

WORK → INT



Assessing and enhancing integration in workplaces

RESEARCH REPORT

WORKPLACE INTEGRATION OF MIGRANT HEALTH WORKERS IN IRELAND

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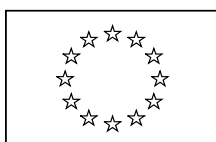
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1. Introduction

1.1 General design and research objectives

In the last decade, the healthcare sector in Europe has undergone growing labour shortages, which have been increasingly filled by international migrants, although with significant differences according to the various national contexts. Institutional and regulatory framework of the national health systems, highlighted shortages of national staff in the health sector, national policies aimed at filling them and at regulating the recognition of educational and professional titles of EU and non-EU migrant health workers (MHWs) and their access to the health labour market vary sensibly according to the different European countries (see Background national reports). As a result, non-EU and EU MHWs contribute to different segments of the health industry, with highly varying degrees of integration into this sector¹, according to the different European contexts.

While most of the studies on the economic integration of migrants into the European labour market and its impact on the broader society has been mostly concentrated on the macro level, mainly using quantitative approaches, little empirical evidence is available on the micro-level, namely in workplaces. However, the contexts where the integration into the receiving economies and the interaction between immigrant minorities and native majorities take place and can be primarily tackled is within firms and specific workplaces.

Furthermore, the research available on the foreign labour force in European countries has been mainly focused on the supply side, i.e. on the analysis of the processes and outcomes of insertion of immigrant workers in European labour markets, while the perspective of the demand, i.e. of employers, but also the concurrent role of other relevant actors, such as trade unions, professional associations and other civil society organisations has been generally downplayed. The latter are key actors in the dynamics of labour market integration of migrant workers at different levels and their perspective and role need to be integrated more systematically in the study of migrants' integration in workplaces.

The WORK-INT project aims at contributing to the broader scientific debate on the labour market integration of migrants in the health sector in Europe, by adopting a research approach, which is *qualitative*, i.e. allowing in-depth insights on the phenomenon; *micro-level*, i.e. taking workplaces (hospitals) as a main context of analysis; *multi-stakeholder*, where the role, the perspective and the professional and inter-personal relations are taken in consideration according to the different involved actors (employers, national, EU and non-EU employees, trade unions, professional associations, etc.).

The MHWs' integration at a workplace level was studied, in particular, as based on four main dimensions

¹ See Villosio, 2015 for a comparative statistical analysis on Migrant Health Workers in the health sector in the 5 target European countries, based on Eurostat Labour Force Survey (EU-LFS) data.

(Zincone, 2009): the *systemic dimension* (health care firms' policies or specific measures concerning the recruitment and integration of MHWs and impact of MHWs on the competitiveness and efficiency of health care services); the *individual dimension* (subjective wellbeing, perception and degree of satisfaction of own integration within the workplace, etc.); the *relational dimension* (considering horizontal and vertical relations, i.e. with colleagues in equal and higher/lower positions); the *transnational dimension* (declined as the ties with the health workers' community in the country of origin and/or in other countries, the contribution to the origin country as a professional while abroad and the intentions to return as a health worker in the country of origin or to re-migrate elsewhere)².

The WORK-INT research is an EIF-EU Commission funded project aimed at assessing and analysing the integration of immigrant workers in private and public health structures (hospitals) in five European countries: Ireland, Germany, UK, Spain and Italy³.

As a first step, background reports were prepared in each target country, with the objective of providing an overview of: the institutional and regulatory framework of the health system in each target country; the shortages of national staff in the health sector and the national policies aimed at filling this gap; the active admission policies of non-EU MHWs; the policies regulating the recognition of educational and professional titles of EU and non-EU MHWs; the regulations concerning the access of MHWs to the health labour market in each country.⁴

As a second phase, a fieldwork research was undertaken in 5 medium-large European cities hosting large numbers of migrant workers: Dublin, Hamburg, Oxford, Madrid and Turin⁵. In each city two health structures (hospitals) were selected as case studies. Managers, human resource officers, non-EU/EU/national workers were interviewed using a common protocol of research, including common qualitative guides for interviews for national/foreign workers, managers and other stakeholders.

1.1 The Irish context

Like other European economies, Ireland has been experiencing staff shortages in the healthcare sector for a number of years. Indeed, despite efforts to increase the number of graduates in medical and nursing

² For further details, please see the Castagnone and Salis, 2015.

³ For further information, see: www.workint.eu

⁴ All reports from the WORK → INT project can be downloaded here: <http://www.work-int.eu/research-materials/>

⁵ In each city, the study was undertaken by a local research institution, which is partner of the WORK-INT project: FIERI in Turin, COMPAS in London, Universidad Complutense de Madrid in Madrid, Hamburgisches WeltWirtschafts Institut in Hamburg, Trinity College of Dublin in Dublin. The project includes also a policy dialogue component, coordinated by the IOM Regional Office in Bruxelles.

programmes,⁶ there are still vacancies that can be described as 'difficult to fill', as they cannot be covered by Irish professionals. This is partially a result of the continuing emigration of doctors and nurses, who move to other countries such as the UK and Australia for financial reasons, career opportunities or better working conditions. While nurses can find better earnings abroad, doctors usually leave the country due to obstacles to career progression in Ireland and an insufficient number of consultancy posts available to them at the end of their specialist training.

In order to address these shortages, the Irish state, as well as particular public and private hospitals, has adopted different recruitment strategies. These can be categorised as either passive or active. The former refers to a situation where the immigration of people in certain occupational categories is facilitated. The movement is then initiated by individuals themselves. In the latter case, the employers actively run recruitment campaigns overseas in order to fill the gaps. As opposed to passive recruitment, active recruitment also often attracts individuals who did not previously consider re-locating to a specific country (Humphries et al. 2012).

In relation to passive recruitment, certain immigration regulations were introduced to facilitate the immigration of non-EEA⁷ medical workers willing to come to Ireland. For example, the current Critical Skills Employment Permit,⁸ which is designed to attract highly skilled people to enter the Irish labour market, can be issued for jobs with an annual remuneration of €60,000 and over. Medical practitioners or specialised nurses, can be issued with a Critical Skills Employment Permit below the usual earning threshold (Department of Jobs, Enterprise and Innovation, 2014).

Active recruitment to Ireland focused mainly on nurses. This began in the early 2000s and continued until the recruitment freeze which followed the 2008 economic downturn⁹. Between the years 2000 and 2006, almost 10,000 visas were issued to nurses and the majority of them came from India and Philippines (Humphries et al., 2008). There were a number of recruitment agencies involved in this process, with representatives travelling to these two countries (Quinn, 2006). In addition, the Health Services Executive¹⁰ (HSE) built a relationship with the Philippines in order to attract skilled nurses from this region (Barret and Rust, 2009). In 2011, due to the critical shortage of non-consultant hospital doctors (NCHDs),¹¹ Ireland ran an active

⁶ The number of Irish graduates registering with the Irish Nursing Board has been rising since the early 2000s. The only exception was the year 2005, when the nursing diploma was raised to a tertiary qualification. The government also increased the number of places for Irish and EU citizens on medical programmes in 2007.

⁷ The EEA stands for the European Economic Area, which provides for free movement of goods, persons, services and capital among 27 of 28 members of the European Union and three out of four member states of the European Free Trade Association.

⁸ The Critical Skills Employment Permit is one of nine different types of employment permit in Ireland. It was introduced in October 2014 and replaced the Green Card Permit.

⁹ As it will be further discussed in this report, this moratorium will cease in 2015

¹⁰ The HSE is a government body responsible for the provision of healthcare and personal social services for all Irish residents. It is funded and governed by the State.

¹¹ Non-Consultant Hospital Doctors is a term used to describe all doctors working below consultancy level.

recruitment drive from countries such as India and Pakistan (Talbot, 2013). A second recruitment campaign was launched in 2013 and focused on Pakistan and South Africa (Humphries et al., 2013).

As a result of both the active and passive recruitment of foreign-born health professionals in Ireland, most of the hospitals in this country became multicultural within less than a decade. While the multicultural workplace in the health sector is not unique to Ireland, it is important to emphasise that the change happened here in a relatively short period of time. It was also accompanied by the changing profile of the Irish population, as a result of large inflows of migrants since the mid-1990s.

To date, there have been a number of studies addressing the issue of the international mobility of health professionals in Ireland (e.g. Bidwell and Norman, 2012; Bidwell et al., 2012; Bobek et al., 2011; Humphries et al., 2008; Humphries et al., 2014; Walsh and O'Shea, 2009; Yeats, 2008). These mainly examined the perspective of foreign-born doctors and nurses, their social and structural integration, job satisfaction, and other factors influencing their wellbeing. This report distinguishes itself by focusing on particular workplaces and by bringing together the perspectives of those who have a migration background, as well as Irish-born employees and hospital managers. Such an approach allows for the examination of different points of view on a multicultural environment in Irish hospitals. As will be further discussed, managers and workers often have different expectations and thus may develop different attitudes towards diversity in their hospitals. Furthermore, multiculturalism affects not only the foreign-born workers but also those who have an Irish background. Finally, these three groups all aim to provide the best service for their patients, who may also be of different ethnic origins. Hospital settings thus provide an excellent opportunity to observe interactions in the context of diversity in the Irish workplace.

The report will be structured as follows: after a brief discussion of methodology, this report will explore the structure, recruitment processes and diversity policies of two selected hospitals; one public and one private, both based in the Greater Dublin Area. This section will be based on qualitative interviews conducted with managers working in these hospitals as well as an analysis of some internal hospital policy documents. The second part of the report will discuss different perspectives on diversity in the workplace. This part will focus on employees, both foreign and Irish-born, as well as their managers and the relevant stakeholders. In this section, the analysis will include interviews with those working in a broader selection of hospitals around Dublin. First, we will explore the migration motivations and initial work experience of foreign health professionals, as well as examining their career opportunities in Ireland. This will be followed by a discussion of multicultural workplaces and relations between professionals of Irish and of foreign background. This section highlights the challenge of language and communication in a multicultural environment. Finally, we will discuss the transnational dimension of the contemporary health sector in Ireland. This section will focus on the connections that health professionals of non-Irish origin have with their countries of origin. It will also briefly explore their future plans, including possibilities to move either back home, or to another country.

2. Methodology

2.1. Research design

This report is based on a qualitative study, which examined the integration of non-Irish born professionals employed in Dublin hospitals. It consisted of semi-structured interviews with employees and their managers. The main focus of the research was the workplace in selected health organisations, therefore some of the participants were of Irish origin. Furthermore, we conducted several interviews with key stakeholders related to the health sector.

The original design of the project envisaged only two organisations being involved in this research: one public and one private hospital. However, during fieldwork it became apparent that this strategy would not be feasible in the Irish case. Therefore we adopted a broader strategy, which involved interviewing professionals working in a larger number of health organisations around Dublin. There were several rationales behind this change in strategy, including:

- (a) Sampling considerations: It was originally planned that the participants for this study would be recruited through the management. However, in the case of both hospitals participating in the project, the managers could not assist us with accessing a sample of interviewees. In addition, workplace integration analysis in just two selected hospitals was not applicable to doctors below consultant level, as most of the junior doctors in Ireland need to change employer every six to twelve months as part of their training programme. Spending such a short time in each hospital does not allow for full integration in a particular workplace and career progression is also not dependant on one employer. Nurses, on the other hand, while being more settled in one hospital, often changed units and wards, especially when working evenings and weekends. They were thus frequently exposed to different settings and worked with different colleagues. Finally, a large proportion of consultant doctors had more than one practice, and their working time was divided between different private and public hospitals.
- (b) Ethical considerations: Furthermore, there were strong ethical considerations in relation to only recruiting participants in the two hospitals. Firstly, the managers expressed concern that their assistance with sampling might be perceived by employees as employer coercion. Secondly, given the relatively small size of most of the private hospitals in Dublin, there was a danger that the anonymity of the participants would be jeopardised.

However, in order to gain a detailed overview of institutional settings, we did conduct interviews with managers in one public and one independent hospital. Through these interviews we were able to analyse the structure of these two institutions, their workforce as well as the diversity management adopted by the employers. The interviews with the employees, on the other hand, provided us with details about migration motivations, career paths, and the overall experience of working in a multicultural environment. All of the interviews were fully transcribed and analysed with the NVivo Qualitative Data Analysis Software.

2.2. Sampling and recruitment

In selecting the two main organisations as case studies for this project, we contacted a number of public and private hospitals around Dublin. Eventually, two hospitals agreed to participate: one public (HSE funded) and one independent (privately funded). The Human Resource (HR) managers were approached directly. They provided us with interviews explaining the hospital structure and issues related to managing a culturally diverse workforce. We were also able to gain access to some official documents from the public hospital, including the recruitment and dignity at work policies.

For the purpose of the second part of the report, which focuses on the individual experience of those employed in Irish hospitals, we used elements of purposive sampling and snowball sampling. As most of those of non-Irish origin working in Dublin hospitals are employed either as doctors or nurses, the sample consisted of a mixture of professionals from these two groups. In addition, we categorised health professionals according to their origins and the origin of their qualifications, as follows:

- (a) Irish origin trained in Ireland;
- (b) Irish origin trained abroad;
- (c) EU origin trained in Ireland;
- (d) EU origin trained abroad;
- (e) Non-EU origin trained in Ireland;
- (f) Non-EU origin trained in another EU country;
- (g) Non-EU origin trained outside of Europe.

In order to cover a broad range of experience and opinions, the sampling procedures aimed to recruit individuals representing all of the above categories. In order to ensure congruency with statistical data on the national origin and origin of qualifications of non-Irish born health professionals in Ireland,¹² most of the non-Irish born participants selected were originally from non-EU countries and were trained outside of Ireland. While the nationality of non-EAA doctors varied, most of the non-Irish born nurses in our sample came originally from the Philippines. It needs to be emphasised that as the foreign recruitment of health professionals to Ireland became significant in the early 2000s, most of our interviewees had lived in Ireland for about ten years and had obtained Irish citizenship at the time we interviewed them. Yet, as will be further discussed in this report, their foreign background had a strong influence on their professional and personal experience of working in the Irish health sector. In addition, some of the Irish-born professionals had a significant history of working outside of the country, which also had an impact on their personal opinions about cultural diversity and equality in their hospitals.

¹² For details see Census 2011 Microdata, available at www.cso.ie

Potential participants were contacted either directly or through their professional or personal networks. There were several challenges associated with the recruitment of interviewees, especially those with a non-EU background. Some were concerned about the anonymity of the interviews, despite re-assurances that no details related to their identities would ever be disclosed. This was particularly the case of foreign-born nurses. Doctors, on the other hand, worked extremely long hours and often did not have sufficient time to meet for an interview. In general, those health professionals who were personally involved in research projects in their own field were more willing to participate.

Nevertheless, the qualitative interviews conducted with health professionals provided us with many insights into the experience of working in hospitals in Dublin. Most of the participants were willing to share their opinions on the advantages and challenges of the multicultural workplace. They also shared their personal stories and enriched the study with interesting examples deriving from their professional practice.

Altogether we interviewed thirty people, including those in medical managerial positions, as well as the representatives of Human Resource Management, in the two selected hospitals. The anonymised list of participants can be found in Annex 1.

Most of the participants were employed in public hospitals, which reflects the structure of the Irish health system. As of 2014, the public health sector employs over 115,000 people (HSE, 2013), roughly half of these working as either doctors or nurses. At the same time, private hospitals employ approximately 8,000 (Independent Hospitals Association of Ireland).

Finally, we conducted eight interviews with key stakeholders related to the Irish health sector.¹³ These included representatives of professionals associations, educational institutions, trade unions and government bodies. These interviews complimented the main findings from the fieldwork conducted with hospital employees. In particular, the experts involved in this study provided us with detailed information about the Irish health system and clarified certain issues that seemed to influence the career progression, job satisfaction and workplace integration of those with non-Irish backgrounds.

2.3. Interview process

All the interviews with health professionals followed a similar interview guide. The guide was designed prior to the fieldwork. However, it was then amended after the initial pilot interviews. Questions were organised thematically around the following issues: (1) educational and professional history; (2) push and pull factors throughout the migration process; (3) current employment and unit structure; (4) workplace relations; (5) opinion on working in multicultural workplace; (6) career development, training, and plans for the future. These main themes also featured in the codebook developed for the purpose of qualitative analysis. Interview guides for stakeholders and managers were customised according to their roles and the nature of their unit or organisation.

¹³ See Annex 1 for details.

As the project did not provide the participants with any direct incentives, the interviews were scheduled at the convenience of the participants. Most of them were held in public settings, either in places of employment or in coffee shops. Two interviews were conducted in participants' homes, due to their family commitments. Most of the interviews were 40-60 minutes long, except for some of those with consultant doctors. As the latter met us in their busy work environment and could not afford longer breaks from their duties, these meetings lasted for approximately 30 minutes. All of the interviews were recorded. Two of the interviewees did not agree to any quotes being used and only gave their consent to an interview summary. The rest agreed to full transcripts.

2.4. Ethics

All the participants were briefed about the purpose and design of the study prior to the interview. They were also issued with an information leaflet explaining the aims and objectives of this research. Furthermore, they were encouraged to express their individual concerns about working in the Irish health sector and to share their views about the possible improvements they could envisage. All the interviews were fully anonymised. Participants were referred to by a code rather than name, which ensures that their nationality is not exposed. Countries of origin were also grouped into categories and not referred to directly, as some of the participants could be identified by their origin. Finally, hospital names, as well as specialised units, are not to be used in any publication resulting from this study. All the participants were assured that their identity would never be disclosed.

3. Systemic integration at hospital level: policies and practices in selected hospitals

3.1. Structure 1: Large Public Hospital

The first organisation examined here is a large voluntary teaching hospital in Dublin. There are 48 public hospitals in Ireland and these consist of a mixture of HSE-owned hospitals and 28 voluntary public hospitals. The latter are run on a not-for-profit basis by private organisations; however, they receive most of their funding from the HSE (Nolan, 2005). Voluntary hospitals are concentrated in major cities, leaving public provision in the rest of the country to the HSE (Bidgood, 2013). Teaching hospitals are both HSE and voluntary and are affiliated with universities.

3.1.1. Hospital structure and occupational and ethnic composition

The hospital currently employs more than 2,500 people, which is standard across most of the large teaching hospitals in Dublin (HSE, 2013). The majority of health professionals are employed as nurses, followed by

Support Staff and Allied Health Professionals.¹⁴ Almost 80 per cent of all the employees are Irish born, with those of Indian and Filipino origin being the two largest groups of foreign-born professionals. Most of those of Indian and Filipino origin work as nurses. Indeed, the largest share of non-Irish employees (almost 30 per cent) are nurses, followed by those working as medical professionals (approximately 25 per cent). The nationality of doctors varied: 1.67 per cent came from India, while all the rest were categorised by the hospital HR department as 'others' (WKIN-DUB08). In addition, most of the consultants employed in this hospital are Irish born; however there are a number of non-EU doctors who had progressed to senior level over the last few years.

As a voluntary hospital, this organisation does not generally use HSE policies, procedures and guidelines in relation to staff management (WKIN-DUB-15). They rather develop their own; however they sometimes adapt a HSE policy for their own organisation. There is also national legislation that the hospital has to comply with, including the Health and Safety Code of Practice, the Employment Equality Act and legislation on Prevention of Workplace Bullying.

3.1.2. Shortages and recruitment strategies

As this is a large city-based hospital, providing formal medical teaching and training, it has been attractive to both Irish and non-Irish doctors. Although it faces challenges related to the emigration of junior doctors, the hospital usually does not have major problems filling vacancies. It was emphasised that teaching and training are extremely important for doctors and that due to the facilities offered by this organisation, the recruitment process requires less effort when compared to smaller county hospitals. Recruitment is conducted within Ireland, however, the application process is open to third-country nationals. There are also a number of Irish-born doctors, working abroad, who usually apply for consultancy positions, as opposed to more junior positions, in this hospital.

The Nursing department, on the other hand, has been affected by severe shortages. This was the case prior to the economic downturn as well as during the recession. This shortfall is a result of an insufficient number of specialised nurses in Ireland and the emigration of Irish nurses. Currently the major shortfall applies to those specialising in critical care, especially in the Intensive Care Unit (ICU), and cardiothoracic nurses. Since the early 2000s, these professionals have come from overseas as the numbers of Irish nurses were insufficient to fill in the gap.

Prior to the recession the hospital was involved in recruiting staff outside of Ireland. During that time there was a designated person employed by the hospital who was responsible for overseas recruitment. The role involved travelling to the Philippines, India, and other non-EU countries in order to interview potential candidates. This is not the practice anymore, as the hospital does not have available resources. In addition, due to the government recruitment moratorium, introduced in the public sector in 2007 (Rogers, 2014), the

¹⁴ The last category includes physiotherapists, dieticians, occupational therapists, medical scientists, social workers and radiographers.

opportunities for new positions to be advertised are limited. While the government recently announced the end of this embargo in 2015, the situation was still challenging when this fieldwork took place.

Across the hospital, there are currently over a hundred vacancies in the nursing division. Almost half of them are covered either by agency workers or by the hospital employees undertaking overtime. While in some cases the hospital encourages their employees to upskill in order to fill the gaps, some vacancies need to be advertised externally. The available positions are allocated on a priority basis; the position is first advertised internally for a number of weeks and if there is no suitable candidate among the existing staff, the hospital then accepts external applications. Potential candidates undergo an interview which follows the Competency Based Framework. This framework was developed by the hospital in 2011 in order to ensure that there is equity and equality across the service. As will be further discussed in the following section, this interview process is applicable not only to new entrants, but also to existing staff members who wish to move up or change position within the hospital.

3.1.3. Training and promotion opportunities

The hospital provides training and promotion opportunities to all its staff members. As previously mentioned, it also adopted a Competency Based Framework in order to ensure the application of a fair and transparent selection process. This is a common practice in most Irish public hospitals and is based on the HSE guidelines. As part of this framework, employees who apply for a promotion are required to give examples of situations which demonstrate skills and competencies relevant to the job description.

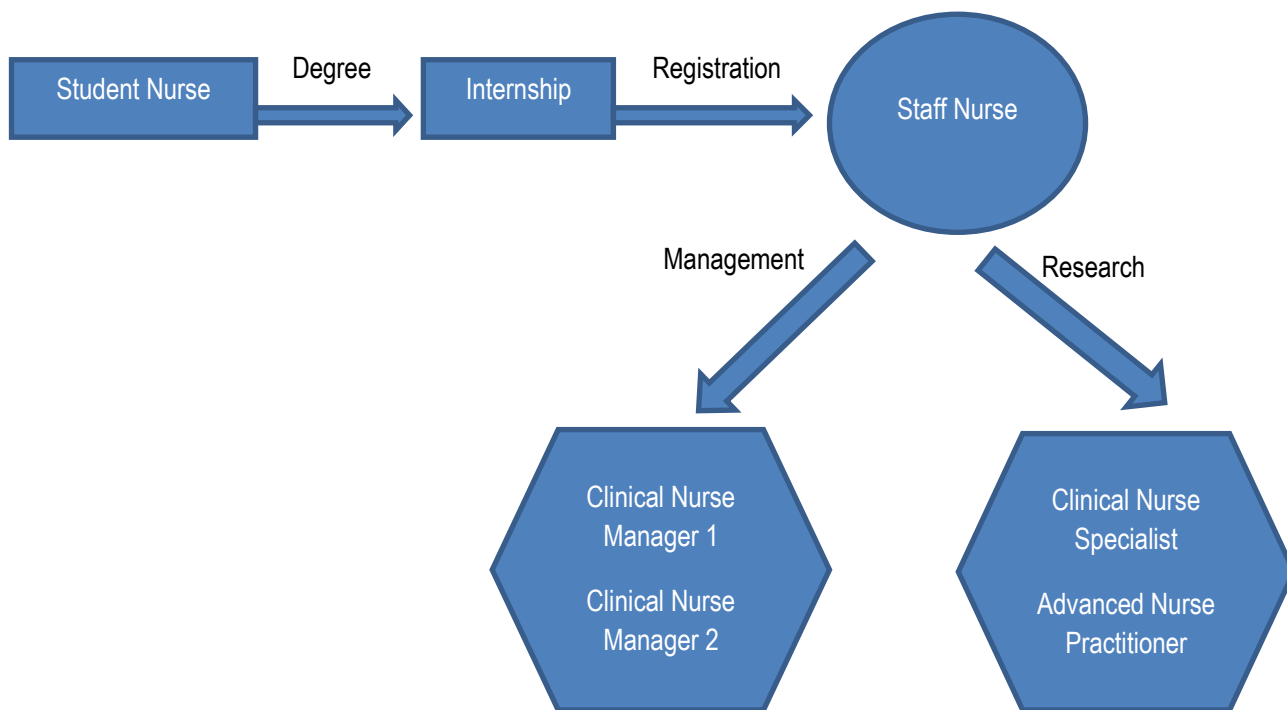
Regarding the career path for nurses (see chart 1), student nurses are placed in the hospital, working alongside regular staff members, during their degree programme. After that they usually do an internship¹⁵ with the same employer and often apply for a staff nurse position there. At later stages they have two main options for career advancement in either management or research. The first path does not require any further qualification, although a diploma in management is desirable. The research path requires postgraduate education. Clinical Nurse Specialists need a relevant postgraduate diploma and there is a requirement to obtain a Masters degree in order to become an Advanced Nurse Practitioner.

According to the hospital management, all nurses are treated equally in terms of training and promotion; they are supported in their individual educational needs and encouraged to develop their expertise. Those at managerial level can enrol on the Leadership and Management course available within the hospital. Alternatively, they can complete a Masters degree in Health Management. There are also short programmes for those who wish to specialise in a specific area, such as Orthopaedic or Vascular nursing. Furthermore, nurses willing to undertake postgraduate level programmes can seek funding for this from the hospital. Such

¹⁵ These internships are mandatory and usually undertaken in the same hospital where the intern was employed as a student nurse. The duration of the internship is 36 weeks. Current initial intern salary is set at 13,207.28 per annum, raising to 14,082.34 after the first 12 weeks and to 15,852.81 for the final 12 weeks (Source: Irish Nursing and Midwifery Organisation).

funding is available if the course is relevant to their work: examples would include a Postgraduate Diploma in Intensive Care, an M.Sc. in Palliative Care or an M.Sc. in Nursing (Advanced Practice).

Chart 1: Career path for nurses working on hospital wards



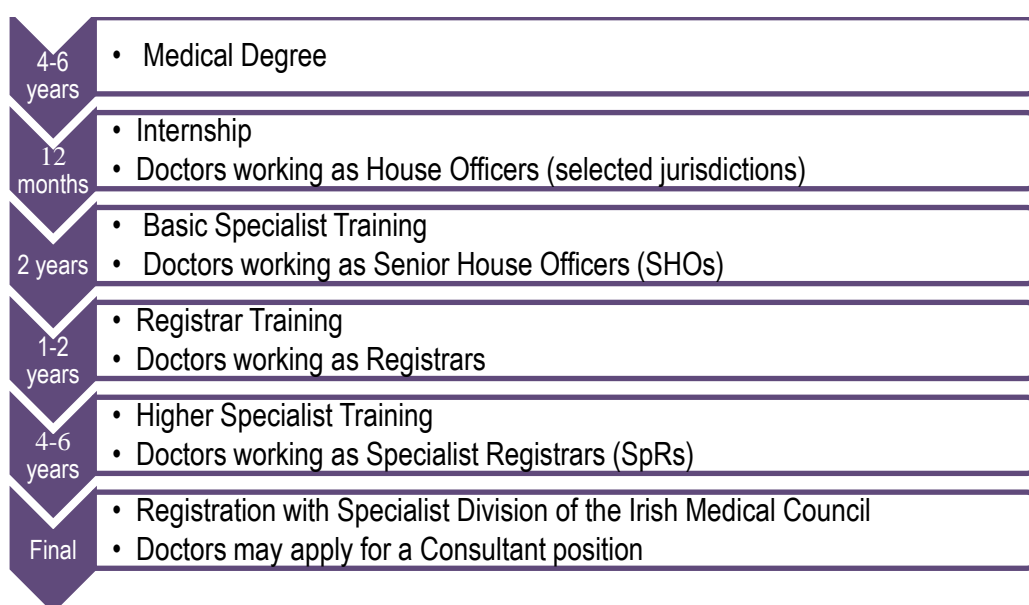
Source: WKIN-DUB-15

Most of the overseas nurses were initially employed as staff nurses, regardless of their previous experience in other countries. As it will be further discussed, all of the non-EU nurses also had to undergo a period of adaptation, during which they were supervised by full time staff members. There are a number of Filipino and Indian nurses, who came to Ireland in the early 2000s, who are now in managerial positions, mostly employed as Clinical Nurse Managers 1 (CNM1) or Clinical Nurse Managers 2 (CNM2) in different hospital wards. While the exact numbers were not available for the purpose of this report, the hospital managers seemed to be quite content with the numbers of nurses of a foreign background who had availed of promotion opportunities in this organisation. The managers also reported that some of the nurses of non-Irish origin, while being encouraged to apply for a promotion, were not willing to do so. It was claimed that those who were supporting families back home aimed to maximise their income and undertake a lot of overtime and weekend work. As these hours would be paid significantly higher, the overseas nurses did not want to lose this benefit. Becoming a manager, at least in the initial period, would result in a financial loss, as the salary rise after the promotion would not be significant, and those in managerial positions usually work only regular hours. In addition, some of the nurses, both Irish and non-Irish born, preferred to stay at the staff nurse grade, as moving up to the managerial position would mean less contact with patients. The latter seemed to be of great importance to many nursing

professionals. For those who are not aspiring to higher grades, there is an option of either becoming a senior staff nurse, or of specialising in a particular area.

Career paths for doctors, on the other hand, are very distinct. The major difference from the nursing professionals was that the structured training for doctors in Ireland does not take place in one hospital. These doctors take part in a rotation system, meaning that they change their location every six or twelve months.¹⁶ The training is also not provided by the employer, but by a designated training body, typically either the Royal College of Physicians or the Royal College of Surgeons. It also takes much longer to achieve a senior position when compared to nurses. The figure below illustrates the career path for doctors in Ireland.

Chart 2: Career path and structured training for doctors



Source: Irish Medical Council

The majority of non-Irish born professionals in this hospital are employed at a junior level, and most of the consultants are Irish-born. This includes those doctors who were initially trained in Ireland, gained international experience and then moved back after obtaining their speciality training elsewhere. Several consultants of non-Irish background were appointed over the last few years, however, the management did not have data on grades including nationality background. It was, nevertheless, agreed by the senior consultants working in this hospital that becoming a consultant was more challenging for those of non-EEA background. As will be further discussed, this is not as a result of any discrimination at the hospital level. It is rather due to the difficulties with enrolment on Higher Speciality Training Programmes, experienced by many of the non-EEA doctors.

¹⁶ The rotation applies to doctors who are in training as well as non-training positions (Humphries et al., 2013).

3.1.4. Diversity management

The hospital employed a Cultural Diversity Officer until 2008 who was responsible for raising cultural awareness around the hospital. This included organising a cultural diversity day every year with presentations about different countries and nationalities. They also provided cultural diversity modules as part of the induction for new staff. This module focused on working with people of different cultures as well as caring for patients of different origins. In addition, during the recruitment drives for foreign nursing professionals, there was an officer to support the incoming overseas nurses. According to the HR Manager, there was a specific need for these officers at that time, when large numbers of foreign nurses were arriving to work in the hospital. As the HR manager explained:

There was a specific person to support nurses. And it was for all the practical stuff. You know, where to rent a room, all that type of stuff... when you got here. Because we were, as an employer, bringing people straight into this country from a completely different environment, and that support was here for a while. And that support was required when we had groups of nurses coming over the course of... I don't know if it was one or two years. But we haven't had sort of a mass, large group coming [recently], so we don't have that system anymore. (WKIN-DUB-08)

There is currently one HR Business partner¹⁷ in the organisation who is responsible for equality issues, including ethnic diversity among staff members and patients. He is also responsible for employee relations. In addition, this business partner is the Access Officer for the hospital; responsible for ensuring that the hospital is accessible for all its patients, including those of different national backgrounds.

The hospital management has also developed a Dignity at Work Policy, which states that staff members must be treated equally based on the nine grounds featuring in Irish equality legislation. These are: (1) marital status; (2) family status; (3) race; (4) religion; (5) age; (6) disability; (7) sexual orientation; (8) gender; (9) membership of the Traveller Community (HSEA, 2004). While following the state-level equality policy, Dignity at Work is a policy specific to this hospital. The main principle behind this framework is that all of the employees 'must be respected and not treated differently, with no harassment and no bullying' (WKIN-DUB-08). This policy is emphasised to all of the new employees during their induction. As part of the Dignity at Work Policy, the hospital also runs the Support Contact Persons Network. This network provides support to any staff member who might have an issue related to discrimination, for example. The service is fully confidential. The organisation did not have a specific Equal Opportunities Policy at the time of interview but it is now being developed (WKIN-DUB-15). Also, as explained by one of the managers, the hospital has an equal opportunities ethos, which is reflected in all of the recruitment policy documents as well as in the HR policies.

The current focus of diversity management is on patients and the quality of care delivered to those coming from different cultural backgrounds. The managers interviewed for this study did not feel that there was any requirement to develop any diversity management measures for staff beyond the existing Dignity at Work

¹⁷ The hospital has a HR business partner model of delivery of services. The human resources department participates in strategic planning, rather than just concentrating on HR duties (e.g. payroll or employee relations).

Policy. According to these managers, multiculturalism in the hospital is an 'everyday norm' rather than an issue that needs to be emphasised. This is how one of the nursing managers perceived it:

We would have events over in our Social Department, where, you know, there might be a particular nationality on one day, (...) you know, different things about their countries, or whatever it was. But there was great learning in that. But I think things have changed so much in the hospital in the past 10 or 15 or 20 years, that I don't think that there is a real necessity to do that anymore. Because everybody has travelled so much now, and our patients...We have a multicultural patient cohort as well as staff cohort. So, I don't think it is necessary to kind of even segregate like that anymore.

Currently there are occasional national food days held in the hospital canteen, which is one of the few organised diversity events that featured in any interviews conducted with employees of hospitals around Dublin. The hospital management was also involved in organising fundraising events after the typhoon in the Philippines in 2013. Religious diversity was also recognized by this particular employer. For those of non-Christian origin, there are a number of quiet rooms available, in which staff members as well as patients can pray. Muslim employees were also facilitated through the period of Ramadan. There is also a new development at the hospital which will provide a prayer facility for those of all religions; the centre will be of a multi-denominational character and will not have a church format. The managers believed that such a centre would be of benefit for both staff and patients.

Finally, there are formal complaint procedures for any staff members who might feel mistreated or discriminated against. These procedures are also part of the Dignity at Work Policy, which encourages employees to bring up their issues with the local management prior to formalising them and contacting the HR. The Equality Officer asserted that most of the cases must have been solved at the local level as he was not aware of any recent formal discrimination cases within the hospital.

3.1.5. Advantages and challenges of a multicultural workforce

The managers recognized both advantages and challenges related to employing a multicultural workforce. However, the advantages seemed to be of more importance. Different sets of skills and different points of views deriving from professional experience in overseas countries were perceived of particular benefit. In addition, some of the nurses, especially those coming from India, had specialised training that complemented the hospital needs. This was particularly the case of overseas critical care nurses bringing their expertise acquired in the place of origin.

As the profile of the patients had recently changed, having a multicultural workforce was also perceived as an asset. While it would not always be possible to match patients with staff members of the same ethnic background, diversity within the hospital workforce has provided management with a better understanding of different cultures. As explained by the Equality Officer:

If I am working with people from different backgrounds, I will have a better understanding, potentially, of what is coming through my door in terms of people's, whatever, cultural or spiritual beliefs [...] And their expectations in terms of service delivery [...]. So I think if I work with people from different backgrounds, I would be in a better position to deliver a better service to people from different backgrounds.

The hospital normally uses interpreters provided by a specialist agency to deal with those patients who do not have sufficient English. However, it was reported by some of the managers that they would occasionally ask another staff member to act as translator, if they knew the language of the patient. In some units it was preferred to have somebody with a medical background to translate to the patients. In such cases having an ethnically and linguistically diverse workforce was of advantage to the hospital management.

The only challenge of the multicultural workplace identified by the HR managers was the occasional communication problem. Such issues were mainly related to overseas workers who had stronger accents. According to the HR managers, these did not, however, have any major influence on hospital performance in terms of treating their patients.

3.2. Structure 2: Medium-sized Private Hospital

The second organisation examined is a private hospital based in Dublin. The hospital is one of twenty hospitals that are members of the Independent Hospitals Association of Ireland (IHA). Private hospitals in Ireland treat around 20 per cent of all patients and the majority of them come through the private insurance system. By 2008 these hospitals provided almost 2000 beds for their privately-insured patients. In addition, these hospitals may also facilitate some HSE patients if specific procedures are required. As noted above, they also employ significantly fewer individuals than public sector hospitals: by 2014 there were around 8,000 staff working in these organisations (IHA rep. interview). Seventeen hospitals provide general or acute services while three specialise in mental health services. All members of the IHA are accredited by one of the following: Joint Commission International, Caspe Healthcare Knowledge Systems (CHKS) or Mental Health Commissioner Ireland. Health professionals working in these hospitals are also registered with relevant professional bodies, including the Irish Nursing Board and the Medical Council of Ireland.

3.2.1. Hospital structure and occupational and ethnic composition

This is a medium-size hospital, employing fewer than 500 people in total; the full time equivalent of approximately 300 employees. Originally most of the staff was Irish born; however this has changed since shortages started to occur in the early 2000s. Currently less than 30 per cent of employees are Irish born and the largest proportion of those who are foreign born is from within the EEA. This is an unusual situation for the Irish health sector, where the majority of non-Irish born health professionals are from non-EEA countries and it appears to be a result of specific recruitment strategies adopted by this hospital, as discussed below. Most of

the psychiatric nurses are Irish, English or Scottish, while the general nurses are originally from Europe, India and the Philippines. The hospital also uses agency nurses, which is common practice within the private health sector in Ireland.

A small number of doctors were directly employed by the hospital and all of these were Irish born, which is not unusual among private hospitals in Ireland. As explained by the representative of the Independent Hospitals Association of Ireland, some of the consultant doctors employed in public hospitals are also permitted to undertake a certain number of hours in private practice, which can be held in an independent hospital. In such cases, the consultant is not employed by the latter, but is 'contracting in their own right to undertake some work' (IHA rep. interview). The hospital also takes part in an internship programme, through which they train NCHD interns. This experience is recognized as part of medical training for doctors in Ireland.

3.2.2. Shortages and recruitment strategies

Similar to most of the public and private hospitals in Ireland, this employer has been experiencing staff shortages since the early 2000s, especially of below consultant level doctors and general or specialised nursing professionals. Up until 2004, the hospital recruited their foreign nursing staff from countries like India, the Philippines and some African states. This strategy, however, proved to be very financially consuming for a number of reasons. First of all, the hospital was obliged to cover the costs of work permits and green cards¹⁸ for the overseas recruits, as well as their initial accommodation. The incoming employees from outside of the EEA were also required to undertake adaptation programmes in different hospitals in Dublin, which generated additional costs. Finally, the managers of the private hospitals also found that often, after the initial period of six weeks adaptation, their recruits were offered a different position in the place where the adaptation was undertaken. They were thus losing some of their potential employees. In addition, as the overseas staff members were arriving from different environments and different healthcare systems, they required time to professionally adapt to their new settings. Some were also employed in general hospitals in their countries of origin. In such cases, they would often lack the specific skills sets required by this private hospital. Nevertheless, according to the HR manager, those who remained in this hospital integrated into the system and proved to be a great asset to the employer.

After the 2004 EU Enlargement, the hospital changed their strategy and shifted to the recruitment of Eastern European professionals¹⁹. The managers were no longer involved in overseas recruitment trips, but rather employed those who were already in Ireland, or used phone interviews set up by an employment agency. Up until recently Irish graduates were also applying for jobs directly with the hospital. However, this passive

¹⁸ Work permits are available for positions with remuneration of €30,000 or more. Green Cards are designed to attract skilled migrants to Ireland and are available for jobs with remuneration of over €60,000. However, certain skilled jobs are exempt for the income threshold.

¹⁹ This hospital continued to recruit overseas nurses during the recession as they were not affected by the government moratorium on recruitment in the public sector.

recruitment strategy does not seem to be effective any more. According to the managers, there have been large outflows of Irish-trained nurses, who are leaving the country due to a perceived worsening standard of living.

As a result the hospital is currently experiencing severe shortages. Without enough Irish graduates applying for jobs and the pool of qualified Eastern Europeans in the country diminishing, the HR department is recruiting from outside of Ireland again, mainly through recruitment trips to Eastern and Southern Europe. These trips are organised by an agency in the relevant country. Potential recruits are also offered a 'package' which includes flights, accommodation and nursing registration covered by the hospital.

During the recruitment process, the managers have looked for both qualifications and experience. There is currently no language test or exam, as language skills are assessed at the interview. However, as English fluency has been an issue for some of those coming from Eastern and Southern Europe, some of the new employees might be required to work as care assistants while improving their English. In addition, some of these new recruits undertake English classes in their own time.

3.2.3. Training and promotion opportunities

All the mandatory training that is required by the Irish Health Information and Quality Authority (HIQA) is provided. There are also additional courses available for employees if they are related to the services provided by the hospital. Furthermore, the hospital offers funding for any relevant courses in other educational or medical institutions in Ireland. There has been a lot of interest from staff in such opportunities and therefore the hospital is currently developing a formal policy for educational funding. These requests are being filed by employees of different nationalities while the decision on funding can be based on length of the service within the hospital. There are also promotion opportunities for all staff members and, according to the HR manager, everybody is encouraged to apply for higher positions. If successful, they would also be supported with relevant management courses when required. The current managerial staff in the hospital is of Irish, Filipino, Indian and Eastern European origin.²⁰

3.2.4. Diversity management

The hospital has its own equality and anti-discrimination policy in compliance with Irish and European regulations. The management did not foresee any necessity to develop additional diversity measures at the time of interview. In their opinion, the workers of non-Irish origin have been integrating very well and the hospital considered itself to be 'completely multicultural'. Indeed, ethnic diversity has become the norm in the

²⁰ In order to protect their anonymity, the hospital managers did not provide us with exact figures on this.

hospital. There are, nonetheless, cultural days organised by the management, especially by those of Filipino origin.

There have been cases of employees of foreign background asserting that they were not treated equally due to their nationality. However, according to the HR manager, a number of Irish-born employees also maintained that they were not treated equally. The HR management of the hospital maintains that they have an open-door policy with all of their employees, regardless of their cultural or ethnic background.

3.2.5. Advantages and challenges of a multicultural workforce

Despite some initial challenges, the HR manager perceived professionals with a migrant background as a major asset. First of all, the hospital considered them to be necessary for the hospital to function properly, as there were not enough Irish-trained nurses to fill vacancies. These professionals also had their own personal strengths, while some would also bring additional skills developed through working in different healthcare systems. These included, for example, leadership experience gained in their home country. Coming from a different professional environment could also be a challenge; however, the managers felt that it depended on the individual. Those who were able to adapt to their new setting integrated well in this workplace. According to the HR managers, the majority of their employees are now well adjusted to the Irish health system.

The main challenge identified by the manager of this hospital concerned language. Some of the Eastern European nurses, who were recruited through a phone interview, had some difficulties in adjusting as their level of English was not sufficient. What occurred to this employer after these experiences was that face-to-face interviews, as opposed to phone interviews, were a much better tool for assessing language level. It has also been an issue for some of those coming from Southern Europe; however, according to the HR manager in this hospital, the majority of the latter have good English.

3.3. Public and private hospital: comparative perspective

Both organisations discussed in this section can be described as 'multicultural'. This is particularly the case in relation to their nursing staff. Such diversity is a result of long-term shortages that could not be filled by Irish-trained professionals. Both hospitals were originally involved in active recruitment of nurses from non-EEA countries, which is not the case anymore. Public hospitals do not have funds for such activities as their budgets were reduced after the 2008 economic crisis. This hospital has also been constrained by the ongoing recruitment moratorium in the Irish public sector. Private hospitals, even though they were not affected by this freeze, also stopped importing their nurses from outside of the EEA. Instead, they adopted the cheaper strategy of recruiting new staff from Eastern and Southern Europe.

Despite a large number of foreign-born employees, both hospitals seemed to have quite relaxed policies regarding their diversity management. It was emphasised by the managers in the public hospital that such measures were of more importance during the initial recruitment drives in the early 2000s. In that period, the

multicultural workplace in the Irish health sector was quite a novel phenomenon. Over time, however, such multiculturalism became the norm. As a result, occasional culture days for their staff have become the only diversity events. In addition, both hospitals had an equal opportunities ethos, covering a range of grounds, not just nationality.

The managers in both hospitals were satisfied with the level of integration among their employees. They also were not aware of any major problems deriving from the diversity of their workforces. Notably, they focused on positives related to having staff of foreign backgrounds. As will be further discussed, however, there are also challenges faced by the individual professionals employed in such hospitals. These apply to both Irish born and non-Irish workers who share their multicultural environments. They range from occasional cultural differences or communication problems to institutional discrimination in some cases. While these issues did not seem to affect everyday care for the patients, they should be addressed in order to improve the everyday experience of health professionals in Ireland.

4. (Inter)subjective perspectives on MHWs integration in workplaces

As argued by Hunt (2007), the migration of health professionals is linked with two, often different, sets of expectations: those of the managers and those of employees. What is most important for the managers is to fill vacancies and ensure that the right set of skills is in place in order to provide optimum levels of health care. Professionals of foreign origin, on the other hand, arrive at their destination with certain expectations related to potential career opportunities, financial incentives or simply a better lifestyle. Furthermore, diversity in the workplace also includes the indigenous workers who share their space and practice with those of different cultural background (Kundu, 2003; Hearn, 2007). Finally, there are patients who expect the best care provided by the health professionals regardless of their origin (Tregunno, 2009). Some of them, however, may also experience ethnic diversity among doctors and nurses as a new challenge.

This part of the report will discuss all of the above issues in detail. Firstly, we will explore the migrants' perspective on working in Ireland, including their expectations and lived experience. Secondly, the analysis will focus on the multicultural workplace from the perspective of different groups; migrants, their Irish-born colleagues, as well as key stakeholders. Finally, we will briefly discuss the positive and negative aspects of having a multicultural workforce in dealing with patients of different national backgrounds.

4.1 Migrant Health Professionals: migration motivations, adaptation and career opportunities

The analysis of interviews with our participants of foreign background shows that the individual experiences of working in Irish hospitals varied; while some of the participants had success stories in terms of their career in Ireland, others were challenged by a variety of obstacles. Variation in experiences depended on a number of factors. Firstly, what seems to be of importance are the motivations for international mobility and whether expectations were met in Ireland. Regarding the latter, for example, many non-EEA doctors experienced

difficulties with accessing structured higher-speciality training programmes, which obstructed their career progression; one of the most important goals motivating the move to Ireland. Secondly, the experience of settling into the Irish system varied among participants, depending on individual characteristics such as linguistic skills, the occupation concerned, and the work unit individuals happened to be placed in.

4.1.1. Migration motivations

It is traditionally understood that migrants from less developed countries who move to work in Europe are primarily driven by financial motivations (Stark, 1991). Recently, however, some scholars have argued that the reasons for migration can be more complex and may include, for example, the desire for a better lifestyle (King, 2002). In addition, the migrants who were the focus of this research are also professionals. People in this category usually move between countries in order to advance their career opportunities (Ariss, 2010; Iredale, 2001; Kangasniemi et al., 2007; Richardson, 2009).

In their study on international nurses working in the UK, Allan and Aggergaard (2003) distinguished between four types of motives behind the movement of nursing professionals coming from less developed parts of the world: (1) personal motives (including a desire to travel and experience living in other places); (2) professional motives (career opportunities); (3) financial motives; and (4) social motives (family ties back home and in the destination country). All of the above factors featured in the interviews with those participating in our study. However, the financial motive was not as strong as expected and was usually accompanied by other reasons. Furthermore, while the financial element was important for both doctors and nurses, these two groups differed in relation to other motivations. In general, nurses wanted to gain new life experience and have the opportunity to travel, while doctors moved for professional reasons. For example, this is how a doctor, originally from Africa, explains why he left his country of origin:

Well, for two reasons: first of all you have a better postgraduate training here and [secondly] for financial reasons as well. Half economical and half professional reasons. (Consultant, non-EEA, public hospital WKIN-DUB-19)

Indeed, what emerges from the data is that the majority of the doctors interviewed came to Europe for international experience which, in their opinion, would enhance their future opportunities back home or elsewhere. For another African doctor, who had moved to the UK prior to coming to Ireland, training and experience in the 'Western' world was of most importance. This is how he elaborates on his motivations:

Well, I moved for, you know, a kind of higher training...Because everyone back home would have a membership of either the Royal College of Physicians in the UK or Ireland in their speciality, be it medicine, or surgery, or something else. And I wanted to have a little bit of Western experience and then go back after that. (...) When you obtain a membership you will be looked at differently, you know... It is getting the Western certificate and a Western experience, you know. Maybe a little bit of prestige and stuff like that as well, you know. (NCHD, non-EEA, public hospital, WKIN-DUB-03)

Nursing professionals, on the other hand, in addition to being motivated by financial factors, or insufficient employment opportunities back home, frequently mentioned personal reasons: a desire to travel and to live in different parts of the world. For this nurse, it was actually a mixture of both, as she could not afford holidays abroad with her salary back home:

I wanted to travel. I wouldn't be able to afford to travel if I stayed in [name of the country in Asia]. The salary was ok for me because my parents have a house I didn't have to pay a rent, so basically my salary was mine. So basically if you're single and you just go out and buy your personal stuff- it's enough, but if I were renting, and I would be paying for my food- that would be a different story. I wanted to travel, and I couldn't afford it, so I said I would go abroad. (Staff nurse, non-EEA, public hospital, WKIN-DUB-26)

This nurse wanted to travel and this was her main motivation in moving abroad. The majority of non-Irish nurses who participated in this study discussed better quality of life elsewhere as the most important motivating factor for migration. Higher wages abroad would allow them to afford higher standards of living. Some had an opportunity to work in the Middle East, however most did not consider this option due to the social conditions in these countries. Instead they were seeking positions in Europe, especially the UK and Ireland. In addition, some of the Asian nurses wanted to be able to provide for their relatives back home. As explained by one of the participants who came from the Philippines, it is a 'custom' in their country that family members working abroad should support those left behind. While regular remittances were mentioned by a few interviewees, the majority sent money for specific causes, such as financing siblings' education or paying for medical treatment for elderly parents.

Finally, social motives often seemed to act as a deciding 'push' factor for choosing Ireland as a new destination. While most of the overseas nurses came to the country through the recruitment drive, a large proportion of participating doctors had moved to Ireland as they already had family members or friends living there. This consultant doctor, who initially worked in his country of origin, and looked for other opportunities abroad, was in fact approached by one of his colleagues who had moved to Dublin. This is how he described his decision-making process:

And then I wanted to do some more training in a specific area, so I looked around. And one of my friends was in Ireland, so I decided... He invited me over and said: 'look, if you want to come and do the fellowship with the Royal College, it would be good, because it's well respectable'. So I said 'fine'. So I came over and did the fellowship. And I became a fellow with the Royal College. (Consultant, non-EEA, public hospital, WKIN-DUB-19)

This is a clear example of the important role of migrant networks in the international mobility of individuals. Interestingly, such networks are usually associated with less skilled migrants who need to use their connections in order to compensate for the lack of human capital, such as education or the host country's language (Massey, 1998). Professional migrants, on the other hand, tend to use channels such as transfers within multi-national companies or international recruitment companies (Iredale, 2001; Findlay and Garrick, 1989). Recruitment agencies played an important role for the mobility of nurses, especially from countries like

the Philippines and nurses who moved within organised recruitment processes had no previous ties with Ireland. However, the majority of doctors were passively recruited, which means that they moved on their own, and chose this country due to existing connections established 'back home'. Most of them had colleagues, friends or family members who were already in Ireland and who encouraged them to choose this destination. It is also important to emphasise that many of the nurses who came to Ireland via active recruitment were then followed by their family members after the initial settlement; further illustrating the importance of social networks in fostering migration.

In sum, it is important to identify the different types of motives influencing the international movement of health professionals. As will be further explored, if career opportunities and advanced training in Ireland were the most important motivations for the migration of doctors, then their workplace satisfaction would be influenced by their ability to achieve these goals. In such cases, institutional factors such as difficulties with enrolment on formal training schemes may significantly hinder their integration and even push these professionals out of Ireland. On the contrary, none of the nurses discussed better career opportunities as influencing their decision to leave their countries of origin. It was rather the desire to improve their financial situation, either to support families back home or to support a better lifestyle in their new destination.

4.1.2. Initial experience in Ireland

The majority of the participants came to Ireland in the early to mid-2000s. Non-EEA nurses coming from Asia already had their contracts arranged through either the recruitment agencies back home, or directly with the employer. They all described the interview process as relatively smooth and did not have any issues either with the recognition of their qualification or with registration by the Irish Nursing Board.

Doctors, on the other hand, usually did not have anything set up prior to the move and dealt with the registration as well as job search after coming to Ireland. With one exception, the registration process was described as straight forward. All of them found their first jobs soon after the settlement.

All of the non-EEA nurses were required to pass a period of initial adaptation. This training has only been available in selected hospitals, so most of them undertook the adaptation in a place and a setting different from their designated employer. While the adaptation was originally supposed to take six weeks, for some it took longer; usually a result of a ward manager not feeling that the nurse had fulfilled all the requirements to work independently in the Irish health sector. The experience of the adaptation depended on the specific ward that a nurse was assigned to. Some participants found it smooth and useful; for example, this how one of the nurses describes her adaptation period:

Oh it was grand. I had no problem with the adaptation. The integration wasn't difficult for me. Some Filipinos or Indians, they find it difficult to understand when the Dubliners speak, I don't. If I go to Donegal I don't find it difficult to understand them, but some people in my group were finding it very difficult (...) Luckily I don't have that problem. (...) [My Irish mentor], she was teaching me how to do stuff like you know... Back home everything is like manual, like the blood

pressure, everything is manual, and here all you have to do is press the button, everything is being done for you. That would be the kind of change for me (...) here is so different, it's so easy because I was used to work being difficult and it wasn't very difficult for me [here]. (Staff nurse, non-EEA, public hospital, WKIN-DUB-25)

For this nurse the hospital procedures and equipment represented a major change. Nevertheless, she had a rather good experience of the adaptation. Unlike many other Asian nurses she did not have any initial language problems and the Irish-born colleagues in the ward were also very supportive. The other nurses who were interviewed had a mixture of positive and negative memories of their adaptation. The main issue reported by most of the nurses who went through this process was the language difficulty, mainly related to understanding different Irish accents. In fact, language is an issue that commonly features in various studies on international nurses (Winkelman-Gleed and Seely, 2005; Tregunno et al. 2009). While most of those coming from Asian countries completed their nursing education in English, understanding the natives in the host countries was often very challenging for the newcomers. The majority of Filipino nurses reported problems with certain idioms used in Ireland, which they were not previously familiar with.

'Culture shock' featured in the interviews as well. Firstly, the interaction with colleagues and patients was different from the experience they had had in their country of origin. One of the examples of this was calling people by their first names in Ireland, as opposed to addressing them as 'Sir' and 'Madam'. They also found some differences in relation to their duties at work. In addition to more modern equipment, they found that the day-to-day tasks of nurses in Ireland differed to those 'back home'. Some claimed that they were allowed to work more independently in their countries of origin. There were also issues related to personal care provided to patients: in countries such as the Philippines, such duties are usually the responsibility of other family members. It was reported by a number of our interviewees that they did not expect to have to provide this care in Ireland. In addition, they felt homesick and lonely, which did not make the experience any easier. Nevertheless, the majority of the interviewees claimed that they received enough professional support from their Irish-born colleagues.

Some of the participants remembered their adaptation period as difficult. For example, an Asian nurse was assigned to a ward that was of a different speciality than hers and therefore she found it difficult to adapt. In addition, she reported that although there were other nurses from her country already working there, she received no support from them. This experience further influenced her feelings of loneliness in the new surroundings. In one extreme case, an Asian nurse felt bullied by the ward managers who were supervising her adaptation. She was assigned tasks that other nurses, who going through the same process in different units, were never asked to do. In addition, she felt that the speciality of the ward was not relevant to her qualifications and professional experience, thus she could not perform at the expected level. This particular nurse asked the adaptation programme coordinator to change the ward and her request was fulfilled. This change, however, meant that her adaptation took longer.

Non-EEA doctors who were trained outside of Europe did not require such a formal process of adaptation. They rather had to undertake what they called a 'period of shadowing' or 'attachment'. This involved working in

a ward with other doctors, and observing their practice for a couple of weeks. Apart from some initial language issues, most participants remembered this period as rather positive because they were able to familiarise themselves with the Irish system. For those who were trained in Europe, as well as for EEA nationals, there was no such period of shadowing. In fact, one of the EEA doctors who participated in this study reported working independently from the beginning. She was employed in a private hospital and was not part of a bigger team. This proved to be challenging for her as, despite her European experience, there were differences between the Irish and her home country's health system. This example shows that the adaptation or shadowing period is of benefit for individuals and for hospitals.

4.1.3. Further training and career opportunities

Most of the participants came to Ireland having completed their medical or nursing degree. A small number of interviewees had undertaken their training in Ireland. Furthermore, the majority had a significant experience of working outside of Europe prior to the move. Nevertheless, some experienced what Shuval (1995: 556) calls "downward internal occupational mobility". This implies that individuals' credentials are recognized and they are able to be employed in their professions, however their previous practice would not be really taken into account (Ribero, 2008). Such downward mobility was perceived as a serious issue for some of the physicians in our sample, especially if they aimed to achieve consultancy posts in Ireland. Despite their previous experience, all of them had to start at a lower level and move up either through formal training programmes or through advanced practice.

As previously explained, career progression in Ireland was of most importance for overseas doctors. Those who were initially willing to return to their home countries were also hoping to get adequate training which would advance their status on return. This could be achieved by enrolling on specialist training programmes or by working in teaching hospitals. However, while they had come to Ireland with certain expectations of professional opportunities, the reality sometimes proved to be different. Some of our participants mentioned regulations that prioritised Irish and EU doctors in accessing higher speciality training programmes. This was not confirmed by any of the stakeholders. However, this seems to be a policy followed by the main training bodies such as Royal College of Surgeons and Royal College of Physicians. Both organisations explicitly state in their Allocation of Places on Specialist Training Programmes documentation that:

Available specialist training places will be allocated by the Royal College of Physicians/Surgeons in Ireland in the first instance to those candidates who at the time of application are citizens of Ireland or nationals of another Member States of the European Union. (RCPI, 2013: 2; RCSI, 2014)

This mirrors some of the media reports, including those stating that the training bodies were requested by government agencies to 'positively discriminate' in favour of Irish and EU nationals in the allocation of training posts (Mudiwa, 2014). It was also claimed by a representative of an Irish regulatory body that those who

received their specialist training outside of the EU were less likely to be registered on the Specialist Division of the Irish Medical Council.

Furthermore, some of the participants complained about the requirement to change hospitals every six to twelve months before reaching a more senior post. This applied to interviewees of Irish and non-Irish origin. The majority of them had to relocate several times to different parts of Ireland. It caused particular difficulties for those with families, especially if the children were of school-going age. Most had to commute between home and their workplaces, which were often far apart.

In addition, some of our interviewees claimed that non-EEA doctors are recruited to Ireland to cover positions unpopular among Irish-born professionals. This reflects findings from other studies. It has been argued that non-EEA doctors are hired simply to 'wear white coats and fill the gaps' (Baxter, 2005), mostly in 'service posts' that are not part of any formal training schemes (Humphries et al., 2013). As a result, these doctors had limited opportunities for career progression and professional development. This issue was also recognized by senior Irish-born doctors who participated in this study. They were particularly concerned about foreign-trained doctors, who were 'promised' a good career in Ireland but for whom the reality proved to be different. One of the senior consultants claimed that there are a lot of foreign-born doctors who are assigned to county-hospital jobs where they practice general rather than specialised medicine and therefore experience downward mobility in their occupation. He felt that it was 'not fair' to mainly offer foreign-born professionals, who seek international training, jobs that the Irish graduates reject.

The difficulty in career progression for overseas doctors is not a unique situation for Ireland. Other studies conducted in the UK found that almost two thirds of doctors who qualified overseas worked below consultant grade (Decker, 2001). This was a result of either their lack of understanding of how the system works (Jinks et al., 2000) or was related to their needs being systematically ignored (Unwin, 2001). In both cases, the medical professionals of foreign background experienced an 'ethnic penalty'; less access to training and unequal opportunities in career progression (Bach, 2003).

Despite these obstacles, some of the non-EEA doctors were still able to move up the career ladder. Instead of enrolling on the higher speciality training, they were, as they often described, 'moving around the system'. One of the participants was advised to get some foreign experience in another EEA country, despite many years of practice in his home country. This strategy was successful for him as after a year abroad he was able to secure a consultant position. Another non-EEA doctor decided to choose a different path which allowed him to remain in Ireland. He was able to secure a number of 'approved' contracts, recognized as part of his training. According to him, this career path can be described as 'stand-alone training'. While those on the structured schemes usually knew how long it would take them to finish, it was not clear to this participant from the beginning. Nevertheless, he eventually got his training recognized by the Royal College of Physicians and became a consultant in his speciality (WKIN-DUB-19).

Unlike the doctors, the nurses who participated in this study were less focused on their career advancement. Some deliberately did not apply for positions higher than staff nurse. There were two main reasons for this: financial incentives and the nature of the post. Those working as staff nurses were able to work extra hours of

overtime as well as the weekends, which were paid at a much higher rate. If they moved to a managerial position, these hours would no longer be available. At the same time, the rise at the first increment for a Clinical Nurse Manager was not significant and as a result they would actually be earning less. This was the case of one of our participants who was encouraged to apply for a CNM position in her unit, but in the end decided not to. At that time she was trying to maximise her income in order to support her sister back home and to maintain a desired lifestyle in Ireland. In the end she decided to remain at the staff nurse grade as this allowed her to take overtime hours as well as night shifts.

Some of the nurses who we interviewed did apply for higher positions. One of our respondents was not successful. In her opinion, however, the decision was not discriminatory, but was rather made on a personal basis. She claimed that a lot of promotions in her hospital depended on personal connections and thus the Irish nationals, who were there longer, had more chances of achieving higher grades. Another non-EEA nurse who is now in a CNM1 position was actually pleased with her application process and with her new role. After years of working as acting CNM1 and CNM2, she finally decided to apply for a formal promotion. She felt that the interview process was meritocratic. Also, her initial hesitation about the financial constraints, as well as new duties, was premature. First of all, the hospital recognized her previous experience and placed her on the accurate salary scale. Secondly, she was still able to have contact with patients, which was her main concern.

Generally speaking, it seems to be the case that overseas nurses have recently been promoted to managerial positions, even though they started their work in Ireland at lower grades. This is how a representative of trade unions commented on this issue:

So everyone kind of starts generally as a staff nurse. [However], not so much in the Nigerian community, but certainly quite a number from the Filipino and Indian community I know are nurse managers now. And they are getting promoted to ward sister and assistant director of nursing. And I know one or two directors of nursing who are from the Philippines. So that's good, and it shows a high level of integration within the system. There isn't really a huge difficulty with the qualifications (Irish Nursing and Midwifery Organisation, STH-DUB-03)

Furthermore, according to our interviewees, there were training opportunities available in most hospitals. Some of our non-Irish born respondents, including non-EEA nurses, received postgraduate education in Ireland. Most, employed in public hospitals, were supported financially by their hospital. It was claimed by a nurse who worked in a private hospital that, due to the financial situation of her employer, it would be challenging to get funding for her desired training. The main issue for those who undertook training was that these additional credentials were not later appreciated by the hospital, as additional training did not always result in promotion or a salary rise. These participants, as well as well-trained doctors working in junior positions for extended lengths of time, experienced not only downward occupational mobility, but were also in a situation that could be described as 'brain waste' (Humphries et al., 2013; Salt, 1997). Furthermore, doctors who worked in private hospitals could not further progress with their specialist training as such programmes were only available in the public sector. This, in fact, was one of the reasons why private hospitals were not preferred as employers for Irish and non-Irish born doctors.

As discussed in this section, doctors and nurses had different motivations for migrating to Ireland, different adaptation experiences and different experiences of career progression. The following table summarises these differences:

	Doctors	Nurses
Migration motivations	<ul style="list-style-type: none"> • 'Push' factors: desire to gain international experience; career advancement; financial opportunities • 'Pull' factors: friends or colleagues already in Ireland 	<ul style="list-style-type: none"> • 'Push' factors: travel and adventure; better quality of life in Europe • 'Pull' factors: recruitment drives organised by Irish hospitals
Initial experience in Ireland	<ul style="list-style-type: none"> • Short periods of 'shadowing' in hospitals; positive experience • Some language difficulties during the first few months 	<ul style="list-style-type: none"> • Formal adaptation process; mixture of positive and negative experience • Issues with understanding Irish colleagues and patients
Career progression	<ul style="list-style-type: none"> • Problems with enrolling on Higher Specialist Training programmes • Often placed in 'service' positions • More complicated paths to becoming a consultant when compared to Irish and EEA colleagues 	<ul style="list-style-type: none"> • Training available and often funded by the employer • Often encouraged to apply for promotions • Some not willing to climb the career ladder for financial, professional and personal reasons

In general, doctors of non-Irish origin seemed to have rather positive experiences during their initial time in Ireland. Their expectations of career advancement through specialist training in a 'Western' country, however, were often not met. Instead they often filled positions not desired by their Irish-born colleagues and did not have an opportunity for career progression. For nurses, on the other hand, the main motivations for migration were financial rewards, travel and experiencing a different quality of life in Europe. While they had some difficulties for the first few years of working in Ireland, with time, they were able to secure positions with rather high levels of job satisfaction. They were generally also positive about their salaries. As will be explored in the following sections, these two groups also sometimes had different experiences of workplace relations in the multicultural environments of hospitals that they were working in.

4.2. Multicultural workplaces in Irish hospitals: perspectives of Irish and foreign-born health professionals

As previously explained, a multicultural workplace does not only affect foreign-born workers, but is also a challenge (or asset) for those with a native background. This section will bring together the perspectives of the two groups in order to explore a broader picture of working in an ethnically diverse environment.

It is important to emphasise that it was not only the foreign-born workers who had had a migratory experience. Some of our Irish-born participants were also either trained in other countries or had worked abroad for a significant amount of time. This was especially the case of more senior doctors, who are now at the consultant level. With very limited training opportunities in the Irish health sector a few decades ago, going abroad was the only option to become experts in their specialities. This international experience of both doctors and nurses not only enhanced their career options after coming back, but also allowed them to get a better understanding of working as a 'foreigner' in a multicultural environment elsewhere. In the interviews, they frequently referred to this experience when discussing their current workplace and relationships with their colleagues.

Both Irish and non-Irish born professionals perceived ethnic diversity in the workplace as an asset and a challenge at the same time. While they shared some opinions, they also had different perspectives on some of the issues. In this section we will explore workplace structure and intercultural relations, including language and communication, followed by a brief discussion of perceptions of ethnic diversity in the Irish health sector as a whole, in particular the issue of dealing with patients of different ethnic backgrounds.

4.2.1. Workplace structure and intercultural relations

Most of the participants worked in truly multicultural units. The majority of wards had more than a dozen nurses working on the floor, supervised by between one and three nurse managers. There were also up to three consultants supported by a number of more junior doctors, including SHOs and Registrars. In most cases there were at least a few professionals of foreign background working in such wards. Sometimes, especially among nurses, the Irish born were actually in the minority. Such diversity was present in both public and private hospitals.

Most of the consultant doctors working with our respondents were of Irish origin or had resided in the country for a significant length of time. Junior doctors varied in terms of their origin. It is important to emphasise that, with the rotation system for NCHDs, the ethnic composition of medical staff would change every six to twelve months. Nevertheless, most were of non-EEA origin, mainly from Asia and Africa. Some interviewees reported that recently there were more European doctors, often coming from Southern Europe. In general, non-Irish NCHDs accounted for about half of junior doctors working in a ward.

What featured in the interviews were the internal divisions within units, especially in the case of wards employing larger numbers of individuals. Firstly, the occupational structure seemed to have an influence, as doctors generally tended to group together, while nurses formed a separate category. In one case, a proactive member of the nursing staff succeeded in getting doctors involved in their social activities, for example competitions based on popular TV programmes. According to the nurse, it improved the atmosphere at work and also brought the two groups together. Junior doctors, many of whom are non-Irish born, saw themselves as a separate category to the consultants; they claimed, however, that they were a cohesive group with no divisions based on nationality. It was somewhat different among the nurses. In wards which had a large proportion of nursing staff from specific countries, there was evidence of 'ethnic grouping', with those who

were from minority nationalities feeling excluded. Sometimes it was the Irish who were perceived to be 'sticking together', but there were also reports of Indian or Filipino nurses forming strong social circles and not allowing outsiders to enter their group.

The majority of the participants described overall relations with their colleagues as positive and the majority did not report any significant issues. Conflict situations that occurred were mostly resolved at a local level and mostly had a professional character. There were two cases brought to a higher level and one of them was resolved with the involvement of the trade unions. This participant did not feel that it was a case of discrimination as there were also Irish-born colleagues involved in the dispute with the management. The participant involved in the second case believed that it was discrimination based on sexual orientation grounds.

Indeed, a minority of nurses with non-Irish backgrounds felt discriminated against in the workplace. Some described it as 'subtle bullying'. Such discriminatory practices included, for example, being assigned with less favourable shifts or being asked to perform tasks irrelevant to their job description. One of the EU nurses who worked in a ward with mainly Irish and Filipino nurses experienced such 'subtle bullying' on a regular basis; for others it was not an everyday issue. There were also a few Filipino nurses who claimed that their manager favoured certain staff nurses and that such 'favourism' had a personal rather than professional character. This corresponds with findings from other studies on foreign-born nurses in Ireland (Humphries et al. 2009). Interestingly, however, while these participants claimed that it was clearly related to their nationality, the same issues were reported by the Irish-born respondents. An Irish nurse, furthermore, maintained that these cases of workplace conflict could be partly explained by the fact that nursing is still a highly feminized occupation and that female working environments tend to be tense:

There are always tensions when you are working with a crowd of women. There is, it doesn't matter where they are from, there is always a tension. (Nurse, Irish, public hospital, WKIN-DUB-10)

Previous studies reported a greater extent of discrimination against foreign-born health professionals in Irish hospitals (e.g. Humphries et al., 2009). There are several explanations for the difference in findings. Some of the nurses, after the initial time in Ireland, might have gradually adapted to their work environment and become more confident. It could also be related to the fact that the majority of our respondents have lived in Ireland for at least ten years and had already obtained Irish citizenship, which gave them more freedom on the labour market. Moreover, the majority of non-Irish born nurses in our sample were from the Philippines. It was maintained by stakeholders that this group is particularly well organised and integrated within the Irish health sector. This report's finding of a relatively positive workplace integration of non-Irish born health professionals should, however, be further explored by obtaining information from a larger sample of respondents and including more diverse groups of participants.

Doctors in general did not report any conflicts that were not related to professional issues. These participants explained that their work environment is extremely tense and stressful, and therefore tensions between colleagues are inevitable. While the non-Irish born doctors did not feel particularly discriminated against in the

workplace, some felt quite strongly about the institutional discrimination preventing them from further career advancement. As this Asian doctor, who is now a consultant, explains:

Have I never faced any discrimination? Oh, I have. Oh yeah, many times. So it all depends on whether you anticipated it (...) Whether you wanted to take cognition of that and report it. It all matters. When I came, there were only a few foreigners in this country, mainly doctors. And you know, there was the community, an educated community, so there wasn't an open racism. But you know that you are being... You are not being chosen. And a local candidate is being chosen over you in a training programme. There is absolutely no way, if I had applied, to get onto a training scheme. (Consultant, non-EEA, public hospital, WKIN-DUB-09)

Having said this, most of the doctors with non-EEA background felt that the preference for European or Irish candidates on the training schemes was rather a 'normal' practice. They argued that training organisations in many other countries, not only in Europe, would give their own nationals preferential treatment. The same doctor continued to elaborate on this issue and said as follows:

If you talk to anybody in Ireland... Because the positions are limited. And preference is clearly given to people who are trained here and they have no other option. I can look at it this way: I am an Indian, I studied and did my medicine there (...). And I came here looking for a place. Whereas a guy who is trained here, he can't just go to India and start working there. So he needs to be looked after. (...) So there is a reason why it is done, and you can't go against that. So there is no point in breaking your head, you just work around it. Nobody said it was going to be easy. (Consultant, non-EEA, public hospital, WKIN-DUB-09)

Finally, workplace relations were sometimes extended after hours. Most of our participants claimed that they did socialise with their co-workers, however in most cases it was only on rare occasions. These included Christmas parties, leaving parties and birthday celebrations. The majority of interviewees explained that it was the busy work schedule that prevented them from socialising more with their colleagues. In addition, nurses worked different shifts, including nights, while most of the doctors, even at consultant level, often spent more than 50 hours per week at work.

Overall, our participants identified a number of advantages and challenges associated with the diversity in their workplaces. There was a shared view that having people with diverse backgrounds was an asset in terms of knowledge exchange. As this Irish-trained junior doctor explains:

Personally I like having people from different cultures around and I like experiencing different people's view points, and I think that can add... to the patients overall care. And different perspectives can be good. (NCHD, Irish, public hospital, WKIN-DUB-05)

Some participants felt that diversity could be challenging at times. Language and cultural differences were identified as the main sources of tensions in the workplace, particularly among nurses. While these did not seem to affect the professional performance of health workers, it sometimes had an influence on the everyday atmosphere and relations between these workers.

4.2.1.1. Language and communication

As briefly discussed in section 4.1, language was a challenge for our participants during the initial stage of adaptation in Ireland. Even though English was often the language of instruction during their education abroad, dealing with different Irish accents was sometimes difficult. This issue seemed to be largely overcome after a certain amount of time. Moreover, the foreign accents of overseas doctors and nurses were also not a major problem for those professionals who were born in Ireland. However, communication is a persistent problem in terms of 'cultural' language and the ways of communicating, as opposed to knowledge of grammar or understanding different accents. The Irish-born employees were often perceived by the foreign-born participants as almost 'too polite' and not direct enough. One of the EEA nurses, originally from Southern Europe, expressed her opinion in the following way:

You know, in my country, we are not like this, we don't need to say please or sorry or...for everything, you know. It's not like we are rude, it's the way, the culture is like that. But here, it's everything, it's 'would you mind...?'. It's all very, very polite, very...And sometimes I think it's too much. (Nurse, EEA, private hospital, WKIN-DUB-06)

At the same time, the same nurse was not entirely happy with the manner of her non-EEA colleagues, namely the Filipino CNMs, who she perceived to be too abrupt. On the other hand, one of the Irish nurses got on well with those who were originally from the Philippines but found it difficult to work with African nurses:

Like these Filipinos are really mannerly. Really mannerly...You know, we might have some black nurses occasionally, agency black nurses, coming in. And I would say... Maybe you might ask them to do something for you, and they are - 'why can't you do it?' (Staff Nurse, Irish, public hospital, WKIN-DUB-20)

The same respondent also reported difficulties with understanding the accents of those who were originally from Africa. She speculated that her lack of knowledge of their culture could be an issue; that while the African nurses may be perceived as 'being rude', it could simply be a reflection of their culture and the way they normally speak in their native tongue.

Interestingly, one of the Irish-born nurses who had worked outside of Europe for a significant length of time also criticised the 'politeness' of her fellow Irish colleagues. This was something she realised when working with other nationalities during her overseas experience. In her opinion, Irish people were not direct enough and thus could be misunderstood by somebody of a different background. She also claimed that it was something that should be challenged rather than just taken for granted. (WKIN-DUB-21)

Overall, cultural background seemed to continue to affect both Irish and non-Irish born professionals in their everyday interactions. While most of the participants recognized this as an issue, very few reflected on it in a deeper way. This could potentially lead to misunderstandings or even conflicts in workplaces, therefore this should be addressed more directly by those dealing with diversity management in Irish hospitals. It has been

argued in other studies that 'culture does not belong solely to minority ethnic groups' (Hunt, 2007: 2255). Indeed, communication issues in this case 'belonged' to different groups, including the Irish.

Finally, in those places where there were a lot of nurses of the same nationality, speaking in their own language was perceived as an issue. The management usually had introduced a policy that the official language used in the hospital is English and no other language should be spoken, even during breaks. In reality, the situation was often different. One of the Irish-born nurses who frequently worked night shifts with her Filipino colleagues felt ambivalent about it:

Sometimes at nights, you know...I know that when they started, initially, and the hospital management would have said to them 'you are not to speak your own language in the hospital'. And that was the way it was for a long time. But now, because...I am in the minority, and they are the majority. They do break into their conversations (...) You know, if we're sitting down doing our notes, they might start talking to each other. You know, three of us. And they start talking their own language, and I am just there... [laughing]. (Staff nurse, Irish, public hospital, WKIN-DUB-20)

While she claimed that it was not a serious problem for her, sometimes it was a major issue for the management. In one of the hospitals a CNM introduced a 'Filipino penalty' for those who spoke Filipino on any occasion while on the hospital grounds. While the nurses understood that they should be using English, in this case they also felt offended as their nationality was highlighted and there was no mention of doctors using their national languages during their breaks (WKIN-DUB17).

4.2.3 Multicultural workers and multicultural patients

As previously discussed, the profile of healthcare professionals has changed in Ireland as the entire country has become more multicultural. This has been especially the case in Dublin, where some of the inner-city hospitals deal with people of many different nationalities. Once again, having a diverse workforce was perceived as an advantage here. Being able to translate was one of the assets and cultural familiarity between some of the patients and staff was perceived as a positive aspect. It was, for example, common knowledge amongst respondents that a Muslim woman should be seen by a female doctor and preferably of Muslim background too.

While this was a positive aspect of workforce diversity in Irish hospitals, some of the doctors and nurses also experienced a certain level of discrimination from patients. It was especially the case of older Irish people, who preferred to be seen by an Irish doctor. Interestingly, while professionals with foreign backgrounds claimed that this did not upset them when it happened, their Irish colleagues were very unhappy about it. One of the nurses in our sample said that it was unacceptable for a patient to be 'racist' and she compared this to her experience in the UK, when she did not want to be treated in a different way just because she was Irish. Her attitude was a clear example of how the migration experience of Irish professionals affected their perception of diversity in Irish hospitals. Interestingly, hospital management did not report any cases of discriminatory behaviour towards non-Irish doctors.

5. Transnational dimension

Most of those who participated in the study have lived in Ireland for a significant length of time and some of them have been here for more than ten years. This was especially the case with nurses, who came to Ireland through the initial recruitment drives of the early 2000s. The majority also had achieved long-term residency or citizenship and no longer required work permits. This is of great importance, as they were not tied to an employer to the extent that they perhaps were before.

Most of those of non-EEA origin had their partner and children living with them in Ireland, however they stayed in touch with extended family members and friends back home. Those from Asia and Africa mainly kept in touch by phone calls and the Internet, however, some of them did travel back home every few years. Nevertheless, this option was expensive and also complicated. These health workers were often prevented by their managers from taking longer periods of holidays in order to travel back home. This, in fact, depended on specific hospital policies or even on a specific unit. One of the Irish nurses who worked in a large hospital told us that it was not a problem for her Filipino colleague to go home for a few weeks. In fact, she was allowed to take some time off during Christmas one year, which is generally not common practice. The situation was completely different in another place. One of the Irish-born nurses who took part in this study perceived the holiday issue as a serious problem. This is how she felt about it:

But the management are very cruel in their annual leave towards the girls. It just happened years ago, that they used to get five weeks off. Because it's a long, long way home, for those girls. Now they stopped all of that. And management have said 'well, you know, the Irish nurses are just as entitled to the same amount of time, and not everybody in the ward can get five weeks off'. So they cut it back to three weeks. (...) Not allowed off for Christmas (...) You either work Christmas or New Year. You are not allowed to go home for Christmas. (...) I really think that is cruel. For ten years, these girls haven't seen Christmas at home. (Staff nurse, Irish, public hospital, WKIN-DUB-20)

Interestingly, the management of all hospitals that our participants worked in were extremely supportive after the 2012 typhoon in Philippines. Like in the public hospital that was discussed in section 3, most of the hospitals had fundraising events. This even happened in those organisations that are charity-funded and normally would not allow any events like that on their grounds. One of our respondents also went to the Philippines to help there as a volunteer; in fact, the employer allowed her to take paid leave in order to do that:

There was a letter from the Minister of Health, from the HSE, that it will be a paid leave for one month. So they did that, and I spoke to the matron and they were really supportive, maybe because I'm really from that place. Yeah, I'm really delighted that they allowed me to do that. (CNM1, non-EEA, public hospital, WKIN-DUB-14)

In addition to keeping in touch with family and friends in their countries of origin, some of our participants also had friends and colleagues in other countries, particularly in the UK. These international networks seem to be

a result of the further mobility of health workers. A number of participants, especially doctors, reported that a significant proportion of their colleagues with non-Irish background had left Ireland and moved overseas to seek better opportunities. The UK was perceived as a more favourable place for medical professionals as the career paths were more structured and there were more consultant posts available. This is an issue documented by other studies. As argued by Humphries et al. (2013), the Irish health sector can be characterised by a cycle of brain drain, brain gain and further brain drain. Irish doctors emigrate in the first place, due to poor working conditions and difficulties with career progress in Ireland. This creates significant shortages, which are filled by those coming from overseas. As the well-qualified non-EEA doctors often then experience 'brain waste', after a period of time spent in Ireland, they then decide to seek better opportunities elsewhere.

In the interviews, a lot of our participants also discussed the possibilities of further international mobility. In the past they had considered going to the Middle East due to the excellent financial package offered to them in these countries. This was, however, no longer an option, due to the political situation in that region. Some were thinking about moving to the UK, as they believed it was easier to become a consultant over there. Others felt that they would ultimately leave Ireland due to the lack of career progression but were unsure of when and where they would go. This is how one of the junior doctors, currently working in a private hospital, described his future plans:

Ultimately I would go somewhere. My plan is maybe go back home ultimately. But in between I don't really mind. As long as there's a chance and an opportunity, I would go there. (...) After I finished my medical school my career was going upward, but now I have stepped aside. So I might need to push to the registrar level and I might need to go a little bit further up (...) and once I feel stagnant for the second time, I will go somewhere. (NCHD, non-EEA, private hospital, WKIN-DUB-22)

Furthermore, career paths were not the only issue when considering moving somewhere else. For example, it seems to be the case that the healthcare system in some of the sending countries has improved significantly over the past number of years. Going back would thus not only mean better professional opportunities, but also a much improved material situation. Finally, the social standing of doctors in those countries was, according to one junior doctor, much higher:

[Name of the Asian country] was flourishing hugely, economically. (...) medical scene has changed so much. It's taken off big time, because of the improving economy and improving ability to spend. Huge changes now. So people who were trained with me, who are consultants in [name of the country], are...I can't imagine. They have their own, maybe 200-bed hospitals, they are huge consultants, and they do fantastic work. When I was just appointed here, the crash came in and everything came down, and you had more pay-cuts here. So, although professionally it's a great place, socially and financially it is not as good...Nowhere near to what it would be if I was living in [name of the country]. I will be making ten times easily more than I am making here. And I will be spending about a quarter of the amount that I am spending here and have a better quality

of life right now. Plus the social status in [name of the country] for a doctor is something different. It is different there, they look up to you. And you are respected. (Consultant, non-EEA, public hospital, WKIN-DUB-09)

What kept this doctor in Ireland, however, were his children and the better educational opportunities they may have in Europe. This was a common feature in a lot interviews. Many of our respondents had children who were still in school here and it was the aspiration of their parents that they would later attend a good university either in Ireland or in the UK. Therefore, even though further mobility was often considered, it was rather something that may happen in the future. Only one participant, who was a doctor originally from an EEA country, was actively seeking employment abroad. All the others were considering it, but not making any formal inquires about such possibilities. Most the respondents also felt that their experience in Ireland would be easily transferable to other countries, including their country of origin. Even though some elements of their practice were different, medicine was generally perceived as an international, rather than country-specific, profession.

6. Conclusion

As discussed throughout this report, the migration of health professionals to Ireland can be perceived as both a challenge and an advantage. From a management perspective, foreign-trained health workers are crucial as they fill severe gaps in Irish hospitals. They also bring their skills and knowledge, especially if they are highly qualified in specialised areas. Furthermore, with the changing profile of patients in Ireland, particularly in Dublin, having diverse workforces in hospitals was considered desirable. It was generally agreed that having health professionals of different backgrounds caring for patients from similar cultures to theirs was a positive aspect of such diversity.

While the managers' expectations were mostly fulfilled, the individual stories of health professionals varied. Foreign-born doctors faced institutional discrimination on a systemic level. It needs to be emphasised that many of them came to Ireland in order to gain international training and experience. While some of them succeeded, and eventually became consultants, some were offered service posts with limited training options. This had a significant impact on their experience of the Irish workplace. It was claimed by most of the foreign-born doctors that achieving consultancy posts was more challenging and more time consuming for them. They reported major difficulties with accessing structured training programmes, which negatively influenced their career progression. This is a result of the policies of the main training bodies, which prioritize Irish and EU citizens when allocating places on the Higher Speciality Training Programmes.

Most of the nurses, on the other hand, left their countries of origin for financial and lifestyle reasons. Some deliberately did not apply for a promotion as it would mean financial loss as well as undesirable administrative duties. It needs to be emphasised, however, that a large proportion of nurses who participated in this study were encouraged to apply for managerial positions. It was their decision to decline this option.

Furthermore, the majority of this study's participants worked in multicultural units. Overall workplace relations can be described as positive; however there were internal divisions within the wards that they worked in. Firstly, doctors and nurses seemed to form distinct groups and while working together professionally, they did not really form social relationships. There were also ethnic divisions amongst the nurses, which occurred when a large number of people from one country were working in the same unit. This was a problem for those who did not belong to that national group.

Participants were also occasionally involved in conflict situations at work; however the majority had a professional or personal character rather than a cultural or ethnic one. There were, nonetheless, a number of non-Irish born nurses who felt discriminated against at work, for example in the allocation of shifts. However, some of their Irish colleagues also felt that they had not been treated fairly, which poses the question of to what extent the discrimination felt by the non-Irish born nurses was based on their ethnicity.

All of the respondents perceived their multicultural workplaces as both an asset and a challenge. They believed that working with people of different backgrounds brings together different skills and expertise. At the same time, cultural differences, in particular communication problems, seemed to pose the biggest challenge to workplace relations. This was an issue reported by both Irish and non-Irish born professionals, particularly nurses. While the Irish were often perceived as 'too polite', those coming from African and Asian countries were frequently regarded as 'abrupt'. These cultural differences, as opposed to linguistic competency, influenced everyday relations in the workplace. However, they were argued not to adversely affect professional performance and patients' welfare. There was, moreover concern about foreign-born nurses speaking their native tongue in the workplace, to the exclusion of those of other linguistic backgrounds.

The presence of different cultures in the workplace helped Irish-born professionals to understand some of their non-Irish born patients better. However some of the Irish patients preferred to be treated by Irish doctors and nurses, which was seen as particularly unacceptable by Irish-born nurses.

Finally, the transnational dimension was of importance for participants. Most kept in touch with those back home, although the majority had their immediate families based in Ireland. Further mobility was also considered. This was especially the case for doctors who felt that their career progression in Ireland was unsatisfactory. They discussed the possibilities of moving either back home or to another country, where the system would allow them to achieve senior posts in a more structured way. Medical skills were also perceived as international and consequently the transferability of skills was not envisaged as an issue. Nevertheless, as many had children in Ireland who were of school-going age, all of those plans have been made for a distant rather than an immediate future.

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Annex: List of interviews**Table 1: Hospital Employees**

Interviewee's Code	Occupation and Grade	Region of Origin	Region of Training
WKIN-DUB-01	Staff Nurse	EEA	Ireland
WKIN-DUB-02	NCHD	EEA	EEA
WKIN-DUB-03	NCHD	Africa	Africa
WKIN-DUB-04	NCHD	Africa	Africa
WKIN-DUB-05	NCHD	Ireland	Ireland
WKIN-DUB-06	Staff Nurse	EEA	EEA
WKIN-DUB-07	Staff Nurse	Africa	Africa
WKIN-DUB-08	HR	Ireland	n/a
WKIN-DUB-09	Consultant	Asia	Asia
WKIN-DUB-10	Staff Nurse	Ireland	UK
WKIN-DUB-11	Consultant	Ireland	Ireland/USA
WKIN-DUB-12	Consultant	Ireland	Ireland/UK
WKIN-DUB-13	Staff Nurse	Asia	Asia
WKIN-DUB-14	CNM	Asia	Asia
WKIN-DUB-15	Nursing Admin	Ireland	Ireland
WKIN-DUB-16	SHO	Asia	UK
WKIN-DUB-17	Staff Nurse	Asia	Asia
WKIN-DUB-18	Staff Nurse	Asia	Asia
WKIN-DUB-19	Consultant	Africa	Africa
WKIN-DUB-20	Staff Nurse	Ireland	UK
WKIN-DUB-21	Assistant Director of Nursing	Ireland	Ireland
WKIN-DUB-22	SHO	Asia	Ireland

WKIN-DUB-23	HR Manager	Ireland	n/a
WKIN-DUB-24	CNM	Asia	Asia
WKIN-DUB-25	Staff Nurse	Asia	Asia
WKIN-DUB-26	Staff Nurse	Asia	Asia
WKIN-DUB-27	CNM	Ireland	Ireland
WKIN-DUB-28	Staff Nurse	Asia	Asia
WKIN-DUB-29	Staff Nurse	Asia	Asia
WKIN-DUB-30	Staff Nurse	Asia	Asia

Table 2: Stakeholders

Interviewee's Code	Role/Organisation
STH-DUB-01	Researcher (Training Body)
STH-DUB-02	Independent Hospitals Association of Ireland
STH-DUB-03	Trade Unions
STH-DUB-04	School of Nursing (University)
STH-DUB-05	School of Medicine (University)
STH-DUB-06	Researcher (University)
STH-DUB-07	Irish Medical Council
STH-DUB-08	HSE