought that data would be more valuable when collected through personal interviews. However, later on I realised that a more pragmatic approach was to collect data from some participants by means other than face-to-face interviews (Greenfield et al., 2000).

Sturges and Hanrahan (2004) remark that some issues are central when considering telephone interviews to collect data from participants. I have chosen to access migrant nurses, who are considered to be hard to reach (Faugier and Sargeant, 1997). I assumed that most, if not all migrant nurses owned a telephone, because they need it to stay in touch with their home country and also the host country. This triggered a possible medium for collecting data from the participants. Difficulty in reaching migrant nurses stems from their diasporas (Martin, 2003), and their geographic dispersion. The telephone makes it possible to include data from nurses who are not reachable within the resources available for the research.

Two major circumstances guided me to consider the telephone as a medium for interviews. Firstly, negotiating accessibility to the study participants with gatekeepers involved one or more telephone calls, before sending letters or making an appointment. For example, I found the NMC representative happy to receive the phone calls initially, rather than letters or personal visits. Secondly, the planned study strategy included collecting data and information, from participants who have lived in a wide geographical area. This assured that the telephone was a useful means for collecting important information.

The telephone interview is a cost effective data collection method, in comparison with the personal interview (Burnard, 1994). It saves time, cost, and the effort required to plan and conduct face-to-face interviews. This technique could save time and money, specifically when the study participants are found in a wide geographical area (2004). The telephone interviews allow access to participants, where the more familiar face-to-face interview would not. The researcher can gather data quickly and relatively easily from the appropriate participants, regardless of their distance from the researcher. Moreover, the telephone interview gives the researcher a means to obtain a higher response rate, more than, for example, in a postal survey, because little initiative is required from the participant.

Many quantitative studies have adopted the telephone interview, and have recommended it for future research (Rose et al., 1996; McCarthy et al., 2003; Biemer, 2001; Greenfield et al., 2000; Groves, 1990). However, the use of telephone for qualitative interviews remains unpopular, and little research is done by this means (Sturges and Hanrahan, 2004; Barriball et al., 1996; Greenfield et al., 2000).

Sturges and Hanrahan (2000) argue that the quality of data collected by telephone, in comparison with the personal interview, is equal. Comparisons of quantitative data obtained through personal and telephone interviews have been made in a study of alcohol consumption (Greenfield, Midanik et al. (2000), and concluded that telephone interview results are comparable to those of personal interviews. However, in qualitative studies the issue is not yet clear, because few studies have applied telephone interviews (Rose, 1998; Greenfield et al., 2000; Burnard, 1994). Interestingly, Sturges and Hanrahan (2004) qualitatively compared the two methods, and concluded that similar information was yielded from both interviews.

Sturges and Hanrahan (2004) added that providing potential participants with the choice between personal and telephone interview would result in a wider variety of respondents. In addition, they reported that potential participants make more use of telephone technology in their lives. I found in this study that the migrant nurses were more dependent on the telephone as a means of connection with the family, relatives, and colleagues in the host and the home country. Interestingly, with the technology of mobile phones, the migrant nurses have a portable address where their families and employers can contact them. When the technology was less developed, Groves (1990) reported that reliance on the telephone did not allow the researcher to see the participants' informal, nonverbal communication. However, she recommended using it, when the researcher did not otherwise have access to the participants.

The mode of telephone interviews entails a greater social distance between the researcher and the participant (Groves, 1990). This distance is required by some participants to reveal characteristics, which they sometimes would not talk about, during the physical presence of the researcher. Telephone communication reduces the participant thoughts about what would be construed by the researcher as negative (Sturges and Hanrahan, 2004). Several studies reported that the participants were more comfortable with the relative anonymity of the telephone interview (Sturges and Hanrahan, 2004; Burnard, 1994).

Before proceeding to the process of data collection, here is a description of the study population and sampling.

3.2.2 Generating the survey and the sample: gatekeepers and snowballing

A major challenge for this study was locating the appropriate participants. The population was confined to Jordanian nurses working or living in the UK. However, locating the key participants was a difficult task, because Jordanian nurses, like many

other migrant nurses, do not update their data and contacts immediately with the registration body. Therefore, it was difficult to identify those people who had the appropriate information, and were willing to talk and share their experiences. Within these circumstances, I recruited the participants in two phases: access through gatekeeper, and snowball sampling.

3.2.2.1 NMC as a gatekeeper

The gatekeeper is the person or organisation, who withholds contact details, or permission to reach the study participants. Migrant nurses in the UK usually keep a record with the nurse's registration body, the nurses' union, and their work place. Literature on approaching the participants through gatekeepers implies the practicality and importance of the gatekeeper, at least in launching the study. Larsen et al (2001) launched their study of internationally recruited nurses in the UK through the use of the Royal College of Nurses (RCN) database. Withers and Snowball (2004), and Brooks and MacDonald (2004) approached their study participants through the National Health Services (NHS) trust, and during adaptation training. Alexis and Vydelingum (2004) reported a study with 12 nurses recruited from one NHS trust in southern England. Gerrish and Griffith (2003) recruited nurses for their study during the adaptation course. Buchan (2005) reported on data collected through the Nursing and Midwifery Council (NMC) database.

The Nursing and Midwifery Council database holds information on all registered nurses in the UK. Therefore, it was useful in identification of potential participants with private addresses all over the UK. Using a third party or gatekeepers to recruit participants usually has advantages and disadvantages (Vallance, 2001; McCosker et al., 2001). There were several advantages for approaching Jordanian nurses through the NMC. First, the NMC has a good network, and contacts with overseas nurses.

Secondly, it has ability to screen and arrange for contacting the nurses; I approached the NMC board to contact the Jordanian nurses. Thirdly, liaising with the NMC met the research ethics measures of giving the participant freedom of refusing to participate. However, approaching the nurses through the NMC also had some limitations. Firstly, not every Jordanian nurse in the UK has a record in the NMC database; therefore, this access point limited the participants in case others were not approached in a different way. Secondly, the database was limited in terms of capturing all of the target population, because their records only showed first registration of overseas nurses. Thirdly, some nurses do not update the NMC records, and become unreachable, because they had moved from their previous addresses.

The NMC sent invitations sent to the seventeen nurses who appeared in their records as being Jordanian in 2005. The figure registered with the NMC was not an indicator of all the Jordanian nurses in the UK, for several reasons. Firstly, nursing regulations in the UK require each nurse to register with the NMC prior to practice, and to update the registration once every 3 years (Nursing and Midwifery Council, 2005; Nursing and Midwifery Council, 2007). However, the NMC keeps a record of the country of origin for the first application only, so therefore, a registered nurse will not appear as Jordanian in the record after the first year of registration. Secondly, the NMC does not keep profiles of non-updated applications, and non-registered nurses, therefore, it was possible that some Jordanian nurses were not able to meet the requirements of registration. Thirdly, some nurses may not apply at all, and choose to work as care assistants, or take any job other than nursing, or may not work at all. With the presence of these limitations, four participants were identified by this recruitment phase. Therefore, I moved to the second phase to approach nurses through their network (snowball).

3.2.2.2 Snowball sample

The snowball is an alternative method for tracking a small group of people mixed with a large number of others (Hanneman, 2000). Snowball sampling proved to be the recruitment method of choice when Allan and Larsen (2003) faced the difficulty of reaching enough participants through their study gatekeeper (RCN) database. Browne (1997) mentioned that a snowball sample is created through 'a series of referrals which are made within a circle of people who know each other'. This circle can be, for example, elites, contact networks, deviant sub-cultures, friendship and kinship networks, and many other structures can be effectively located and described by snowball methods (Atkinson and Flint, 2001). Snowball sampling is a feasible strategy for recruiting participants from a hard-to-reach population. Faugier and Sargeant (1997) recommended using snowballing when the list of study population is difficult to develop, or missing, or when the sample frame is not readily available. Moreover, a snowball sample provides an economical way of locating participants, mainly those who are difficult or impossible to contact (Frank and Snijders, 1994).

There are two major potential limitations and weaknesses of snowball methods. Firstly, individuals who are not connected (i.e. "isolates") are not located by this method (Hanneman, 2000; Shelton and Rianon, 2004; Dicicco-Bloom, 2004). The presence and numbers of isolates can be a very important feature of populations with regard to some analytic purposes. The snowball method may also tend to overstate the "connectedness" and "solidarity" of populations who are not isolated. For this reason, I used the network to approach participants for a survey to generate a database for the study population. Moreover, there was no guaranteed way of finding all of the connected individuals in the population. It is assumed that someone in the group would know the others, to whom I could be directed. However, some people live

isolated from others, and they have no social networks. Previous literature indicated a research fatigue among migrant nurses, because they were subject to previous studies (Allan and Larsen, 2003). This was probably resolved by rapport and trust with the initial participants, more patience, and by repeating the cycle with other individuals whose social networks were intact.

Deciding how to initiate the snowball sample meant identifying the key group. If I started in the wrong place or places, I could have missed whole subgroups of nurses who were connected - but not attached to my starting point. I strengthened the snowball approach by giving some thought to the procedure for selecting the initial nodes. In many studies, there may be a natural starting point, and in migration studies, for example, it is common to begin snowball searches with the migrant group representatives. While such an approach will probably overlook most of the migrants' community (those who are "isolated" from the gatekeeper network), nevertheless the approach is still very likely to capture the migrants network quite effectively. However, for this study, the gatekeeper was the NMC, and its respondents were geographically diffused (one from Scotland, one from Midlands and two from south and north London) (see Figure 3-1). Therefore, those initial contacts formed a good starting point to avoid the drawback of snowballing.

3.2.2.3 Sampling for the survey

The survey questionnaire was used here to collect data for the purpose of a fuller description of the study population. It was designed to collect descriptive information, to provide a minimum dataset on the broad population of the Jordanian nurses. Specifically, it was used to collect personal data, qualifications, employment experience, migration information, and other details of the Jordanian nurses' life and work in the UK

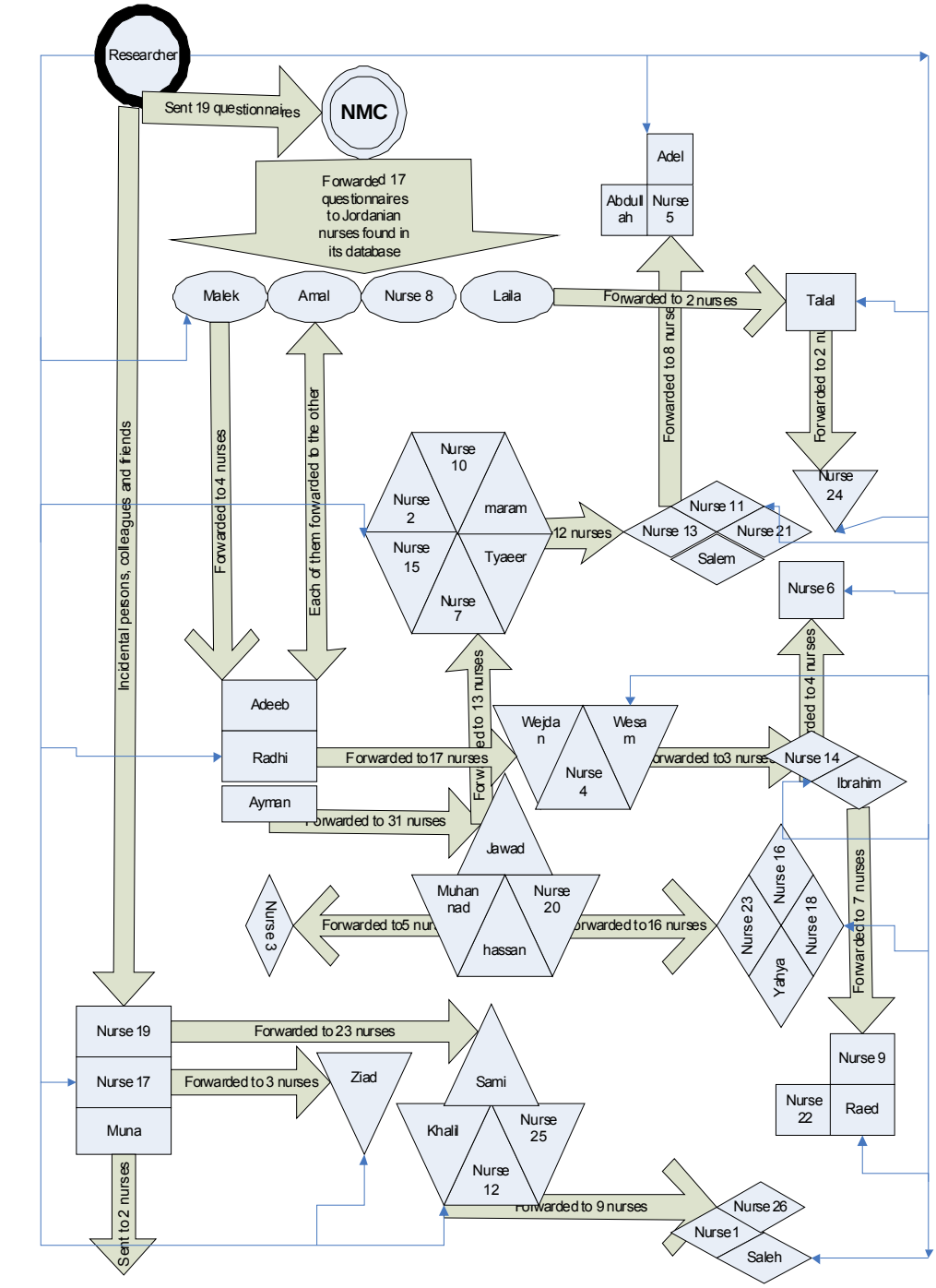
The NMC sent the invitations in a recruitment package. This package included an information sheet and consent form (see appendix 3), a survey questionnaire (see appendix 2), and a prepaid envelope. Four nurses replied, and each one was given extra packs on request, which they distributed to their Jordanian friends and colleagues as part of the snowball sample (Shelton and Rianon, 2004; Faugier and Sargeant, 1997). Those interested in taking part in the research answered the questionnaire, and returned it by post in the pre-addressed and stamped envelope. Furthermore, those interested in taking part in the interview added their contact details in the space provided within the questionnaire.

I recorded the returned questionnaires on form no. (6) (see Appendix 4), using the serial number, date of receipt, the respondent's work place, and gave each one a receiving number. Returned questionnaires containing details regarding a volunteer for interview were entered on form no. (7) (See Appendix 4), where I kept a record of the contacts of participants, eligible for interview. Respondents who were willing to participate in the interview volunteered, and included their contact details. Volunteers were categorised into quotas in order to select the participants for the interviews (see Table 3-1).

I sent the survey to all contactable Jordanian nurses in the UK. While estimations vary, there are approximately of 300 Jordanian nurses in the UK (Jordanian Nursing Council, 2005). Using the NMC database as an initial access point, I used snowball sampling to supplement this, as there was no comprehensive formal list. Recognising the limitations of sample collection, this was nevertheless the largest survey undertaken of Jordanian nurses. The two phases (NMC and snowball) of recruitment generated 52 participants; these were respondents to the questionnaire sent in the recruitment package. The respondents were given the option to volunteer for an

interview. The participants for survey questionnaires were not selected for statistical representation, however, because the target population was relatively small and dispersed, it was planned to collect information about as much of the population as was reachable.

Figure 3-1: Study population and snowball sample development



Key:

Names	Survey & interview	→	Contact with the researcher
Nurse X	survey only		
⬭	First round of the snowball	◇	4th round of snowball
▭	2nd round of snowball	▭	Last round of snowball
▽	3rd round of snowball		

3.2.2.4 Sampling for the interview

Cutcliffe (2000) stated after Morse (1991), that a good participant for an interview is one who has the knowledge and the experience required by the researcher, has the ability to reflect, is articulate, has the time to be interviewed and is willing to participate in the study. Furthermore, Morse (1991) argues, it is essential for the researcher to shortlist the most appropriate participants before beginning the interviews, and that the participants must be carefully selected according to specific qualities. She added that participants must be knowledgeable about the topic, and experts by virtue of their involvement in specific life events and/or associations.

MacDougall and Fudge (2001) encouraged researchers when sampling, to consider the kind of people to be included, and the time at which to contact participants, whether it be daytime, evening, weekends, or in particular seasons. Reviews and reports of research using interviews indicated that there could be difficulties in recruiting participants, such as when "gatekeepers" withheld access (MacDougall and Fudge, 2001; Kvale, 1996). To overcome this difficulty during survey distribution, I considered a range of recruiting strategies. I recruited through informal networks of colleagues, community organizations, and community agencies (Faugier and Sargeant, 1997; Shelton and Rianon, 2004). I recruited through existing organisations and networks, enlisting the assistance of a contact person to gain entrée (Saunders et al., 2003). I recruited from lists, for example, of registered nurses (MacDougall and Fudge, 2001). I sent individual letters, followed by a telephone call, to prompt and confirm participation, ensuring that they were personalized, and stressed that the participant had experiences and insights which would be of value to the study, and that the study had benefits for the community (Buchanan and Buchanan, 1993; Patton,

2002). Finally, I sent follow-up invitations, and arranged meeting times which did not conflict with the participants' activities and functions, and then I contacted the participants by telephone, 2 weeks and 1 day before the meeting (Patton, 2002; MacDougall and Fudge, 2001).

Another issue in sampling which warrants attention is that of the choice between breadth and depth, or in other words, a narrow sample, or a diverse and maximum variation sample. Participation in the interviews was restricted to the survey participants, who were willing to give further details, and meet the criteria of maximum demographic variation (Sandelowski, 1995). With this type of sampling, participants were purposefully selected to represent the variations that exist, with the expectation that important common patterns would be identified. In this case, the participants were selected because they were either in an extremely marginal group, or in a common group of the Jordanian nurses in the UK, or both, according to the demographic categorisation of survey respondents (see Table 3-1).

Table 3-1: Interview sample selection matrix

Interview no.	Interviewee Name	Age			Gender		UK Registration			Migration pattern		Marital Status		Work place		Notes
		<30	31-40	>40	M	F	< 2yr	2-5yrs	>6yrs	Direct from Jordan	Via other country	Married	Single Widowed divorced	London	Other	Grade
1.	Sami	√			√		√				√	√			√	D= Band 5
2.	Ayman	√			√			√		√			√	√		F
3.	Raed	√			√			√			√		√	√		Band 5
4.	Khaleel	√			√				√	√			√	√		E =Band 6
5.	Malek	√			√		√				√	√		√		Band 5
6.	Jawad	√			√				√	√		√		√		Band 6
7.	Radhi		√		√				√		√	√		√		F
8.	Abdullah		√		√			√		√		√		√		E = Band 6
9.	Salem	√			√			√		√		√		√		E = Band 6
10.	Ibrahim		√		√				√	√		√		√		F
11.	Tayseer		√		√			√		√		√		√		E = Band 6
12.	Maram	√				√		√		√		√		√		E = Band 6
13.	Adel	√			√				√	√		√		√		G
14.	Wesam		√		√				√	√		√		√		F
15.	Adeeb		√		√			√			√	√			√	F
16.	Wejdan					√				√		√		√		
17.	Hassan		√						√	√		√		√		Lecturer
18.	Yahya		√		√				√	√		√			√	G
19.	Saleh		√		√				√	√		√			√	Band 5
20.	Laila	√				√	√			√		√			√	D= Band 5
21.	Talal	√			√		√			√		√			√	D= Band 5
22.	Amal		√			√	√				√		√		√	D= Band 5
23.	Muhannad		√		√				√		√	√		√		I
24.	Muna		√			√			√	√		√		√		D= Band 5
25.	Ziad		√		√			√		√		√			√	D= Band 5

I have conducted personal and telephone interviews to collect individual data. Each interview comprised either one-to-one interaction with a single participant or with a couple. The participants were selected on the basis of providing valuable examples relevant to the study. I selected the interview participants from the respondents to the survey, specifically from those who chose to go further and volunteer to participate in the interviews. I interviewed 25 of the 37 volunteers. However, two of the twelve declined an interview, because their circumstances were not convenient. I contacted the other ten to thank them for responding to the questionnaire, and interestingly they had forgotten about the interview. Although I was prepared to interview them as their stories were interesting, they may be considered for a future study. I selected participants for the interview from volunteers, after consideration of a range of factors: age, sex, length of registration in the UK, migration pattern, and marital status.

I approached the interview participants according to the contact details they provided. The survey participants who were willing to participate in the interviews gave their contact details. The participating volunteers selected for interviews were contacted via email or telephone to arrange a face-to-face or a telephone interview. Whenever it was possible, a personal interview was preferred. However, because I was not able to personally interview 12 of the participants, I conducted telephone interviews with them.

Twenty-five out of thirty-seven volunteers (the total nominees through questionnaires) were purposively selected as a maximum variation sample. Demographic variation was sought on certain nurses' attributes (i.e. may not be representative). Maximum variation was based on age groups (<30years, 31-40 years, >41 years), sex (male, female), geographical location of current work (London,

outside London), length of registration in the UK, migration pattern (direct migration, or via a third country) and marital status (single or married) (see Table 3-1: Interview sample selection matrix). In this sense, the factors gave a range of possible respondents by selecting proportionally from all groups. These factors guided the purposeful selection of the participants to maximise opportunities to elicit data regarding variations among migrant nurses demographics.

I recruited on this basis, as the participants were rich sources of information, rather than making generalisations about others, with similar characteristics. The selection was based on factors deemed to be important analytically, as failure to sample for such variation would probably impede understanding (Richards and Schwartz, 2002). Take, for example, the gender; men usually have different migration experiences as compared to females (George, 2005).

Sample size was determined by informational redundancy (Sandelowski, 1995). I kept interviewing new participants until nothing new came out, and then I interviewed three more persons. The study was drawn on the narratives of 25 Jordanian nurses working in the UK.

3.2.3 Data collection

Before starting with the actual field-work, I 'tried out' the language of the survey questionnaire and interviews (Hundley and Teijlingen, 2002). One of the advantages of conducting the trial for the study was that it gave advance warning about where the main research project could fail, and whether my proposed methods or instruments were inappropriate, too expensive, or too complicated. Testing the language in a qualitative inquiry is different from the quantitative, because of the progressive collection and analysis for the data. Therefore, I gained insights that I used to improve the interview guide. Morse, et al. (2002) assured that the purpose of trying the study

language when used in a qualitative inquiry is to refine data collection strategies, rather than to formulate an analytic scheme or develop a theory.

Kvale (1996 p 147) stated that an interviewer's self-confidence is acquired through practice. Conducting several language interview trials before the actual project interviews increases the researcher's ability to create safe and stimulating interactions.

Teijlingen and Hundley (2001) argued that there had been no separate language trial study in a qualitative inquiry. I conducted five language trial interviews, and I listened to the recordings, from which I improved the questions, the way of introducing the issues to the interviewee, and even added new topics. Moreover, the first few interviews clarified my definition and the focus of the study. This helped me to concentrate data collection into a narrow spectrum of projected analytical topics.

The initial experience of interviewing proved to be of great importance, because of the time and effort needed to reach the geographically dispersed participants. Moreover, the interview guide that I had originally planned changed in a considerable manner. The changes made were primarily concerned with wording, the question sequence, addition of themes of discussion, and with efforts to minimise the question threat, especially concerning sensitive matters.

The actual study proceeded by selecting participating volunteers. These were contacted by email or telephone to arrange a personal or telephone interview. Each interviewee was requested to sign a consent form immediately before the interview (see appendix 3). However, telephone interviews took place after the postal return of signed consent forms. Interviews were generally planned to take about one hour. Moreover, they were conducted following the same guide, and without any fundamental adjustments between telephones or personal.

Note taking is a common practice in interpretive research. A note is a theoretical write-up of ideas, concepts, categories, and their relationships as they strike the researcher whilst in the field, and, or during, data analysis. It is the researcher's note to himself about the data, ideas, method, and the like. It is a narrative representation of the researcher's understanding of certain aspects of the study. This procedure was used to keep track of emerging ideas and categories, stimulated further analysis and data collection, and served as a means for the development of assertions and theory integration. As an analytical process, writing notes helped me in filling out the analytic properties of the descriptive data collected. Subtle connections also emerged during the process of making memos. In the later stages of analysis, the memo helped in connecting the data, assertions, and the theoretical discussions.

Several strategies were used to build a rapport with the participants. The first strategy was the information sheet, and the consent form sent by post, which informed the participant about the objectives of the study, what was involved in it, and the confidentiality of the data given. The second strategy was the use of the questionnaire prior to the interview, to give simple data and the opportunity to volunteer for further participation through the interview. The third strategy was an initial telephone call, which I made to discuss with the volunteer an appropriate time for the interview, and probably answer some of his/her concerns.

Before conducting any interview, I checked the list of documents and procedures required (see appendix 4). The checklist was intended to give the interviewer a reminder of the interview appointment, along with the background and information about the participant.

The interview was arranged for a time and place convenient to the participant. Burnard (1994) argues that it was best to arrange a telephone interview when the participant is at home. However, I conducted 2 out of the 12 interviews, while the participants were not at home, one of them being when the participant was on a mobile away from home. An appointment in advance, and prior follow-up was effective, and reduced the chance of refusal, because nurses perform early morning duty, and late or nightshift, although occasional changes in shift pattern were applied at short notice.

During the interview, a rapport was established with the interviewees, using certain strategies. Firstly, I ensured at the very outset that it was convenient for the participant to continue with the interview, and if not, then another time could be rearranged. Secondly, I used verbal and non-verbal cues in personal interviews, and verbal cues in telephone interviews. Barriball et al. (1996) mentioned that verbal cues had considerable potential in maintaining rapport in telephone interviews.

During my fieldwork, I was more comfortable with using the telephone interview; because many social norms were not applicable. Also, I was able to avoid the generous invitations of my fellow Jordanians in the UK, otherwise, I would have had to spend more time in collecting the data.

Data collected, whether by telephone or personal interview, was recorded digitally, and notes were taken by hand. A digital recorder was attached to the telephone through an adapter before making the phone call. All the participants agreed on the phone call being recorded, and then digital recorder was turned on. Nevertheless, I planned to take detailed hand notes for the interviews of those who may have refused recording their voice.

A milestone for collecting data was assigned on the basis of interviewing additional participants, rather than repeatedly interviewing the same participants (Morse et al., 2002). I continued to bring new participants into the study, rather than interviewing the same participants several times. The purpose was to increase the scope, adequacy, and relevance of the data, and not to elicit data to expand the depth or address gaps in the emerging analysis. I kept interviewing new participants until the data set was complete and till the data became repetitive.

I conducted the interviews during the period between June and October 2006. I interviewed each participant once. The interview took place in English. This was possible because all the participants had their education in English as this added to the language competency for registration and work in the UK.

3.2.4 Ethical issues

Ethical issues are an integral component of the qualitative research design and process, incorporating every step, and should be considered throughout all decisions (Smythe and Murray, 2000; Hadjistavropoulos and Smythe, 2001; Parry and Mauthner, 2004; Richards and Schwartz, 2002). This study was approved by the Medical School Ethics Committee of the University of Nottingham. As I expected, the experiences of Jordanian migrant nurses in the UK raised some ethical concerns, usually consistent with the general code of ethics for research (Richards and Schwartz, 2002). Couchman and Dawson (1995) stated several concerns of any individual involved in a research study, namely voluntary participation, confidentiality, anonymity, informed consent, with no physical risk.

All study participants voluntarily chose to participate without any interference from the researcher, or even a third party. Those who wanted to participate voluntarily responded to the research recruitment packages, which they received on behalf of the

investigator. I did not know the names of the recipients, except those who replied directly to me. Moreover, I explained the right to withdraw at any time without giving a reason. Additional measures were considered to ensure that the confidentiality and anonymity was preserved. Participants were assured of anonymity by removing their names, and ascribing a code during analysis, and when reporting the data. All surveys, audio files or tapes, and transcribed materials were kept in a secure location with restricted access. After completion of the study, all the materials were locked in a secure storeroom, the practice usually followed in the school of nursing at the University of Nottingham.

The study also advocated the use of a consent form (Richards and Schwartz, 2002). The consent form and the accompanying information sheet, included all the information the study participant needed, in order to make an informed decision about whether to participate in the study or not (see appendix 3).

When I sent my application to the ethics committee, they highlighted two issues; firstly, different responses by telephone and face-to-face interview, and secondly, health and safety of the interviewer. I was aware of the committee's concerns, and I gave the following response before they approved the study:

Different response by telephone and face-to-face interview:

Sturges and Hanrahan (2004) argue that there is no difference in the quality of data collected through personal and telephone interviews. In addition, one of my supervisors successfully used this combination of interviewing, as part of a study of self-help groups. Her experience was that there are three key elements to be taken into account: establishing a trusting relationship, data content, and data recording.

The first, developing a relationship of trust in order to ensure data collection, tended to be easier than anticipated. This was because the preliminary work of making contact, explaining the project, and setting up an appropriate interview time had already helped establish a relationship. The respondent had enough interest in the subject to be willing to share their time and information with the interviewer. In terms of the second element, data content, there could be some minor differences in terms of the information elicited; however, most studies suggest that results were comparable (Sturges and Hanrahan 2004, Greenfield at al, 2000; Biemer 2001; McCarthy et al 2003). The most obvious difference was in terms of interpreting what was being elicited through supplementary information of body language, eye movement and so on. However, in my study, this was not a significant issue, as the data was mainly factual information. Furthermore, the data was identified as coming from different sources in the analysis, and written up in a way which made this clear. The final key issue was the recording, where, obviously, the right equipment was required to allow simultaneous hearing, response, recording and ability to write brief notes. The School of Nursing provided these facilities.

Health and safety

I recognised that this was an important issue. I have many years of experience doing home visits as a nurse and also conducting home interviews in Jordan. In terms of my own safety, I had left information with both my wife and the School of Nursing, and carried a mobile phone at all times. Having said this, as each of the respondents had filled in a survey form, taken the trouble to reply to me by mail, and negotiated an interview date, time and place with me, I did not anticipate any problems.

In terms of assuring the safety of others, again, my experience as a nurse doing home visits in Jordan came into use. All the respondents (the majority of whom were male, as it is male Jordanian nurses who are most likely to migrate), were invited to have someone else in the house. I was, of course, very sensitive to Jordanian cultural mores of gender, and a door was left open at all times when I was in a room with a female.

The ethics committee appreciated that I was more likely to improve my interview response rate, if I was able to take into account the respondent's convenience. My response had assured them that I had recognised the significance of the health and safety issue they had raised, and had the experience and techniques which reduced risk to a minimum.

After a short period of data collection, I recognised the need for a slight variation from the original protocol. Therefore, I applied to the ethics committee again, who approved the amendments (see appendix 3). Following feedback from some respondents, the variation was intended to: a) make contact easier and more convenient for respondents in relation to the survey, b) improve the return rate for the survey, c) meet participant demands for joint interviews.

During the interview, I assured each participant of the confidentiality of taking part in the study. Real names were not used at all in the study. All information from the survey and the interview, had the participant's name and address removed so that the identity stays concealed. Moreover, data and archives were made anonymous, so that the participant could not be identified (Parry and Mauthner, 2004).

All the interviews were tape-recorded, and I kept them in a secure place until they were no longer needed. I did not share them with anyone, other than my doctoral supervisors in the University of Nottingham.

The material generated in the questionnaires and interviews was analysed, and became part of a written project, as part of the requirement for a PhD dissertation. I also anticipated publications deriving from this research. The nature of these publications would most likely be, but may not be limited to, scholarly research destined for an academic audience. I also conducted some presentations at conferences.

3.3 Data Analysis

Analysis of text interviews was carried out using thematic principles. The theme was a pattern found in the information, which at the minimum, described and organised the possible observations, or at the maximum interpreted aspects of the phenomenon (Ryan and Bernard, 2003). The themes explain how or why things happen. They are abstract constructs, which link expressions found in texts.

Social scientists use many terms or expressions to indicate themes. In other words, it is difficult to isolate thematic analysis from the other qualitative techniques, which are described by grounded theory (Glaser and Strauss, 1967; Corbin and Strauss, 1990), frameworks (Ritchie and Spencer, 1994), labels (Dey, 1993), and codes (Huberman and Miles, 2002). For me, the theme implies the basic concepts I am trying to describe. The link between the theory and the interview is a concept, and to that extent, I agree with Strauss and Corbin (1990) that the abstract concept is usually discovered when a number of concepts are compared to each other, in relation to one phenomenon.

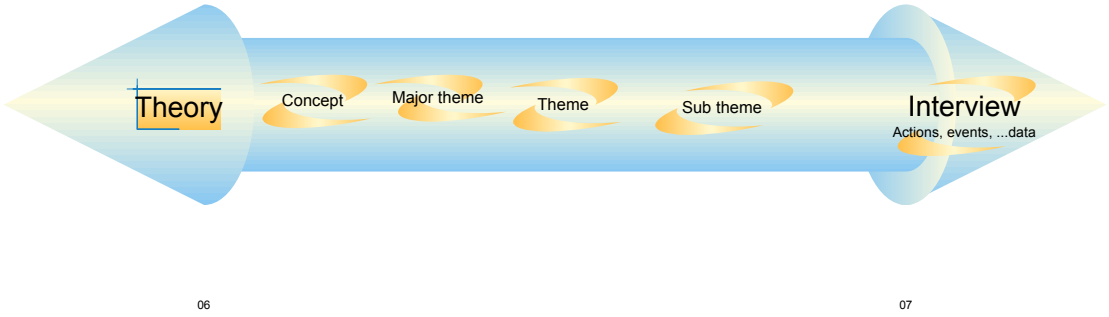
The major contrast between the grounded theory and the analysis I have used, which is thematic analysis in this study in that the first starts at the bottom usually by finding the codes and contrasting them to build up themes. However, thematic analysis discovers provisional themes at the beginning from the data and ends with coding the data for the final themes as it will be explained later in this section.

Themes are not theories, nor do they happen during an interview (see Figure 3-1). They are in-between, so the major themes are closer to the theories, while the sub-themes become closer to the interview, or the daily setting. For me, identifying the themes started during the conduct of the interview. Then, they were developed during the transcription, and after editing my transcripts. Therefore, more themes became apparent when I listen or read my interviews.

3.3.1 Thematic Analyses Steps

Discovering the themes is the basis of much of social science. My approach to analysing data parallels Ryan and Bernard (2003), Attride-Sterling (2001), and Boyatzis (1998). The process of conducting a thematic analysis followed a practical technique, and effective procedures. These techniques and procedures were abstracted in six steps (see Figure 3-2). These steps were finding concepts, identifying themes and sub themes, coding, organising themes, developing a framework, and interpretation. The following is a detailed explanation for these steps.

Figure 3-2: continuum between theoretical and empirical



Finding concepts

Concepts emerged from the data during the process of familiarisation, which I experienced from the time of collecting the data, and throughout the transcription, editing, and reading the transcripts. During this step of the analysis, I listed all the major themes (concepts) that appeared on listening to the interviews, and reading the whole text. The study's theoretical background provided the themes, which I considered for listing in the concepts ordering, or the data chapters.

According to the interview schedule, the concepts in the interviews were oriented around the pre-transition phase, the transition phase and the adaptation for registration, and the post-transition phase. However, carefully listening to the interviews, and reading the transcripts drew out further concepts, such as the decision to migrate, the source and host country policies, multi-cultural exposure, migration through recruitment agency channels, whether the UK was a station or a destination, patterns of male/female migration, and finally, migration in the pursuit of income and higher education.

Identification of concepts was a continuous process, and went parallel to the 2nd, 3rd, and 4th steps of analysis. The process entailed short-listing the themes, which emerged

from the data. Conceptualisation did not, however, end as a process before the final stage of interpretation.

3.3.1.1 Iidentify themes and sub themes:

The concepts were used as a frame for constructing the major themes. These concepts helped me to analyse my data in a manageable way, and provided a structure for the themes, which emerged from reading my interviews carefully. When a new major theme emerged, it was included and added to related concepts.

In general, themes were identified using the following techniques:

Repetition is the first technique in identifying themes. I found listening and reading the same interview repeatedly an easy way to identify themes. The importance of each theme stems from its recurrence. Some times, I found the nurses expressed their thoughts, behaviours and experiences with *analogies and metaphors*. So I found searching the metaphors for underlying meaning, another possibility for producing themes.

The natural shifts in the topics narrated by the nurses usually indicate themes. This is called *transition* by Ryan and Bernard (2003), which indicated the critical points in the journey of the nurses' migration. Therefore, I considered the natural shifts in a nurse's employment and migration experience as an important theme, which deserved further investigation.

I generated *Abstraction of similarities and differences* by taking pairs of ideas or notions, and asking whether they were similar or different from each other. I was aware that there were some techniques, which the native speakers, preferred to use. I am a native speaker of Arabic, as well as my interviewees, and whilst I conducted the interviews in English, during the interviews I found the nurses using metaphors and

linguistic connections, such as 'Municipality Mule' which made sense to me, but perhaps wouldn't have been understood by the native speakers of other languages including English. This was possible because the nurses were Jordanians, and they shared with me the language and the culture. When they gave an Arabic saying, I found myself easily understanding what they meant, which was not the case for my English friend who transcribed one of my interviews.

To a lesser extent, I tried to look for what was not mentioned by the nurses, which sometimes indicated an important theme. I understood that themes discovered by looking at the *missed data* needed careful scrutinising. However, I realised that missing data cannot come from the first reading, but that the text needed reading repeatedly, until all the ready themes were discovered, after which other themes started to appear.

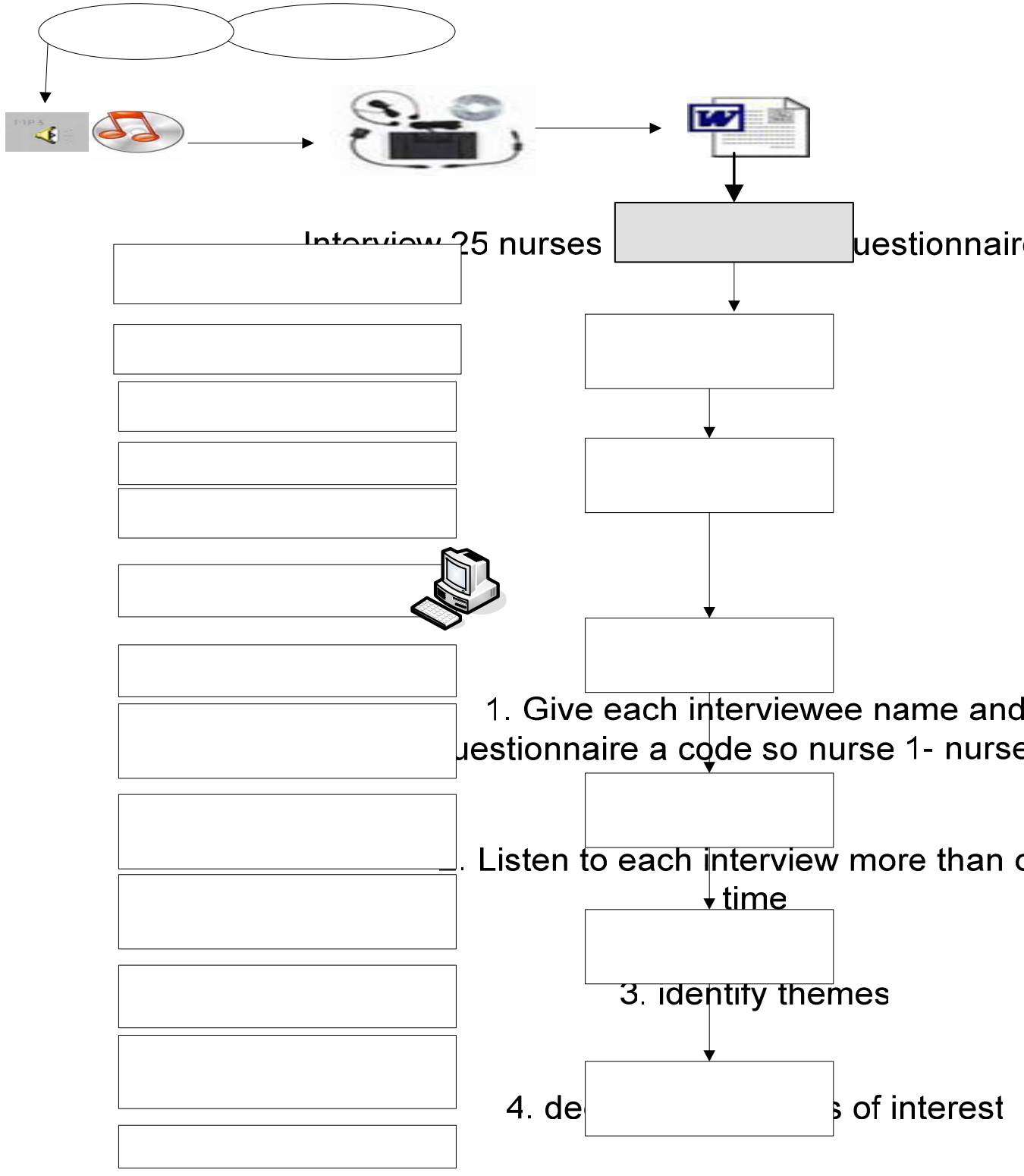
Because I was looking for the most prominent themes, I used the following techniques, and regretted using the others. I did look for the *repetitions, similarities and differences, transitions and language connectors,* because they were more likely to generate themes than the other techniques. Themes emerging from the data were listed under the related topic.

3.3.1.2 Coding

After identifying all the themes and sub-themes, or becoming satisfied with the list, I went through the text and highlighted the main quotes for each theme and sub-theme. To perform this step I used the Nvivo 7 software (see appendix 5). I did this by reading each interview, and coding for one concept at a time. I went through all the interviews, before moving to code for another concept, by reading again the first interview through to the last one, and so on.

During the coding stage, some themes and sub-themes emerged, and I added them to the topics as mentioned previously. It is very important to mention that I noticed some overarching themes during this step, which were recorded and added under a category of over-arching themes. These overarching themes were very important in discovering the patterns of the themes, or organising the themes in a concept.

Figure 3-3: data transcription and analysis



3.3.1.3 Organising themes

The previous steps of 'analysis' involved the breaking down of the evidence into its basic units (Freshwater and Avis, 2004). This step entailed deciding on the final themes to be included, and adding them to the related concepts. Building a tree of the themes and sub-themes gave a structure for these themes (see appendix 5). I created groups of themes conceptually through clustering (Boyatzis, 1998 P. 128). I continued to search for patterns in the themes. The same techniques used to identify the themes, led me to be satisfied or unsatisfied with the list of the themes which I had shortlisted, and this was enhanced by the theoretical background, and the priori research. This also spurred me to find the most appropriate organisation of the themes.

3.3.1.4 Developing a frame

I linked the concepts and the major themes to each other in order to develop a framework. This framework is the core of the three data chapters.

3.3.1.5 Interpretation

According to Freshwater and Avis (2004 p 8), "interpretation is a broadening process in which themes are looked at in relation to a background. Interpretation is inductive, moving from the specific to the general; it is dependent upon building a framework that allows the translation of the results of an analysis into new theoretical contexts." I used interpretation to make sense of what I know about migration, and to build up new insights through induction of facts and experiences that I collected, which have become more than the sum of the parts. This enabled me to present the world in a new light, either from a slightly shifted perception or a transformation (Freshwater and Avis, 2004).

3.3.1.6 Barriers for effective thematic analysis

As a researcher, I cannot prevent the reader from a deviant interpretation of the findings and the conclusion. However, I was able to minimise any chance of misinterpretation. Here, I summarise some of the factors that may threaten thematic analysis, which particularly apply to my study. These were related to my projection, sampling, and my style. The researcher's projection is related to the ego defence mechanisms (Boyatzis, 1998), whether during data collection, or even during analysis and writing the results. Ryan and Bernard (2003) argue that theme identification involves judgments by the researcher. The projection effect decreases the validity of the research findings. This validity can be maximised by clarifying the position of the researcher. This is possible by making judgments clear and explicit to the reader, where he or she can agree or disagree with the findings.

Sampling probably interfered with the themes, which I developed specially for snowball sampling. As I have previously mentioned, one of the major drawbacks in snowballing is that participants may lead you to people who may have similar attributes (Atkinson and Flint, 2001). For this reason, I applied the snowball for the survey, to build a database where I was able to select a sample of maximum variation attributes. In applying this, I followed a detailed protocol prior to the field-work, and considered the unit of analysis as well as the initial unit of coding (Boyatzis, 1998).

Mood and style is another barrier for effective thematic analysis. The quality of the data collected, processed, and analysed, was sometimes threatened by the researcher's fatigue, stress, and distraction (Ryan and Bernard, 2003). I avoided these factors, and others related to the mood, by applying measures such as rest, and establishment of consistent judgment of the data among supervisors and colleagues, and even the participants.

3.3.2 Rigour and Trustworthiness:

Methods for assessing the rigour and trustworthiness of research findings depend on the research paradigm adopted (Morse et al., 2002; Rennie, 2000; Thorne, 2000). For example, positivist research paradigms apply four standard criteria to an inquiry. These are internal validity (to test the truth value), external validity (to test applicability), reliability (to test consistency), and objectivity (to test neutrality) (Denzin and Lincoln, 2005). In contrast, qualitative research is more complex because there are numerous approaches to select from and the qualitative research is concerned with describing, interpreting, and understanding the meaning people attribute to their social world (Silverman, 2001). It would be difficult to generalise, or transfer to other contexts (Patton, 2002). To date, various proposals have been developed and introduced to ensure 'trustworthiness' in the qualitative paradigm; these are credibility, transferability, dependability, and conformability (Morse et al., 2002). Qualitative researchers accept that the social world is multi-faceted, and its outcomes are based on the interaction of human agents. Moreover, the essence of assessing the trustworthiness of any qualitative research is to measure its truth-value. This can be verified by one or more procedure/s of clarifying researcher bias, triangulation, prolonged engagement in the field, member checking, and external audits (Cutcliffe and McKenna, 2004; Rodgers and Cowles, 1993; Thorne, 2000).

The methods in this study paid close attention to specific personal and contextualized experiences, whilst at the same time using techniques which ensured the trustworthiness of results. Use of interview quotations revealed facts about the study which made the findings worthy of attention. These statements will help the reader to judge the work fairly, according to a criterion relevant to the study.

I strived to make explicit, the basis of my interpretations, employing systematic procedures to monitor and check my influence, and I tried to display the results in transparent ways, which allow for confident conclusions. However, I was aware that too much formal trustworthiness could have introduced risks, such as a limited scope of findings, overconfidence in results, and blindness to emergent or marginal phenomena. There are no procedures which guarantee objectivity, but instead, I found a balance between interpretive openness and trustworthiness.

Triangulation is one of the most powerful techniques for strengthening credibility. Denzin and Lincoln (2000) suggested that one of the four major types of triangulation involves the use of multiple methods. Method triangulation involves the corroboration of constructs based on information, derived from at least two different methods. One of the main threats to ensuring qualitative validity is the misinterpretation of the meaning expressed through interview conversations. The use of the questionnaire prior to the interview is one way to check interpretations, as is rechecking with the participant during the interview, whether the interviewer understands and interprets the story of the interviewee correctly. The accounts of the participants' should be continuously checked and rechecked during drafting the data chapters, to maintain rigorous objectivity.

The truth value of this study is embedded in gaining and understanding actions, beliefs and values, with reference to the participants' frame, which was constructed personally, professionally, and socially. Throughout the conduct of this study, I endeavoured to examine the influences on data collection, and the authenticity of findings, by attending to questions, such as the potential introduction of research bias, ensuring that member checks were made to assess representativeness of the data analysis and findings, and that the categories selected for discussion captured the

essence of the phenomenon under study. Hammersly in Cutcliffe and McKenna (2004) asserts that an account is valid or true if it represents accurately those features of the phenomena, which it is intended to describe and understand.

3.4 Conclusion

This chapter has explained the rationale for the applied research methods. Firstly, I outlined the interpretative philosophies, and how they are used in examining migrants' experiences, through biographical and the life history research. Secondly, I provided a detailed account of my research from generating the sample, ethical conduct, and data collection, to the analysis and trustworthiness of the findings. The next chapter provides a background about the Jordanian nurses and the health system, and its relationship with migration.

Chapter Four

4 The health system and nursing workforce in Jordan

4.1 Introduction

This chapter aims to examine the situation of international and regional migration of nurses from Jordan. Because there is no scientific evidence pertaining to this situation, data about nurses' migration from Jordan was drawn from anecdotal resources. This chapter uses best available information to examine the nurses' migration through a review of the context of the health system, and the nursing workforce in Jordan. To do this, the chapter is divided into three profiles; firstly, the Jordan profile, secondly, the health system profile, and thirdly, the health workforce profile.

4.2 The Jordan Profile

The Jordanian Department of Statistics conducted a census in 2004, and found that the population of Jordan was 5.743 million (Department of Public Statistics, 2005). Income per capita was JD1649.1 (£1220) during 2005, and reached JD1805.1 (£1335) during 2006 (Fargues, 2007) . The approximate birth rate in 2006 was 29 per 1,000 of the population, life expectancy was 70 for males and 72 for females (Ministry of Health, 2006).

Fargues (2007) claims that the unemployment rate from the population census was 22.7%. However, this rate was much higher than the unemployment rates identified by the Department of Statistics, which was 14% (Department of Public Statistics, 2005). The high demand for skilled Jordanians by the Gulf States made it necessary for Jordan to import an unskilled and technical labour force from other neighbouring countries, such as Egypt and Syria (Bloom et al., 2001; El-Jardali et al., 2007).

Jordan is a small country in terms of geography and population (see map), however it has the potential to supply highly skilled professionals in different fields and to meet part of the demand from the neighbouring Gulf States (GS) (El-Jardali et al., 2007; Fargues, 2007). As the demand for nurses rises across the world, including the GS, recruitment agents and health care employers in the Gulf States have become increasingly interested in the potential for importing nurses from Jordan. Whilst it does have ability to produce highly skilful nurses, at present Jordan does not have enough nurses to meet its own domestic health service needs (Abu AlRub, 2007).

Figure 4-1: Map of Jordan

4.3 Health system Profile

Health indicators and figures put the health conditions in Jordan at the top, in the Middle East region (El-Jardali et al., 2007). This is due to several factors, the most important of them being the country's stability, and a range of effective development

plans and projects, which included health as a major component. According to Dajani (2002), Jordan approached development from a holistic perspective, realising that poverty, illiteracy, and health form a triangle which must be addressed simultaneously. Achievements of working against poverty and illiteracy, in addition to the spread of sanitation, clean water, adequate nutrition and housing, have combined to make for healthier Jordanians.

Three sectors of public, private, and Non Governmental Organisations (NGOs) provide health services in Jordan. The public sector is represented by the Ministry of Health (MoH), the Royal Medical Services (RMS), and two University Hospitals (Dajani, 2002). Health care is provided almost free of charge by the MoH and the RMS. The MoH provides primary, secondary, and tertiary health care, through a network of health centres, maternity and child health centres, and hospitals. The average travelling time to the nearest centre is 30 minutes (Dajani, 2002). The RMS mainly provides secondary and tertiary services through 10 military hospitals. The two university hospitals serve as referral centres for other health sectors. The MoH is responsible for organising and regulating all health services in the public, private, and NGOs sectors.

The private sector provides primary, secondary, and tertiary health care through a network of private clinics, nursing agencies, and hospitals. There were more than 7000 private physicians, and 21 nursing agencies, during 2003 (Batieha, 2003). The majority of the private clinics and hospitals were located in the capital, Amman.

The NGOs provides health services through the United Nations Relief and Welfare Agency (UNRWA), and local charity trusts, including the Jordanian Red Cross and Crescent. The UNRWA provides primary health care to Palestinian refugees, and has

23 primary health care centres. There are also five hospitals owned by local charity trusts.

Table 4-1: health system figures in Jordan

	Year 2006
Public and Private Hospitals	101
Total hospital beds	11,049
MoH health centres including Mother and Child Health centres and dental clinics	1,361
Registered Nurses and Midwives	8,015
MoH budget as (%) of total government budget	6.1%

Source: adapted from (Jordanian Nursing Council, 2006; Ministry of Health, 2006)

Hospitals are classified according to their public –private association and bed capacity. The health care system has a total of 101 public, private, and military hospitals. The total number of hospital beds was reported to be 11,049 in 2006 (Ministry of Health, 2006). According to table 4-1, in 2006, there were more than eleven thousand hospital beds and over 1350 primary health centres, which employ only 8,015 registered nurses (RNs).

4.4 Health Workforce Profile

Data on the health care workforce varies across the sources, although not by wide margins. Though the recommended international norm for the nurse –physician ratio is between 2/1 and 3/1, according to the MoH statistics 2006 for Jordan, it was at a lower ratio of 1.34/1, per 10,000 of the population, derived from the index of the health care workforce. Taking into account the stock of all registered nurses, midwives, associate and assistant nurses, there were 33 of these, and 24.5 physicians, for each 10,000 of the population (Ministry of Health, 2006).

The nursing workforce plays an important role in the Jordanian healthcare system, because it constitutes the largest group within the healthcare personnel. The nurses

consist of three regulated occupational groups, which work in a variety of roles and organizations across the continuum of care. The Jordanian Nursing Council (JNC) collected data once during the year 2003, concerning the entire nursing workforce. Table 4-2 shows the stock of nursing personnel in Jordan. The survey found that there were 6007 registered nurses (RN), and 1233 registered midwifes (RM), in addition to 1241 associate nurses (AN). One unexpected figure is that the number of males are in excess of 40% (Jordanian Nursing Council, 2006; Ministry of Health, 2006).

It is important to note in this context, that the data about Jordanian nurses and the health workforce is not comprehensive. It does not include data about retirement, inward and outward migration, and death. While, data collection has been neither consistent nor continuous, this kind of data is important for future projections and strategic planning. Such data was the basis for estimations of the nursing workforce required to meet health care needs. It represented the base for calculations, as shown in table 4-3, which was reported by the JNC recently. Moreover, the Higher Health Council (HHC), during the year 2002, estimated similar projections of nurses needed in Jordan for the coming years.

A critical component of long-term planning for nursing personnel, is finding the number of nursing students, and prospective students, entering the system. For information on students, no single key source of updated data exists. Individual nursing education institutions are the only source of updated data. To track the number of students enrolled in, and graduating from a wide range of disciplines, including nursing, there is a need to contact each institution.

Table 4-2: Distribution of nursing personnel according to institutions, qualifications, and gender (2003)

Institution	**RN**	**RM**	**Total AN, PN & Tawjehi**	**Total**	**Total**	
					(F)	(M)
Ministry of Health	2066	893	4639	7598	4006	3592
Royal Medical Services (RMS)	953	101	1581	2635	1621	1014
Private Sector	1606	177	1977	3760	2301	1459
University Hospitals	775	18	241	1034	651	383
Universities (Public, Private)	193	0	0	193	118	75
Colleges (Public and Private)	155	14		169	98	71
Ministry of Education	205			205	156	49
Ministry of Social Development	2		7	9	6	3
UNRWA	44	30	161	235	233	2
Jordanian Nursing Council	2			2	0	2
Public Security	4		8	12	1	11
Civil Defence	2		0	2		2
Total	6007	1233	9463	16095	7516	6632

**Source: adapted, from Jordanian Nursing Council, last accessed 27.8.2007 at http://www.jnc.gov.jo

Excluding nurses working outside Jordan, and including nursing personnel working in institutions such as pharmaceuticals (about 30 females and 20 males).

The number of RNs include about 224 foreign nurses, 137 foreign assistant nurses, & 12 foreign, equivalent to High School Certificate (Tawjihi)

Princess Muna College of Nursing, College of Allied Health Sciences, is under Colleges and Universities.

Total numbers copied from the original source as they were, with all the inconsistencies, because they include RMS in medial units: about (23) RNs (431), practical nurses, and (89) associate degree.

Very little information has been available historically regarding the education, training, and practice of nurses in Jordan. Apparently, a very limited range of data holdings examine the existing nursing workforce, from demographic characteristics, such as age, and sex, to employment and the geographical distribution of nursing professionals. Little is known about the movement of nurses between the different health sectors, migration, work, life, and health, compensation, and remuneration,

workload, and the productivity of nurses, although it is the role of the nurses' association to collect data about the compensation and remuneration, but no such data is available.

*Table 4-3: Estimated number needs of nurses for the five years (as published by JNC 2003)**

Year	population With 2.8% annual increase	Estimated RN need /population 20/10,000	students # graduate BSc /year	Accumulated RN # according to graduates	Surplus /Shortage	Number of Bed with 3.0% annual increase	Number of RN according to beds	RNs shortage according to bed
2003	5,480,000	10,960	591	**8,720**	-2,240	9743	10717	-243
2004	5,633,440	11,267	586	9,311	-1,956	10035	11039	-228
2005	5,791,176	11,582	956	9,897	-1,685	10336	11370	-212
2006	5,953,329	11,907	1,105	10,853	-1,054	10646	11711	-196
2007	6,120,022	12,240	1,100	11,958	-282	10966	12062	-178
2008	6,291,383	12,583	1,200	13,058	475	11295	12424	-158

Source: Jordanian Nursing Council

* Actual numbers are not yet available yet for any of the years

2003 estimations based on **(8720 as base number provided by MOH)** (20 RN For Each 10,000 of the population) and (1.1 RN for each bed)

Beds were estimated according to yearly increase% of bed as published by MoH

Students' #I based on statistics up to 2002

4.4.1 Nursing education

Formal nursing education began with the establishment of a Nursing School by the MoH in 1953, in Albashire hospital, which awarded diplomas. University-connected nursing education started in 1972, with the establishment of a programme at the University of Jordan in Amman, awarding a Bachelors' degree in Nursing (Jordanian Nursing Council, 2004). Entry level eligibility for nursing education was increased from 65% to attaining an average score of 70%, in the high school certificate examination (HSCE) at the age of 18, or after 12 years study in school (Al-Sa'eh, 2007). This was to enhance the quality and competency of nursing graduates. Post secondary programmes include both, a 4-year Bachelor of Science (BSc) degree in nursing, and a 2-year midwifery diploma. These are the minimum requirements for an entry level job of a staff nurse, registered nurse, or midwife, according to the Jordanian Nursing Council law number 74, which was released by a Royal Decree (Council of Ministers, 2006). Another level of study for 2 years, and receiving an Associate nursing degree (AN), is not accredited or registered by the JNC. Nursing education in Jordan witnessed a transformation since the start of the new millennium in terms of the quantity of teaching institutions and gender mix of enrolment students (Shuriquie et al., 2007). As a result, many programmes were reformed and some discontinued, such as the Auxiliary Nurse, and Practical Nurse (PN), which were discontinued in 1995 and 1998 respectively. Auxiliary nurse was awarded upon completion of 18 months of training in hospital-based nursing schools, and practical nurse was the title of HSCE graduates in the nursing high school branch (age 16-18 years), or those who completed 6 months nurse training in a hospital(Abu AlRub, 2007; Shuriquie et al., 2007).

Table 4-4 illustrates the number of institutes, which provide training and education in nursing by types of degree. All nursing programmes are connected to and accredited by the Ministry of Higher Education, except for the Jordanian Nurses and Midwives Association (JNMA) and MoH higher diplomas. During 2004-2005, 983 nurses and midwives graduated from these programmes and there were a total of 5427 students across all year levels, of which only 28% were female (Ahmad and Alasad, 2007; Jordanian Nursing Council, 2005). The first programme for PhDs in nursing started in 2005, in the University of Jordan. A study conducted by the JNC indicated that there were 184 academics in nursing schools, out of which there were 102 PhD holders, 82 Master degree holders, but 50 of the total were non-Jordanians (Jordanian Nursing Council, 2005).

Table 4-4: Nursing education programmes in Jordan according to affiliation and degree type (2007)

Education Organisation Category	PhD Or Master Degree	Postgraduate Diploma	BSc Nursing	BSc Midwifery Or Midwifery Diploma MD	Associate Degree (AD)
Public University	4	-	6	1 BSc	5
Private University	-	-	5	-	-
Ministry Of Health	-	3	2	2 MD	2
JNMA	-	1	-	-	-
Private Colleges	-	-	-	-	19 AD
Royal Medical Service	-	-	-	-	2
UNRWA	-	-	-	-	1
Total	4	4	13	3	29

Resource: researcher adopted from (Jordanian Nursing Council, 2006; Shuriquie et al., 2008)

Nursing education in Jordan is facing several challenges. First, enrolment in courses (called Practical Nurse) outside the accredited programmes is still happening, irrespective of the efforts to stop it. Second, currently academic nursing programmes are still not in accordance with the health needs, and health planning in Jordan. Ahmad and Alasad (2007) explained that the courses were designed without taking into account the needs of the population. They added that the development of

competent nurses required building a curriculum based on health needs for the people of Jordan and the region. This is considering the cultural and economic differences from that of America, where the curriculum is usually designed. Third, little is known about the number of qualified students denied acceptance into Jordanian nursing schools. Fourth, there are other challenges related to nursing specialties and practice areas. To date, nurses in Jordan become specialised, not by qualification, but through experience, except for midwifery. Those who work in childcare, critical care, operating theatres, mental health, and other specialties, have no specialist qualifications, but have gained experience while working in those areas. Fifth, professional development and training courses were established during 2005 by the JNMA, but are still not in compliance with the new levels and national standards, which were defined by JNC law. Training and practice places are inadequate and probably inconvenient to nursing education.

Sixth, the enormous male student recruitment in nursing programmes represents a great challenge for educators and policy makers alike (Nursing and Midwifery Council, 2005). Abu AlRub (2007) indicated some important reasons for the low enrolment of female students in nursing programmes. Families may refuse to let their daughters become nurses in Jordan, because of the patterns of night duty. She suggested that male nurses are culturally more acceptable for this job, as they can take the role during the night. Thus, the enrolment of male students in nursing schools is increasing rapidly. Ahmad and Alasad (2007) argue that the overall current percentage (72%) of male students suggests that the direction of future distribution of nurses' gender will make male nurses dominate the profession. However, the nurses' decision makers recently recognised this challenge, and they are making their efforts

to tackle it. Finally, the number of new nurses leaving the country, or their profession, after successful completion of their nursing degree, is unknown.

4.4.2 Registration

Before the graduates practise nursing in Jordan, they must register with a regulatory authority. Previously, nurses and midwives had to register with the Jordanian Nurses and Midwifes Association (JNMA). During that period registration expired yearly, with renewal upon payment of a small fee, however, there were no requirements for professional development, unlike the nurses in the UK (2005). According to Oweis (2005), a nursing graduate could work as a nurse immediately after application for registration, because there was no formal check process of their acquired skills in Jordan. Registration should certify that all nurses are tested for both clinical and theoretical knowledge components in order to protect the patients from any malpractice.

The Royal Decree in 2002 for the Jordanian Nursing Council (JNC) to be the only body of registration in Jordan. The JNC was established 2002, after a proposal submitted to the MoH from a committee of leading nurses in the country, with a mission to look at nurses registration. While this is a step on the long road of measures for creating competent nurses, nursing registration has to show evidence of the safe and professional practice of nurses, whether newly graduated or working. Other measures of competency suggested by Oweis (2005) might include job descriptions, work based induction programmes, continuing education, and the accreditation of nursing programmes.

According to the JNC regulation, nurses have three professional levels (Council of Ministers, 2006). The first is general nurse (GN), who has to obtain permission to practise professionally after she/he has passed the evaluation, and has held the BSc in

nursing for three years at least. The second is nurse specialist, who has similar requirements to the GN, has obtained a higher or a professional diploma in nursing, and fulfils the specific standards for registration at this level. The third level is clinical nurse specialist (CNS), in which the nurse fulfils GN requirements, and obtains the second university degree (MSc) in a field of specialty, listed and recognized by the Council. The JNC, according to the Royal Decree, after approval from the Senate and Chamber of Deputies (2006), is empowered with the authority and functions to achieve the following objectives:

- Setting the strategy for organizing and developing the profession.
- Proposing policies related to education for the nursing profession.
- Elevating the standard of the profession, and proposing legislations related to its practice.
- Cooperating with local, regional, international entities and parties related to the profession.
- Setting required programmes for developing human resources.
- Coordinating and cooperating with relevant entities to enhance scientific research in the field of nursing and health sciences.

The Higher Council for Health (HCH) has proposed the health policy in Jordan, since it was established in 1976. However, nurses are under-represented in this Council, which limits influence on monitoring, regulating, and coordinating the health sector in Jordan, including education, specialization, and registration. According to Hijazi and Al-Ma'aitah (1999), the absence of nurses from this Council impacted the autonomy of the nursing profession.

4.4.3 Jordanian nurses mobility

According to Shuriquie et al.(2008) nurses in Jordan would have preferred a career in other health field or teaching. Shuriquie et al.(2008) reported three possible factors contribute to their study finding, the general unemployment rate, poor public image of the profession and student enrolment into nursing programs. Those who entered nursing and they had no other choice are more likely to search for exit when their circumstances change. Examination of intentions to change work place and nursing profession revealed several interesting points. Private sector nurses are less likely to change work place when compared to public (Mrayyan, 2005). More male nurses intend to change than females (Al-Ma'aitah et al., 1999; Shuriquie et al., 2008).

Nurses may move within Jordan from the Royal Medical Services (RMS) and the Ministry of Health (MOH), to the private sector or the Primary Health Care (PHC), or from one hospital to another in the private sector (Hijazi and Al-Ma'aitah, 1999). Furthermore, there is movement from hospitals to Maternal Child Health centres (MCH), but details of this continue to be unclear (Hijazi and Al-Ma'aitah, 1999; Oweis, 2005). Movement from Jordan to the Arab Gulf countries or elsewhere abroad, accounts for 18-21% of the total number of nurses employed by hospitals per annum (Jordanian Nursing Council, 2005; Jordanian Nursing Council, 2006). This movement has created a crucial shortage of qualified nurses (Abu AlRub, 2007).

In the absence of official statistics and rigorous studies, the number of Jordanian nurses abroad is not identified. While, anecdotal sources indicated that there are 500 to 700 Jordanian nurses in the UK (Al-Sa'aeh, 2003; Alnsoor, 2005; Nsoor, 2005), the NMC records indicated a number not exceeding 200 nurses, as the figures represent those who register for the first time (see table 4-5). This table shows that Jordan was one of the top twenty countries supplying nurses for the UK.

The number of nurses employed in Jordan indicates that the health system runs with a shortage of nurses. Apparently, this is less than the ratio recommended internationally (see tables 4-1, 4-2 and 4-3). Health policy makers and researchers are misguided by the total figures of nurses, which include non-professionals and technical nurses, when calculating the nurses required in meeting the demand of the health services. Moreover, the employment of technical nurses and non-professionals jeopardises the safety of patients, particularly when they are requested to perform tasks allocated for professional nurses (Shuriquie et al., 2008).

There are four significant factors contributing to shortages of nurses in Jordan (Al-Ma'aitah et al., 1999; Jordanian Nursing Council, 2006; Abu AlRub, 2007). First, producing fewer nurses than required. Second, shortage in supply. The budget allocated for health services, and in particular the amount of money allocated for nurses' development, has restricted the number of nurses recruited, as well as the payment for those employed, which leads nurses to seek employment elsewhere. Third, there is a loss of nurses through migration, and fourth, leaving the profession. Since 1990, health care institutions in the GS have approached Jordan as a source for recruiting well-trained nurses. Much of this recruitment is targeted in the capital, Amman. Some of the best hospitals in Jordan are reportedly experiencing mass resignations, and an exodus of nurses to hospitals abroad (Hijazi and Al-Ma'aitah, 1999). At the same time, Jordanian hospitals have contributed to the process unintentionally, by recruiting and training nurses, who then become qualified to acquire the experience required for employment in the GS. Some of these are prepared to take the nurses examinations for western countries employment. Anecdotal sources indicate that the waiting period for migration to the GS is as short as 1 month, from the time of the first application for a job and visa, and to the UK is

as short as 6 months, whereas for the US it is up to 2 years (Samante, 2006; Dhamrah, 2003; Bladd, 2007).

Table 4-5: initial registration of international nurses in the NMC Register 1998-2005

Country	1998/99	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05
India	30	96	289	994	1830	3073	3690
Philippines	52	1052	3396	7235	5593	4338	2521
Australia	1335	1209	1046	1342	920	1326	981
South Africa	599	1460	1086	2114	1368	1689	933
Nigeria	179	208	347	432	509	511	466
West Indies	221	425	261	248	208	397	352
Zimbabwe	52	221	382	473	485	391	311
New Zealand	527	461	393	443	282	348	289
Ghana	40	74	140	195	251	354	272
Pakistan	3	13	44	207	172	140	205
Zambia	15	40	88	183	133	169	162
USA	139	168	147	122	88	141	105
Mauritius	6	15	41	62	59	95	102
Kenya	19	29	50	155	152	146	99
Botswana	4	-	87	100	39	90	91
Canada	196	130	89	79	52	89	88
Jordan	**3**	**3**	**33**	**49**	**53**	**18**	**17**
Nepal	-	-	-	-	71	43	73
Swaziland	-	-	-	-	-	81	69
China	-	-	-	-	-	-	60
Malawi	1	15	45	75	57	64	52
Sri Lanka	-	-	-	-	23	36	47
Lesotho	-	-	-	-	-	50	43
Japan	-	-	-	-	20	37	34
Singapore	-	-	-	-	-	-	28
Sierra Leone	-	-	-	-	-	-	24
Others	203	329	472	605	418	514	380
TOTAL ALL OVERSEAS		3,621	5,945	8,403	15,064	12,730	14,122

Resource: (Nursing and Midwifery Council, 2004; Nursing and Midwifery Council, 2006)

This shortage has created many professional challenges facing nurses in the health system. Professional nurses frequently report high work loads, clashes with other health professionals and mangers, physician domination regarding patient treatment decisions, absence of clinical empowerment, oppressive work conditions, and a feeling of inadequacy (Abu AlRub, 2004; Abu AlRub, 2007; Jonsson and Halabi, 2006; Mrayyan, 2005; Mrayyan, 2007; Oweis, 2005; Shuriquie et al., 2007). These

challenges contributed to frustration, exhaustion, and many nurses moving to another work place, or leaving the profession for good.

Jonsson and Halabi (2006) reported a number of interesting challenges for nurses, such as achieving the respect of the public, and fellow health professionals, as well as vagueness of the nursing role, and public misunderstanding. These challenges confused the nurses, who were persuaded by constant messages from some people, including knowledgeable and skilful individuals, which convinced them that nursing is a respectable occupation.

Mrayyan and Acorn (2004) noticed that nurses leaving (staff turnover) is one of the most common issues challenging the nursing and hospital development in Jordan. As an illustration, it is reported that nurses working in hospitals are more likely to leave than those practising in other settings, and that males are more likely to leave than females (Hijazi and Al-Ma'aitah, 1999). The number of hospitals has increased by 25% annually since 1999, yet the proportion of male nurses was 40% in 2004, compared to 25% in 1999 (Ahmad and Alasad, 2007; Jordanian Nursing Council, 2006). This is an indication that there are significant changes in the Jordanian nurses' workforce situation, and this is probably associated with the decisions to leave and go abroad.

The government in Jordan noticed the phenomenon of nursing leaving and applied some retention measures, in my opinion they are ineffective. Part of these measures are restricting giving long duration unpaid leaves and refusing the applications of resignation (Abu-Yousef, 2006). For example, Mensah et al. (2005) argue that some nurses, when they intend to work abroad, are forced to break contracts with their work places and not given the opportunity to take unpaid leave or to resign. That means, the

employers in these cases do not keep their records for their future return, or offer them long unpaid leave, but instead, they break their ties with the employee.

In my opinion, nurses in Jordan find their way abroad following one of three methods. First, the nurse may search actively for a job abroad using the adverts in different means of advertising or contacting employers abroad directly. Second, most nurses keep follow adverts and calls from employers who come to Jordan and stand for informal job fair for few days. This kind of hunting for nurses mainly applied by employers in the Gulf States and most Jordanian nurses in the Gulf find their first job by this way. Third and last, some nurses get a job abroad when a campaign launched by recruitment agency.

According to the Social Network Theory, intermediary organisations such as the recruitment agents represent a link for prospective migrants and help them to reach the destination country (Arango, 2000). Kingma (2006b) defined recruitment agencies as profit organisations that link the nurse who look for a job with the employer. During the year 1999, NHS trusts in London hired an international recruitment agency based also in London to recruite overseas nurses. This agency liaised with local recruitment agency in Jordan, who advertised nursing vacancies, on behalf of the employer in the UK, using local daily newspapers. Jordanian nurses spread the advert by word of mouth and many applied for a job in the UK. Kingma (2006b) argues the health organisation usually hires the agency for recruiting nurses; therefore, the recruited nurses need to contribute nothing toward the cost of the process. However, some employers expect the nurses to reimburse the agency once they have begun the work. Chapter five expand the role of active recruitment by drawing on the accounts of Jordanian nurses recruited to the UK.

4.5 Conclusion

A professional nursing workforce is an engine of economic growth and healthy people, but needs to be utilized effectively. Jordan is already pursuing policies to increase the absorption of a large number of people into the nursing workforce, as it leads to productive work, but the anticipated gender and skill-mix transition will increase the challenges of employing them, and retaining the more competent, in the country. Action should be taken soon to reform the pattern of recruiting students to nursing, and to create jobs for them.

Some knowledge gaps are more difficult to fill. Two indicators currently sought by decision-makers, researchers, and the media, are non-migration-related attrition (why nurses leave the workforce), and the number of Jordanian nurses currently working outside Jordan, particularly in the Gulf States, the US, and the UK. Comprehensive, accurate data for these questions is difficult to obtain, in part because these nurses can be difficult to locate and/or survey. The growth in the recruitment of students in nursing programmes, as well as the direct recruitment activities of countries close to Jordan, is a serious and deplete the best qualified nurses in the country. In order to form public policy in this area, it is critically important that data on nurse production, employment, retention, and migration be tracked and analysed. There is no evidence on migrant nurses from Jordan. How do they leave? When do they move? In addition, there is no reliable source of information about their specialties and qualifications, and what support they receive to enable them to move abroad.

Chapter Five

5 Challenging the status quo

5.1 Introduction

International nurse studies reported that the factors of push and pull explain nurses tendency to migrate (Hardill and MacDonald, 2000; Kline, 2003; Aiken et al., 2004; Buchan and Sochalski, 2004; Vujicic et al., 2004; Winkelmann-Gleed, 2006). Although the push and pull model is convenient at the macro level (e.g. from country to country), researchers depend on proxy informants to find its elements (see literature review chapter, pre-transition experiences). The difficulty of reaching the actual informants (see methods chapter) pushes the researchers to use the group of accessible migrants as a representative of the migrant population and to rely upon those who possess information about the migrants (rather than the migrants themselves) to draw information for review. Thus, there is a need to search for the actual reasons each group or country's nurses describe as reasons to migrate, applying more directly to the actual population in question. Reasons have been cited in the migration literature for some countries such as the Philippines, southern African countries and India (ICN, 2003; Dovlo and Martineau, 2004; Mc Gonagle et al., 2004; Thomas, 2006; Brush and Sochalski, 2007; Khadria, 2007; Lorenzo et al., 2007). Despite the difficulty involved in identifying the nurses who are likely to migrate, it is possible to get in touch with them, in the destination country. I followed the Jordanian nurses in the UK and from their interviews, the following three data chapters emerged.

This chapter reports and discusses three issues; first, the 'status quo' reports and examines the nurses' work conditions before the idea of migration, second, discussion of Jordanian nurses' motivations to move abroad, and third, challenging the status quo through a decision of moving to the UK. These three issues discuss the experience of a nurse moving from a state of having no intentions to migrate to a state of taking a

decision to go abroad. Therefore, they form the basis for the presentation of this chapter and establish the platform for discussions in the following data chapters.

5.2 The status quo

This section discusses an important element of the pre-transition experience; it is when nurses shift from a state of no idea about migration to the state of 'it is a good idea'. The existing situation of nurses in Jordan indicates a lack of inclination to migrate because leavers represent one fifth of nursing workforce (Jordanian Nursing Council, 2005). Since the majority of nurses have chosen to stay in Jordan, in my opinion, they are the ones maintaining the status quo. However, some nurses challenge this status and choose to go abroad. The following section describes the attributes of the nurses prior to the decision to move to the UK. In order to find what encourage some Jordanian nurses to go to the UK and the others to stay, I examined the work conditions in the source country (Jordan and the Gulf States) drawing on the leavers' opinions. According to Rassool (2004), the work conditions are the main motivation for nurses' migration. Therefore, after the demographic profile, I discuss the previous work conditions as described by the nurses, and then I examine the nurses' challenge for their previous work conditions.

5.2.1 Demographic profile of Jordanian nurses in the UK

The study identified the participants' demographic characteristics after receiving 52 surveys out of more than 200 sent to Jordanian nurses in the UK. The participants of this study are all Jordanian nurses, but not all of them were in Jordan before they moved to the UK. I use the term 'source country' to indicate all the countries where Jordanian nurses came from before their arrival in the UK. Jordanian nurses either worked in Jordan or had a job in one of the Gulf States (GS), before they moved to the UK. The survey identifies the attributes of nurses who migrated from Jordan and

the Gulf States (GS), such as, nursing qualification, education institute, nursing speciality, gender, and their employers in the source country (see appendix 6). Selected attributes reported in the table 5.1 including the age of the nurse at the year 2006.

According to the Human Capital Theory (HCT), the migrants are young and have perception of gain from migration (Massey et al., 1998). This study reports the Jordanian nurses were young at the time of moving to the UK. Most of them migrated 5 years younger than the age when they participated in this study. They were between 27 and 41 years old, with most of them around the age of thirty. The majority were men; out of a total of 52 participants, only 12 were females. Contrary to the common national and international male-female ratio in nursing workforce, this study reports that females represent a quarter of Jordanian migrant nurses in the UK. This is not surprising as the percentage of males in the Jordanian nursing workforce is on the rise. This percentage for the year 2005, was over 40 per cent (Jordanian Nursing Council, 2005; Ahmad and Alasad, 2007).

According to Chiswick (2000a; 2000b) Dostiey and Legerz (2005), qualification and education can take migrants to distant destinations, instead of closer ones. That is instead of moving to Jordan's neighbour countries, the qualifications of nurses may take them to Europe, United States or Canada. Out of those surveyed for this study, most of the nurses received their nursing qualification from two universities in Jordan; either the University of Jordan or Jordan University of Science and Technology (JUST), one of the participants was from a private university in Jordan and nine had a diploma from a middle university college (teaching nurses for three years). However, two qualified from UK nursing schools and one from an institute in UAE after a qualification from Jordan. Their academic qualification was varied, of the 52 there

were 18 participants had a master's level qualification, 21 nurses had a bachelor's degree and there were 9 diploma holders and four were not mentioned any level. All the nurses were employed in the source country as critical care nurses, barring 10 participants who worked in general wards, specifically medical surgical, paediatric, and oncology. As regards the critical care nurses, specialities were intensive care unit, intensive coronary care, accident and emergency, theatre, haemodialysis, neonatal intensive care and trauma and orthopaedic.

When the nurses arrived in the UK, they had less than 7 years nursing experience. More than half of them had worked for 1 to 3 years in Jordan, before they moved somewhere else or to the UK. Those who explicitly mentioned their previous workplace; one-third were working with private sector and another third in the public sector in Jordan, while the last third was working outside Jordan for hospitals and health organisation in the Gulf States. Most of them were employed in the public sector in the countries of UAE, Saudi Arabia and Oman. Their work conditions varied from country to country therefore, I discuss the situation in Jordan first and then in the GS, depending on the nurses' opinions during the interviews. The description of work conditions in Jordan and the GS implies that the Jordanian nurses, at one point had no desire to migrate, but later started to construe migration as a favourable option.

Table 5-1: Jordanian nurses attributes before moving to the UK

Name	Age	Gender	Qualification	Specialty	Workplace
Abdullah	31	male	Bachelor	Oncology	Jordan
Adeeb	35	male	Master	Trauma and Orthopaedics	UAE
Adel	30	male	Master	General	Jordan
Amal	38	female	Master	General	UAE
Ayman	28	male	Bachelor	ICU	Jordan
Hassan	36	male	Master	NA	NA
Ibrahim	33	male	Bachelor	Theatre	Jordan
Jawad	29	male	Diploma	Cardiology	West Bank
Khaleel	29	male	Bachelor	ICU	Jordan
Laila	30	female	Master	Teacher	Jordan
Malek	29	male	Diploma	ICU	Dubai
Maram	30	female	Bachelor	ICU	Jordan
Muhannad	34	male	Master	ICU	UAE
Muna	35	female	Diploma	Medical	Jordan
Nurse 1	29	male	Master	ICU	Jordan
Nurse 10	34	male	Bachelor	A&E	NA
Nurse 11	31	male	Master	CCU	Jordan
Nurse 12	30	male	Bachelor	ITU	Jordan
Nurse 13	28	male	Diploma	General Medical Surgical	NA
Nurse 14	37	male	Bachelor	Haemodialysis	UAE
Nurse 15	29	female	Diploma	Neonatal ICU	NA
Nurse 16	33	male	Bachelor	Theatre	Jordan
Nurse 17	41	male	Master	Theatre	Jordan
Nurse 18	34	male	Bachelor	ICU	Jordan
Nurse 19	28	male	Master	Coronary Care Nursing	Jordan
Nurse 2	31	female	Bachelor	Child Health	UAE
Nurse 20	39	male	Master	ICU	Oman
Nurse 21	29	female	Diploma	Neonatal ICU	NA
Nurse 22	40	male	Diploma	ICU	UAE
Nurse 23	40	female	Master	ICU	Oman
Nurse 24	40	male	Master	CCU	Jordan
Nurse 25	29	male	Master	ICU	Jordan
Nurse 26	29	male	Bachelor	Oncology	Jordan
Nurse 3	32	female	Master	Medical Surgical	UAE
Nurse 4	30	male	Master	ICU	Jordan
Nurse 5	29	male	Bachelor	NA	Saudi Arabia
Nurse 6	33	male	Bachelor	Critical Care	NA
Nurse 7	31	male	Bachelor	ICU	NA
Nurse 8	29	female	Diploma	NA	NA
Nurse 9	33	female	Bachelor	Cardiac Telemetry Unit	Saudi Arabia
Radhi	35	male	Bachelor	Haemodialysis	UAE
Raed	30	male	Diploma	Medical Surgical	UAE
Saleh	35	male	Master	ICU	Jordan
Salem	29	male	Bachelor	NA	Jordan
Sami	30	male	Master	ICU, CCU, A&E	UAE
Talal	27	male	Master	ICU	NA
Tayseer	34	male	Bachelor	A&E	Jordan
Wejdan	32	female	Bachelor	Medical	NA
Wesam	34	male	Bachelor	Theatre	Jordan
Yahya	35	male	Diploma	Haemodialysis	Jordan
Ziad	36	male	Bachelor	Theatre	Jordan

5.2.2 Nurses' work conditions in Jordan

Aiken and Hunt (2001) reported that nurses experience challenging work conditions which cause dissatisfaction and exhaust them emotionally. They added that the nursing workforce throughout the country, suffered from a low morale. This study found that the nurses' work conditions were challenging because of the workload, work safety, nurse - physician relationship, retention and turnover and lack of career development.

When the nurses are on duty, they are confronted with an excessive amount of workload. One registered nurse was responsible for the care of a large number of patients, that too without any help from anybody or supplementary workers. Wesam admitted:

> *You will find just one staff nurse […] who should look after 26 or 27 patients. (Wesam, 34, Male, Telephone)*

The nurse has to care for the patients for everything, including the tasks that can be done by unskilled workers. This workload may influence the nurse's professional behaviour and has an adverse effect on the way the patients are taken care of. Wesam said:

> *[The nurse] will be stressed, he will shout, he will push, and you can imagine how [many] mistakes he will do! (Wesam, 34, Male, Telephone)*

In the absence of proper planning, workload would increase to limits, which were beyond the ability of the nurse. Wesam was working in theatre, for a peripheral public hospital in Jordan. Their daily tasks were centred on the patients listed for surgery. He expressed his growing frustration with the list, as it would change without prior notice or reason.

> *You can change it at any time, you can put anyone first or second or third or whatever. If the surgeon mood is not good, he will postpone the whole list, or if the manager of the unit is not in good mood, she can change the whole list. (Wesam, 34, Male, Telephone)*

The workload also depended on the total hours the nurses were required to put in, on a weekly basis. Nurses work full-time in Jordan only and they are requested to work usually 8 hours a day or they may choose 12 hours, in some workplaces to accumulate 48 hours a week. Nurses in Jordan are required to work at unsocial hours and instead of monetary compensation, they are paid extra off duty hours per week.

> *[D]uring the night shift we have offered [extra off]. That night week it will be 40 hours instead [off] 48 hours. So, we cut to eight hours a week, you know, for their night shift. So they had [to work] two weeks [and get extra] two days off. (Saleh, 35, Male, Telephone)*

Saleh added:

> *"[U]nsocial hours, the only benefit was its the extra off." (Saleh, 35, Male, Telephone)*

This is consistent with what Adel mentioned about his work in another private hospital, where he used to work for 12 hours every night.

> *[W]e normally work like […] seven nights in a rota and then taken four or five days off. (Adel, 30, Male, Personal)*

Although this type of rota exists, it is not necessary that all hospitals conform to or even stick to it permanently. This workload may affects the patients safety and cause deterioration in the quality of the services offered by the organisation (Stone et al., 2007).

Wesam stated the story of ten years' experience for a nurse can be condensed to describe one day only.

> *In Jordan [it] doesn't matter [if] you are a nurse in theatre, doesn't matter how high you go, you are still a nurse in the theatre and there is no alternative thing you can do. (Wesam, 34, Male, Telephone)*

Wesam mentioned that there were no opportunities for nurses to progress and nurses could work in nursing jobs only. There are no alternatives for a nurse; nurses have to work as a nurse in either a hospital or primary health care centre:

> *There are no more choices as a nurse. You can't get another choice. (Wesam, 34, Male, Telephone)*

He is mainly suggesting that the nurse's income would with time or experience. He said:

> *You should be a nurse,...and your salary scale it would be same for at least 10 years. (Wesam, 34, Male, Telephone)*

This is what happened in one of the public hospitals in Jordan and in all likelihood it also holds true for one or more of the peripheral public hospitals, but not for the central public hospitals. However, private hospitals are more updated and frequently upgrade the medical equipment, although they are less able to retain their nurses. Saleh worked in a private hospital and was able to attain a managerial position after merely three years of employment. He admitted that:

> *[I]t was very quick move, you know, for me to be in management. ... I've been a head nurse for the critical care for intensive care unit. I think I had around fifty nurses with me. ... I had been in intensive care since I started after I qualified since '93 until '97. Yeah I worked as a head nurse until 2000. When I got MSc degree, I had been upgraded to clinical site manager. (Saleh, 35, Male, Telephone)*

His career progress probably happened due to the rapid turnover of the nurses in the unit and the hospital where he worked. Turnover is the number of nurses leaving the organisation yearly (Thompson and Brown, 2002). Rapid turnover can be a sign of poor work conditions, which may prompt the nurses to leave (Brewer and Nauenberg, 2003). The stayers may also be frustrated due to the turnover as the nurses may experience more difficult work conditions (WHO, 2006). Usually, the vacancies are not filled immediately.

The health organisations in Jordan are probably facing a critical challenge, that of a high turnover, particularly the private hospitals. Some participants talked about the general tendency among nurses to quit and move to other regions such as the Gulf States.

> *I was working with a staff nurse who was the head nurse of the ICU […] in Jordan and he has left the unit and went to Dubai (Sami, 30, Male, Personal)*

Frustrations and stress at the place of work was a result not only of the high turnover rate, but also due to irresponsible actions on the part of the management. Some nurses complained that their nursing management did not care about their concerns and that they were not given the opportunity to take any decisions. Wesam mentioned many stories about his nurse manager; he said:

> *[…S]he was refusing any development. She was refusing to do anything we suggest her. (Wesam, 34, Male, Telephone)*

Wesam's frustration increased due to an unsupportive work environment; especially when mistakes occurred, which probably affected the patients. These mistakes probably needed actions by the nurse. However, he lamented that it was not possible even to discuss the issue at hand; especially when the physicians or the consultants were in the wrong.

> *Can you say to a consultant this is wrong, stop? They will kick you out from the hospital and no one will support you whether this is your manager or the chief executive. No one of them support[s] you (Wesam, 34, Male, Telephone)*

Physicians are the nurses' partners in their daily work and they have a major influence on the nurses' satisfaction in their jobs. Some nurses stated that the physicians dictated the setting. The nurses talked about the uneasy relationship they shared with the physicians and the problems in dealing with the physicians. Wesam said:

> *In Jordan, there is no team. The doctor is first whatever he has to do, he has to do. If he is good or bad no one can say that to him, you have just to smile in his face and you do whatever he ask[s] you, as a slave. (Wesam, 34, Male, Telephone)*

He also complained about the fact that the nurses were always treated as subordinates:

> *In Jordan, the surgeon is first the doctor is first then the nurse. Does not matter what the surgeon he said he is right. (Wesam, 34, Male, Telephone)*

The nurse physician relationship also influences the nurse patient relationship. The doctors in private hospitals, where they are usually the owners, dictate the work and nurses have to follow their orders with complete obedience. The nurses have no say in the matter of patient care, and some nurses went so far as saying that the nurses were like the doctors' servants.

> *I worked in Jordan in a private hospital and it's a great demand because you have to do the job because they want it to be done like that, you know what I mean? It has to be in a high standard, you have to be like their servant because it's a private hospital and they are paying money." (Sami, 30, Male, Personal)*

This dissatisfaction and unhappiness drove the nurses to seek more friendly work conditions. In some cases, the nurses were not allowed to quit on account of long term contracts that were signed at an earlier time. Ibrahim mentioned a striking point that

his employer refused his application for resignation and unpaid leave; therefore, he was forced to leave his job and in doing so lost his right for pension and the other benefits.

> *I'm leaving whether you agree with my resignation or not because that's my future. If you give me a chance for unpaid leave or resignation that's fine I might come back and work for the same employer. (Ibrahim, 33 , Male, Personal)*

This employer sponsored the nurse's undergraduate study and wanted him to comply with the contract by working the full term years, which Ibrahim claimed as fullfilled. The employer is unfair as the employee finished the years of his contract and got the right to leave if he wants.

Nurses would migrate in response to the work conditions in Jordan. The nurses who left to work in the nearby Arab Gulf States also have their experiences as regards the work conditions.

5.2.3 Jordanian Nurses work conditions in the Gulf countries

Some Jordanian nurses were working in the Gulf States before the UK. Malek moved from Jordan to Dubai and spent three years there. He described his experience from time of application for job and the promises made by the employer:

> *During the interview they promise you; they will update you they will send you to go to the courses and they will give you many things. I [finished] first 3 months, then 6 months, nothing happened, no courses to go. […] I need to [continue] my study I don't want to be diploma, because I still have a chance […] to complete bachelor and master. I applied for the universities. The [employer] did not give me time for a study. I have to study on my own time. I found it hard [to stay] in the same position. The salary [was] the same and the life expenses [are high] because of the rent there. (Malek, 29, Male, Personal)*

Malek complained, the employer promises were aspirations for the nurses when they applied for the post, but the promise was not kept. However, he was more comfortable in his work in Dubai than in Jordan. This relief was related to the comfortable lifestyle and not to the work as he explained:

> *I love the life there, it was very nice, it was very easy, it was very interesting as well, and everybody I think would like to go there. I have been there for 3 years. Yes, everything was available, but you need to do something you don't want to be in the same position for 3years. (Malek, 29, Male, Personal)*

Females shared their male colleagues' ideas about the comfortable life in UAE. Amal described her experience in Dubai:

> *I was living with my sister there as well… the life was very easy there in Dubai we didn't have any difficulties… living in Dubai makes you spend a lot of money. The life there is so tempting. There were so many things for a single girl. So you would just find yourself going with your friends for a meal, for shopping and all these things of the modern life in Dubai. So these were more tempting than saving. (Amal, 38, Female, Telephone)*

Although the nurses described a comfortable life in some Gulf States, they like the Mediterranean climate with cool summer and cold winter. The climate in the Gulf States is cool in winter and hot in summer. It is obvious that Malek and Amal were not only looking for a comfortable life; they were also thinking about job satisfaction and wanted career progress, which never happened in the Gulf States. Malek and Amal shared their opinions about delayed progress and bleak career prospects with Radhi, who found that the progress was not commensurate with his contribution toward his work.

> *I was working in United Arab Emirate, particularly in Ras El khima. And I was charge nurse in that unit… In UAE as well in Jordan, […] progress is very slow, maybe years until you reach equivalent to F grade or G grade. (Radhi, 35, Male, Personal)*

All the nurses who came from the Gulf States explicitly cite lack of career prospects as the main motivation to leave their jobs. Each of them had high expectations about the opportunities for professional development in the Western countries. Some of them described the lack of training courses offered by the employers, which could have enhanced their skills and knowledge and helped them grow professionally.

> *I always wanted to update my knowledge. I wanted experience, which was not available in Dubai. Because, you have to do the same routine everyday and there were only few courses that you can go to and update knowledge to become a different nurse. (Amal, 38, Female, Telephone)*

Amal raised an important issue about 'on the job training' opportunities, which were less likely to be a concern for the health organisations, both in the Gulf States and Jordan. Moreover, she noted that the nurses were not released from their duties and sent for training outside the organisation. This does not motivate the employee to apply for training, which consequently influences the career progress. Amal went further and compared the nurses' work conditions between Jordan and UAE; she spent several years in a public hospital in UAE and occupied several nursing positions. Her account clarifies the nurses' perceptions about their work and their image as seen by the society.

> *[I]n Dubai it was also the same problems happened. Shortage of nurses and administration wise they were very, very, very strict so we did not have much autonomy and independence as nurses which I used to have more in Jordan as a nurse. The image of nurses in Jordan is much better than in Dubai even. In Dubai you can find only few local nurses from the Emirates people and they won't even be originally from Dubai. They just have the passport. The [local people] just think of nurses as maids or someone without knowledge. May be we did have this in Jordan but now it's changing. In Dubai, because nurses are majority foreigners, so they didn't really change the image of nurses there. So I was always looking for autonomy and independence and more professionalism in my nursing. (Amal, 38, Female, Telephone)*

Amal's stated differences in the image of nurses between the two Arab countries. In Jordan, nurses enjoyed a more positive public image, while the nurses in the UAE are striving to reach that level. According to Amal, the relative negative image in the UAE continues due to the insignificant participation of local or native nurses in the workforce. International nurses fill the places that could be occupied by national nurses; therefore, the society there would not change the stigma attached to the nursing profession. What Amal described implies dissatisfaction with the work conditions in the UAE.

The previous discussion threw light on the work conditions in Jordan and the GS, from the perspective of Jordanian nurses who go to the UK. These perspectives are not necessarily the same for the majority of nurses who stayed in Jordan. The migrants explained how they perceived the work conditions, before they developed the idea of going to the UK. They shared their experiences pertaining to the unpleasant work conditions, at least from their own point view. Their experiences indicated that they were dissatisfied with their jobs. The work conditions were nerve-wracking for them, especially when added to the general life conditions. These factors

influenced the nurses' definition of their status and residency in Jordan and the GS. The wide range of unpleasant events and issues that they were confronted with, influenced some Jordanian nurses' attempts to maintain the status quo and encouraged them to search for another workplace. The following section discusses the motivating factors, which encouraged the Jordanian nurses to challenge the status quo and migrate.

5.3 Motivations to move abroad

The second element of the pre-transition phase is thinking about migration. This section discusses how the Jordanian nurses went through the experience of thinking about migration. Nurses work to create an identity for themselves and want their employers and the society to grant them this status, while some stakeholders in the health system want to maintain the status quo. It is implied from the participants' interviews that their work has an influence on their status and identity. Hardill (2002) positions the status and the identity so it is intimately bound up with the paid work. She argues the status as defined through career trajectory. It is clear that the participants had paid jobs; but the conditions of these jobs contradicted the planned career, which they adopted to define and gain their status. Therefore, the nurses were eager to define themselves and find the status they wanted by their career and through education or finance. Most nurses described their aspirations for higher education and more qualifications, as they thought that this would improve their status in their own eyes and in the eyes of their communities. Other motivations and issues paralleled this aspiration for study, which encouraged them to challenge the status quo. Those are career development, higher financial income and adventure.

5.3.1 Educational motivations

Forty-three of the fifty-two survey respondents said that education was a reason for coming to the UK. Most Jordanian nurses believe that higher education will qualify them to change their situation and enable them to challenge the status quo.

> *The situation in Jordan, […] because it's a young country, everyone is looking for education. [If] you don't have certificates, you don't get higher education, you don't really get a lot in the step of work and salary wise […].(Maram, 30, Female, Personal)*

Seventy percent of the Jordanian population is under 30 years old and education is part of aspirations of families and individuals (Bloom et al., 2001; El-Jardali et al., 2007). The survey results coupled with the interviews made it clear that the nurses harboured a desire for further education. The idea for education started as a challenge for the nurses status quo, mainly for the male nurses (Abu Gharbieh and Suliman, 1992). Some female nurses explained how they were motivated to study. Amal worked in Dubai before she came to the UK. She initially thought about her education before moving out of Dubai, she said:

> *I worked in the staff development department; this gave me the enforcement and motivation to go and do my masters. (Amal, 38, Female, Telephone)*

She realised that to pursue further studies, she would have to move out of Dubai. Therefore, Amal explored the alternatives; she said:

> *I've decided to continue first on my education so I've decided to do Master degree first. So, one of my choices was to come to Britain. (Amal, 38, Female, Telephone)*

Other participants also thought about the alternatives available to them, to continue their studies while they were working. One option was to stay in their jobs and apply for an educational course in the nearest university. Another option was to move

somewhere near a university, in another country and find a job there. The first option was possible for nurses in Jordan, but under challenging conditions. These included working full-time while also studying full-time or choosing between either of the two, the tough competition and compulsory programmes available to study.

> *I did apply to do Masters in Jordan but difficult that time because then I have not enough experience, which was one of the requirements. (Ayman, 28, Male, Personal)*

More challenging conditions were mentioned by Amal when she compared studying in Jordan and the UK:

> *I was thinking if I would study Masters, I would do it at home, which would be less expensive than here [UK]. Nevertheless, coming here was more interesting more exciting for me. I don't like the routine [in the] life, [or]doing the same thing. [In addition], in Jordan I have to study like for two years and then I have the same teachers who taught me when I was [student] nurse. I heard the students their say it is not the same as it is here [UK]. Doing Masters in one year and finish it! I can say; oh yes! one year and I finish then I can do something different. (Amal, 38, Female, Telephone)*

The second alternative involved moving to another country, as in the case of nurses in the Gulf States, where there were no higher education opportunities available. Many nurses expressed that education was the main motivation for leaving these Gulf States and moving to the UK.

> *[I]t was a bit difficult for the nurses because there is no nursing institutions or school of nursing in Dubai. They don't have nursing institutions in general. It was a bit difficult, and if I wanted to go back home, it would be also difficult. Because, I have to fund myself and to study. (Adeeb, 35, Male, Telephone)*

Despite the fact that their primary aim was studying, they chose to work and save money in order to self-fund their educational pursuits. This group of nurses indicated

sometimes that their motivations stemmed from monetary aspirations, because they have not the economic capacity to fund their study. When I asked Ziad why he came to the UK, he said:

> *"… to improve my finance, my salary, for money. The first thing is for money."*
> *(Ziad, 36, Male, Telephone)*

Nevertheless, he admitted during the interview that his aim was to study, and his goal was to save money to pay for the study. While many nurses want to go for postgraduate study, the nursing programs in Jordan are inadequate and competitive and few nurses have been able to secure a place.

> *I could not get an opportunity for higher education or something like that [in Jordan]. (Ziad, 36, Male, Telephone)*

Some nurses were motivated to come to the UK for a PhD study, although they earned their Master degree from Jordan.

> *I thought I might get an opportunity to continue my education. It is one of the most important things in my life. .....I got Master degree from Jordan and I thought [UK is] the best place …to continue [study], as you know we haven't got [educational institutions for] a PhD degree in Jordan. (Saleh, 35, Male, Telephone)*

The British qualification is widely recognised and acceptable all over the world. This was considered as a pull factor for the nurses also.

> *It was studying in England and getting a UK qualification. Getting a qualification, regardless of what it is, will be qualification [credential] and the bonus if it is in the UK. (Hassan, 36, Male, Telephone)*

Another nurse added:

> *I came to get Master [degree], postgraduate qualification. When I come back home […the] people will look at them from different views and not financial way only, but from financial and educational wise. Added to that a better life I tried and the experience of being abroad". (Raed, 30, Male, Personal)*

In Jordan, since the year 2000 the nurses' gender mix has shifted favour of males (Ahmad and Alasad, 2007). Males' enrolment in nursing programs is increasing, therefore, many young men found themselves supervised by the senior female nurses. This phenomenon challenged the newly qualified male nurses in a culture and society characterised by 'androcentrism' (Hofstede and Hofstede, 2005; Oweis, 2005). This was coincident with another cultural challenge, when they faced the stigma, which label nurses as doctors' assistants (Abu AlRub, 2004; Oweis and Mousa Diabat, 2005). Ayman mentioned that to overcome his problem he would aspire to qualify as a physician. He said:

> *"My plan was to do masters to get access to the medical school". (Ayman, 28, Male, Personal)*

He thought that acquiring a master's degree in the UK would equip him with the qualifications required to gain access to a medical school. That is not a challenge for the status of nursing, merely using it to become a doctor by another route. Male nurses often think to challenge the label given by the society; if they are not considered at par with the doctors, they will strive to acquire qualifications, higher than those of a physician.

The Jordanian nurses holding a university degree perceived their professional qualification at the same level as the doctors' and ought to be treated and labelled with independent identity. This perception increased their awareness that they needed autonomy from medical profession and they need to be completely independent.

Some of them believed that it would be worthwhile to gain further education so as to be able to stand against the doctors firmly on a scientific basis and show them that they were better qualified.

> *I was planning when I was still in college before I've got my degree to continue to the master level. (Ayman, 28, Male, Personal)*

Sami was concerned, like many other nurses about education and gaining higher qualification degree.

> *When I was in Jordan my main interest in the future was education, lecturing and that is what I am working for, towards my higher degrees. (Sami, 30, Male, Personal)*

He added:

> *I was thinking of coming outside even Arabic countries because of the chances and the opportunities of getting a better education and getting a higher education in a sub-specialty area. (Sami, 30, Male, Personal)*

The Jordanian nurses shared expectations related to the recognition of the UK as a developed country and with England being perceived as a world leader in nursing. Some of them expressed their expectation of enjoying practicing nursing in the most advanced environment supplied with more advanced technology and updated equipment. This expectations and much of the previous claims about stigma are evident from Ibrahim's account:

> *There were alternatives for me. One of them was to stay in Jordan;[through] finding a job with the university as a teacher assistant or even work in the [Jordan) University hospital. If I wanted to go outside the country [but] with the same context of culture, the option was to go to Gulf States. But, the reason [to come here] get the advantage for me is the UK's study. Because financially you might get the same income compared with the prices in both countries. But, in the Gulf States, they don't provide a chance for education so I'd rather go for education because this was my primary reason for coming here. (Ibrahim, 33, Male, Personal)*

When the nurse has aspirations for study, then the place of study becomes an important part of the decision:

> *I chose here because in this country you have a chance to develop yourself and continue high education like MSc and PhD. (Ayman, 28, Male, Personal)*

Although, the Jordanian nurses planned for their study in the UK, they seldom estimate study prospects before arrival. Some nurses got the opportunity to study and made use of their work permit to reduce the study fees into home student rate and to generate income to pay for study and living expenses.

> *To continue my higher education that was the most important part. As a full time worker, you have the chance to continue your study and to pay local fees. (Adeeb, 35, Male, Telephone)*

Leaving for the UK was the choice of the migrant nurses who were motivated by educational opportunities. However, education was not the sole consideration in their decision to move. All the nurses mentioned education in conjunction with other motivations; such as the career development.

5.3.2 Career Development motivations

Many Jordanian nurses plan their career and life, with their profession at the core. Thirty-nine of the 52 survey respondents said that the career development was their

reason for leaving Jordan and the GS. Where nurses find inadequate opportunity for career development, they may search for another workplace starting with looking for other local opportunities. In the absence of opportunities in the local market, some would not give up and instead continue to search regionally or internationally. Some nurses consider career development as a means for attaining better personal and financial status. Jawad as a means for career development considered the training opportunities, because it gave him the required skills and qualifications to progress in his career. He expected a better financial and personal status by moving up the career ladder.

> *I was looking for a new opportunity, a new improvement and looking for improving my career and my training skills. The main thing that made me come here was to improve my self actually rather than to improve my financial status. (Jawad, 29, Male, Personal)*

The absence of attractive and variant job opportunities for the migrant nurses pushed them to leave and move abroad:

> *"Unfortunately there [were] few jobs and chances [for nurses] to work in Jordan. So they go somewhere else". (Abdullah, 31, Male, Personal)*

Abdullah remarked that there were few options for nurses to choose for employment. Anecdotal sources indicated that there was a shortage in nurses' workforce but there were restrictions on the budget allocated for recruiting new nurses (Al-Nsoor, 2007; Bladd, 2007). According to Abdullah, the options available do not satisfy the nurses' aspirations for a future career. Therefore, many qualified professionals were leaving abroad mainly to the Gulf States, United Kingdom, and the United States of America. Abdullah linked career development with his expectations of better standard of life in the UK; he said:

> *It is a career opportunity I have to say…. A good career opportunity and to develop myself and to get better standard of life. (Abdullah, 31, Male, Personal)*

Another group of nurses was motivated by real experiences in the UK during education or training course. I interviewed two nurses, former employees in the Ministry of Health (MoH) in Jordan, before they moved to the UK. During their previous employment, the MoH sent both of them for a training course to the UK for six months. Both admitted, they never thought of a migration to the UK before the training opportunity. However, the course motivated them to search for a job and to stay in the UK. One of them, a male, secured temporary registration with UKCC (United Kingdom Central Council for Nursing) and a job contract in the UK. However, when he went back to Jordan, he applied for resignation from his previous job and he found an agent recruiting nurses to the UK on contracts with better conditions. The second one, a female met her future husband in the UK, as she was single.

Muhannad had worked one year in Jordan, before her moved to Abu Dhabi, motivated by the salary. He was not satisfied with his career progress in Jordan and was looking to develop himself professionally. He was working with English nurses in Abu Dhabi; they told him about the opportunities for professional development in the UK. However, the English nurses informed him that it would not be financially rewarding for a nurse working in the UAE, to move to the UK. When I interviewed him, he said:

> *I thought, there was no chance for me for any career development in Abu Dhabi. So, I moved to the UK for career development. Because, I knew my clinical skills and knowledge will be appreciated, much more recognised in places like the UK. (Muhannad, 34, Male, Telephone)*

Mohannad worked in UAE (Abu Dhabi) and earned the income he wanted. However, career development and job satisfaction was important for him as much as income.

While the nurses in Jordan are trained to provide high quality care, when they start working they face challenges to provide the same level of care to the patients, due to circumstances beyond their control. Nevertheless, they strive to practice what they learned in their undergraduate studies.

> *"[A]fter we finished four years in the university, we found a gap between the theory which we read in the book and the practice." (Tayseer, 34, Male, Personal)*

Tayseer explained the circumstances and he added:

> *[…] there was a limited resources [supplies] to demonstrate nursing care and to deliver it to the patient. When I decided to come to the UK, my dream was first to improve my English language, to discover a new culture and also to work in … ideal environment, in good conditions environment (Tayseer, 34, Male, Personal)*

Adel explained that he wanted to:

> *[T]ry to get good experience in the UK … everybody knows about the medical [advancement] in the UK. (Tayseer, 34, Male, Personal)*

He searched for a job abroad because of his financial situation. He searched for jobs in the GS and noticed the difference in the salary of nurses, who were educated in the UK. This diverted his attention to the UK, to find a job and gain experience and then after few years to move back to GS. He realised that those with work experience in the UK are able to secure jobs in the GS, at much better terms.

> *… getting [the UK] experience maybe good credit if I want to go to the Gulf States later." (Adel, 30, Male, Personal)*

By *'good credit',* he means, qualifying to recieve higher salary. This is because the employers in the Gulf States pay nurses, who come from Western countries, more than nurses from Arab countries, southern Asia and even their nationals. Career development is significant push and pull factor for most Jordanian nurses; although sometimes they associate it with the financial motivations.

5.3.3 Financial motivations

Thirty-six respondents to the survey said that the pay and income, is a reason for their migration to the UK. Research has shown that migrants in the host countries have diverse backgrounds and slightly different reasons to migrate from the source countries (George, 2005; Buchan et al., 2006; Winkelmann-Gleed, 2006).

Many Jordanian nurses are expected to contribute toward their parents' house expenses and support them financially. This financial contribution is ingrained in the Jordanian culture. The income of a Jordanian nurse might not be sufficient to support several dependants, especially is he is the sole breadwinner.

> *"if I stayed in Jordan may be I could still support and feed myself. May be I could not save some money for my family." (Wesam, 34, Male, Telephone).*

Wesam grew up with five brothers and sisters, which translates into a great demand on his father as an only breadwinner for the family. He had a moral obligation toward his parents to contribute towards the raising of the rest of the brothers and sisters. Wesam explained this family bond and the son or daughter commitment toward his/ her parents:

> *"..my father was retired. He looked after 3 sisters and another 2 brothers. When he needed money while I was in Jordan I could not offer him that money." (Wesam, 34, Male, Telephone)*

On the other hand, the parents support their children' education ,even for postgraduate studies sometimes. Tayseer was postgraduate student in Australia, sponsored by his father. The family was confronted with difficult financial circumstances, which stood against his study project. He explained:

> *I've got six brothers, I've got three sisters so I'm not the only person in the family he's [his father] got to support so he's got a lot of responsibility. (Tayseer, 34, Male, Personal)*

Nurse's monthly income in Jordan is not enough to support one family of two adults and two children. One nurse mentioned his monthly salary for working in a public hospital during the year 1999; (currency exchange during 1999; 1JD almost =£1) he said:

> *"in Jordan our pay, when I was graduated, was like 230 Jordan Dinar; yeah [that's was seven years ago" (Sami, 30, Male, Telephone)*

With this pay amount, many nurses would probably choose to depend on other sources, such as, borrowing money and finding an access to the banks for loans to cover some of their primary needs.

> *... I still pay that bank in Jordan nearly seventy-two [JD] from my salary which was two hundred fifty Jordan Dinar. (Yahya, 35, Male, Telephone)*

This would also be the case for nurses who were working in the private sector. However, few nurses in both public and private sectors were satisfied with their income because of less financial commitments or a better position. Although , they were not faced with financial difficulties, but they were pulled to the UK by better wages.

> *"Compared with my colleagues [the salary] was double or a triple. But, this was around [19]97 I started having around 500 [JD] but with my increment I hit last salary around 700 [JD] or a bit more. (Saleh, 35, Male, Telephone)*

Saleh added he was contributing to his parents' family. Moreover, he was able to buy a house:

> *I have my family and I've got my big family, my parents and brother and sister. Also, I bought a flat in [19]97, which was a challenge for my [counterpart] colleagues as you know because of their wages. (Saleh, 35, Male, Telephone)*

Another nurse had no plans to go beyond the GS and the idea of migration to the UK was not in his mind. He was ambitious to follow his colleagues who were working in the GS. Jawad's account described what was mentioned previously; his salary was not enough to meet his expenses.

> *"I've just been thinking of moving from Jordan for financial reason to improve my financial status. As you know, the salary was not enough to build a good future in Jordan." (Jawad, 29, Male, Personal)*

Abdullah's family was satisfied financially, as he was single and lived with his parents. However, the family wanted him to establish a future for himself by moving abroad. A commonly used tactics is that families send a member to save the rest of the members who are staying at home (Massey et al., 1993; Stark, 1995). Abdullah's case was different, because the family wanted this member to migrate to improve his own financial status.

> *From financial part, me and my family we're I mean financially stable [satisfied]. We were doing fine. I mean we've got good income. So it wasn't the main concern for them but they might have looked at it as it might be a good chance for me to earn more money. Get a better future, which they encouraged and they agreed. (Abdullah, 31, Male, Personal)*

Abdullah's family encouraged him to migrate not for their benefit, he mentioned:

> *It's not kind of directly financial support to them It was more into me, like their son and my future (Abdullah, 31, Male, Personal)*

Adel also motivated by money like many others. He said:

> *My main concern was to get out of Jordan to find a better salary […] to improve my financial status and to get more income. (Adel, 30, Male, Personal)*

Then he explained the financial status by:

> *[T]rying to get higher salary and improve income, looking for a future like getting married and improving family situation. (Adel, 30, Male, Personal)*

Tayseer was a student and a nurse in Australia when he came back to Jordan he realised that nurses' income is not enough to meet his daily expenses. He is married to a woman from Jordan, also she is qualified nurse worked with him in a private hospital in Jordan. Both salaries, as an income for a family, were not enough to meet their financial needs, and to secure a stable future for them and their children. This motivated him to search for a job opportunity abroad:

> *"I started to look for a job in Saudi Arabia or to look for another chance in Western countries." (Tayseer, 34, Male, Personal)*

Financially motivated participants left the source country and moved to the UK in an attempt to get a better status.

> *"You should work for financial status other wise there is no money there is no life." (Tayseer, 34, Male, Personal)*

Many participants in this study believed that their status could be improved by increasing finances. However, most participants thought that an improvement in status

could be secured through education. Jordanian nurses adopted the financial and educational status as means to challenge the nursing status quo in their home country.

5.3.4 Travel and adventure

Young migrant nurses followed the footsteps of their colleagues and friends. Winkelmann-Gleed (2006) pointed that young migrants may decide to work in another country for adventure, curiosity and to develop their English language. This study reports that Jordanian migrant nurses in the UK are young in general. Every participant was younger than 41 years, by mid of 2006, when I conducted the interview, with most of them migrating when they were at the end of their twenties.

> *[T]he idea […] within yourself [is] to go abroad because you're not happy with being at home [country]; which can be for any reason." (Raed, 30, Male, Personal)*

Although, Raed listed push factors as reasons to leave Jordan, he also indirectly stated pull factors, that is, benefits in terms of finances, opportunities, resources etc. Many nurses gain an impression about the destinations from other Jordanians in the GS and Western countries.

> *People come from first world country they bring good investment back home. Also, better opportunities, better resources and different lifestyle, all these are considered as well. (Raed, 30, Male, Personal)*

Raed's account implies another motive in the competition between the colleagues or the discovery of opportunities available for nurses. Early ideas for migration are reinforced when the nurse is encouraged by the positive experiences of other migrants. Jawad listened to the positive part of the stories told by the Jordanian migrant nurses in the GS when they visited Jordan, he explained:

> *All my dreams were to go to Gulf [country] first. We've heard that bla…bla…bla went there and he is making a good money. So, and he is coming back to Jordan with financially comfortable and stable and you know that is guaranteed him as I said a good future. (Jawad, 29, Male, Personal)*

During the interviews with Raed and Jawad, it became apparent that financial, educational and career development might accumulate in one nurse account and motivate him / her for migration. It was common to find one nurse describing more than one factor, during the interview, as reasons for migration and they do not contradict with each other. Nevertheless, the combination of these factors contributes to the final motive, which pulls the nurses toward taking risks and perceive the travel as an adventure.

The survey indicated that some nurses (19/52) were motivated by factors such as a desire for change, travel and adventure; also, they described the standard of life in the UK, as a reason for migration. People look for travel and adventures when they are young, physically able and before they become busy in their life. The participants who said that adventure was a motivation, they used their nursing qualification as a passport to travel to the UK.

> *"I like travelling. I like to see another country in the world not just Jordan." (Ziad, 36 , Male, Telephone)*

Those nurses found an opportunity to travel without any financial cost, particularly, those who were assisted by a recruitment agency. They had no means to sponsor an expensive trip, as they were not wealthy and could not afford it. However, some nurses explained that adventure was a secondary motivation, while the primary factor, was either education or the better financial prospects. Therefore, adventure, curiosity and English language were extra inducements that encouraged them to migrate.

Migration to the UK gave the Jordanian nurses the bridge they needed to cross over to where they wanted to go. Most nurses mentioned their aspiration to live and work in London, when they were in the source country. They had little idea about the life in London. However, they kept this idea in their mind even after a year or more of working in the UK, outside London. Those who worked outside London, once they finished their first year contract, they moved to London.

One nurse said that he knew working in the UK would not be financially rewarding. However, he was motivated because of adventure and travel; he said:

> *"I wanted to come and see how it goes… it's nothing to lose." (Abdullah, 31, Male, Personal)*

Similarly, another nurse mentioned his aspiration to travel and visit other countries. Moreover, he added that living in a foreign country, would be valued in his local community and perceived positively

> *[… B]etter life is tried and the experience of being abroad as well. The adventure of being in Western countries. (Raed, 30, Male, Personal)*

The nurses who had the same thinking like Abdullah and Raed, considered themselves as gaining the opportunity to travel and live for a while in the UK. The cost of their stay was covered as part of their job contract, which they signed before they moved. "It is nothing to lose", an indication that they still have the opportunity to come back to Jordan and get the same job or equivalent.

The nurses who wanted adventure and travel were lucky because, it is not always that nurses get the opportunity to travel by simply applying to a recruitment agency. The process usually takes a long time and much effort is required from several parties. The recruitment agency considers the nurses who fit the criteria and meet the conditions of

the employers. The employers usually carry one or more interview with the candidates and choose the candidates most likely to succeed in carrying out the duties and reduce the dropouts later. The candidates apply and send many documents, which require a lot of time, in order to follow the long process of the application and selection.

The Jordanian nurses experienced these motivations during the time of thinking about moving abroad. The motivations encouraged them to try migration and to take a decision, which challenge the status quo.

5.4 Opportunities to challenge the status quo

This section discusses two important elements of the pre-transition phase; these are when the nurse says: 'I will give it a try' and 'I will go'. While the nurses who stayed in Jordan, probably tried it, the nurses who moved abroad followed a road to the UK, paved by either the recruitment agency or the pioneers. The previous motivations were the fuel for migration, waiting for an ignition to happen. The nurses decision to migrate was most likely triggered by active recruitment from the destination country or and the pioneers (Martin, 2003; Eyck, 2004; Buchan et al., 2006). Countries search for international nurses, by launching a recruitment campaign ,carried out either directly by the employers or through the recruitment agents on behalf of the employers (Buchan et al., 2006; Walters, 2008). Another factor that encouraged migration was the interaction of Jordanian nurses in the Gulf States, with nurses of other nationalities who apprised them of the advantages of working in the UK. Both, the recruitment agencies and the interaction with other nationalities, paved the road for the Jordanian nurses who where desperate to find a job opportunity in the UK.

5.4.1 Active Recruitment in the Source Country

Thirty-five out of the fifty-two respondents stated that a recruitment agency was involved in their migration to the UK. While four nurses did not give a clue, whether assisted or not, only 13 nurses were self-dependent during their migration.

Saleh was nurse supervisor in one of the hospitals, he claimed that his nurses asked him to give them references, he said:

> *I think I wrote around ten references or twelve to my employees. (Saleh, 35, Male, Telephone)*

These references were mainly for the recruitment in the UK, by one unit in a hospital over a very short period. Those references were required as part of the application to the agency, which launched the recruitment campaign in Jordan in 1999. The large number of applications was an indicator how much the nurses wanted to leave their workplaces.

Some nurses had no idea about migration and never thought about going to the UK. However, the emergence of recruitment agencies prompted them to take the decision to migrate. Adeeb said:

> *[T]here was an agency in Dubai recruiting nurses […] for international [positions]. I went with one of my friends and they offered me an interview at the same time and we had a chat about England and the study, work [and] everything (Adeeb, 35, Male, Telephone)*

Another nurse had seen one agent's adverts, she said:

> *During the year 2000, […] there was agencies coming to Dubai [to recruit] nurses to come and work [in the UK]. I applied and I got a contract and they decided the hospital and everything (Amal, 38, Female, Telephone)*

The advert was also circulated in local Jordanian newspapers and between friends.

> *There were advertising in Jordan that they want nurses in the UK. It was in the newspapers but I didn't read it myself. Actually, one of my friends read it and told me about it and I thought that might be a good chance for me. (Abdullah, 31, Male, Personal)*

Despite the adverts of the agents in the local newspapers, most nurses heard about the campaign from their friends. Ayman said:

> *My friend told me about this offer (Ayman, 28, Male, Personal)*

Another nurse said:

> *I heard about the agency from a friend of mine, I went to them, and we just initially had a very brief interview. (Raed, 30, Male, Personal)*

Interesting, how some nurses moved from no idea about migration to the state of going through the process of application through the agency. Ayman perceived the idea as a joke and suddenly he realised his involvement:

> *I've said don't be ridiculous you know, they are not gonna take us. Because we are talking about Great Britain, and we are just qualified last year, one year experience is nothing. (Ayman, 28, Male, Personal)*

Then he continued to depend on his friends as a source of information. His friend was able to convince him:

> *He said, okay we are not gonna lose anything, just go ahead, lets go ahead fill up a [application] form. Then we went to the centre [inaudible] to fill the form (Ayman, 28, Male, Personal)*

The recruitment campaigns triggered many nurses to take the decision of getting involved in the process of migration. Jordanian nurses were easily attracted to the adverts and job offers abroad because the GS employers have recruitment campaigns

there annually. A nurse receiving 300 JD is bound to accept an offer of three times or more and move away from the family and home country.

> *You would get like 1,000 Jordan Dinar as a salary. You will get the tickets and you will get if I remember 20 - 30,000 [UAE] Dirhams or like for accommodation. So you could save at least 500 JD, which is double your salary in Jordan without spending anything. So, that was a good financial reason to leave and go to Dubai. They told me, it was an American hospital or American managed hospital, which was a good chance for me. They said it was like a multicultural hospital as well and you have the chance to improve yourself, improve your[English] language and all this. In addition, from there you might get other chances even to go to Australia, Canada, and America or any part of the world. (Sami, 30, Male, Telephone)*

On the other hand, this coincides with the needs of the UK for international nurses. As described by several studies there was a real shortage of nurses in the UK in 1998 that forced the Labour Government to adopt a policy of recruiting international nurses (Buchan et al., 2004; Buchan and Calman, 2005). Jordan was one of the countries that neither the UK employers nor the recruitment agents considered as a source of nurses. This was the other side of the story, as mentioned by the participants. Recruitment of Jordanian nurses happened for two reasons. A Jordanian nurse (pioneer) worked for one of the major trusts in London and he was involved in inducting the internationally recruited nurses and helping them adapt to the new work environment, at that time. He had relations with the personnel department as part of his normal duty; therefore, he provided them with the curriculum of nurses from Jordan, which was required by the UKCC to decide about the quality and qualifications of recruited nurses.

> *I think it was the year 2000 when we started bringing people in, and that was a national strategy. There was a shortage in nursing in this country.[…] I was in a position when I was a charge nurse to supervise one of the first groups to arrive from Jordan. I was able to support them and prepare their studying here or their adaptation here and to help them to start their work … (Hassan, 36, Male, Telephone)*

I was informed by three participants that this was coincident with what a recruitment agent found among recruiting nurses from UAE. This takes us to the other reason, an Indian nurse who worked in Dubai, asked her Jordanian colleague; whether he would be interested in taking up a job in the UK. The agency representative took the opportunity to interview the Jordanian nurse about the various aspects of nursing in Jordan such as the qualifications of the nurses etc. This guided the agency to plan a visit for Jordan in order to recruit directly. I contacted that agency by telephone and they confirmed that they had recruited around 300 nurses from Jordan, during that period. However, the agency destroys the documents of every campaign after two years of the contract; therefore, I was not able to get more details.

Active recruitment from Jordan was the ignition for the large-scale migration of the Jordanian nurses. This was the first ignition, and it was enough to bring the first group of migrants to the UK. However, nurse workforce in Jordan was not large enough for the recruitment agent to repeat the campaign for more groups; because, professional nurses at that time were less than 8000 in number. In spite of that, migration did not stop; individual or as self-recruited nurses continued to arrive to the UK. Jordanian nurses migration developed over the years with a dropping curve as indicated by the numbers registered with the NMC (see Table 5-2). This continuous flow is consistent with what was explained by migration theorists as networking influence (PSI, 2003; Krissman, 2005).

Table 5-2: initial registration of Jordanian nurses in the NMC Register 1998-2005

Year	1998/99	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05
Nurses registered	**3**	**3**	**33**	**49**	**53**	**18**	**17**

Resource: (Nursing and Midwifery Council, 2004; Nursing and Midwifery Council, 2006)

Even though, many Jordanian nurses want to go to the GS, Australia, the UK and USA, these countries' borders are not open always and for everyone. Every country has complete control on deciding when, how many nurses and from which country will enter and who will be granted a work permit. Although with the help of the pioneers or active recruitment campaigns, the nurse needs to take the decision in person in order to migrate.

5.4.2 Decision to migrate

The previous motivations encouraged Jordanian nurses to consider moving abroad, in particular to the countries of active international nurse recruitment. This section discusses an important element in the pre-transition phase, in which the nurse experience shifting from a state of 'I will try it' to a state of 'I will go'. The decision is not a sudden one and usually it needs one or more of the previous motivations to reach the threshold of taking the decision. While one motivation is enough to reach the threshold for some nurses, others need a combination of motivations to take such a decision. Nurses are less likely to challenge the status quo and that is why many nurses stay in their home country, regardless of their perception for the motivations and the challenges facing them (WHO, 2006).

According to the Human Capital approach an individual will take the decision to migrate, when it will maximise his or her expected lifetime earnings (Bartel, 1979; Isbister, 1996). This is a form of investing in him or herself, which is an investment in

human capital. According to this approach, the nurse migration is an investment made for achieving lifetime earnings. A nurse who was considering migration, was characterised as expecting his or her potential lifetime achievements without migration to be fewer than achievements with migration. If the expected achievements were less where the nurse is then he or she would be justified to take the decision and thus migrate. The decision would involve searching for job abroad, finding sources for information about the destination, choosing between alternatives, and probably involving the family in the decision.

Nurses search for job abroad if they aspire to migrate. Aspirations are developed by recognition of needs. One participant described how Jordanian nurses thought about migration and how the idea of migration began.

> *Everyone wanted to get outside the country, tried to get higher salary and to improve his life. This was important to get married and improve family situation. My concern was to get out of Jordan and find better salary. (Adel, 30, Male, Personal)*

Most Jordanian nurses mentioned they searched for a job in the UK either by coincidence or after several attempts of searching in the GS. It was coincidence that recruitment agency or a friend or as described previously a training course got them thinking of the UK.

> *UK was not the only choice. I tried everywhere. I sent my CV everywhere during my work in Amman [x] Hospital at that time. (Adel, 30, Male, Personal)*

Adel described how he searched for a job and sent applications simultaneously to everywhere. His account is an example of nurses' action when they search for jobs abroad.

> *I have applied at three hospitals in Saudi Arabia and I have applied at four hospitals in the United Arab Emirates. It became like a routine to apply and then not accepted, apply then accepted. So I came to conclusion that I need to keep trying; because none of the options was best offer or sure. No, no I never take the option for sure until I get guarantees for that. Therefore, I applied for another hospital and then for the third hospital before they replied, I used the time to apply to different places. This happened exactly and I considered the UK. It was like any application to Gulf States because I could not imagine that I am going there. (Adel, 30, Male, Personal)*

Nurses in Jordan seek information about working abroad from different resources. They usually rely on their friends and colleagues, as a trusted source of information. At the same time, those may reflect on their ideas and opinions and give them the advice they are seeking.

> *One of my friends when he got the job to go to the UK we were working together and then he was like my main person to discuss all these with him afterwards. When he said okay, I am going there I was like asking so many details. (Adel, 30, Male, Personal)*

The nurses took a decision, which opened for them the pathway of endless choices and decisions. Some nurses, as mentioned previously heard about nursing opportunities in the Gulf States and others read about opportunities in the Western countries. On the other hand some nurses noticed professionals and nurses who went to the Gulf States and saw them achieving what they aspired to. Most of the nurses started to search actively for a job abroad, and some of them found the opportunity to do so, without any effort.

> *I had two offers, one for Saudi Arabia and other one from the UK. In fact, I have a good offer in Saudi Arabia; I mean money wise and social situation (Ayman, 28, Male, Personal)*

When Ayman found himself in a position to choose between the UK and Arabia, he thought about his career development. He ended with choosing the offer from the UK and sacrificed the opportunity to make more money, which points to the priority of other motivations, over money in his case. Money allure in Arabia did not attract him even though he was lacking information about the expenses of living in the UK.

> *It was good offer. Money wise it was almost double salary of what I am getting here, free tax and free accommodation. (Ayman, 28, Male, Personal)*

He added that professional development is a stronger motivation than money. He explained that if he had moved to Saudi Arabia, there would not have been opportunities for professional advancement:

> *[I]f I went there [to Arabia] it would be the end of my professional development. I am not going to develop any more, I am going to stay staff registered nurse or may be charge nurse. However, it is not a good chance like here to gain more education and qualification (Ayman, 28, Male, Personal)*

Another option was to go to the Western countries. The UK was one of the alternatives available for the nurses in Jordan, but it was not the only one. However, getting a visa for the UK or finding a job while in Jordan was a difficult task for nurses in their previous conditions. Some of them considered, like many other professionals or even the ordinary people, to enter the UK on a student visa. Hassan was an anaesthesia technician in Jordan, he had been thinking seriously about how to come to the UK and found his way by applying to universities. He secured a visa and came to study nursing in one of the universities. He completed his diploma study 1994 and started his work soon after that.

> *It was the one option I found that I tried it. It took me two years. Planning from Jordan to get in to study in this country. Therefore, after awhile you probably would not go and try to find somewhere else. There were some other options probably but I did not go to those options. (Hassan, 36, Male, Telephone)*

More participants mentioned how they had chosen between the alternatives that came across, during their decision. One of the alternatives was which country to go for and work as a nurse. Abdullah had chosen the UK and found it easier than going to the USA. He described his choice experience:

> *I had an interview for a job in the states, and I was offered the job as well. Although, going to the states might seem a bit more exciting. I was offered the job but the process of going to America was more complicated. You've got to do exams and go through different things and the immigration rules are very tight with Americans. So I picked up the easy one which is the UK. (Abdullah, 31, Male, Personal)*

Another participant found himself in a position to choose between Saudia Arabia and the UK. It was not difficult for him to go for the UK choice as he explained:

> *I got a good offer from Saudi Arabia; I mean money wise and situations. But, the reason I chose here was in this country [UK] you have a chance to develop yourself and continue doing your high education like MSc and PhD. (Ayman, 28, Male, Personal)*

What I have discussed above represents the choices of the nurses as individuals. However, the nurse usually is a member of a family, and in Jordan, it is unusual for a member of the family to take a strategic decision without interference or influence of family members. Interestingly the Jordanian nurses' decision to migrate was not purely an individual indecision, but one that was influenced by family participation. Most Jordanian nurses indicated that their families had a role to play in their decisions

to come to the UK. As expected, all the participants came to the UK without breaking their personal and family connections at home.

5.4.3 The family influence on the nurse decision

The New Economics Theory (NET) assumes important role for the family in the migration process of its member/s (Isbister, 1996; Arango, 2000). This study found that there are different forces and powers playing a part, in the decision game when the nurse thinks about migration. Some of these forces want the nurse to leave and others want him or her to stay in the country. One of these forces is the family members of the nurse.

> *Our culture is different from here. We have to share our thinking with our families, like my dad and mom but at the end, it was my decision. My mom was not happy for me to come over here, because it's different culture, different things and it is other side of the world. But I decided and I chose to come over here. I share my thinking with my family but just you know as a culture respecting them other wise it's my decision here. (Ayman, 28, Male, Personal)*

It seems the parents usually have a different opinion from the brothers and sisters and all they have an influence. One of the participants mentioned his parents' opinion as regards migration to the UK :

> *My parents looked at it as a good chance but you know it's their son and they don't want me be away from them (Abdullah, 31, Male, Personal)*

He added about the other party of the family:

> *My brothers and sisters wanted me to go, as they were young and optimistic. (Abdullah, 31, Male, Personal)*

Abdullah was single and he lived with an extended family. They had their own business, which they were running together. However, they were excited at the

beginning when he told them about his intentions. Abdullah was middle in the rank of the children and he played an active role as all of them consulted him in their personal and planning issues. Probably this helped him to gain their support.

> *I was in the middle although I have a strong position among them like I've got an influence on all of them. And I do play a good part in the family relationships and social matters. But even though it wasn't a big problem for me to go. Over all, I didn't need much effort to convince them that I'm going." (Abdullah, 31, Male, Personal)*

This was not the case with Abdullah, being the older son in the family.

> *The older one it could be a bit more difficult for me to go. You know, always the older one is holding all the responsibilities and that's the way it is in our countries, isn't it? (Abdullah, 31, Male, Personal)*

Another male participant, who was the remaining son in a family with two sons and five sisters, had a similar experience. The parents were against his decision to move, because his older brother was working outside Jordan. However, because his goal was to study further and as his fiancé was studying in the UK, he was able to get his family's permission to migrate to the UK.

5.5 Conclusion

This chapter reported and examined the experience of Jordanian nurses before transition. The nurses' accounts indicate that the pre-transition phase was experienced in five elements. In the first phase, the nurse had no intentions to move abroad or he or she continued to maintain the status quo. Second, the nurse started to realise that moving abroad was good idea. In the third phase, the nurse thought about migration. Fourth, when the nurse considered trying out for migration and finally in the fifth

phase the nurse decided to move abroad. These elements imply the theme under discussion, which I called it ‘challenging the status quo’.

The nurses during pre-transition phase experienced motivations to go to the UK. Whether push or pull, the nurses were motivated to leave in search of better work conditions, education opportunities, financial rewards that satisfy their needs, in search of career development and for travel and adventure. Many nurses in Jordan were not getting what they wanted, as they maintained the status quo. Therefore, they accepted the challenge by taking a decision to leave the family and their jobs and to go to the UK. While the nurses eventually took the decision individually, there was enormous contribution and influence exerted by their families and friends.

The nurses in their decisions set up aims for themselves. These aims go beyond simply moving to the UK and rather constitute goals that can be achieved after reasonable time of residency in the UK. The pathway toward the aim, examined through the nurses’ experiences after transition, represents the material for chapter seven of this study. On the other hand, the relations with the employer in the source country, the family and friends, and building relationships are in the UK examined in the next chapter. The following chapter presents findings of interviews with Jordanian nurses talking about the transitional real experience.

Chapter Six

6 Source to host country: disconnecting and connecting

6.1 Introduction

The previous chapter reported and examined how the Jordanian nurses moved from a state of no plan about migration to the state of deciding to go abroad. However, the pre-transition phase ended with the theoretical decision, rather than the actual steps toward migration. This chapter reports on what I have identified as the 'transition phase', and examines the actions and practical measures taken by Jordanian nurses to relocate from Jordan and the Gulf States (GS), as source countries, to the United Kingdom (UK) as the destination.

The transition emerges as a theme when studying life history of overseas nurses and represents a phase in the migration process, which starts with the nurse's decision to migrate and ends with the relocation to the UK. While the start is evidenced by actions of application to get a visa or work permit, the end is determined by achieving registration with the Nursing and Midwifery Council (NMC) or continuous residency in the UK for six months. I have given this theme the name of 'Source to host country: disconnecting and connecting' and examined in the light of the migration literature on social networks.

The chapter aims to report and examine the nurse's experiences of navigating through the transition phase. This chapter has been divided into four sections; first, the Jordanian nurses aspirations and worries during the transition. Second how they navigated their relationships in Jordan or the Gulf States (GS). Third, the opportunities and challenges experienced as migrant nurses, to build relationships in the UK. Finally, the experiences of excitement and shock as part of the transition.

6.2 Transition: aspirations and worries

This section describes the transition experience of nurses, particularly their aspirations and worries. Transition is a migration phase that results in changed relationships, routines, assumptions and roles. It has been discussed here as the transformation that nurses undergo when they move from the source country to the UK.

6.2.1 Aspirations:

The period before the migrant nurses leave the source country is crucial, because the prospective migrants establish initial ideas and aspirations immediately after the decision to go to the UK. Those nurses who choose to migrate, start to form images of their destination and acquire aspirations. Walters (2008) reported on migrant nurses from south east Asia to Austaralia who experienced trust and fear when they went for job interview. Those nurses expressed happiness because they got a chance for challenge of going abroad.

Ayman admitted that he had achieved a dream when he received a UK work permit. He describes the moment when migration became realisable:

> *I remember when I've got my visa … I just laughed and the Minicab driver said: Are you crazy? Why are you laughing without any reason?... I said: Well; I've got a visa now. They gave me a visa to the UK! I was really happy. And I fel[t] happy for two days. I didn't work. I just kept thinking what I was going to do. I can't explain my feelings about a visa [on my passport] …(Ayman, 28 , Male, personal)*

The participants build up aspirations and conjure up images of the UK, depending on the information they receive. For examples, some Jordanian nurses used predetermined images of nursing, whether they gained them from the curriculum

designed in the west or from the media. Adel's aspiration to work in the UK was influenced by the TV series, 'Emergency Room' and the dynamism of the actors.

> *Okay when I was looking at the ER [TV] series, you know about emergency room ... I like the idea of running around and just like fiddling, working with patients and having very good communications very high skills and all that. (Adel, 30, Male, Personal)*

Other nurses aspired to study or work and live in the UK, which stemmed from their motivation to go abroad, as discussed in the previous chapter. For example, some nurses wanted to study in western countries as a means to experience a different culture and lifestyle.

> *I liked to do my degree in a different language, a different culture, to find another standard of life …. I liked to do it abroad and to improve my English and see other cultures, see another life […]. It was something different to go abroad and be outside of Jordan, (Laila, 30, Female, Telephone)*

Laila's dream to go abroad was fuelled by a desire to learn more about different cultures and improver her English. Learning a language was another aspiration for the nurses when they migrated. Some participants described how keen they were to learn and speak English fluently. Although their undergraduate studies were conducted in English, they described how challenging the English language was. Radhi mentioned:

> *Okay we studied nursing in Jordan in English. But, still our language especially in writing is not good. (Radhi, 35, Male, Personal)*

When a nurse is engaged or married, the partner may have a share in the aspirations. They dream together and participate in the process of transition together. Laila

explained that she and her husband progressed systematically in the process of applying for their places at UK universities. Moreover, he was the one who helped her complete her application forms. The aspirations of the wife coincided with those of her husband and of the sponsor of her future studies in the UK. However, when a female is not married, it is likely that her parents and close family will influence her aspirations.

> *From the first attempt that I started to send application to the different universities, he [the husband] knew and helped me at every step. ... The university was involved in this decision and my husband encouraged me. All these things helped [me] to come here. (Laila, 30, Female, Telephone)*

Some nurses are perfectionist and believe that there are health care professionals' who can practice in an ideal environment and others who cannot. In their opinion, while the practice environment in Jordan hinders their aspiration, their counterparts in the UK accomplish perfect practise due to ideal environment. Their claims stem, either from the textbooks during their education, as mentioned in the previous chapter or from the amount of research carried out in the western countries.

> *When I decided to come to the UK, my dream was first to improve my English, to discover a new culture and to work in an ideal environment, in good conditions, because [the] UK is developed country and usually there's [much] research done [t]here. So it [was a] good chance for me to work in the UK. (Tayseer, 34, Male, Personal)*

For some Jordanian nurses the journey to the UK is a detour, which is likely to bring them back to their home country. Their hope is that the work conditions, education opportunities and wages in Jordan will rise up to reach a level, where they can satisfy their aspirations and achieve what they wanted, without moving abroad.

Some nurses' aspirations were unrealistic before they arrived to the UK. They imagined nursing in the UK to be exactly as described in the textbooks. In their opinion, the nursing image they gained during their undergraduate study was different from practices in Jordan and the Gulf States. Although they overrated the nursing conditions in the UK, they underestimated their own abilities and skills. They came to the UK with a feeling of inadequacy, when they compared themselves to the UK nurses.

> *I've been expecting a lot. …coming to major country in the world, different kind of nurses, more up to date. You know what I mean, more equipment. I thought I'm not going to know anything [of] what they [are] doing or what they talk. You know what I mean. Maybe the[…British nurses] know more information or [have] more education or more skills. That's what I expected. (Muna, 35, Female, Telephone)*

Migrant nurses with such expectations, found themselves disappointed when they reached the UK. Moreover, they became confused and some of them found themselves unable to describe their feelings properly. Muna compared the previous situation in Jordan with the new situation she found in the UK:

> *I [was] disappointed, because, nursing [here] is not like what we think back home. We are up to date like them and may be educated more than them and we have more skills and we can help [the patients] in our hospitals more than they can help in their hospitals. (Muna, 35, Female, Telephone)*

Muna claimed that the nurses' abilities in Jordan were not any different from the UK nurses. After the Jordanian arrived and gaining some experience in the UK, most of them rated their abilities at par with the UK nurses. This indicates that the Jordanian nurses do not have enough knowledge about work conditions and nursing in the UK before they moved, just as Jawad said:

> *We didn't know about the UK… (Jawad, 29, Male, Personal)*

While nurses expected better work conditions and high standard of practice, rumours circulated in Jordan to warn them.

> *…they said in the hospital [rumour] they are taking us to work in hospitals where no one wanted to work. (Jawad, 29, Male, Personal)*

Jawad questioned his expectations and he talked about the rumours relating to the issue of nurses shortage.

> *…we never heard that there's a shortage [of nurse] in England. Because […] we heard a lot of English nurses […] were going to the Gulf. So how come they're going and travelling while there was a shortage. (Jawad, 29, Male, Personal)*

The lure of working in the UK did not stand against challenging the reality of their job contracts, and they started to think why England needs them. Those who paid heed to

the rumours become less enthusiastic and delayed their travel plans, until they got more information from the group who left first. They had worries about equality and fair management in the UK, particularly in assignments where they would be working with the English nurses. The next section describes and explains the Jordanian nurses' worries, which they experienced immediately before leaving the home.

6.2.2 Worries:

Many Jordanian nurses began to develop a range of anxieties, which can roughly be divided into five groups. First, an inability to communicate; second, the high cost of living in the UK; third, their professional competency or capability; fourth, failure and inevitable return home; and fifth, family problems. The nurses identified these anxieties both when they were still in Jordan and later when they arrived in the UK.

> *It was stressful for three or four months before I came here. In the UK [both the] language and lifestyle are completely different. [So,] the nursing could be anticipated as different. How will my language improve? How will I cope [interact] with the patients? ...If the[employers] are not happy about my progress within three months I will not get a [NMC] PIN number and they will send me back to Jordan. There my job [in Jordan] is already lost. So, it was very stressful and I [changed] my mind many times before I came here. (Yahya, 35, Male, telephone)*

Omeri and Atkins (2002) reported in a study conducted in Australia that migrant nurses experienced worries related to their engagement with others. The Jordanian nurses experienced communication worries, when the recruitment agency informed them of the preparation schedule for making the journey to the UK. These worries increased when they realised some difficulties of using English to communicate with

the lay people for purposes other than medical. The group of Jordanian nurses who came to the UK during 1999 and 2000, applied to the recruitment agency and were not asked to provide any formal evidence of English competency. The personal interview was used by the agency as evidence, however, they did not check language competency. While the interviewers' perspective does not feature in this study, future research should focus on the language issue. While some nurses have shown language abilities and skills related to nursing, day to day fluency with ordinary people also needs to be checked. More recently, the NMC-UK began to check language competency, before applicants attend adaptation training which leads to the acquisition of a PIN number (Nursing and Midwifery Council, 2005).

Some participants mentioned how they were worried about their professional competency and capability. Their worries were related to the expectations of inability to use advanced equipment and higher technology available in a first world country. Clearly, their expectations led them to underestimate skill transferability to their destination country.

> *The other worry was dealing with equipment. Coming from a third world country to a first world country you would expect [more advanced] technology. You know, that involves dealing with computers, dealing with advanced machines. [This] was a worry at that time, I have to say. (Jawad, 29, Male, Personal)*

Some nurses went through a nightmare of worries about having to return home if they could not cope with work and life in the UK. They had fears of being stigmatised as unsuccessful in Jordanian society. In their opinion, their relatives, friends, colleagues

and employers would have looked at the migrants who returned, with contempt and considered them as failures.

Females' anxieties at the time of application and probably before their move to the UK were different. Those who wear the headscarf worried about their uniform and many of them refused to apply for a job abroad because of the nurse uniform. Amal had worked in UAE before her move to study in the UK, in the year 2004. She applied with other nurses to an agency, which was recruiting nurses during 2000. She raised many questions with her interviewers and the recruitment agency before deciding to decline the job offer. She refused the offer because of her worries of living in a foreign country and because the employer did not accommodate her request for a uniform, which would suit her religious convictions.

> *I was not sure about […] the situation in the UK especially for a Muslim girl. I asked the one who interviewed me about [nurse's] uniform and their policy about that. And would they [would] allow [me] to wear like you know Muslim uniform, full sleeve and with Hijab [head scarf]. So the lady there said she wasn't sure and this might not be guaranteed. So this made me a little bit reluctant to complete the thing [application] and at the same time I was afraid of coming to the UK. You know different country, different culture, different language everything is different. So I decided to stay were I was. (Amal, 38, Female, Telephone)*

The candidates' anxieties increased when rumours circulated about unfair work conditions in the UK, for the migrant nurses. These rumours brought to the attention of nurses, how they could be treated in the UK and scared them of the possible

consequences. The nurses suspected their previous employers had an interest in spreading these rumours, as they did not want them to leave. Interestingly, these rumours spread simultaneously with research which reported the possibility of discrimination against overseas nurses in the UK. Allan and Larsen (2003 p. 5) found " evidence suggests the possibility that [international recruited nurses] IRNs meet prejudice and racism and that they are treated as unequal compared to British nurses". The Jordanian nurses listened to these rumours while still in Jordan and information about the UK, the destination country, was scarce. Rumours were aimed at suppressing the nurses' desire to leave and encouraged them to not think about migration.

> *...oh no, don't think about it because, [UK employers] want some nurses to work with the infectious diseases, AIDS, with extremely ill people ... You won't be treated like British nurses. This is why they want nurses from the Middle East or from the Far East; or from where-ever. (Adel, 30, Male, personal)*

The Jordanian nurses were determined to realise their nursing career aspirations regardless of the difficulties and therefore for those who did migrate these rumours did not prevent their decision. Although some nurses were less enthusiastic, the equal opportunity legislation in the UK was enough to reassure them.

Some nurses, before they left Jordan had worries about the cost of living in the UK. However, the other nurses did not express this concern because they had no data for comparison between living expenses in Jordan and the UK:

> *The last three weeks or four weeks before I left Jordan I had a chat with my father and he heard one of my friends saying that a cup of coffee will cost £2 (Adel, 30, Male, personal)*

The Jordanian nurses often discussed their worries about the cost of living with their family and sometimes, their friends. Adel's father challenged the claim of one friend and asked his son to check whether it was actually true. He warned Adel not to leave his job in Jordan and advised him to avoid the risks of moving to an expensive place. Adel's case is not unique but it is an example of family worries. He had to support his parents, brothers and sisters. This is evident from their worries about his decision. During the interview, he also mentioned:

> *They were worried about me having this adventure. Because they were thinking about okay, what about if, I fail? We won't really have any money by then. (Adel, 30, Male, personal)*

In my opinion this example, represents an issue for some families, where the family finds it challenging to receive criticism, as they have learned to avoid risk-taking, lest they failed. This attitude can be compared with the attitude of some young Jordanian nurses who did migrate. If they did not make any progress, they simply say: 'well, not to worry! I'll have another go'. They took the risk.

Additionally, some nurses were concerned about missing their family's support in their daily living. They developed anxieties after their transition to the UK, because of inter-dependency. It may be that singles, whether males or females, depend on their families longer than their counterparts in the West. This inter-dependence probably gives the person an excuse to live with the family until marriage or even later (Dwairy et al., 2006). Young males mainly expressed their fears of leaving because

their daily-living would no longer organised by and have the support of their mothers and sisters.

> *I was twenty-three years old. I [was] fully dependent on my family. I mean my Mom, my sister. ... I'm gonna lose my Mom […and] my sister [support] and I need somebody to sort my things … I mean, like cooking, cleaning, bla bla, [inaudible]. I started to think how I'm gonna do this thing. (Ayman, 28, Male, Personal)*

There is no evidence whether these worries or others were directly connected to moving abroad. While only Jordanian nurses who moved to the UK were included in this study, other nurses who applied to move, but continued to stay in Jordan were not. Therefore, I anticipate that the worries mentioned in this study only mitigated the participants' willingness to migrate.

Ultimately, the participants challenged their worries and took the risks. Ibrahim, as in the next section, was not worried about leaving his job or taking unpaid leave because he knew about the situation in the UK and had confidence in his abilities to succeed. Although his previous employer in Jordan refused both; to approve unpaid leave or the resign application, he took a risk of leaving the job without employer consent and at the cost of his pension.

6.3 Disconnection from employer and family

This section describes how the participants dealt with the experience of disconnecting from their previous employment, family and friends in Jordan. A nurse may break the link with his/ her employer by applying for a resignation or an annual unpaid leave. Both resignation and unpaid leave require reasonable notice to be given by the

employee. Unpaid leave also requires the agreement of the employer; however, some employers in Jordan refuse to approve it. Ibrahim said:

> *If you give me a chance to take unpaid leave or resign that's fine I might come back and work directly for the same employer. (Ibrahim, 33, Male, personal)*

Ibrahim took the decision to leave without the consent of his employer, because his employer refused his application for one year's unpaid leave and did not accept his resignation. This conforms findings of Mensah et al. (2005) that some nurses, when they intend to work abroad, are forced to break contracts with their work places and not given the opportunity to take unpaid leave or to resign. Although government regulations require four years to pass before a job 'loser' can seek another job within its premises, he was confident of finding a job with other employers if he decided to return to Jordan.

> *… at the end of the day I'm going back to the same country whether serving the Ministry of Health or a university [I am] serving the country and serving myself. So, it doesn't make any difference to me. (Ibrahim, 33, Male, personal)*

Ibrahim justified his determination to take the action of leaving his previous job in Jordan and moving to the UK with interesting reasons. It was possible for him to apply for a job with another employer. His plan included studying for a higher qualification, which was not required by the previous employer. Therefore, he left that job with no intention to go back and join the same employer. Ibrahim told his employer:

"I'm leaving whether you [approve] my resignation or not because it's my future." (Ibrahim, 33, Male, Personal)

This unusual situation was rarely seen with other participants. Ibrahim was making little progress in being able to provide for his family, with his former job at the Ministry of Health. He was confident that moving to the UK would be much rewarding financially which would enable him to support his family and he anticipated few risks in his decision. He added: *"[t]he chance to fail is not that big."* This confidence would not have come so easily, without his previous experience in the UK, during his training course as mentioned in the previous chapter.

Termination of the job contract with a similar level of confidence was noticed in the case of a single female nurse who had also visited the UK for a training course. Because she met her future husband who was a resident of the UK, she went back to Jordan and announced her resignation from the job, to join her husband. Interestingly, Muna's resignation was approved by the Ministry of Health and she received the due end-of- job compensation as well as a pension. According to her, the process went smoothly.

Disconnection from employer and family can be gender specific. Migrant nurses in the UK, have the opportunity to bring their family, who may join them as dependents. Some nurses send for their families to join them soon after their arrival. Some Jordanians are married to nurses, but did not have the opportunity to bring them as job contract holders, but were later able to bring them as dependents. The Jordanian woman is usually 'obedient' and sacrifices even her job to join her husband, who plays the role of a breadwinner for the family and has the main responsibility of fulfilling the financial needs of all the family's members.

> *[B]ack home, the wife goes where the man is. So, I needed to leave my job to join him. (Wejdan, 32 , Female, telephone)*

Although nurses moved to the UK only on confirmation of a job contract, some of them explained the risks and uncertainties. Expanding the finding from Walter (2008) when South East Asian nurses experienced fears even after the successful job interviews. The Jordanian nurses managed uncertainties by the gradual migration of the different family members of the nurse. The nurses had to forsake a life of certainty in Jordan, in favour of a life full of uncertainties in the UK. Interesting, these findings conforms the New Economics Theory when family send one member rather than the entire family (Arango, 2000; Stark, 1995). Wesam was not sure about his situation in the UK; therefore, the option of moving the whole family in one go was impossible, when he first came.

> *It was a very hard decision to take at that time because my salary was lower than I've got now. The life is very expensive in England, so I have to study it carefully to decide [whether] to bring the family or not. When I came, I said to my wife just give me 6 months just to study the whole condition then I will let you know. ... I have been for 6 months alone, alright, until I got my registration [PIN #] (Wesam, 34, Male, Telephone)*

When an individual moved to the UK, the temporary disconnection that ensued, challenged his / her family. And the disconnection was based on uncertainties. Although Wesam spent six months in the UK before his family joined him, he spent the first half preparing for the family's arrival and the second half in securing his registration with the Nursing and Midwifery Council (NMC).

> *I was alone in England for the first 3 months because I wanted to know how is the life in England, how secure is it, and how secure my job will be. I wanted to know [about] accommodation and life [here]. How it's easy or how difficult, because I wanted to take the decision to bring my family. (Wesam, 34, Male, Telephone)*

Another challenge contributed to the temporary disconnection between the family members and the migrant nurse. Wesam and his wife, Wejdan applied together to the recruitment agency and they were both offered jobs, but in two distant places.

> *He had to work in London and I had to work in Bristol. (Wejdan, 32, Female, Telephone)*

When the husband first moved to the UK, the wife stayed behind for six months in Jordan.

> *… it was difficult for us to come with the two children and each [parent live] in a [different] city. So, our decision was: he's going to go to London and see how it is, the accommodation, […] the cost of living, and if we can afford both of us to live here. (Wejdan, 32, Female, Telephone)*

Wejdan pointed to an interesting issue about breaking the ties between the children and the grandparents. She described how her parents-in-law were very close to the children and how they used to see them everyday. Therefore, when they decided to leave with the children it was stressful, having to separate the grandparents from them. However, the lure of living in the UK and the likely fulfilment of aspirations for their children and their parents for a good life, probably, made it less stressful. On the other hand, the children missed the love of their grandparents and had to leave for

a place where they knew nobody. This increased the challenges facing the parents because had no choice but to adapt.

> *It was difficult to leave everything behind and come to a place we don't know anything about it or nobody before. (Wejdan, 32, Female, Telephone)*

The nurses were likely to be sad about leaving their families and friends, and , their frustration grew due the unfamiliar surroundings and way of life in a new country.

> *[F]irst time I came to [this] foreign country … I met many people here; different in culture, different in language, different in belief,[and] different in everything. …I was in doubt about my feelings, leaving my friends and family, and coming to something that I don't have any idea what it is. (Talal, 27, Male, Telephone)*

The nurses' excitement, as they reached the UK was blurred by feelings of homesickness. The family, whether parents or a wife and children, were an important part of these nurses' aspirations, when they where in transit. Some moved with their family. Some left the family behind until they became acclimatised to their new situation. Others moved, with or without having taken a firm decision to leave their family back in Jordan, while repatriating money on a regular monthly basis.

6.4 Connecting: opportunities and challenges

The Jordanian nurses took the opportunity to build new friendships in the UK. Most of them established a network within their workplace and their local community. This undoubtedly helped them to adapt to their new environment. Although there were many opportunities open to them, the nurses encountered critical challenges. Four such opportunities emerged from the nurses' accounts. First, access to the UK;

second, travel from Jordan to the UK; third, their induction upon arrival; and fourth, the adaptation course, which helped them to cope with their new life.

6.4.1 Connecting opportunities

Though the nurses may have arrived in the UK by air or sea, the NMC or a recruitment agency enabled and facilitated their arrival. One of the means available for international nurses to connect with their employers in the UK was the NMC, adaptation training, which is required for registration. Nurses trained abroad are required to adapt to the work settings in the UK and to obtain approval that they can follow the guidelines, which are monitored by the NMC (Nursing and Midwifery Council, 2005). Adaptation training is an opportunity for a gradual and safe transition for the nurses. However, it can become a challenge and difficulty, especially for nurses who were self-directed migrants and particularly for those who arrived without a job contract.

> *I tried may be two hundred places all over [the] UK. Those [were] running the adaptation [programmes]. So, I called them each time and made a list ...after seven months I got the adaptation [placement].*
> *(Talal, 27, Male, Telephone)*

Allan and Larsen (2003) reported on international nurses experinces during adaptation and described challenges facing them in the nursing homes. Similar to that, Talal encountered a challenge, when no adaptation placement was assigned to him by any workplace in Scotland. As a result, he applied for a placement in the Midlands and volunteered to work for a nursing home, free of charge for the first month. After one month, the manger paid him as a health-care assistant (HCA). He obtained a document after three months of certification, that he had completed three months under supervision. This document certified his competency in skills related to

professional nursing practice. He spent the three months travelling every week to and from Scotland, because his wife was there and could not join him.

> *[A]fter I finished my adaptation I was thinking to write [a] complaint to the NMC because I didn't get any adaptation… I was working completely as a care assistant [HCA]. (Talal, 27, Male, Telephone)*

Although he did not process his complaint formally, the nursing home in his opinion abused the adaptation course, regretted supervising a nurse, and still then requested him to do the job of HCA. Previous research reported similar experiences, before the NMC reformed the nursing adaptation scheme and enforced new regulations (Allan and Larsen, 2003). Talal also noted that other nurses from different nationalities were facing the same treatment (they worked as HCA instead of commencing their adaptation).

> *I met two Indian nurses and one African nurse they were doing adaptation in the same place where I did. They have the same problem like me. (Talal, 27, Male, Telephone)*

Speaking English is an important factor that helps in integration with the British people. Recognition by the employer, colleagues and the preceptor that overseas nurses only speak English as a second language was helpful to the international nurses. When this recognition was highlighted within a department and an organisation, nurses were likely to receive much support and help from colleagues, supervisors and patients, in improving language skills.

> *[W]e had the support from people with the higher Grades; like F Grades, G Grades. They know that we don't speak English. We speak Arabic and English is our second language (Salem, 29, Male, Personal)*

When nurses from the same country and culture meet together in a host country, they feel more comfortable together, as it provides them with an opportunity for establishing a support system and sharing fond memories of their home country. However, some migrants relied excessively on such relationships. This could have had a detrimental effect on their ability to improve their English.

The nurses appreciated the fact that some workplaces offered opportunities for international nurses to develop their English language and usually they made use of it. Salem pointed out:

> *[W]e did one of the courses for English; even the people who speak proper English they attended it. I feel they were very supportive especially Human Resources [and] managers in the ITU (Salem, 29, Male, Personal)*

The nurses' competency in English was often influenced by the communication environment in their previous work place. For example, Jordanian nurses who worked in the Gulf States had a greater exposure to an English speaking environment, than the nurses who worked only in Jordan.

> *... they worked in other countries [such as] Dubai, and they don't have any problem [to converse in English] when we came here. They used to speak English before we came. (Salem, 29, Male, Personal)*

While the medical staffs in Dubai workplaces were also international, with a variety of various mother tongues, English is the convenient language as the means of communication. The nurses who came from such environments were more prepared for English conversation. Therefore, Salem claimed that his colleagues, who came from the Gulf States, were more likely able to understand the British accent than the nurses who came directly from Jordan.

Most employers in the UK require applicants to provide evidence of vaccination against certain diseases. This requirement may be in addition to the routine requirements placed by the UK government that visitors or travellers from certain countries needed to provide a certificate of vaccination against particular diseases. One nurse found this measure unexpected and discovered that he needed to do a medical check-up at the airport:

> *They took me to the hotel for one night to do the test in the hospital. It takes some time, but I went to the hotel. It was near the hospital and after the results; they took me to the accommodation. (Salem, 29, Male, Personal)*

Although he provided the certificate on arrival, the vaccinations were not exactly the one requested.

Some nurses took their previous training in the UK, as an opportunity to establish and develop connections with employers in the UK for the purpose of future employment.

> *[The] WHO offered sponsorship for two nurses of the government [hospitals in Jordan]… for six months training… in United Kingdom. I applied […] and I've been one of the two […] chosen by the WHO. […] My colleague went to Brighton and I came to London. (Muna, 35, Female, Telephone)*

The adaptation course is an opportunity to empower the international nurses and supply them with the confidence they need to perform their job.

> *… to do everything for the patient starting from feeding to washing, cleaning… everything. So, […] it made me stronger [and] more confidant. (Wejdan, 32, Female, telephone)*

According to the Social Network Theory (SNT), migrants are more likely to leave the source country for places where their friends or relatives live (in the destination country) (Krissman, 2005). Some Jordanian nurses in the UK stated that their move to the UK resulted from the encouragement of friends and relatives. The latter, being familiar with the country, were in a position to give an accurate account of what to expect.

> *…lucky enough, a guy who had been through the same experience helped me. If I were in his position or his shoes I would definitely had much harder circumstances. … So, I think, he helped me a lot. When he went back home he went through the main basic things; what I need to know, and what […] to avoid and how to approach the patients, how to approach relatives, doctors, staff and all the multi-disciplinary team. (Raed, 30, Male, Personal)*

Information from other Jordanians can act as an informal induction and consequently accelerate early adaptation by new arrivals. In this way, induction can be adapted to the understanding and culture of these nurses. However, it is important for these nurses to go through a formal induction to avoid missing important parts of orientation and to avoid misinterpretation by their fellow Jordanians. It would seem that an official induction is appropriate for a newly recruited nurses and cannot be replaced by an informal one offered by friends and colleagues.

6.4.2 Connecting challenges

Establishment of connections to gain social support is important for the new migrants. Because nurses may have moved without establishing connections or support in the source country, they find it a challenge to build new ones in the host country. Socialisation in the host country is difficult for two main reasons: the attitudes and beliefs carried by the nurses and the attitudes of the host society toward them as new arrivals.

> *Socialising was the most difficult thing at first. But later, more nurses arrived from Jordan and we had other friends around us, which helped a lot. Actually sometimes, we felt like we were at home. (Wejdan, 32, Female, telephone)*

Most Jordanian nurses maintain social relations mainly with the other Jordanians. A few build tenuous relationships with the local people. Nurses tend to connect with people from the same cultural milieu, which often acts as a remedy against homesickness.

> *...we missed the family and we wanted to go back. Every time we had a problem or one of the children was sick or we felt sick, I wanted to go home. (Wejdan, 32, Female, telephone)*

Those nurses, who arrive in the UK without their families, face the challenge of adaptation to life with less support. They had the support of their parents and relatives in Jordan, such as childcare support, as provided by the grandmothers. Therefore, on transition some female nurses found themselves lacking the skills of caring for their children, while most male nurses have never had the skill. However, many of these mothers and fathers found no choice but to train themselves to take care of the children, due to the cost high of living. Wejdan described that her experience of caring for two children was more difficult in a foreign country.

> *[I]t was more difficult for me to look after two young children alone. I didn't have the experience before (Wejdan, 32, Female, telephone)*

According to dual labour market theory, low-wage jobs in destination countries are perceived as employment opportunities for low income country workers (Fields, 2004). This is true in the case of non-skilful jobs, however, in as far as nursing is concerned, the migrants are willing to start at the beginning of the career ladder. Because of that, the Jordanian nurses admitted that their earnings as new arrivals were less than their monthly requirements. Most of them adopt a strategy of spending less, by prioritising their needs and finding substitutes for their more expensive needs. For instance, some of them fulfil their needs by getting furniture and toys from second-hand shops. Wejdan, the mother of three children arrived 6 months after her husband Wesam. She spent two years unemployed, in order to look after her children. She explained how an expensive life was and that it presented a challenge. She added:

We were not able to buy anything at that time like [a] T.V., computer, furniture (Wejdan, 32, Female, telephone)

Nurses who worked in the source country and were unemployed when they first arrived to the UK, found it very stressful. These nurses disliked being unemployed.

... I worked in Jordan, then [no] work here. This was difficult for me. So it was very difficult very stressful to be not working while I am used to work. (Wejdan, 32, Female, telephone)

One important challenge mentioned by some nurses was to find a job for their partners who were qualified nurses. They had qualified in Jordan and worked in one or more of the source countries. However, they were not registered with the NMC in the UK. Despite the need for nurses, it took them longer to find a job.

When I had the adaptation course for three months I had three interviews and I did extremely well as far as I know. I was off work for one year at that time. (Wejdan, 32, Female, telephone)

She had no job for one year because employers rejected her applications. Wejdan did not give many details when I asked her, but in her opinion:

I was refused [by the employer] and another nurse was taken, because I was wearing hijab [headscarf]. (Wejdan, 32, Female, telephone)

I was sceptical about the validity of this explanation, because during the interview I got the feeling that perhaps Wejdan was not enthusiastic enough during the application process or probably her English skills were not satisfactory. Though some studies have been conducted about discrimination against international nurses in the UK, none of the studies pointed to discrimination on the basis of uniform or the head dress (Allan and Larsen, 2003; Kyriakides and Virdee, 2003; Winkelmann-Gleed and

Seeley, 2005). When I asked Wejdan if she sought an explanation, she replied that the feeling of estrangement did not allow her to follow it, but she did not give up, applied elsewhere, and was eventually shortlisted.

When an organisation such as a hospital recruits for the first time from overseas, it encounters challenges. A lack of planning or preparation to receive new employees can develop difficulties even for the local nurses. Some Jordanian nurses explained that they worked for hospitals, which had recruited overseas for the first time and experienced a stressful start. They link the stress to the lack of adequate induction. For example, the long waiting time in the airport could be explained by the muddled arrangements made by the employer and the agent. Some had waited 3-4 hours until the organisation sent someone to welcome them. In fact, most Jordanian nurses did not even know the way from the airport to the hospital.

> *I didn't have a proper induction programme in the hospital when I first arrived. I arrived to England on Friday evening and Monday morning I was at work, early shift after I sorted my uniform and my ID. I was at work yeah, without having any sort of basic understanding of the English way of running the system. The second thing I found myself in the hospital at work and that was very much confusing, very challenging and it made my first couple of months very stressful. (Raed, 30, Male, Personal)*

Although the Jordanian nurses encountered challenges to establish connections in the host country, they were excited about their presence in the UK. Their accounts carry more details about the transition.

6.5 Transition: excitement and shock

There was no single pattern to the nurses' transition. They went through various stages and levels of aspirations and worries, excitement and shock. When nurses had obtained their visa, they were out of Jordan in one day. Many were excited by their rapid access to Heathrow (airport) and to London or somewhere else, where they would have their first exposure to a completely different culture and where no one would be familiar..

6.5.1 Excitement

Excitement is the emotion of great happiness and the joy experienced by a person and the Jordanian migrants expressed it in several ways. Some were excited because of the language difference and some by the medical equipment and machines they were required to use. Others were excited by the travel and transition from Jordan to the UK.

Excitement made some participants feel, on their entry to the UK that they were the luckiest Jordanian nurses. All of them expressed excitement with their migration to the UK, happy to know that they had a visa, a job contract or an offer to study in the UK. They were consumed by their joy.

Some participants explicitly mentioned how excited they were working as registered nurses after they had finished their adaptation course. Even though Jordanian nurses had been exposed to advanced technology before they arrived to the UK, the technologically advanced work environment excited them. They were pleased and excited because their skills, which were acquired in Jordan, were appropriate to the western setting and they did not need to learn new skills.

> *… after we got the experience they were pleased with [us], to be honest with the way we progressed and the way we were … working, the knowledge we have; because they did not expect that we have good experience. We started to look after the patients ourselves, it was really good experience to us; because you know you are exposed to new machines, better technology than what we [had been] used to. (Khaleel, 29, Male, Personal)*

Talal was excited when he arrived to the UK.

> *It's a very strange feeling that first time I came to [a] foreign country. Different feeling, because it's not my mother tongue. I met some people different in culture, different in language, different in belief, different in everything. So at that time … I was happy (Talal, 27, Male, Telephone)*

Those differences demanded that the nurses adjust themselves to a new life style.

> *…a new life style, I have started everything almost from scratch. I have learnt their language, their culture, their way of life. You have to understand the basic rules and the principles of the people. What's good and what's bad. And I have sometime compromised and adjusted to their way of living rather than [keep] to my way of living (Raed, 30, Male, personal)*

Some Jordanian nurses were living for the first time away from their parents and their homes. Those who came directly from Jordan admitted that they had to build their life afresh. Everything was unfamiliar for them because they had no idea about their new daily routines. However, the friendly reception and interaction by the people of the

host country, made them feel welcome. Although the actual routines were different, they were able to adjust easily because the tasks that they were required to perform were not different from those in their home country. The differences in the work and life routine excited and stimulated them to cope with their new life. However, the need for making adjustments came as a shock for some nurses in the early stages of their transition.

6.5.2 Shock:

Most Jordanian nurses suffered during their first few months. They described life as a nightmare because everything was unfamiliar. Although I interviewed most of the participants after a few years of their arrival, they spoke about their early experiences in the UK as if they had happened a few days or weeks earlier. I asked them how they had prepared themselves to cope with the differences in their work and life.

Most of the nurses experienced a culture shock. Although, some of them left Jordan with the expectation of having to face unfamiliar routines and customs, the nurses never thought that emotionally, it would take so long to adjust. Moreover, their adjustment produced unexpected reactions.

Some nurses experienced difficulties in coping and felt overwhelmed by the unfamiliarity. They were overcome with anxiety at being unable to understand, control or predict other people's behaviour.

> *Our first three month as a family [in the UK] was very difficult. [My wife] was scared and she did not feel secure. She thought anyone could break in the door and just come in the house to steal or whatever…We thought everyone is bad, everyone may be [a] killer, robber, and we couldn't change our mind until we lived in that experience on our own. (Wesam, 34, Male, Telephone)*

It is common that some migrants experience mood swings, isolation, loneliness, apathy and frustration, in addition to physical symptoms such as headaches, stomach upsets and insomnia (Yi, 1993; Mumford, 1998). However, each new migrant nurse had differing reactions from the others. Most Jordanian nurses found themselves engulfed with feelings of loneliness and isolation, even though people surrounded them all the time. Some described feelings of homesickness, such as their desire to speak Arabic, because they struggled in the beginning to find someone they could converse with in Arabic, on a daily basis. Adeeb explained that his friend was on a different shift and neither realised that there was a possibility of asking for a change in the rota, in order to meet each other.

> *I was alone here so it was more difficult for me. […] first two months I didn't say any word in Arabic. (Adeeb, 35, Male, Telephone)*

Some of the stress experienced by migrants is classified as culture shock (Mumford, 1998; Kingma, 2006c; McElmurry et al., 2006). Some Jordanian nurses felt that they had to cope with this shock immediately after their arrival in the UK. It is commonly acknowledged that many people feel a culture shock when they live in a culture different from their own. It is characterised by irritability, homesickness, isolation and sometimes depression (Mumford, 1998).

Another worry cited by the nurses was a lack of feeling of safety and insecurity. These feelings did not worry them while they were still in the home country, but usually after their arrival as migrants. It happens for two main reasons. One is a lack of self-confidence and trust in persons they do not know. Trust usually needs time to build up. The second is, news received from the media or their Jordanian friends in the UK. Some friends in the new environment would keep warning the newcomers about safety and security, and this would lead the newly arrived migrants to believe that their new community was hostile and dangerous. The new migrants would usually believe everything until the opposite is proved. As Wesam previously mentioned, such were the feelings of his wife when she first arrived with the children to London. His wife came from a town in Jordan where she left the doors of the home unlocked, except when leaving the house.

Leininger and McFarland (2002 p.50) mentioned that "feelings of helplessness, depression, and not knowing what to do are often experienced by nurses [who experiencing a] cultural shock." This kind of shock happens due to insufficient exposure, knowledge or orientation about the new culture to which a person is about to move. The nurse who described situations, in which people were more likely to suffer a culture shock, was aware of the fact that these people had committed the mistake of not educating themselves about the English culture before they arrived in the UK. As stated by Leininger and McFarland (2002) migrant nurses can overcome and limit cultural shock by studying and learning about the English people and their culture before they going to the UK and working with patients.

> *[B]eing in a foreign country, you have the issue of being exposed to what's called cultural shock and not having a proper preparation for it. I imagine if you opened a book or […used] the internet …that would made things far much easier. (Raed, 30, Male, Personal)*

Most nurses who came directly from Jordan generally tended to suffer because of their monocultured orientation. Before leaving Jordan, many believed that their domestic culture prevailed through out the entire universe. However, when they moved to the UK, they discovered a diverse society characterised by many different ethnicities and subcultures, within their neighbourhood and the new work setting. These cultures have to be recognised, valued and understood for their differences and similarities with their own culture. Their transition then is not only from a monoculture to a multicultural country, it also entails a transition from a society where their culture is predominant to a society with a different predominant culture; therefore, all other cultures would be marginal. This transition excited the nurses in the beginning, before shocked them later on, when they recognised it.

6.6 Conclusion

The nurses realise the migration experience by constantly oscillating between the familiar environment and the unfamiliar. The Migrant Jordanian nurses lived constant tension between issues from both countries. The migrant nurses' experiences during transition phase are divided between the home country and host country. Three elements of experience occur before the actual move; those are aspirations, worries and disconnecting relationships in the home country. Another three occur after move; those are establishing relationships in the host country, excitement and shock.

Jordanian migrant nurses possess high levels of aspiration, irrespective of the country they worked in before the UK, irrespective of gender and age or whether they had been encouraged by a recruitment agency or had taken the initiative on their own.

The migrant nurses experience a disruption in most relationships in the home country; with the previous employer, most of their friends and distant relatives. On the other hand, the nurse maintains relationships with the close family members. The disconnected relationships in the home country are replaced by new relationships with the new employer in the host country and particularly with work colleagues of the same culture milieu. They make the best of their opportunities and face enormous challenges during the transition. Some nurses take whatever opportunities they can, in order to survive and achieve their desire to work and live in the UK. Although, some nurses face enormous challenges, they hold on and never give up.

A part of the transition phase is that migrant nurses need to realise that they would be undergoing significant changes in their profession and life. The transition phase has a great influence on the post-transition phase, in terms of nurses' goals' transformation and diversion of their pathways. The findings and discussion in the next chapter consider what happens to migrant nurses once they have settled in their host country, by examining their personal and professional experiences during this phase.

Chapter 7

7 Away from home: profession transformation and route diversion

7.1 Introduction

The previous chapter discussed the findings related to the transitional phase of Jordanian nurses' migration to the United Kingdom (UK). The transition phase was full of opportunities and challenges as a result of the move from a well-known work and life environment to an unknown and unstable work and life environment. While the push and pull factors were in question during transition, the nurses weighed up their expectations after the transition and when they settled.

This study reported in chapter five that nurses use their skills as a passport, which is consistent with previous literature (Choy, 2003; Ineson and Seeling, 2005; Kingma, 2006c).; however, little is reported on what happens to the nurses skills, when they settle in the destination country. The Cumulative Causation Theory (CCT) argues that each act of migration amends migrant attributes, although this manipulates the subsequent decisions for migration (Arango, 2000). According to Fussell and Massey (2004), migration transforms the migrant's socio-economic characteristics, which promote additional actions.

This chapter aims to identify and examine the key elements of the post-transition phase; that is six months after the nurses' arrival to the UK or getting a registration PIN number with the Nursing and Midwifery Council (NMC). The discussion is carried out in three sections: profession transformation, life transformation and the future, UK, a station or destination. 'Professional transformation' represents the outcome of shifting and adjusting migrant nurses' competencies to fit the new work place. 'Life transformation' is the changes in personal norms and values or the

adaptation to daily routine and culture in the UK, which is different from that in Jordan. Opportunities and challenges, which stem for professional and life transformation, divert migrant nurses' future and route plans. There are four groups of migrant nurses in terms of future planning: those who want to stay in the UK, those who will leave for a third country, those who have not yet made up their mind and those who will return to Jordan. These are considered in the section, the UK, a station or destination.

7.2 Professional Transformation

An interesting account mentioned during the interviews was about the British nurses who were working in Gulf States (GS). Despite their ordinary nursing qualification and junior experience, they had better positions and higher remuneration, than their counterparts from other countries:

> *My manager there [Gulf State] was British, and she was an E grade here. She had a Diploma […] but [was] recruited as a unit manager there. (Muhannad, 34, Male, Telephone)*

This raises the question of why at times, overseas nurses are preferred over local nurses. Muhammad's opinion is that the employers consider the Westerners more competent and are considered as possessing other preferable qualities as nurses. On the other hand, he made one striking point in terms of professional attitude and values among local nurses (in the GS):

> *If you are a local nurse basically you are not touching the patient. You are just sitting in the office and just come drink tea and eat and go back early if you like, yeah and take the [work] shift you like and obviously the salary you multiply it by 3 or 4. (Muhannad, 34, Male, Telephone)*

Although these two quotations are talking about non-Jordanian nurses, but both imply the influence of professionalism, attitudes and values on nurses' intentions and future plans to migrate. Professional nurses ought to be valued and recognised in other countries, when their values and attitudes meet the requirements of the workforce market. It is not where they come from or what racial group they belong to but their professionalism, attitudes and values. When international nurses work in the UK, they are equal with local nurses under the umbrella of equal opportunity regulations, both have their professional duties and responsibilities, identified in the NMC Code of Conduct (Nursing and Midwifery Council, 2008).

This is just one aspect of differences in the work setting between the present and former environment, for overseas nurses. While, migrant nurses live and work in the UK, they experience a different routine at work, at home and on the street. This influences their professional and personal life, regardless of the transferability of their professional skills, which are used as a passport to reach the host countries (Choy, 2003; Ineson and Seeling, 2005; Kingma, 2005; Percot, 2005). Although the nursing skills and procedures have considerable transferability, senses of professionalism, work policies and regulations differ between countries (Winkelmann-Gleed, 2006). It would seem that the nursing skills and previous experience from source countries, do not contribute as much as the migrant nurses expected, in their adaptation process to the new work place. Jordanian nurses, for example, are confronted with new policies and new work patterns such as rota patterns and job descriptions. This became very clear within the few months of their arrival.

7.2.1 Work patterns:

In chapter five, the Jordanian nurses described the work rota in Jordan and the GS as rigid, with limited options for the nurse to choose. However, in the UK working hours

are more flexible. In London, for example, nursing managers design long shifts, to reduce weekly and monthly travel journeys, to and from work. Moreover, those on long shifts are provided with additional and longer break times, conforms with national regulations, so that the nurses can refresh their energy. One of the participants mentioned how he was fascinated with the working hour's rota system when he arrived to the UK:

> *My working hours are 37.5 [hours/ week]. In the 1st place we used to do short shifts like early, late and night shifts. But because of [shortages], they had lots of covering and shifts they had to do long shifts, days and nights. So, by the next half of my year and a half, they started to do long days, which I was really satisfied with because they give us more time off. Thirty-seven and half will be 12.5 hours a day, so three days working and 4 days off [per week]. (Khaleel, 29, Male, Personal)*

Flexibility and working part-time in the UK, gives Jordanian nurses an opportunity to experience different work places and gain extra money while they are doing their full time job. The systems of bank and agency nurses is not applied in Jordan, because, all the jobs are full-time and there is no opportunity to do a part-time nursing work. Khaleel talked about working extra shifts, on the basis of a contract with a nursing agency:

> *… you can do shifts in different places in the hospital, like high dependency unit, other places in the hospital, and again you can do it in the same place you work in, [e.g.] in intensive care. And they pay you different like [a nurse from outside] ITU. So, I do some shifts with them in the same hospital, because there is lots of work available in the hospital. I don't need to travel to get [work] anywhere else. (Khaleel, 29 , Male, Personal)*

Rota patterns in the UK give nurses a sense of flexibility in performing their duties. However, this flexibility does not imply a lack of rules or a loss of control.

> *Here they have more guidelines, more forms to fill out, more protocols and many things. But as a nurse you do mainly the same things. It's only the policy and the protocols that they follow. Everything has to be according to standards, protocols and guidelines. In Jordan, we have few of these. (Amal, 38, Female, Telephone)*

Due to these protocols and the control systems, there are plenty of forms and paperwork to complete in fulfilling their duty:

> *[W]e do a lot of paper work here. So I have to fill; monthly one, weekly one, and whatever…. I think paper work is taking more time here. (Yahya, 35, Male, Telephone)*

Nurses in Jordan and the Gulf States follow a rigid work rota, regardless of their productivity. For example, the only option available is that of full time work and a two or three-shifts rota, regardless of the circumstances of the nurse. As a result, some nurses take the opportunities of any loophole in the regulations to overcome this rigidity whenever possible.

> *I did have problems […] because my staff […] used to come late or leave earlier or leave the patients sometimes. (Yahya, 35, Male, Telephone)*

Work regulations and job descriptions for nurses in the UK create more structured work patterns. Because of this structure every nurse's duties and responsibilities are well defined, and performance can be measured and appraised.

> *Everybody got a clear job description and what I am expecting from them. So there is respect and appreciation. But, as a manager you have a target that you have to achieve and like any manager I do review their performance. If there is any problem I put them on the proper disciplinary channel. I do loads of appraisals for them; If they done anything good, I thank them and I always try to highlight everything been done, push it just to encourage other people and if there is something done wrong I highlight it again so we can learn and reflect on it. (Muhannad, 34, Male, Telephone)*

Many Jordanian nurses in the UK have learned about themselves and others by looking cross-culturally and ascertaining what they have in common as nurses and what makes them unique. Interestingly, migration gives the opportunity to some nurses, to recognise unprofessional and irresponsible behaviours on their part, which were overlooked in Jordan. For example, Yahya had a habit of wandering around during duty; he went one day in the UK to a Jordanian colleague in another department to go for a break. Bear in mind, both were on duty and they had not arranged a break with the head nurse:

> *Some behaviour we used to do in Jordan was wrong… in Jordan we weren't very strict like here. If you work in some wards, you can go to visit other wards, which I used to. Now … when I thought about it I was stupid. …It wasn't [a]good idea for me. I completely change my mind. I think I was wrong. (Yahya, 35, Male, Telephone)*

Some Jordanian nurses reflected on the work conditions in the UK and compared it with what they were in the Gulf States. Muhannad had been in the United Arab Emirates (UAE) and reflecting on his nursing work and his health organisation, he complained of the lack of a system and policies for professional development.

> *[N]o system in place. They don't invest in people; because […]you are foreigner (they think), you are coming for 5 or 6 years and you will go back home. So, what's the point of teaching you and spend money on you and all that sort of things. (Muhannad, 34, Male, Telephone)*

Those accounts imply that Jordanian nurses experienced imperfect work patterns, prior to their arrival and the improved employment conditions in the UK. It is worth pointing out that though they gain in some aspects of work patterns, they lose out in some aspects in terms of skills. For example, in their native countries, the nurses would perform task such as drawing blood and applying IV canulas; however, this is

not part of the job description for most nurses in the UK. Jordanian migrant nurses especially were unhappy about some of their skills not being recognised.

> *[in Jordan] I used to cannulate patients, take peripheral blood and did some clinical procedure which we are not allowed to do here. (Ayman, 28, Male, Personal)*

Literature debated over this issue, which called 'deskilling migrant nurses (MN)' for two reasons (Matiti and Taylor, 2005; Bloch, 2006; Smith et al., 2006a). First, these accounts probably report on nurses soon after their arrival in the UK. Such problems ceased to exist in the case of those who had spent considerable time in the UK, and had achieved their registration with the NMC. In more detail, most international nurses work initially as health care assistants (HCA), before getting a PIN number and becoming fully registered nurses (RGN). The studies reported procedures such as giving medication-which is not part of the HCA role, because it is assigned for RGNs. Second, nurses in some countries take on tasks of other health professions, such as minor suturing, which is assigned to doctors in most workplaces in the UK (MacAlister and Chiam, 1995; Shuriquie et al., 2007).

Migrant nurses experience a professional transformation because the education and work policies in the UK adopt evidence-based practice. An interesting account mentioned by Laila indicates that nursing in Jordan is not evidence-based practice. Again, this account explains the decision of some participants in Chapter 5, when they decided not to leave Jordan for the GS because they thought they would miss working in Jordan.

> *[E]verything is evidence-based practice here. So everything you read in literature or in book you see it in the clinical setting. There is something different here; they do the research for a purpose. So, they wait for the research findings and then they will try to get used of it. In Jordan, I think there is a gap between the research and the clinical setting. (Laila, 30, Female, Telephone)*

All the participants agree that there are regulations and controls for every aspect of their job in the UK, which is not hold true for the source countries. It is implied from their statements that the organisational culture in the UK is more formal and employees stick to the regulations and their work practices.

7.2.2 Organisational patterns

The participants reported key elements that distinguish the nursing care organisational patterns in the UK from that in Jordan. One element is the influence played by the leadership turnover with the nurse managers changing every now and then and each one pumps new blood into the work:

> *The idea of looking after people in the UK is more [related] to the accountability. It's promoted by updated ideas and different people input. [i.e.] Renewing policies, new managers come in and old managers go out, which influence the work. (Abdullah, 31, Male, Personal)*

A second element is applying a holistic nursing approach to taking care of patients. Nurses in Jordan are trained in providing comprehensive care for the patients including physical, psychological and social aspects. However, in their previous work places, the physical or psychological care would be provided independently from each other. For those nurses crossing borders entailed exposure to the idea of practicing a holistic approach:

> *Medicine here [is] more comprehensive. It covers the social issues, emotional issues; how the patients are living and their conditions at home, we look at everything. […] In Jordan there was concentration on the cure [treatment] of people. You know there were no social issues and no communication [with the patients]. A prescription was given to the patients… and that's it. (Abdullah, 31, Male, Personal)*

A third element is accountability. The levels of responsibility and accountability to which nurses are exposed, during their duties can influence competency. In general, nurses had less responsibility when they were in Jordan, they were not accountable as much as they are in the UK.

> *I moved to Dubai it's like [in] between. Some protocols you have to follow but you still have less responsibility [than in the UK]. (Malek, 29, Male, Personal)*

A fourth element is the culture and the organisational structures. According to the participants, nursing care in the UK means adopting a team approach, while, in Jordan and the GS, it is structured on a hierarchical basis.

> *[Here] we are team. In Jordan there is no team. The doctor is first whatever he wants I have to do. (Wesam, 34, Male, Telephone)*

What Wesam said is confirmed by Muhannad:

> *Basically, in the wards each night there is only 1 doctor so they want somebody to manage the team there. The whole team there is 18 G grade and 6 F grade [staff] and there is me an I grade (Muhannad, 34, Male, Telephone)*

Muhannad is a nurse who works as a team leader; he stated that the doctor in the UK is a member of the team rather than a leader.

Finally, it is not only the organisational differences between the source and destination country which can influence nurses' work but the cultural differences too.

Next I report and examine how the Jordanian nurses' work is transformed in a cultural context.

7.2.3 Cultural context of professional transformation:

Jordanian nurses decided to move to the UK because they wanted to explore the world. Translated, this means that they had a desire to learn about other cultures. Tortumluoglu (2006) defined the cultural desire as "the spiritual and pivotal construct of cultural competence that provides the energy source and foundation for one's journey towards cultural competence".

Cultural competency here means the state of being capable of functioning effectively in the context of cultural differences. According to Campinha-Bacote (2002), cultural competence in nursing entails five components: awareness, knowledge, skill, encounter and desire. She explained that 'desire' requires awareness of the existence of cultures' diversity and sensitivity to differences, and she referred 'cultural awareness' to the process of becoming sensitive to cultural differences (Campinha-Bacote, 2003).

Migrant nurses go through the process of learning and developing awareness about cultural differences first about themselves. For example, a Jordanian nurse asked the matron to show sensitivity toward her attire, which was an integral part of her culture and religion:

> *I told the matron that I cover my hair and I don't wear short sleeves and all these things. […] I explained, this is the way I am and it is my faith so I can't change myself. I've been doing this since I was a teenager. So I can't change myself because I just came to different country. […] I really like it because I respect myself, my religion and all my practices (Amal, 38, Female, Telephone)*

Many work places in the UK accommodate and accept the Muslim women's uniform of covering the arms and wearing a headscarf. However, awareness can develop into a deeper understanding of knowledge about cultural differences, as the migrant nurse spends more and more time in the host country. The Muslim female nurse, particularly the one who wears the scarf, may have to contend with frequent questions about her attire. This happens because she is dealing with the general public and patients from different national, cultural and ethnic backgrounds. For example it is not a surprise to find curious patients, particularly children, asking questions such as those Maram faced during her duty:

> *A [child of] five years old will come and say: what religion is that? Why are you wearing this one? And why [are] you covering it? So you have to explain it to them. Sometimes the parents don't know anything and they feel shy to ask…. But once they know you don't have any problem in talking about it and this is part of your religion and culture. They're more than happy about it. (Maram, 30, Female, Personal)*

Bareheaded females are common in the UK because only a few women cover their heads. Therefore, a woman wearing a headscarf is identified easily, but not many know of its importance to many of Muslim females. For some Muslim women the headscarf represents a commitment to her faith, Islam. Amal said:

> *[T]hey were more curious about me than the others. You know being a nurse and wearing a hijab and covering from head to toe. They were all asking me what's that? Then they would just laugh and ask me; are you feeling cold? They ask; where are you from? and all these questions. (Amal, 38, Female, Telephone)*

Another interviewee added:

> *[T]hey had a lot of things to ask about Islam and Arabic and they had these myths about Arab women and that was the beginning. They just want to know things about us and our life which gives them completely different picture. (Maram, 30, Female, Personal)*

'Cultural skill' refers to the ability to apply knowledge of the new culture in the assessment of patients (Campinha-Bacote, 2006). Religious values and cultural attitudes may sometimes involve transition of nurse from one nursing speciality to another, particularly where taking care of patients of the opposite sex was in the picture. For example, when Maram was working in an ICU in Jordan before she arrived to the UK, she was dealing with both male and female adult patients. She changed to childcare instead of adults, because she anticipated that her future colleagues in the UK would not understand her frequent requests for assistance when dealing with male patients, as she used to in Jordan. Therefore, she decided to choose a speciality, which would not be incompatible with her beliefs and values:

> *[I was working in] Intensive Care Unit back home. The[recruitment agency] gave me a choice if I want to go through but I wanted to try something different. So I chose to go to the paediatric one. When I was in the ITU I started in the last year of my experience to specialize more in children. And it just developed with me. In the end I just want to be a paediatric nurse. (Maram, 30, Female, Personal)*

Nurses may find themselves spurned by some patients, for any reason including the female headscarf.

> *During the five years [of working in the UK], we have people who were really racist and they really refused from the moment they'd see you, regardless if you are a good nurse or not. From the first moment they see you they don't want you to even get near them and so that was very rarely I would have to say, I only had three or four. (Maram, 30, Female, Personal)*

The fact that these patients raised an objection left the nurse embarrassed. However, working in a different culture is an opportunity to enhance cultural competency through knowledge. *Cultural knowledge* involves developing an understanding of beliefs, practices and coping with customs and habits of other groups.

> *[H]ere the elderly they like to be independent. They like to do many things on their own, which is the way they live. It's different from our culture because, [our] elders would like to stay with their children and be more reliant on them than being more independent. But the people here like the way they had been brought up and they want to be independent. (Amal, 38, Female, Telephone)*

'Cultural encounter' refers to the ongoing process of engaging with culturally diverse clients or staff and continually developing ones' knowledge and skills (Campinha-Bacote, 2003). Muslims perform prayers five times everyday; about one hour before sunrise, noontime, mid-afternoon, sunset and the last is about two hours after sunset. For each prayer time the person needs between 10-20 minutes. Many nurses in the Muslim world perform it during their own break time. A Muslim can perform the prayer in front of others almost anywhere. However, women may prefer to pray in a place, which gives them privacy from the gaze of males.

> *At work, it was difficult to find the right place to pray 'cause there was no proper places to pray. (Amal, 38, Female, Telephone)*

As such women might need some flexibility while on duty, which might conflict with the routines of their work place. This may put some of them in a difficult position, perceiving choosing between their religious obligations and work commitments, which may lead to delaying the prayers to more convenient time. Amal observed that:

> *I told the matron sometimes I need [break] to go and pray. She said: I don't mind, as long as this doesn't interfere with your work and the patients' needs. (Amal, 38, Female, Telephone)*

Cultural encounter involves exposure to different values and probably beliefs. Nurses in Jordan are familiar with patients similar to their cultural milieu. There was no need to know about other cultures to provide nursing care.

> *Jordan is not a multicultural society, not at all, it's just one kind of people and one culture. Let us say, I did not see any foreigners in the work place in Jordan. We did have Arab people coming from different countries it's like Yemen and maybe Libya. But I couldn't call it a multi cultural environment. (Abdullah, 31, Male, Personal)*

In addition, the nurses want to learn about other cultures and it is likely that opportunities would not have come by, without leaving the country:

> *I didn't have the chance to be exposed to this multicultures. (Ibrahim, 33, Male, Personal)*

The cultural competency of nurses develops as they continuously learn from their exposure to different cultures. Jordanian female nurses have very interesting views about working in a multicultural setting:

> *I managed to build a good relationship with all the staff here not only with the clients or with the residents. Yeah, so I was trying to understand their cultures. The way they're eating. The way they're talking, you know. Even the TV programs they are watching I used to watch at home; so I can go back the second day and talk with them and have chat what is happening there and they will be very happy with that. (Amal, 38, Female, Telephone)*

She also pointed out:

you have to understand the way they're thinking, their religious practices and all these things. So being open may be what makes people approach you, understand you and be ready to deal with you. (Amal, 38, Female, Telephone)

In summary, the literature indicated that migrant nurse pushed and pulled to destination countries for career development opportunities, however little was mentioned about the development in the profession after transition (Buchan et al., 2004; Hardill, 2004; Huston, 2006; Larsen, 2007). This study reported the migrant nurses' experiences, shifting in their career and profession. Jordanian nurses described a desirable professional transformation, because the nursing experience that they have gained in the UK are important for their career advancement. It provides an opportunity for them to learn about the need to respect regulations and follow the procedure manuals, in order to provide the right nursing care. When Jordanian nurses arrive in the UK with a passport of their skills and knowledge, they have to go through a professional conversion because of the huge differences between the new work settings and those they experienced in the source countries.

The next section sheds light on the kind of personal and social transformation, migrant nurses' encounter during their daily life to survive in the UK. This probably will offer pointers to the future plans of these nurses, as we will see in the third section of this chapter.

7.3 Life transformation

[Life in the UK is] great, it's wonderful actually. I learn a lot about people and this is one of the best things that I could have in this country….in the UK I see every single culture in the world. I heard about countries that I have never heard about and I met people that I have never expected to meet them in my life. From all sort of cultures and all sort of backgrounds….(Abdullah, 31, Male, Personal)

Professional transformation is not the only feature of a nurse's competency. Life transformation is another one. The environment and the society in which the person lives, usually have a great influence on his or her competencies. In order to understand this transformation, I will examine the personal and social changes in their lives. Personal transformation involves mainly identity and personal development, while, social transformation explains how individuals and families adapt to new lifestyles.

7.3.1 Personal transformation

Personal transformation is a kind of character- changing process, which enables the person to realise his/her identity. Most Jordanian nurses were happy to talk about the internal changes that they experienced. Abdullah confessed how the experience of migration has had an enormous influence on his life. He explained:

> *[L]iving in the UK is different than living in Jordan. I think I've got more experience and chances here than in Jordan […] I would have not got this chance in Jordan […] first world country gives you more ideas about life. You might change your attitudes not the beliefs. My beliefs are quite firm today. (Abdullah, 31, Male, Personal)*

His attitudes, as Abdullah says, have shifted due to the formation of new perspectives on life as a result of living in a different country. I asked him about his new life. He said:

> *I've got calmer and I take more time to take a decision. It influenced my way of thinking and my way of understanding of life. (Abdullah, 31, Male, Personal)*

Women have also gained new attitudes, which have transformed their identity and status. Amal remarked about her life in the UK:

> *I think this has boosted my confidence and my autonomy, my independence living, on my own and all these things. (Amal, 38, Female, Telephone)*

Many nurses had not recognised the components of their own culture until they lived in a culture, different from their own. Their exposure to the different cultures in the UK has enhanced understanding of their own culture.

> *[L]iving in the UK was kind of exploring chance for me. You know, knowing how the west living, how is their normal life, what they are doing and sometimes you get the idea of you westernizing yourself and being more into this culture. So we were going now to connect with people. How they are living and what they are wearing? what they are eating? After all we had input from the community on us and we think that we reserved our own behaviours and our own thoughts and beliefs. (Abdullah, 31, Male, Personal)*

This implies these nurses have reflected on their original identity and gained additional identities (Caldas-Coulthard and Iedema., 2008). They come from similar social and cultural backgrounds, where things are taken for granted without any questions. Moving into a different community and culture brings everything into question. Does this go with their values and attitudes or not? Take for example the food:

> *[W]hen we arrived the last thing we were thinking of is the food to be honest. You got the opportunity of coming to the west. And then after you got hungry, and you got to look for food now. then you face the fact that we are Muslims and we got to eat Halal food and stuff like that which we have not thought of before we came to this country. (Abdullah, 31, Male, Personal)*

Contrary to the expectation that migrant values would be changed by the influence of the host society, the Jordanian nurses' values and identity seem to have become confirmed:

> *We have been here five years. We've had a lot of challenges to face us. But I have to say that we discovered it strengthened our beliefs more than making them weak or get away from our culture and our religion. (Maram, 30, Female, Personal)*

Life on a day-to-day basis, for a single Jordanian woman can be easier than some would think in the home country. The liberal lifestyle gives women the opportunity to lead a life in the UK, without the restrictions of their own culture.

> *I feel more free during the day to go and shop. Nobody ask where are you going? Or why you dress like that? Or whatever...I didn't really find it difficult to wear hijab here… it's very open country here and they respect other people's faith, practices and religions... So what I'm wearing back home I'm wearing here and I haven't any problem. (Amal, 38, Female, Telephone)*

When I asked a married female nurse about her advice for Jordanian women willing to live and practise nursing in the UK, she said:

> *It goes down to their personality and their attitude and how they think, and if they have a strong belief nothing can change it. They have to stick with what they believe in and not compromise on basic things […] if they have any doubt that's going to be a breaking point for them and they will not be able to carry on. And they are just going to feel vulnerable for any condition that comes to them. But, once they know themselves they will know their ability and what they can do. (Maram, 30, Female, Personal)*

In her view, the Jordanian nurse does not need to carry two contradicting identities because she moved to the UK. The experience of living in the UK has probably granted the nurses new identities. Most have learned a lot from their experiences, and they become entitled for new identities added to their original identity. For example, they are entitled for identity of migrant nurse and UK resident.

Although the Jordanian nurses have imbibed a lot of British attitudes and values, which confirm the British identity, they have always maintained their home country identity. As Jordanian nurses become more diverse in their identities, they become more confident of the Jordanian identity as well as nursing identity, despite their professional and personal transformation. The maintenance of their identity is reflected in their continuous contacts and visits to Jordan. While the identity is debatable, it can not be given enough depth of explanation in this study, therefore some literature may add to what discussed previously (Caldas-Coulthard and Iedema., 2008; Lawler, 2008).

7.3.2 Social changes

Another transformation in nurses' lifestyles involves their social network. The core of Jordanian nurses' social life is their family, particularly the relationship between husband and wife and their children; then with their parents' families in Jordan, and also with their Jordanian friends in the UK. I asked the participants, , in case of an important development, good or bad, whom they would tell first.

> *My very first one is my wife, because; she lived [my] hardness; I should share [with] her the happiness. (Ibrahim, 33, Male, Personal)*

Then he added:

> *[M]y family back home. I always update them with good things and bad things (Ibrahim, 33, Male, Personal)*

Most Jordanian nurses in the UK have social relations among themselves:

> *I have good connections here with Jordanians, which is the same culture friends. I can say they are real friends and I update them [of my news] (Ibrahim, 33, Male, Personal)*

Because most of the nurses came to the UK on their own, they developed good social relations among themselves. When they were singles, all the good and bad news would first be shared with a friend, before anyone else. When I asked Malik who he would first tell about good or bad news he said:

> *[M]y friend [who is Jordanian]…. So if I need something, my friend will come and talk to me and [would] tell me what to do. (Malek, 29, Male, Personal)*

Some nurses argue that socialising with British people may involve pubs, public and private parties and probably private invitations. They are not keen to take risks in attending events where alcohol is usually served, as Muslims are forbidden to consume alcohol. Although there are Jordanian nurses who socialise with others in some of these activities, the others admit everyone respects the others' values and beliefs.

> *[W]hen you go for night out with your group; once you tell them for example I don't drink alcohol they respect your way. Nobody will push you or encourage you to drink even one sip of alcohol. (Tayseer, 34, Male, Personal)*

Food and drink play an important part in connecting with people, because both are involved in most social gatherings (Hofstede and Hofstede, 2005). However, both may present constraints for Jordanian nurses to socialise with British people. Although Jordanian nurses are tolerant and accept other people's freedom of choice, they understand their own freedom to choose not to drink alcohol.

> *It is cultural and religious wise. Because I don't drink, I don't party. So if you want to be involved with English colleagues or other cultures, they always go for parties, drink and that doesn't suit me. So I'll try to be with friends who know what is my culture […] or they adhere to culture similar to me.(Khaleel, 29 , Male, Personal)*

Socialising with Jordanian friends enables them to share issues of interest:

> *[We are] talking about work always, the discussion as well about family life, troubles, happiness, good things and bad things. (Ibrahim, 33, Male, Personal)*

Another one added:

> *I would say it's fantastic to be in a group where you sit, chat and have your Jordanian stuff and Jordanian food. We sit together [men only]; sing [folklore], dance and watch TV. (Abdullah, 31, Male, Personal)*

However, socialising with people of the same nationality is not always appropriate choice for some participants. There can be many adverse effects from this choice, particularly the delay in learning to speak the language of the host country; and there may be difficulties, which may arise out of competition inside the group.

> *[B]eing in a group was delaying our progress; we sit together we speak in Arabic, and the language was quite challenge for us. It was one of the problems. We were not used to speak fluent English [….] We were all chatting in Arabic. We didn't have a chance to speak to people in English outside work. So the time we were practicing language was quite limited. Which I think and some of my friends agree that it delayed our progress and our ability to speak English language. (Abdullah, 31, Male, Personal)*

This difference of values does not stop others from socialising when there are other means of connection. Feeling of loneliness and the presence of children will often promote new relationships, at least with neighbours.

> *We lived in a third floor flat. The first floor was a Jewish lady, and the second floor was a Christian. We lived together 4 years, peacefully and nice. In this country does not matter what you believe you have to adapt together, to live together and it was really nice because, we supported each other. My wife was not feeling really secure and happy before that, particularly when I have to do some night shifts from time to time. (Wesam, 34, Male, Telephone)*

Wesam admitted that his wife, before the establishment of these relationships, was feeling lonely in a foreign country. This is true for all the foreigners, because people are programmed when they are young to learn their society's culture and to take it for granted (Hofstede and Hofstede, 2005). Their culture is deeply ingrained in their subconscious mind. When people move to a foreign country, their cultural programming is thrown into disarray, as in the case of Wejdan. At times, this resulted in her forming false assumptions about what the others were doing. To avoid these false assumptions, Wejdan chose to be lonely during the first year of residency in the UK.

> *[B]eing alone with two children and we had no friends at that time around to talk with and socialise. This was the most difficult thing at first but after that there were more nurses came from Jordan and we had other friends around us which helped a lot actually and sometimes we feel like we are home. (Wejdan, 32, Female, Telephone)*

Building social networks with neighbours and the society is not a one-day activity. It takes a long, time because, both parties need to earn each other's trust, before establishing strong relations with others.

> *Slowly, slowly she was a bit, you know, open to the community she visited our neighbours and she just say hello. She has a relation with two or three of our neighbours and she just go to them, have a chat and we visit them at Christmas, that's all and one of them they visit us in Ramadan. (Wesam, 34, Male, Telephone)*

The parents and close relatives in Jordan continue to be a part of the lives of the nurses even while they are living in the UK. (Antoun, 2005). Some family members in Jordan receive constant, some intermittent, financial support from their son or daughter who works in the UK. Jordanian nurses are economic and social assets to their parents, brothers and sisters, back home or living as diasporas.

> *[G]iving something to my parents because it is in our culture. Always have to give something to our parents (Amal, 38, Female, Telephone)*

Another one added:

> *[W]e've got a lot of responsibilities back home. We have to help our family; I do some extra work to send to my parents and my responsibilities here and in Jordan. […B]ecause I've got lots of brothers and sisters and that's for my parents and helping them […] it's our culture there. (Ayman, 28, Male, Personal)*

Bearing in mind Ayman is single; I asked him whether he would contribute to his family back in Jordan when he has a wife and children. He replied:

> *I do not know the experience of being married in helping the family. But I think most [of my friends] are married now and still they are supporting their families back home. (Ayman, 28, Male, Personal)*

Although many participants arrived in the UK alone, most of them got married and brought their families after their arrival. Once they become a family, they face a different life from the life of the singles. Life is full of responsibilities and sometimes challenges. Confrontation increases when families have children, i.e. the parents need to make enormous efforts to teach children in the UK, their Jordanian values and culture:

> *We respect the culture here and we like the way people behaved and raised. But we have found our way of life may be different than what we want them to be in. It is difficult for me as a father I have two daughters, to realise my daughters live in a western society. (Tayseer, 34, Male, Personal)*

The mother explained in a different way. Because the daughters want to be raised as Muslims, they usually face many questions every day:

> *[T]hey don't have to justify themselves as being Muslim. Why they are wearing headscarf or anything, why things are done in the name of Islam. There's no need to put them in that position at all. We've been through it. There's no need for them to go through it. (Maram, 30, Female, Personal)*

Life is expensive in the UK particularly for a family. It is a challenge for a family to survive on one person's income, particularly when there are children. Most of these nurses with families are either single breadwinners already, or they will be soon.

> *I am supporting my family here and I'm the only employed, my wife doesn't work over here. So that makes the situation a bit […] harder for me. (Jawad, 29, Male, Personal)*

Another situation was common in Jordan and recently changed; that is, a single man looking for a who wife prefers to stay at home (Barhoum, 1983; Dwairy et al., 2006). He does not want his future wife to work in order to earn money, because he believes her house will be her kingdom.

> *I need to work harder to maintain a family without work of wife as I prefer. (Khaleel, 29 , Male, Personal)*

On the other hand, two male participants, who were married to nurses who were unemployed, said their wives were not registered with the NMC and both wives had chosen to raise their children. Unfortunately, both women declined to participate in the interview and did not give a reason for their reluctance. However, one husband explained:

> *[S]he decided to look after the kids also she wants to continue her study next year. She is not registered in the UK; because of the kids we decided to wait for my youngest child to go to school next year. We have three boys; we don't know where to send them we didn't have anybody to look after them. (Adeeb, 35, Male, Telephone)*

The nurse, Saleh, is also married to a nurse who worked in Jordan until a year before they came to the UK.

> *She's a nurse but never worked here. She was employed back home. She had resigned when we got the second child. This was in '98. (Saleh, 35, Male, Telephone)*

I asked him if his wife was looking for work. He replied that she was not registered. When I asked why, he said:

> *Because; we need somebody to look after our children. She can't leave them, because they are very young. (Saleh, 35, Male, Telephone)*

The families in the UK are faced with this kind of problem, and some parents deal with it by working part time and alternating shifts. Although, Saleh does not make use of this strategy because his wife has chosen to stay at home, two other families applied it with great success. Muhannad and Wesam are married to working nurses. However, both families are planning to save, in order to give their wives the chance to stay at home. Again, the underlying reason being, taking care of the children:

> *[I]t's difficult to look after our kids who are 8 – 9 years old and need somebody to teach them, talk to them, play with them (Muhannad, 34, Male, Telephone)*

Children can be an opportunity for migrant nurses' families to socialise and integrate with their local communities:

> *She was taking one of our kids 2.5 years to nursery. She was volunteering for some activities in the school as well. For example she take some sweet in Eid Alfitr [Muslim feast after fasting month of Ramadhan] to the kids and to the teachers. They give her ten minutes speech with the kids and families to explain what Eid Alfitr means to the Muslims (Wesam, 34, Male, Telephone)*

According to Wesam and Wejdan, the voluntary work gave them access to other activities in the community. I interviewed the wife separately, she also talked about

integrating with the rest of the society. She had been unemployed for three years after her arrival from Jordan. Her daily activities consisted of:

> *[C]ooking, cleaning, looking after the children, shopping, discovering the area around me and talking to the neighbours. This period gave me big idea about the country, rules and what to do in case of an emergency. Those made me stronger woman. (Wejdan, 32, Female, Telephone)*

This account indicates the importance of holidays and off-duty time for socialising. With their time and energy consumed by their day or night duty; nurses are not able to participate in any social activities. Dual-nurse families had no time to socialise even off duty, because:

> *[S]omebody needs to stay at home with the kids, so I and Wesam alternate our shift at work. I find it extremely generous of my manager to give me the shift and off duty I want. She's giving me annual leave as I ask and she's very supportive. (Wejdan, 32, Female, Telephone)*

Without appropriate alternating of shifts, Wejdan and her husband will be in trouble in minding their children. When they were in Jordan, their parents assumed the role of bringing up the children, so they had no need of child- care services. Ultimately, life transformation for Jordanian nurses in the UK is not what everyone wants. These changed circumstances in their life and profession drove some of them to change their plans as explained next.

7.4 Future: UK a station or destination

Massey et al (1994) in the cumulative causation theory (CCT) argued that the migrants will acquire personal knowledge about, and experience in their destination. This may lead them to repeat the action whether to the same destination or elsewhere.

[W]e are not going to stay here forever. It's a station in our life.

(Tayseer, 34, Male, Personal)

Most Jordanian nurses move to the UK without intending to stay forever. They shift from this goal during work in the UK or their goals develop into turning points, after transformation of their lifestyle. For example, Malek set a goal and *"will get married"* to a woman from Jordan and move to Gulf States. Another example, Amal came with a goal to get a masters degree in nursing.

[W]hen I finished master, I couldn't feel it giving me everything particularly research wise. I wanted to go and teach in a university … I have to be really qualified for that. PhD would help me to get a position at a university. (Amal, 38, Female, Telephone)

The accomplishment of her initial objective paved the way for the next milestone that she wanted to achieve i.e. earning a PhD degree, with the eventual objective of securing a teaching post. I am not intending to discuss short versus long-term goals in this section. Nevertheless, I want to shed light on the turning points of some migrant nurses' plans and objectives. Future goal diversions are reflected in these accounts. This sub-theme, which has emerged from the survey and interviews, distinguishes four groups of nurses. First, migrants who plan to settle in Britain; second, those who intend to move on to a third country; third, those who are uncertain of their future plans; and, fourth, those who intend to go back to Jordan.

7.4.1 Stay in the UK

Those who want to continue to stay are the one who are satisfied with their life in the UK. They have transformed their lives and professions to fit their present situation:

> *[T]he life style I'm used to right now is different from the one at home. I can not afford if I go back [to Jordan]. I can't go back to work as a nurse for three or four hundred Jordanian Dinars. My needs are different now. (Raed, 30, Male, Personal)*

Although Raed planned for his stay to last a few years in the UK, after he arrived, he changed his mind and extended his stay.

> *I'm very happy with being in England. I am enjoying my work and life style here. That's why I will stay for longer. (Raed, 30, Male, Personal)*

Some nurses have long-term goals on two issues. One concerns study:

> *I might start in January PhD [study]; so my next step is a big commitment. I think it's going to take another 6 years or something like that. But anyway I have nothing to loose, because I got the full funds and study time from the hospital. (Muhannad, 34, Male, Telephone)*

Education was also a priority for another nurse who wanted:

> *[T]o finish one year MSc in pain management. (Radhi, 35, Male, Personal)*

Another long-term goal concerns buying a house or paying off the mortgage for a house bought previously.

> *I probably consider myself one of the lucky ones who managed to buy a house and so I have my own property. Most of [my colleagues], their salary go on accommodation. And the bigger the family the bigger the accommodation you need and that will take the bulk of the salary. (Hassan, 36, Male, Telephone)*

Muna wanted to:

> *[F]inish my mortgage. ... I'm thinking to go for another course to get the senior job (Muna, 35, Female, Telephone)*

Apparently, Muna was planning to settle down for good in the UK. She is married to a British citizen, who came from the Middle East and now runs a business in London.

Buying a house probably is concerned with long-term settlement as perceived by some Jordanian nurses at least when they arrived in the UK. Two participants live in their own properties, while the rest live in rented accommodations. Khaleel bought a house for the reasons below, but also his account implies that he probably wants to stay in the UK for life.

> *I need to buy a house because I need to live in my own space. Because, I need to get my family with me. Many landlords refused to let me because I have children, they prefer families without children. (Khaleel, 29, Male, Personal)*

Renting accommodation in the UK is expensive in relation to income, therefore, buying a house is a long-term investment strategy (Hardill, 2002). While, buying or selling a house in Jordan is a long process, many people build their own property and they keep it for life. Most Jordanian nurses arrived in the UK aiming to stay for few years and chose to stay in rented accommodation. However, few of them realised after their arrival in the UK, that the houses market is dynamic, and that a property ownership may change twice during one year. The two nurses, who live in their own accommodation, are not the only ones who will stay in the UK, others who rent may also want to stay. The account of the 23 interviewees who rented implies an intention to move in the future to a third country or to return home.

7.4.2 Leaving UK for the Gulf States

Buchan and his colleagues (2005a; , 2005b) argued that international nurses are aware of professional development opportunities elsewhere. Therefore, many international nurses have reported that they may decide to leave the UK. This study found that most Jordanian nurses came to the UK for professional development, and many of them have plan to move, once they have fulfilled their own expectations and fulfilled their legal requirement by finishing their job contracts. They have plans either to return

home or to move to a third country. In particular, they were thinking to move to GS and United States of America. A group of Jordanian male nurses in the UK showed an inclination to move to the GS.

> *I might move to Saudi Arabia or one of the GS to get better life for the family. It is cheaper, easier to get long with my culture, because I am eastern [-minded] man with different beliefs, religion and lifestyle [from UK]. It is easier for a married man and for the family to settle down in those countries. (Khaleel, 29 , Male, Personal)*

Interestingly, what was raised by Khaleel was stated by others, who have families and children. These nurses want their children to grow up in a culture and environment similar to where they had grown up themselves.

> *I have a daughter now, she is nearly seven. She goes to school covering her hair, prays and does everything. Because, British life is completely different from the Muslim life and the eastern life I am worried about her. […] she is influenced by the environment [and] her friends in the school. (Yahya, 35, Male, Telephone)*

To raise a child in the midst of a culture, different from their own represents a burden for the parents. Children in the UK are exposed to a multi-cultural environment and a variety of faiths, which is not what the parents want. Therefore, some parents want to move to a country, where their children would be brought up more specifically in the desired cultural background.

In contrast some nurses were applying to gain indefinite leave at the time of my fieldwork and sending off the documents to gain the British nationality. I was interested in exploring their perceptions of British passport benefits for a nurse, in particular the extent to which they might wish to use it if they leave UK. The first benefit cited was better employment opportunities internationally. One nurse told me about his previous experience in the GS. The employer paid him much less than

junior nurses, employed from western countries. He claimed that the passport was a privilege. The second benefit is that it opens borders for travel with less hassle. Their experiences of marginalisation on some countries' borders drove them to think a British passport is the key for hassle-free travel.

> *[…] all the family got a British passport it is easy for travelling. You can go to any country now without any visa. I been two weeks ago in Spain. I been three four months ago in Belgium. (Yahya, 35, Male, Telephone)*

Interestingly, British citizenship was not a primary goal for most of the participants. In particular, nurses who came directly from Jordan never thought about it, when first applying for a job in the UK as they say in their statements. But Yahya, explicitly mentioned that British nationality became a primary goal during the latter years of his residency in the UK.

> *[M]y goal have been changed to get the passport for my children and my wife. [...] the most important goal is getting the British passport. (Yahya, 35, Male, Telephone)*

This transformation in participants' goals happened after they realised the advantages of holding a British passport.

> *[G]et the citizenship and after that the passport. Which make my life easier for travelling. (Radhi, 35, Male, Personal)*

Ultimately, an application for British nationality is the sign for an intended long settlement in the UK, because it requires at least six years of residency. These nurses are interested in getting a nationality that facilitates border crossing during travel, because many countries give priority to British citizens. Some nurses, after getting a British passport, showed intentions of working in the GS. Early in chapter five, Muhannad and Ayman mentioned that GS recognise British qualifications and experience by giving the holder a value, higher than other countries' qualifications

and experience. When Jordanian nurses plan to leave the UK for a third country, they are seeking financial status or a social environment dominated by culture similar to their own, for family and children. They want to move to the GS, but this time as British nationals. Some of them encountered challenges in adapting to life in the UK. This is a significant driver to searching for places where they may easily integrate.

7.4.3 The undecided

Those who have not been able to make up their minds, are identifiable by comments in their accounts, when I asked about their future plans. Three nurses' accounts will clarify this. First: Abdullah is reluctant to choose between study, nursing, staying in the UK or leaving:

> *I am still looking for developing my career more than that. I am going to do more courses. Also, I'm thinking of doing studies but it might be not relate to nursing. If I start doing that I might stay here for another four or five years. But, if I continue as a nurse I think will not stay here for long time. (Abdullah, 31, Male, Personal)*

Second: Yahya is keen to stay, he explained:

> *I am very, very satisfied with the situation here about the job about the life about everything. […] if I gamble [take risk] and go somewhere else maybe I'll lose. […] I'm satisfied with my job and I don't want to change." (Yahya, 35, Male, Telephone)*

However, he is concerned about the potential impact of British life on his daughters; therefore, he is willing to move to a place where cultural differences are less:

> *I don't have any serious thinking to move now. But might be within two years I will go back or go to GS, I don't know. But I just think about my children sometimes. (Yahya, 35, Male, Telephone)*

Third: Jawad is not sure because he wants to establish a business in Jordan or move to a non-clinical job and study part-time in the UK, or get a job contract in one of the GS:

> *I'm looking to do my own business back home, and not to be employee anymore. […] If I get good contract in the Gulf I'll move over there. If I didn't I'm going to do my degree part-time and I might look for another non-clinical job actually, like research or as a rehabilitation nurse. (Jawad, 29, Male, Personal)*

Essentially, all of them can fit in to any of the three other categories, including those who plan a return to Jordan.

7.4.4 Returning to Jordan

Although the fourth group was satisfied with their achievement in the UK, they have taken action to return and /or expressed a willingness to return to Jordan. This group consists of nurses, who are satisfied with what they have accomplished but they are homesick. Many nurses when they arrive in the UK, struggle with the fact that they are all alone. It is a challenge to bring dependents, particularly if there are no other sources of income or the partner is not contributing. In some cases, the challenges are not affordable and may lead to immature decisions, such as returning home without enough planning.

> *Difficult to start, it's not as easy as people might think. The biggest hurdle in this country is accommodation. It's very expensive to find accommodation. (Hassan, 36, Male, Telephone)*

A nurse may find it difficult to cope with life or work in the UK, but returning to Jordan may create more instability and challenges. Some have problems with the length of their stay in the UK, their possible sense of underachievement and the thought that they might have attained more in Jordan if they had returned earlier.

Even a year after his return to Jordan, Ziad was not sure that he had made the right decision.

> *I just think am I right? [Whether] I got the right decision by leaving UK or not? (Ziad, 36, Male, Telephone)*

Ziad moved to Jordan in 2005 for personal reasons, he said:

> *I left my family. I have a wife and four daughters, beautiful daughters here in Jordan. I left them when I was [in the UK]. Then I could not stay more than three years. Because, everything is very expensive in London. I can't bring my family there and struggle financially. I got a job now in Jordan. (Ziad, 36, Male, Telephone)*

Although he wanted to stay in the UK, the emotional pressure from his children and his wife encouraged him to return. Although, communication technology allowed Ziad easy contact with his family in Jordan, he was consumed emotionally after every call with his wife and children:

> *They always called me and wanted me to come back. My wife overwhelmed of the daughters responsibility. All of them were not happy at all. (Ziad, 36, Male, Telephone)*

Another group still in the UK, who were planning to return to Jordan. Their plans were implied on three accounts: one group of nurses rented their accommodation in the UK even though they may have been able to afford to buy a house. A second group invested their savings in real estate in Jordan. These two groups echo what Tayseer and his wife did. They rented their accommodation in the UK, having first bought a building in Jordan. They are planning not to stay in the UK because of their children, as described previously. Although Tayseer plans to stay longer than his wife and the children, they are determined that they will eventually return to Jordan:

> *I will stay in the UK for ten years. Then I will go back to Jordan and stay with my family. I have my British passport if I want to work or to travel around the world. I am paying National Pension in Jordan. So, I can earn my salary as early pension when I am 45. I think it is the time to stay with my family and also start another life in Jordan. (Tayseer, 34, Male, Personal)*

A third group is striving to gain knowledge and skills from their work and life in the UK:

> *To apply whatever I learned here through research or through the clinical setting. I'll try to apply it in Jordan and will try to make a difference there (Laila, 30, Female, Telephone)*

Ultimately, whether they intend to stay, leave or have yet to make up their minds, Jordanian nurses do not regret their experience in the UK and they urge other colleagues to go and enjoy work and life in the UK. Despite the demanding life in Britain, they mention the wide range of job opportunities available

> *[There are] lots of opportunities here. Financially, you can do much [more] than what you can do in Jordan. […] it's very easy everyone helping you to go on in your life and… they make it easy for you. […] It's five hours to Jordan, […] if you do not like it. (Muna, 35, Female, Telephone)*

Migration to the UK is part of these nurses' journey and for some absolutely not the final destination. To use railways as a metaphor, on their way to their train's destination, many will experience lots of twists and turns, and some may reach their planned destination on time. Although most of them planned their move to the UK as a railway journey, they have discovered that they are on the right track. Most nurses value the future over the present, which implies that their journey is one along which the points can be changed, so that they achieve their journey's end whether it be in the UK, GS or in Jordan.

7.5 The findings: international workforce and migration policies perspective

This study started from a point where there were limited amount of literature, which directly examined migrant nurses experiences. However, the argument in this thesis is that experiences are related to migration national and international contexts. In doing so, it may contribute to a broader understanding of international health workforce migration and has the potential to inform international policies governing migration. Migration is an act of the individual, but also it can be speculated at the national levels. This study confirms the prior evidence of economic motivation as a factor in migration experiences of nurses; however, the professional and personal motivations play a significant role in migrant nurses experiences. Nurses may confront regulations that limit their movement whether in the home country or the host country even for those countries which labelled as exporting nurses and health care professionals. From the international perspective, the findings report that motivations to migrate have two elements, one exists in the home country and the other exists in the host country. During the course of nurse's migration there are continuous transformations. Migrant nurses realise a change in motivations which may drive them to move again away from the host country. Moving again is enhanced also by the transferability of nursing skills they gained along the journey. However, national regulations play an important role in restricting or facilitating this movement. National regulations are policies formulated following situations such as workforce shortage, ethics of employment, and the need to provide high standard of health care.

Nurses migration, motives and experiences are related to the national and the international contexts. The findings show that from the Jordanian national perspective men in a masculine society were attracted to a traditional feminine profession.

The study also addressed the current gaps in understanding of migrant nurses home contexts, migration motives and experiences, based on empirical findings from an exploratory examination among Jordanian nurses working in the UK. These are used to provide four evidences: first descriptive account of nurses' socioeconomic, cultural and professional contexts and position in Jordan. Second, it provides evidence on these contexts relations with the nurse migration motives and rationales. Third, the study provides evidence for perspectives on transition from home to host country and during working in the UK system. Fourth, it contributes to bridging the gab in understanding the nurses' circumstances and perspectives as they relate to conditions of internationalisation. This is an addition to Buchans et al (2006) and Larsen et al (2005) analysis.

The findings of the lived experiences study among Jordanian migrant nurses in the UK potentially may suggest the strategic insights for the understanding of international workforce migration and the global policies for migration. Those experiences may point to refined broader understandings of Arab (or other developing world-) nurses' migration motives and experiences and how these relate to dynamics of internationalisation. As such the experiences may provide starting points or boundaries for comparison for further research. Such research and evidence is suggested: to assess and better manage developing country–UK nursing migration internationally and to approach appropriate (home-country specific) strategies to improve migrant nurses recruitment (in the host country) or return to the home country.

The experience of Jordanian migrant nurses in the UK provides evidence with respect to the impact, regulation and policy approaches to international migration of health workforce. It confirms that practical evidence is available on the theory practice-gap

in nursing, health workforce shortages, ethics of international recruitment, international standardisation of nursing practice, institutional racism and discrimination.

A number of 'motivations to migrate' such as professional development, educational and economic drives play a role in encouraging migration of nurses. Even though the nurses experience a driving force to move from the home country, their expectations of the host country increase their motivation to migrate.

These driving forces of international migration of nurses suggest that migration is likely to continue. As this is likely to be the case, there will need to be a focus on how the process of international migration of nurses can be managed and regulated in ways that confer benefits on nurses as individuals and on both home and host countries.

The evidence from this study suggests that ‘migrant nurses’ experiences need to be understood in the context of the home country and the host country. This means policies related to migration in the home country influence the nurses when they are in the host country. Moreover the policies in the host country influence the nurses even before they migrate; for example, it affects their intentions.

7.6 Conclusion

Although the nurses use their skills as a passport to move abroad (Choy, 2003; Ineson and Seeling, 2005; Kingma, 2006c), they encounter challenges in the host country and struggle to adjust after their transition. The Cumulative Causation Theory suggests that the current migration situation and patterns determine the future projections and intentions of migrants (Fussell and Massey, 2004). This chapter identified that the professional and life transformation is a major feature for migrant nurses, during the post-transition phase. Professional transformation is the outcome of integration into a new work place and is promoted by differences in policies and regulations of nursing

practice between the source and host country. This shift gives the migrants a competency and standard of work and the ability to work worldwide. These nurses will be in a better position to choose between workplaces in future. They will have the power to select where to work, instead of being recruited by, and having to conform with, international employers' conditions.

Chapter Eight

8 Nurse Migration: Personal and Professional Reinvention

8.1 Introduction

This thesis argues that incorporating personal and professional dimensions provide a viable means of examining patterns and trends of the migration of nurses. Migration theories, however, focus on economic, social and political perspectives. Labour migration theories give a general account of international workforce mobility, but do not account of skill level or qualification. Often, they also fail to address the problem that many professionals face, being treated as non skilful migrants (Massey et al., 1993; Ghatak et al., 1996; Arango, 2000; McNeil-Walsh, 2004). Although professionals' migration has commonalities with the migration of non skilled migrants (such as income imbalances and issues related to the workforce requirements of host countries) there are differences even among professionals in terms of the specifics of the experience. Nurses and physicians, for example, many have entirely different experiences as migrant workers. The differences are related to characteristics of each profession, which imply different experiences (Brettell and Hollifield, 2000; Iredale, 2001; Awases et al., 2004; Alkire and Chen, 2006).

Buchan and his colleagues (2005c) argued that little is known about the experiences of migrant nurses in the host countries, in terms of their profile and career plans. Another issue is the lack of focus in the current body of literature regarding the situation of migrant nurses from the countries that have an established practice of nurses to other countries. Such countries include the Philippines, India, Southern African countries, and the Caribbean (Daniel et al., 2001; Collins, 2004; Thomas, 2006; Brush and Sochalski, 2007; Dovolo, 2007), emergent countries such as Jordan.

None of these countries are regularly mentioned in research nor are their particular situations considered in any great depth.

This study has been an examination of professional and personal experiences of migrant nurses from Jordan in the UK. The overall impression of a nurse's experience during migration is dynamic and demonstrates changing professional and personal attributes, along the different phases of migration. Three themes have emerged from an analysis of the participants' accounts. These are presented in the data chapters: 'Challenging the status quo', 'Source to host country: disconnecting and connecting', and 'Away from home: professional transformation and routes diversion'. The three chapters show the nurses' experiences of the migration process and its social and economic complexities.

As a conclusion, running through the three chapters are two significant strands of focus, not otherwise apparent either within the literature on migration or the three data themes reviewed. In addition, to the push and pull factors, the two strands are the personal reinvention and professional reinvention of Jordanian nurses. Reinvention is defined as the creation of a new identity for Jordanian nurses as a result of their migration experience in the UK. The reinvention is seen to occur on both a personal and a professional level.

This chapter aims to present these strands through the following four sections. First, discussion and conclusion of findings related to push and pull factors; second, discussion and conclusion of findings related to professional reinvention during migration; third, discussion and conclusion of findings related to personal reinvention; and fourth, presentation of the study implications and limitations.

8.2 Push and pull factors

One common factor for migration that runs along all the labour migration theories is economic driver (Massey et al., 1993). Examination of each theory, however, has shown other factors to be key in motivating professionals to migrate (Iredale, 2001). Economic improvement is significant in the migration of professionals from developing countries to the UK (Martineau et al., 2002; Dovlo and Martineau, 2004; Khadria, 2004; Stilwell et al., 2004; Võrk et al., 2004; Ogilvie et al., 2007). The findings of this study are in contrast to this, however, with financial gain less frequently referred to as a key factor in migration to the UK. Indeed, the other factors are significant and outweigh the higher income in the host country. For the most part, the cost of living in the host country negates the higher income status.

Jordanian nurses have reported other reasons for leaving, among them working conditions, lack of educational opportunities, lack of career opportunities, failure to appreciate their recreational and travel needs in addition to the fact that their income is insufficient to meet their needs. These are similar to the 'push factors' reported by previous researcher studying migration trends in other countries and regions (Kline, 2003; Padarath et al., 2003; Buchan et al., 2004; Dovlo and Martineau, 2004; Rassool, 2004; Buchan et al., 2005a; Buchan et al., 2005b; Thomas, 2006). However, Jordanian nurses consider their educational and career development to be the primary motive, while travel and economic reasons for their move abroad are secondary.

The nurses in Jordan feel that a status quo mentality exists and the authorities have failed to give them what they need. Indeed nursing is a profession without a publicly approved identity; nurses often conceal their profession to avoid disrespect. Nurses say their profession is afforded little respect because of work overload, low pay, and

bleak career prospects. These also are the underlying factors, which motivate them to leave the country.

The previous literature reported push and pull factors that motivate nurse to move and then remain in their host country after the actual migration (Kline, 2003; Dovlo and Martineau, 2004; Buchan et al., 2005b; Buchan et al., 2006; Huston, 2006; Thomas, 2006). This study adds that the push and pull factors are carried with the nurses to the host country, then modified according to what each of the individual nurses achieves and the situation in the new country. For example, some migrant nurses aim primarily to improve their financial status, which may become secondary after arrival in the host country. Indeed, the aim may have to be adjusted several times. Some migrants moved to the UK to enhance their professional qualifications or career development but then struggled with the language and the living expenses. They adjust their immediate goals to focus on surviving and integrating into the new work place and community.

8.3 Professional Reinvention

While national identity (passport) does not entitle some people to enter other countries, the nurse's professional identity opens many doors (Kingma, 2005). Migrants use their professional identity, rather than their home country passport to gain access to the host country in pursuit of employment. This study corroborates Hardill's (2002) argument that work gives identity to a person; nurses can acquire an identity through their profession. The status quo, maintained by the authorities and some stakeholders, takes away from the nurses' professional identity in the home country. Some nurses leave their home country to challenge this, and discover that while nursing is a reason for leaving the home country, it emerges as an identity in the

destination country. The nurse's identity evolves from hidden to overt through migration.

This study also supports the arguments of Choy (2003) and Kingma (2006c) that nursing is a passport for travel. Findings expand this notion to apply nursing as a means of broadening one's identity since many migrants identify themselves as nurses, and learn about self-worth because of the importance of their profession. This identity is enhanced once the migrants recognise that nursing skills in the home country are not different from those in the host country. Professional identity for the migrants transcends their country-of-origin and country-of-residency identity. Recognition of the nursing profession internationally and the emergence of a nursing identity encourages the nurses to be more mobile in future. Nurses can chose to go anywhere and have an immediate escape if their circumstances change for the worse.

When nurses migrate and live in a country different from their former place of employment and residency, disruption in professional status and identity inevitably follows. In most cases however, it is a passing phase. According to the human capital theory, when arriving at a destination, there is a need to adapt to the language, culture, and economic system (Chiswick 2000b). This study conforms and adds that migrant nurse encounters roles and regulations in the host country, different from those in the source country. Migrant nurses establish a bond with their new employer after moving to the new work place. For the newly arrived nurses, induction programs play a significant role in establishing a good connection. Moreover, adaptation training, as required by the Nursing and Midwifery Council (NMC) is important for a nurse's settlement and adjustment to the work place and life in the UK.

Often the nurses are programmed on a routine in the home country, to carry out their duties (Hofstede and Hofstede, 2005). When they move to a new workplace, the routine is different, therefore their programme goes through a process of adaptation to the roles and regulations post-transition; this what I called the professional transformation

Migrant nurses develop a sense of pride and identity as it helps them enhance their status and they feel that they have better life experiences than nurses who have never migrated. In the UK workenvironment, Jordanian nurses are more confident of disclosing their professional identity. Travel broadens the individual's mind and helps build multiple identities, one of which is based on profession (Caldas-Coulthard and Iedema., 2008; Lawler, 2008). Migration also helps nurses to develop the ability to practise nursing under different regulations and policies and within other cultures. Migrants tend to use their nursing identity more than their national identity while working in their host country.

According to the Social Network Theory, recruitment agents are part of the networks, which usually assist migrants to overcome entry barriers to host countries (Arango, 2000). A migrant nurse is a potential customer for international recruitment agencies. Buchan et al. (2006) reported that two-thirds of international nurses have moved to London with the help of recruitment agencies. The evidence in this study confirms the involvement of recruitment agents in their migration to the UK. Moreover, Buchan et al. (2006) indicated that a third of the overseas nurses, contacted by recruitment agents were offered work outside the UK. The group of Jordanian nurses who have intentions to move to a third country assure this, in particular, when the adverts for vacancies in other countries, placed by the same agencies capture the same nurses' attention.

Once international nurses gain British nationality, they chase these agents when they advertise vacancies in a third country. That is evidenced in the example of Jordanian nurses when they chased the recruitment agents to find job in one of the Gulf States. This conforms to Kingma's (2006b) theory about migration as a business and adds that agencies use the nurses they have recruited previously as a pool to fill job vacancies abroad. Recruiting the same nurses when they have finished their job contract is one a strategy for openning two vacancies, instead of one and thereby maintaining a demand for recruiter services in the healthcare organisations.

On the other hand, nurses, once the time comes for them to leave their home country, are prone to experience a number of concerns. Some are related to professional competency. First, whether they be able to compete with their host country's nurses in terms of skills and knowledge. Second, whether their command over English good enough to communicate with the staff and patients. Third, whether they may have to return home due to 'failure' to settle or inability to cope with the job. These worries can often be exacerbated by rumours, which can arise during the recruitment campaign. Fortunately, most of these worries are eradicated once the nurses get away from their employer and leave their colleagues in the home country.

Nurses in Jordan normally leave their employers and go abroad by applying for unpaid leave for one year, and occasionally by resignation. This is a strategy to minimise risk of unsuccessful migration. Mensah et al. (2005), argued the employers force the applicants to break their job contracts in case they decided to leave, as a retention strategy, which was confirmed in this study. Some employers refused to accept a nurse's application for leave.

Professional issues clearly do not stand in isolation, but are interrelate or run parallel with other issues.

8.4 Personal Reinvention

According to the human capital theory, what is acquired in terms of education, skills, and abilities in a home country transfers with difficulty abroad (Chiswick 2000b). This study adds that transition between two countries that belong to different categories (developed and developing, for example) leads to personal transformation. This transformation happens due to the adjustment process in response to differences in climate, food, finance, accommodation, language, and social systems. Differences in the level of development between two countries also allow nurses to gain more in terms of international perspective and personal expansion. The more divergent the host country from the home country, the greater is the requirement in terms of personal transformation on the part of the migrant (Hofstede and Hofstede, 2005).

Another point of personal transformation is related to self-reliance or independence (Antoun, 2005; Hofstede and Hofstede, 2005; Dwairy et al., 2006). Persons who have never travelled are usually more dependent on personal and social relationships back home and many of their tasks can only be achieved by collaboration with others. This is not the case when they move to a different area, particularly abroad, because they need time to build relations in the new place. Migrant nurses adapt to this by adopting independent roles and setting goals and tasks that are more realistic and achievable without relying on others.

Migration challenges the nurse's established beliefs and perspectives, and thereby, stimulates the personal cognitive development. It increases self-confidence, self-awareness and self-reliance. This happens as a consequence of the enormous shifts in

terms of relationships, goals, quality of life and gender related issues. It is likely that many Jordanian nurses realise this when they re-visit Jordan after a long stay in the UK. When migrants return to their home country, they can feel estranged because many of their previous connections have been broken during the years of residence abroad. They might find huge changes as compared to the period, prior to migration. Also, those who knew them previously, might find changes in the nurses as well. This indicates the nurses adjusted their mind programme to the culture and the routine of the host country, and in the process forget the routine of their home country.

Despite this, many Jordanian nurses are still motivated to live and work in the UK in their quest for a better quality of life. Although quality of life is relative from one individual to another, some are happy with the life quality in the UK and others are not. Those who are happy typically find that their aspirations for an improved quality of life are met by the standard of life that they encounter in the UK. They supplement former Jordanian personage in favour of one available to them in the host country. They choose this standard not only for themselves but also, if married, for their partner and children.

According to the Dual Labour Theory (DLT) those who are not happy about life in the host country accept the situation because it is temporary, want to return home some day, and otherwise want to maintain the status and prestige. What counts for them is how their migration experience is perceived at home, and not how their background is perceived in the host country (Massey et al., 1998). This study adds to the DLT that migrants who feel awkward and unhappy with life in the host country feel this way for one of two reasons; either they live in the host country in the context of their home country or they consider that their present life is no different from what it was back home. Those who live in the context of their home like life in the host

country and want it, but they feel no joy because they miss things they were used to in home country. Those who consider that their life is the same as the one in home country save every pound and make all efforts to collect enough as they plan to return home which conforms with DLT (Fields, 2004). In their opinion, life in the host country is not enjoyable enough with respect to their goals and aspirations with the result that they consider it a temporary station. This group usually ignores what goes on around them and focuses on the goals they had before their shift to the host country. it is more likely that most nurses of this group return to their home country and never go to a third country or stay in the host country even if they have failed to achieve their goal. Both groups forget the significance of the years that they have spent in the host country, which formed a considerable portion of their life.

The Social Netork Theory (SNT) put forward migration as likely to happen when there are friends or relatives living in the host country (Krissman, 2005). This study conforms this and expand that migrant nurses go through a transformation in their social relationships. Both temporary and permanent relationships change because of migration. Examples of permanent change are manifest in the relationships and frequency with which they contact their family in the home country.

Kingma (2006b) argues that to sustain relationships with parents and relatives in the home country, migrant nurses usually use phone calls. This study adds that they use new means of communication such as the mobile phone, the internet and frequently visit home. Many migrant nurses consider this very important because it provides them with emotional and psychological support. For some, it is a question of maintaining a commitment to their parents, before and after they moved to the host country. Relationships with distant relatives and friends in the home country mostly lapse, however, and are replaced by new relationships in the host country. They lose

contact with their friends at home and continue with their parents' families because maintenance of any more relations will negatively influence their happiness and quality of life as well as distract their efforts to settle in the host country.

The other type is the intermittent relationships that involve a new array of relationships formed in the process of settling down in the new country. Migrant nurses may end relations that prejudice their ability to settlement in the host country and establish new relations that accommodate the new situation. It is more likely that the relationships with colleagues and friends in the source country lapse while new relations emerge in the host country; this helps the nurse to become involved with the society in which he or she lives. These new relationships are definitely different from those formerly established in the source country; they exist in a different environment and with new people. On the other hand, nurses who are planning to return home or move to a third country will follow the steps leading them there. These are further educational qualifications, remitting to their home country and maintenance of relationships outside the country where they are working.

Previous friendships are suspended and may be disconnected because of the distance and the cost of maintaining them. As an adjustment, the nurse in the host country builds relationships with three kinds of people, mostly from the same field of work: locals of the host country, other international migrants in the same field, and acquaintances of the home country. A significant relationship for the migrant is that with people from same cultural milieu. Such a relationship usually plays a significant role in helping the migrant to understand life around them and provides a reliable support system (Massey and Zenteno 1999). Careful utilisation of this relationship can be a source of support particularly for fresh migrants and failure to utilise it may lead to unanticipated consequences. Utilisation of this relationship is important because of

the array of new links and enormous disconnections of previous bonds in the home country. Any alteration in relationships is emotionally and economically exhausting.

In relation to nurses migrating from Jordan, it is important to consider gender when discussing personal issues. Jordanian men are more likely to move abroad than women for cultural reasons (Antoun, 2005; Jordanian Nursing Council, 2005; Abu AlRub, 2007; El-Jardali et al., 2007). This study found the majority of the migrant nurses from Jordan in the UK are men. Although some of their wives are qualified nurses and registered in Jordan, most are not working in the UK. According to the husbands, their wives had declined job contracts in the UK because of worries related to dress preferences. Those people's religious and cultural beliefs require a nurse's uniform that covers most of the body except the face and hands. Many female nurses who apply for jobs in the UK ask their employers to let them modify their uniform so that it accommodates their religious and cultural beliefs. Some female nurses working in the UK said that many employers accommodate this desire, so long as it does not affect the standard of care.

8.5 Implications and limitations

The flow of migrants did not continue, as stated by the Social Network Theory (SNT) (Krissman, 2005) and the presence of Jordanian nurses in the UK has partially encouraged others to follow them. The NMC figures indicate a decline in Jordanian nurses recruitment in the UK (Nursing and Midwifery Council, 2002; Nursing and Midwifery Council, 2003; Nursing and Midwifery Council, 2007). A suggestion for future research is the exploration of whether the carrying capacity (or the lack thereof) of the UK labour market for international nurses is the reason for this decline or whether it is in fact the shallow pool of Jordanian nurses currently available. It was

deemed beyond the scope of this study to examine whether or not the Jordanian nurses' experiences in the UK are associated with the patterns of flow.

If the male ratio in the Jordanian nurses workforce is similar to their ratio in this study, then Jordan needs to recruit female nurses from other countries or enforce policies that encourage females enrolment into the profession. Anecdotal sources indicate that male students' enrolment in the nursing programs exceeds all estimations (Ahmad and Alasad 2007). Gender imbalances in Jordan's nursing profession is alarming; migration can be a temporary policy measure to tackle it. There is anecdotal evidence on policies adopted by the authorities regarding this matter in Jordan. An adoption of nurse-exporting policy to overcome the surplus of males and a campaign under the patronage of HRH Princess Muna of Jordan to increase enrolment of female students into nursing. Such a policy would give a boost to the development of the nursing profession. For example, imbalances in the numbers of male versus female enrolment in nursing programs may increase competition for males to get a place of study. This would give these institutions the chance to choose students with higher academic abilities in order to produce nurses that are more competent for the future. At the same time, when nurses migrate, they can remit and return with a better financial status because of the differences in the currency exchange rates. This will also enhance the image of the nursing profession in the eyes of the Jordanian society.

The authorities in Jordan may be encouraged by this study to follow a policy of sending nurses abroad. However, it is important to encourage nurses to leave without threatening the national health care system. The current situation is such that the nurses want to leave because the conditions in Jordan were not giving them the positive professional experience they want or expect.

On the other hand, the study has implications for retention policies whether at the national or local health organisation level. To retain nurses, policy makers and employers may find implications in understanding why nurses want to migrate. Some positive suggestions for policy makers and employers in Jordan: adopt part time work policy, develop better career prospects for nurses, improve working conditions, offer better educational opportunities, and pay salaries that will cover their financial needs.

Drawing on the experiences of Jordanian nurses in the UK, there are implications for the migrant nurses. Nurses with intentions to migrate are suggested to consider making direct contact with the employer or seeking assistance of a recruitment agency. Nurses who have independently moved abroad have generally found it hard while the others have generally made much progress and effectively utilised the assistance offered by the employer and the recruitment agency.

Prospective migrant nurses are advised to take more time over preparation for the migration. Time is required to learn about the post-transition phase. There is also a need to learn about the host country, particularly the culture and values, the work environment, and the daily routines of life. More time is required when the nurse is not competent in the language of the people in the host country. It is important to learn the language as early as possible before leaving the home country and also learn how the layperson uses it in daily life. On the other hand, the nurse needs to allocate time for learning the language after arrival and before starting the work life.

Before moving, nurses need to consider how they will handle relations in the home country: managing the connections before leaving requires consideration of all possible problems. This is important because nurses who come from a society that is

rich in social relationships suffer in an environment that is lacking in this regard. This in turn will influence the decision about settling in a foreign country.

8.5.1 Study limitations

During this study, I was able to contact a sample of Jordanian nurses in the UK. That said, it is possible that I missed important data about their migration experiences by not interviewing family members of these nurses. Partners and children of migrant nurses may have an entirely different but no less valid perception of the transition and transformation of their nurse-relative during and after migration. It is also possible that I missed data from previous employers and current employers as well as from the recruitment agents who facilitated their migration to the UK. This study relies on recall of migration experiences, and cross sectional interviews were relatively short; too short to bring up many details of a rich experience.

During the different stages of this study, I noticed other aspects, which may be of interest to researchers because it requires further examination. Some of them are not part of my specific area of research but they may contribute to other areas and therefore I mention them here. My commitment toward the study aim and management of the research project take precedence.

What this study did not examine are the experiences of nurses who have returned to Jordan and those who moved to the Gulf States from the UK. There is little in the literature about return migration and studying the experiences of nurses who move out of the UK can contribute to the general body of knowledge (Potter et al., 2005). Some nurses have clearly ‘failed’ in their migration experience and their experiences and coping strategies will be worth an in-depth study. What factors contribute to ‘failure’ in the migration experiences of nurses? What challenges do households encounter

when the migration attempts of a member of the household 'fails'? What forms of remedy do failed migrant nurses need?

Turnover among international nurses is not yet fully evidenced because it is difficult to measure. Data about migrant nurses are inconsistent and inaccurate because each holder collects data required for its own use only and so the general picture is hazy. This subject is important at least in deciding whether recruiting international nurses is the right choice or not for health organisations. Organisations in many cases need to use the services of a recruitment agency to develop a retention strategy, which mainly targets this group of nurses.

While most of the study participants are males, the gender not given enough focus. The number of males in the nursing workforce in Jordan and among the migrant group is growing beyond anyone's expectations and needs further investigation to be able to understand the underlying reasons and the consequences. The tendency for male nurses to migrate decreases their numbers in the source country and increases their percentage in the host. However, the number of male nurses is increasing in Jordan to a percentage exceeding its counterparts in any part of the world. This is more likely to happen when other factors are neutral. In the absence of scientific evidence about this increase, we still depend on anecdotal sources.

Another limitation for this study, however it is interesting point related to gender imbalances is the dual nurse household among Jordanian nurses in the UK. While writing the conclusion for this study, the stories of a couple of dual nurse household in the data motivated me to investigate all the participants' data, to discover another seven dual nurse households. This came to me as a revelation because the study was designed for nurses registered and working in the UK and therefore, these seven

partners were not within the study population. While the husband is working as a nurse in the UK, his wife is qualified as a nurse in Jordan and does not work while in the UK. It may be worthwhile to understand why these female nurses are not active members of the workforce in the UK when they had worked before their arrival to the UK. The study of dual career households carried out by Irene Hardill (2002) would represent a good start for any further research. Furthermore, Sheba George's study (2005) of gender and class in international migration may inspire further investigation.

Finally, all the study participants were from Jordan and it is therefore not known if the same experiences apply to nurses from other countries. More research is needed regarding this; however, I anticipate that, although individual experiences may differ, the process of migration that I have reported will be useful in analyses of other groups.

8.6 Conclusion

This study addressed current gaps in understanding migrant nurses home contexts, migration motives and experiences, based on empirical findings from an exploratory examination among Jordanian nurses working in the UK. Four general key points emerged from the study, all of which relate to the experiences of migrant nurses. they are: Account of nurses' socioeconomic, cultural and professional contexts and position in Jordan. Multiple contexts shape migration motives and rationales. Experiences of and perspectives on transition from home to host country and during working in the UK system. In addition to understanding the nurses' circumstances and perspectives as they reflect conditions of internationalisation.

The findings of the lived experiences of Jordanian migrant nurses in the UK potentially offer strategic insights into world wide workforce migration and

international migration policies. They may point to refined broader understanding of Arab (or other developing world) nurses' migration motives and experiences and how these relate to dynamics of internationalisation. As such they may provide starting points or boundaries for comparison for further research. Such research and consequent evidence is needed in order to assess and better manage developing country–UK nursing migration internationally and to approach appropriate strategies to improve migrant nurses employment and retention in the host country or return to home country.

The experience of Jordanian migrant nurses in the UK provides evidence with respect to the impact, regulation and policy approaches to international migration of health workforce. It confirms that practical evidence is available on theory practice gap in nursing, health workforce shortages, ethics of international recruitment, international standardisation of nursing practice and institutional racism and discrimination.

The experiences of Jordanian nurses reveal to us that migration is professionally produced, personally expressed and professional and personal in effect. The employment journeys of international nurses varied and involve complicated movement stories of qualified people leaving their home country on an employment journey. On the way they may stop at different countries, adding to their qualifications. It is a journey of men and women who re-package themselves, using their qualifications and skills. As such they are highly valued by their employers in their targeted markets. In contrast, on crossing the border they have to undergo radical personal and professional transformations to adjust to their new life and cope with the new work environment.

Jordanian nurses enriched their professional and personal life by the experience of living and working in the UK. They invented and reinvented their personal and

professional pathway, starting by a decision to move abroad and not ending by commencing the job and adapting to life and work. This study showed how economic and social patterns in migration are interwoven with the professional and personal elements. The professional and personal patterns of the migrant nurse interlink with the social and cultural milieu, as they are in the British health care system. When nurses migrate, they encounter enormous economic and social transformation.

Finally, this thesis adds to the knowledge about under researched subject, that is the emerging personal and professional paradigms in nursing migration. However, attributes and responses to the professional and personal patterns in nurse migration are constantly transforming, even since I commenced this research. The personal and professional experiences could be compared in the future with other patterns, particularly the economic and the social not only at the macro level but also at the organisational and individual level.

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Appendices