Supporting International Nurse & Midwife Graduates

health

Literature Review

Overview

This literature review was undertaken in 2011 by the Nursing and Midwifery Policy unit as part of a review of the Department's International Nurse & Midwife Graduates (INMG) Bridging Program Grants. Specifically, the literature review supported the policy work for revising the grant structure to provide a more targeted program with greater accountability and clearer outcomes.

In 1999, the former Department of Human Services commenced funding of the Pre-Registration Scholarships for International Nurse Graduates Program to help INMGs[1] meet the requirements of registration in Victoria. Since that time more than 400 scholarships have been provided to individuals (via approved course providers) who have been assessed by the regulator as needing to undertake a pre-registration or bridging program prior to being registered in Victoria/Australia.

To inform the policy and revision of the program, the literature review focused on the barriers and facilitators of workplace adjustment of INMGs and on identifying the structural and organisational responses to support INMG workplace adjustment and retention. The review includes national and international literature published after 2000, covering health systems that are similar to the Australian health system.

In her work focusing on supportive interventions that assist overseas nurses to adjust to Australian nursing practice, Konno (2006) found that the amount of published research was very limited. In 2007, Jeon & Chenoweth found there were few research-based reports. Given the lack of research-based reports, and the level of evidence in Konno's paper being the highest of those reviewed, this paper is based on those findings of Konno that are relevant to the workplace adjustment of INMGs. Konno was able to meta-synthesise a total of two phenomenological papers but found that other identified studies, while not having high levels of evidence, nevertheless largely supported the syntheses. Similarly, the five literature reviews included in this paper[2] support Konno's findings, as do the included case series and expert opinions.

Utility of the review

From 2012-13, the department's revised INMG Employment Support Grants are available to eligible health services to tailor individual and organisational activities to meet the specific needs of the INMG they employ who are working for the first time in Australia as a nurse or midwife. This literature review is recommended as an evidence base to inform employers' decisions made about the focus of support an INMG may require.

[1] In this context INMG refers to nurses and midwives who obtained their professional entry qualifications and initial registration in a country other than Australia or New Zealand and specifically those from countries where the healthcare and social context are sufficiently different to potentially affect professional practice standards.

[2] Consisting of one 'systematic', three 'integrative' and one 'selected' review, and another 'literature' review.

Summary of the findings

Global movement of healthcare professionals occurs as a result of various factors and INMGs are making the decision to migrate to Australia. Once here, they can encounter homesickness, social isolation and loneliness in the workplace. There is a strong link between isolation and the inability to communicate effectively in English, and ineffective communication contributes to cultural clash. There is also conflation of language difficulties and lack of professional ability. Isolation, language difficulties, cultural clash and Australian ethnocentricity constitute barriers to INMGs adjusting to the Australian workplace. Overcoming these barriers requires cultural responsiveness at systemic, organisational and individual levels, the promotion of formal and informal networks, and the involvement of English language experts.

There is minimal research into the effectiveness of transitional (or bridging) programs in general (Zizzo & Xu 2009) and none on the bridging courses completed by INMGs who received scholarships. There is also limited evidence of how INMGs make the transition to the Australian health care system once they achieve registration (Jeon & Chenoweth 2007).

Background

The global movement of healthcare professionals, especially in nursing and medicine, is occurring as a result of various factors, including conflict, political and social unrest, economic instability, environmental disasters, family reunion and refugee schemes (Jeon & Chenoweth 2007).

In some developing countries, such as the Philippines and parts of India, an excess of nurses is educated with a view to migration (Woodbridge & Bland 2010).

The decision to migrate is complex (Alonso-Garbayo & Maben 2009) and in migrating to Australia, INMGs may be seeking asylum, personal and professional development, better wages and working conditions, greater job satisfaction and/or higher standards of living (Alonso-Garbayo & Maben 2009; Deegan et al. 2009; Jeon & Chenoweth 2007, Nichols & Campbell 2010). They may also be responding to the Department of Immigration and Citizenship's inclusion of nursing and midwifery on the Skilled Occupation List and the associated statement that there is "a shortage of nurses and excellent career opportunities in Australia".

Barriers to INMG workplace adjustment

Dislocation from family and friends

INMGs often feel homesick, socially isolated and lonely in the workplace (Wellard & Stockhausen 2010; Deegan & Simkin 2010; Brunero & Bates 2008; Konno 2006). Konno notes that the feeling of being an outsider and its associated problems, such as the complexity of English in nursing practice, is discussed in all the research-based and expert opinion papers in her study.

Oral and written communication

There is a strong link between social isolation and the inability to communicate effectively in English (Wellard & Stockhausen 2010; Konno 2006) and INMGs commonly face the difficulty of ineffective communication with colleagues, patients and families (Takeno 2010; Jeon & Chenowth 2007). Enunciation and pronunciation are problematic, as are colloquial expressions, semantic differences, jokes, sarcasm, euphemisms, jargon, the names of medications and equipment and abbreviations (Wellard & Stockhausen 2010; Woodbridge & Bland 2010; O'Kougha & Tilki 2010; Blythe et al. 2009; Tregunno et al. 2009; Kawi & Xu 2009; Omeri 2006). These difficulties are particularly pronounced when using the telephone (Woodbridge & Bland 2010; Tregunno et al. 2009; Kawi & Xu 2009).

Professional ability and language problems are separate issues (Takeno 2010) but accent and language deficiency can negatively affect patients', peers' and supervisors' perceptions of competence (Xu & Kim 2008). Accent and language deficiency can also undermine the potential to practise competently, to advocate for patients, to be a team member, and to gain opportunities for professional development (Xu & Kim 2008; Jeon & Chenoweth 2007; Konno 2006). In addition, INMGs speaking their own languages at work can be a source of contention and conflict (Xu et al. 2008).

Cultural incongruence

Jeon and Chenoweth (2007) observe that communication in a language different from one's own is not a skill that is mastered through study alone. Language is part of the fabric of a culture that may convey meanings known only to those who live in that culture.

(Nursing) Culture

The essence of nursing is universal but the practice of nursing is socially shaped and is reflective of socio-cultural, political and economic contexts (Smith et al. 2011; Mattson 2009). Recurrent themes in the Nichols & Campbell integrative review of studies in the United Kingdom (2010) are the different understandings of the role and purpose of the nurse. INMGs, with significant years of experience and sometimes in senior roles, encounter culture shock and surprise at unfamiliar nursing roles and unfamiliar approaches to patient care.

In line with the findings of Nichols and Campbell, Mattson (2009), in writing about the United States, observes that nurses carry their cultural values and perspectives into the healthcare setting and that these values and perspectives are often in conflict with, or at least different from, American values. These values include patients' autonomy, an individualistic approach to relationships, and peer relationships rather than hierarchical ones.

Xu et al. (2008) draw on a range of sources in identifying the differences between Western and Asian nursing practice, including the requirement for accountability; INMGs are often unaccustomed to the legal significance and the time-consuming nature of nursing documentation in Western healthcare. Differences in scope of practice are evidenced by the perception of many Asian nurses that assisting with activities of daily living is 'deskilling' and 'a waste of education', and in their frustration that Western families are largely uninvolved in these activities. In their home countries, this type of nursing would usually be carried out by untrained workers or family and is therefore viewed as unskilled (Nichols & Campbell 2010). Conversely, Xu et al. (2008) note that some immigrant nurses to the UK found the nurse's role there to be narrow and restricted as fewer UK nurses performed the technical skills that these INMGs view as central to their identity. Furthermore, they found the plethora of specialist nursing roles as a further fragmentation of their role. In rural Australia, on the other hand, Francis et al. (2008) observe that most of the INMGs recruited for their study were nurses who lived and worked in major metropolitan hospitals in their country of origin and were specialists rather than generalists. They had to adjust to working in most wards/units.

The Canadian study of Tregunno et al. (2009) cites the role of patients and families in decision making as another point of difference, while Takeno (2010) includes psychological support of patients as an area that can vary widely between nursing cultures.

(Dominant) Culture

Tregunno et al. (2009) suggest that INMGs 'take a U-turn from clinical expert to cultural novice when they enter practice in their adopted country'. They observe that a striking feature of the literature is the subtext that depicts successful workplace integration as assimilation into the dominant culture – 'In

other words, successful integration occurs when the migrant nurse has taken on the values, behaviours, norms and lifeways of their domestically educated counterparts'.

Jeon and Chenoweth (2007) refer to INMGs being 'surrounded by a dominant culture' and losing the confidence to employ previously learned skills, to exercise their own cultural approaches to care, and to respond to their own values and ethics. They challenge the view that INMGs must adjust to the ethnocentric (Smith et al. 2011) Australian way or improve the quality of their care, and note that there is a lack of evidence that 'a peculiarly Australian way of nursing' is superior to others. They further suggest that the imposition of a particular worldview may cause the loss of INMG knowledge and skills and disadvantage members of culturally and linguistically diverse populations. This view is supported by Nichols & Campbell (2010).

The potential problems of INMGs seem greater than the potential contribution of mirroring a culturally and linguistically diverse population and providing culturally congruent care (Woodbridge & Bland 2010; Jeon & Chenoweth 2007). The 'socio-cultural capital' that INMGs from non-Anglo backgrounds bring with them does not appear to be viewed as a valuable asset (Office for Women's Policy et al. 2006).

Lack of support in the clinical environment and being relegated to novice status contribute to feelings of disempowerment (Deegan & Simkin 2009; Konno 2006) while the over-helpfulness of colleagues undermines professional ability (Takeno 2010). INMGs may be clinical experts and novices in culture and fluency at the same time (Tregunno et al. (2009).

Which structural and organisational responses support INMG workplace adjustment and retention?

From the two syntheses of her qualitative research findings, Konno (2006) identified two needs:

- Transition programs must address the clash of cultures between overseas nurses and the dominant Australian culture, and
- Formal networks must be provided for overseas nurses, as well as support to facilitate the establishment of informal networks.

These syntheses and Konno's subsequent implications for practice were supportive of findings from other studies and are in turn supported by the literature reviews, case series and expert opinions included in this paper.

Addressing cultural clash

Addressing cultural clash requires an infrastructure that promotes and values cultural diversity and a two-way exchange of knowledge, experience and openness to new ideas (Nichols & Campbell 2010; Office for Women's Policy et al. 2006). Local nurses and midwives who know more about the human face of INMGs and who understand what they go through to achieve immigration, registration and adjustment to a new life and work, contribute to a culturally safe environment where mutual respect reigns (Nichols & Campbell 2010; Woodbridge & Bland 2010; Jeon & Chenoweth 2007).

It may be said that a culturally safe environment is the product of a culturally competent approach. There are various definitions of cultural competence (Victoria University 2009). The National Health and Medical Research Council (2006) defines the concept as a set of congruent behaviours, attitudes and policies that integrates culture into health services and is much more than an awareness of cultural differences. Cultural competence

- values diversity
- has the capacity for cultural self-assessment
- is conscious of the dynamics that occur when cultures interact

- institutionalises cultural knowledge, and
- adapts service delivery so that it reflects an understanding of the diversity between and within cultures.

There are also criticisms of the concept of cultural competence. Gregg & Saha (2006) maintain that cultural competence, in trying to define cultural boundaries or norms, may inadvertently reinforce racial and ethnic biases and stereotypes while doing little to clarify complex socio-cultural contexts. The idea of 'a culture' being considered as a neatly packaged and separable whole is antiquated, and individuals invariably belong to multiple cultures. Gregg & Saha go on to maintain that cultures are non-distinct, that individual behaviour is not determined by any set of definable cultural norms, and that an individual's race or ethnicity cannot serve as a guide for how one should interact with them. They believe that the concept of 'cultural competence' tends to oversimplify the notion of culture, that it does not treat culture as a dynamic and changing factor, and runs the risk of perpetuating cultural stereotypes.

Victoria University (2009), commissioned by the former Victorian Department of Human Services to review cultural and linguistic diversity and cultural competence in Victorian health services, notes the complexity of conceptualising and applying cultural competence to health care, and adopts the term 'cultural responsiveness' instead. Cultural responsiveness refers to being aware of, and capable of functioning in the context of cultural difference. It relates to being relevant to the needs of culturally and linguistically diverse communities whose members identify as having non-mainstream cultural or linguistic affiliations by virtue of their place of birth, ancestry or ethnic origin, religion, preferred language or language spoken at home.

The concepts of cultural competence and cultural responsiveness both rely on being built into all levels of culturally diverse infrastructure: in systemic, organisational and individual practice. The acquisition of skills, knowledge, attitudes and behaviours that define cultural competence or cultural responsiveness in an individual can only be fostered when they are an integral part of the wider system (Victoria University 2009; Office for Women's Policy et al. 2006).

Establishing networks

Konno found that the difficulty of entering Australian culture from diverse cultural backgrounds was widely discussed and the use of preceptorships or 'buddy' nurses was reported to facilitate INMGs' adjustment to Australian nursing culture – 'If strategies to assist overseas nurses to establish informal networks of friends and professional colleagues were in place, the transition to becoming effective practitioners could be enhanced'.

Nichols & Campbell (2010) cite the central importance and value of a good mentor and the Office for Women's Policy et al. (2006) recommend champion/mentoring support, including a 'buddy' system and/or a mentoring model where the support is targeted. Champions or mentors can be accessed from the local community, from private business, local councils and health organizations, creating supportive and nurturing environments around individuals who would welcome this approach. In addition to a 'champion model' of support, this report notes the consistent identification of the need for an independent advocate/support person for INMGs.

Networks and communication

In acknowledging the strong link between social isolation and the inability to communicate effectively, Konno recommends the involvement of English language education specialists in bridging programs. Similarly, the Office for Women's Policy et al. (2006) recommends access to social and vocational language programs. Such programs would include the social rules of communication, Australian colloquialism and the terminology of the Australian health system. These recommendations are

supported by Zizzo & Xu (2009), who maintain that language or communications skills training must be an integral part of an evidence-based transitional program.

Retention in rural areas

The literature of immigration and health workforce has minimal specific exploration of regional or rural practice contexts, and where there is interest in rural workforce, it is predominantly focused on medical graduates (Wellard & Stockhausen 2010). Wellard & Stockhausen note that in Australia, doctors' levels of satisfaction with factors such as family and personal resettlement, access to education for children, opportunities for spousal employment and contact with their own ethnic community, are closely linked with retention. Many Australian communities have developed active social integration programs to assist overseas trained doctors to find accommodation and social 'fit'.

The recruitment of INMGs into rural health settings is vastly different from recruiting into metropolitan settings with multiethnic staff and clientele (Wellard & Stockhausen 2010; Blythe et al 2009). These Australian researchers argue that INMGs contribute significantly to the social capital of their communities through their immersion in the social networks integral to rural life.

Francis et al. (2008) note that rural hospitals in Victoria have recently had difficulties recruiting nurses from the USA and UK and have been more successful in recruiting from Malaysia, Singapore and African countries. In their pilot report they conclude that recruitment of married INMGs is more sustainable than the recruitment of single nurses in rural areas. For the 'married women', securing a position in a hospital was an important part of the journey. They were committed to working for the organisation beyond the expected contract time as it provided some semblance of security and belonging. However, the process for the hospital and potential employees is costly. 'Rural hospitality' diffuses some of the expense by providing cheap accommodation and the loan of household goods. Members of staff continued to provide support to the INMGs in this pilot study by engaging them with the local community, but the extended supernumerary costs and facilitating part-time work on completion of contractual arrangements are burdensome hidden costs for rural employers.

Cultural responsiveness framework in Victoria

Governments at state and federal levels have developed policy and legislative frameworks which stipulate the need for health care systems and health professionals to be culturally responsive to ensure high quality health care for the whole population. To address cultural diversity in Victorian health, the Department of Health developed the Cultural responsiveness framework – Guidelines for Victorian health services (2009). This framework articulates six standards for culturally responsive practice in Victorian health services:

Standard 1: A whole-of-organisation approach to cultural responsiveness is demonstrated

Standard 2: Leadership for cultural responsiveness is demonstrated by the health service

Standard 3: Accredited interpreters are provided to patients who require one

Standard 4: Inclusive practice in care planning is demonstrated, including but not limited to dietary, spiritual, family, attitudinal, and other cultural practices

Standard 5: Culturally and Linguistically Diverse (CALD) consumer, carer and community members are involved in the planning, improvement and review of programs and services on an ongoing basis

Standard 6: Staff at all levels are provided with professional development opportunities to enhance their cultural responsiveness.

While the focus of this framework and its standards is patient care, they could equally be applied to the care and inclusion of INMGs.

Conclusion

There is general agreement in the literature about the global movement of nurses and midwives and the reasons for it. There is also agreement that the decision to migrate to Australia is often a complex one and that adjustment involves adaptation to personal, professional, social, cultural and organisational experiences in new environments (Kawi and Xu 2009).

Significant numbers of INMGs continue to arrive in Victoria. The literature indicates that many encounter barriers to adjustment in the workplace through social isolation, difficulties with communication in English and cultural clash. The literature indicates that most INMGs in Victoria, and by extension the public health system and the public interest, would benefit from systems and approaches described in the Cultural Responsiveness Framework For Victorian Health Services. While this framework is focused on patient care, it could also support the inclusion of INMGs, development of formal and informal networks for INMGs within and around health services, and the involvement of English language specialists.

Nursing & Midwifery Policy

July 2012

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