

THE TRANSITION TO PRACTICE IN CANADA:
THE EXPERIENCES OF NURSES EDUCATED OUTSIDE OF CANADA

by

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Abstract

To address the current and predicted nurse shortage in Canada many organizations are recruiting nurses from abroad (Canadian Nurses Association [CNA], 2002b). It is projected that in order to meet future demand estimates, an increasing number of nurses educated outside of Canada will need to be recruited. Across Canada in 2002, there were more than 1800 new nurse registrants from other countries, a significant increase from the 1,072 who registered in 2000 (Barry, Sweatman, Little, & Davies, 2003; CNA, 2002b).

The transition to practice engages nurses in a complex, challenging process of adaptation. The purpose of this study is to describe and understand the experiences of nurses, educated in a country other than Canada, as they make the transition to practice within the Canadian health care system.

A qualitative design using ethnographic methods of data collection, namely in-depth interviews, was used in this study. For the purposes of in-depth interviewing it was important that the participants were able to provide a rich description of their transition experience to practicing in Canada. For this reason purposeful sampling was utilized to select the 13 participants. Participants include 11 women and 2 men who had moved to Canada in the past 4 years from Australia, Britain, and the Philippines. Seven of the participants were married and five had children. There were six nurses with work permits, another six have landed immigrant status and one is a permanent resident. Most were employed full-time in acute care; one nurse was unemployed at the time of the interview.

The participants' descriptions of the experiences of making the transition to practice in Canada led to a better understanding of why nurses choose to move, misconceptions that occur related to relocation, and challenges nurses experience in adapting to Canada. Other

themes identified in the findings include: isolation, professional support, questioning one's own competence, feeling valued, and the significance of work and social support networks. Recommendations identified from the findings relate to government sectors of human resources, customs, and immigration, regulatory bodies, health care organizations, future immigrant nurses, and research.

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◀ Chapter 1 ▶

Introduction

To address the current and predicted nurse shortage in Canada many organizations are recruiting nurses from abroad (Canadian Nurses Association [CNA], 2002b). Nearly half of the registered nurses in British Columbia (BC) received their education outside of the province (Branswell, 2003). In 2000, of the 948 new registrants in BC more than 19% were from other countries, which is a 10% increase over 1999. The majority of these new registrants came from the Philippines ($n = 97$), followed by Britain ($n = 23$), the United States ($n = 19$), and Australia ($n = 17$) (Registered Nurses Association of British Columbia [RNABC], 2001). Ryten (1997) projects that in order to meet future demand estimates, an increasing number of nurses educated outside of Canada will need to be recruited. More recent projections for the addition of nurses between 2001 and 2010 show that the recruitment of nurses educated outside of Canada is expected to add 11,700 new nurses by 2011 (CNA, 2002b).

Although one may project the need for nurses educated outside of Canada, the actual number of additions of these nurses is very difficult to project due to the statistical irregularities of their commencing nursing practice in Canada (CNA, 2002b). Some immigrants may decide not to practice as a nurse in Canada while others may not successfully pass the registration exam. Adding to the Canadian supply of nurses is not directly related to attracting more immigrants who are nurses, but more about how many will actually become registered nurses when in Canada. Across Canada in 2002, there were more than 1800 new nurse registrants from other countries, a significant increase from the 1,072 who registered in 2000 (Barry, Sweatman, Little, & Davies, 2003; CNA, 2002b). According

to the CNA (2002b), nurses who immigrate are typically between the ages of 35 to 44 when they start practicing in Canada. Consequently, their nursing careers are shorter, making a successful transition into the Canadian health care system essential.

Yet nurses who have emigrated from other countries to work in Canada often share stories of the challenges they experienced in making the transition into a new health care system. Often their self-confidence and belief in their ability as a nurse is shattered when they begin to practice in a new setting (Pilette, 1989). One is compelled to question what it is about such a transfer from one country to another within the profession of nursing that creates immense challenges and potentially devastating effects, and how nurses educated outside of Canada can best overcome these obstacles. Colleagues of mine who have immigrated to Canada share similar stories. At times they doubted their decision to move and thought it would have been easier to return home to their original country and position rather than to continue nursing in Canada. They expressed anxiety and stress around encountering a whole new health care system and numerous differences in practice. What helped these nurses succeed through such a challenging transition time? What enabled them to confidently, competently, and safely practice nursing? How did they get over the hurdles of low self-esteem, lack of confidence, disillusionment, and confusion?

Throughout this paper reference to “nurses” is focused on those who are non-Canadian born registered nurses who completed their nursing education in a country other than Canada, unless otherwise specified. These nurses may have immigrated to Canada to live permanently or temporarily migrated to fulfill a short-term contract. They came voluntarily by their own choosing and legally traveled or immigrated here to reside and work (Boyle, 2003). It is recognized that there may be Canadian registered nurses who completed

their education in another country; however, because the aim of this study is related to issues of migration and transition to a new country, this group was excluded from this study.

Problem Statement

There are no studies to date specifically exploring the transition process experienced by nurses from other countries when coming to Canada. Furthermore, most of the studies pertaining to nurses practicing in countries different from where they were educated have been completed in the United States and Britain. Lipson, McElmurry, and LaRosa (1997) identify that much of the literature focuses on the physical and psychological dysfunction experienced by immigrants rather than highlighting individuals who have had a successful transition. Research needs to focus on the dynamics of adaptation, which, although difficult to characterize, provides a more realistic perspective of migration (Lipson et al.). Making a transition to practice in Canada engages nurses in a complex, challenging process of adaptation. In this study the experiences of transition were explored, thereby beginning to fill a gap in research and potentially be the impetus for an expanding body of research.

The transition experience needs to be explored to enable a full understanding of the nurses' responses to the stress of migration (Meleis, 2003). Cravener (1992) notes that even highly skillful, resilient individuals may experience difficulty and inadequacy of their coping skills when confronted by the multiple challenges of immigration. Hence, it is predictable that a proportion of immigrants could definitely benefit from services designed to assist with the transition to the new culture. When both the physical and psychological needs of the nurse are met, there is increased job satisfaction and professional performance (Dijkhuizen, 1995). The primary issue of concern is the transition experience of nurses educated outside of Canada.

Purpose

The purpose of this study is to describe and understand the experiences of nurses, educated in a country other than Canada, as they make the transition to practice within the Canadian health care system. The thesis is organized in five chapters. An introduction and background to the issue of study was presented in Chapter 1. An overview of the literature related to the stressors of migration, migration and women, and migration and nurses comprises Chapter 2. In Chapter 3 there is a discussion of the research method used to complete the research. The findings of the study are outlined in Chapter 4 with a summary of findings, conclusions, and recommendations in Chapter 5.

◀ Chapter 2 ▶

Literature Review

The impetus to explore the transition experience of nurses educated outside of Canada to practicing within the Canadian health care system came from reading the literature synthesis *Immigrant Women and Their Health* by Aroian (2001), combined with overseas recruitment by my employer at the time. The synthesis provided direction to further exploration of the literature. To facilitate the search of the literature the Cumulated Index to Nursing and Allied Health Literature (CINAHL) (1982 – 2003), MEDLINE (1980 – 2003), and the Social Sciences Citation Index (1992 – 2003) were utilized in retrieving articles in the time periods specified within the parentheses. The key search words/phrases used independently or in conjunction with “nurse” or “education” include: foreign, immigrant/immigration, international, assimilation, acculturation, adjustment process, recruitment, and travel. Other search words were: race, racism, racialization, marginalization, discrimination, culture, cultural safety, and social well-being. Using the aforementioned words the library systems of the University of British Columbia (UBC) and the RNABC were also searched. The references of each article were also reviewed for potential literature that would be beneficial to examine. The research that was reviewed is summarized in Appendix A. The literature reviewed is organized around core themes: stressors of migration, migration and women, and migration and nurses. A summary of the state of knowledge will be presented followed by the research question.

The issues of migration related to the core themes are interdependent. A focused discussion of each issue will be presented under one of the themes. In the section related to stressors of migration, loss and the effect of stressors will be explored. Employment,

language, and social support will be expounded upon in the section on migration and women. In the final section, migration and nurses, the issues of novelty, discrimination, work environment, regulations for recruitment and retention, and support strategies will be highlighted.

Stressors of Migration

“Migration is a stressful experience requiring accommodation, adaptation, or coping” (Lipson et al., 1997, p. 50). In a Canadian survey by Matuk (1996), “84% of all newcomers reported that their lives were ‘very’ to ‘fairly’ stressful” (p. 54). The stressors of migration have been conceptualized as novelty, occupation, language, discrimination, loss, and not feeling at home (Aroian, Norris, Patsdaughter, & Tran, 1998). Meleis and Rogers (1987) state, “Understanding the process of decision making related to immigration is significant in understanding the health and adjustment of immigrants in their new locale” (p. 207).

Loss. The major sense of loss is not feeling at home. Being in an unfamiliar environment is uneasy for most people. In moving, the familiar is left behind including physical space and social contexts. Immigrants tend to more closely examine the values and beliefs that make them different. As they deeply explore their separateness, isolation, and what they left behind, immigrants are forced to sort, evaluate, retain, and let go of some of those values, beliefs, and behaviors that identify their self-concept (Pilette, 1989). “The changes that occur can influence the way they live and think as well as their personal health” (Shin & Shin, 1999, p. 603). According to Dijkhuizen (1995), integration occurs more rapidly when basic needs are identified and appropriate interventions are implemented to meet them.

Effect of stressors. The pressure of multiple stressors in a time of adaptation can have a negative impact on some individuals. Immigrants focus on their psychological discomfort, which may manifest as physical or social issues (Boyle, 2003; Lipson et al., 1997; Pilette, 1989). Pilette identifies excessive fatigue, headaches, and gastrointestinal dysfunction as the common physical complaints. Immigrants tend to pay little attention to their physical health unless they require treatment (Matuk, 1996). Psychological distress is greater among immigrants than the host population (Franks & Faux, 1990); however, there does not appear to be significant differences in the incidence of mental/emotional illness according to culture or race (Cravener, 1992). In a survey of 860 Korean immigrants to Canada, it was found that women are eight times more likely to manifest distress as depression and anxiety than men (Noh, Wu, Speechley, & Kaspar, 1992). The researchers found that men capitalize better on the benefits of social resources such as education, marriage, employment, and income than do women. Aroian et al. (1998), in a correlational study of former Soviet immigrants to the United States, also found differences in psychological distress to be a function of gender. The cross-sectional survey of four ethnocultural groups in Canada by Franks and Faux revealed high depression scores throughout all of the groups. These are significant findings to consider, as 95% of nurses in Canada are female (CNA, 2002a). For working immigrant women distress may originate from the relational aspects within the setting, such as discrimination and estrangement by colleagues (Jackson, 1996). Franks and Faux found research to associate depression, coping styles, and social resources. They noted the link between depression and stress and the acceptance of the adverse impact of psychological stress on mental health.

The primary effects of stress for immigrant women are depression, loneliness, and tension, which take precedence over physical health problems (Anderson, 1985). Lack of social support and loss of identity leads to loneliness and, eventually, depression. Depression is disabling to women as they experience increased physical ailments and functional limitations (Boyle, 2003). Meleis and Rogers (1987) correlate women's physical and mental health with three primary roles: marriage, employment, and parenthood. Anderson notes that the mental health issues immigrant women encounter have a long-lasting impact. Feelings of depression and loneliness may still be felt years after being in Canada.

Migration and Women

The focus of the literature review will now be on the impact of migration on women because the overwhelming proportion of nurses in Canada is female (CNA, 2002a). The experiences outlined are common to many women in the literature reviewed; however, not all experiences are the same. The transitions and adjustments required of people when migrating create exponential stress, which is particularly concerning for women. The results of a cross-sectional survey of Canadian women show that immigrant women's high risk of mental illness is attributable to the factors of employment, language skill, social support, and cultural attitudes (Franks & Faux, 1990).

Employment. A shift in responsibility may occur within a family as the woman moving to a new country may solely carry the duty to settle and fit in to the new society (Fox, 1991). Distress might result from the imposed pressure to succeed in the new culture (Shin & Shin, 1999). If they are the first to be employed or move to Canada, and the family follows, another potential stressor women may encounter is a change in their role (Matuk, 1996; Shin & Shin). There could possibly be a change in power dynamics within marriages

as the wife may now be earning more than her spouse. Due to the abovementioned factors, women may be carrying the total family and economic responsibility.

Language. Language becomes a social power through which interpretation occurs and meaning is created (Reimer Kirkham et al., 2002). A key to gaining acceptance by the host society is proficiency of language. The value of language training is repeatedly emphasized by the literature (Aroian, 1990; Aroian et al., 1998; Jackson, 1996; Matuk, 1996; Yahes & Dunn, 1996).

Language skill is related not only to proficiency in speaking, but also in understanding. Lynam (1985), in an ethnographic study of 12 Canadian women, describes a feeling of isolation sensed by immigrant women due to a lack of mutual understanding. Immigrant women described their own lack of “understanding of the cultural values guiding social interactions or the cultural context within which social resources or services were developed” in this study (Lynam, p. 329). Hence, they often felt misunderstood or completely avoid contact with outsiders. For those working with immigrant women, Meleis and Rogers (1987) state “knowledge of the identity, values, and norms of families in different sectors of community is essential” (p. 214). A Canadian ethnographic study of 30 Chinese and Euro-Canadian women by Anderson, Blue, Holbrook, and Ng (1993) found that knowledge of everyday life circumstances needs to be incorporated daily into clinical practice so that day-to-day social issues are considered within health care decisions.

Social support. It is women who generally facilitate the process of creating balance and harmony between assimilating into a new culture while maintaining traditions and characteristics of the old for their families (Meleis & Rogers, 1987). Schreiber, Stern, and Wilson’s (1998) grounded theory study describes the experience of role burdening as being

when immigrant women are still expected to fully care for their family and home while working. In a new community, continuing to act as the negotiator and mediator in the family may become more frustrating and demanding and less rewarding for immigrant women (Meleis & Rogers). There may be limited access to, or a lack of, resources that support women in these roles. When seeking help, immigrant women tend to turn to their private selves; that is, relatives and close friends, rather than outsiders (Lynam, 1985; Meleis & Rogers). Women who are experiencing psychological issues may be stigmatized by ethnic groups as well as health professionals, so women may view alterations and difficulties as part of a normal life cycle (Anderson, 1987; Franks & Faux, 1990). Frustrations arise in “starting over” due to a lack of transferability of status and accomplishments from their home country. Social inequity becomes the prominent concern for immigrant women related to a heightened sense of socioeconomic inequality (Meleis & Rogers). If the transition to the new society is approached in a supportive manner, immigrants may thrive on the strong foundation provided to assist in their integration.

Migration and Nurses

The discussion will now focus on the experience of migration related specifically to nurses including recommendations from the literature as to how nurses can best be supported throughout this experience. Nurses are motivated to move related to: novelty of travel and employment abroad; better economic, working, and living conditions; improved learning and practice opportunities; and personal safety (International Council of Nurses (ICN), 2002a; Kingma, 2001).

Novelty. There is so much that is new when moving to a new country that a lack of basic information and knowledge can be overwhelming (Aroian, 1990). Soon the very

attraction to immigration, opportunistic social conditions, especially in the labour market, may in turn cause some of the greatest angst in the adjustment process (Meleis & Rogers, 1987). Migrants begin to closely examine their decision and consider the losses and gains of their choice. The old life and job back home may be reflected on as better than that of the present.

It is recognized that nurses moving to another country to practice experience a period of transition to their new setting beginning with a “honeymoon phase” when everything is new and exciting (Davis & Maroun, 1997; Witchell & Ousch, 2002). This is followed by a possible period of disillusionment and frustration when the reality of living and working in a new culture is evident. During this stage the nurse may also feel impatient, incompetent, and angry (Witchell & Ousch). Pilette (1989) identifies individuals that immigrate from a similar culture to be at risk of interpreting life in the new setting as they did at home, which may create some difficult social challenges. Eventually a turning point is reached when the nurse either decides to return home or is more positive and understanding in relation to migrating. When the nurse recognizes that the new culture has much to offer integration occurs (Witchell & Ousch).

Nurses are challenged even in meeting their basic needs, especially in relation to housing and finances (Dijkhuizen, 1995; Pearce, 2002). Upon arrival, nurses are often placed in housing pre-arranged by the employer, which may compromise the safety and support of the individual depending on location and with whom the residence is shared. According to a British anecdote, within a short period of time, these nurses are forced to find suitable, affordable housing in an unfamiliar city with little support – a daunting task (Pearce). Additionally, nurses find the monies promised in recruitment are insufficient to cover their

cost of living. There is little left to save or send back home to family left behind. The prosperity and high income nurses educated in other countries anticipate is often never attained as they enter a downward spiral of occupational mobility by accepting a status demotion to lower level positions than they previously held (Aroian, 1990; Godfrey, 1999; Pearce). Through the processes of reorganization and deskilling, hospitals further erode the status of nurses educated in other countries (Das Gupta, 1996).

Discrimination. Nurses educated in other countries have raised concerns related to racism and discrimination in the workplace (Das Gupta, 1996; Pearce, 2002). Despite sharing experiences arising from the intersection of gender and migration, nurses educated in other countries have a lot of diversity within the group and cannot be characterized unidimensionally (Meleis, 2003). Nurses educated outside of North America often stand out from the mainstream because of their accents, mannerisms, or responses (Meleis). These differences may lead to feelings of marginalization. Das Gupta, in detailing the experiences of two Black nurses with racism, outlines that being seen as different equates being targeted as a scapegoat, which is compounded during times of economic crisis. Protection must be provided to ensure fair treatment of nurses educated outside of Canada in order to prevent wage abuse, sufferable living conditions, and sexual harassment (Dijkhuizen, 1995; Tabone, 2000). To develop knowledge that is not marginalizing, an exploration of power differentials in relationships and of the groups themselves needs to be included (Meleis & Im, 1999).

Work environment. Occupational adjustment has been identified as the essential component of successful migration (Aroian, 1990). This is often challenged by a lack of transferability of credentials and status demotion when a job is secured. There is greater stress when one is unemployed and not looking for work than when an individual is actively

seeking employment (Aroian et al., 1998). Bernstein and Shuval (1998) in a cohort follow-up study found older respondents to be at an occupational disadvantage. Pilette (1989) states that being able to "internalize work and societal norms potentiates acculturation" (p. 280). In a grounded theory study by Aroian, Polish immigrants to the United States described financial opportunities, self growth, and freedom as positive aspects of migration. Having a job that is commensurate with one's education and experience also increases morale (Aroian et al.).

It is essential that a nurse be able to competently function within the work setting. There is an assumption by employers that, on arrival, nurses are ready to work even though they often are not immediately fit to practice. The safety and competency in the provision of patient care is the key concern in nursing. The phenomenon of culture shock is accompanied by depression and learned helplessness, which may inhibit a nurse's effectiveness and ability to practice (Davis & Maroun, 1997). Trouble in the workplace may first appear as a breakdown in communication due to inaccurate or inappropriate use of language (Burner, Cunningham, & Hattar, 1990). When working with staff of diverse backgrounds, Giger and Mood (1997) note that achieving effective interpersonal communication is quite likely to be a formidable barrier between team members. There may be fear or embarrassment to admit a lack of understanding for both the immigrant and the person who is from the host country (Burner et al.). Nurses may long for their familiar support system, as they are seemingly unable to resolve issues and function successfully within the new culture and organization (Davis & Maroun).

Regulations for recruitment and registration. In response to aggressive recruitment of nurses worldwide, the ICN (2002b) developed a position statement on ethical nurse recruitment, which outlines thirteen key principles. These principles create an ethical

framework for nurse recruitment based on: effective human resources planning and development; credible nursing regulation; access to full employment; freedom of movement; freedom from discrimination; good faith contracting; equal pay for work of equal value; access to grievance procedures; safe work environment; effective orientation, mentoring, and supervision; employment trial periods; freedom of association; and regulation of recruitment (ICN, 2001). The ICN emphasizes that the credibility, strength, and universality of these principles is dependent on the actions of health care stakeholders and the implementation of regulatory mechanisms. Central to the position statement, *Ethical Nurse Recruitment*, is the belief that quality health care has a direct correlation with an adequate supply of qualified and committed nursing personnel and good working conditions.

Canada has no organized system of support in place to assist nurses educated in other countries in their transition to practicing within the Canadian health care system, even though there is increased recruitment of nurses from abroad. A recent article (Barry et al., 2003) highlighted a regulatory framework that has been created by CNA to guide the process of registration and integration of nurses educated outside of Canada. This is to ensure that the registration requirements for nursing in Canada are respected. The framework outlines components of the transition process that are the function of the nurse as well as the regulatory body. It also encompasses new national initiatives that will support nurses educated outside of Canada and streamline components of the transition process.

According to the *Standards for Registered Nursing Practice in British Columbia* (RNABC, 2003), nurses must individually assume the primary responsibility for maintaining competence and fitness to practice; that is, one's own physical, mental, and emotional well-being. To ensure competency, an organization needs to foster an environment that

encourages individual initiative, accountability, communication, and a commitment to fulfill the development of the individual's capacity for personal growth (Koerner, 1997). For nurses from other countries, the lack of education about the workings of the Canadian health care system is a barrier in striving towards excellence in practice. Without this education, the practice of these nurses may be compromised, which may lead to detrimental patient outcomes.

Support strategies. Further measures are needed to minimize the stress of a transition to a new practice setting and living in a new country. Variables associated with psychological distress may include: potential language difficulty (e.g., different names for medications); different methods of care delivery; variance of policies and procedures; different organizational and social culture; and lack of social support (Bernstein & Shuval, 1998; Hurh & Kim, 1990). Pilette (1989) suggests that the recruitment interview be used as an assessment tool to estimate the adjustment of a prospective employee. A nurse experiencing somatic symptoms related to a challenging transition will be at risk of engaging in unsafe practice and face the potential of being deemed incompetent. Aroian et al. (1998) suggest that interventions be focused on alleviating feelings of discrimination, loss, and discomfort. A session on values clarification that explores values and cultural differences is recommended (Williams, 1992). This may enhance awareness of one's own cultural values and enable recognition of how they may intersect with aspects of the culture of the new country. Immigrant women need support during the transition to Canada through validation and credit for their roles, knowledge about resources, and social equality (Meleis & Rogers, 1987). This support may be in the form of programs for relocation, training, and language skill instruction. Simply giving a list of resources is not sufficient; women need to sense a

genuine interest by others to facilitate their participation (Meleis & Rogers). Pilette notes that addressing psychological issues requires a considerable amount of inner strength and conflict resolution skill. Formation of a support group may help in the development of coping skills through the promotion of therapeutic relationships (Williams; Yahes & Dunn, 1996). Yahes and Dunn, as a result of a survey on the continuing education needs of nurses educated in other countries, suggest that by emphasizing one's uniqueness, there will be enhancement of self-esteem, which leads to improved professional performance. Franks and Faux call for a re-examination of the provision of psychological health care to immigrant women to enable an integration of social and life skills with care of their physical health needs.

Employers who recruit and hire nurses educated outside of Canada should have strategies and programs in place to ease the transition into the workplace. Williams (1992) recommends an extended orientation course that highlights the role of the nurse in the given setting, communication and the use of idioms, pharmacology of medications used in the agency, nursing process including physical assessment and a mock code, time management, assertiveness skills, and support services. Orientation programs should be further strengthened through the incorporation of social and cultural experiences that instill intercultural understanding (Pacquiao, 2002). The RNABC is able to provide information on resources available through other agencies to provide nurses educated outside of Canada with refresher courses, transition programs, and language skill workshops specifically designed to target those educated outside of Canada. However, information from the RNABC can be difficult to obtain and nurses must take the initiative to seek it out.

Summary of the State of Knowledge

Migration is clearly a stressful event: stress increases with increasing age and for women (Aroian, 1990; Aroian et al., 1998; Franks & Faux, 1990; Matuk, 1996; Noh et al., 1992). Common factors that relate to stress in the transition process include: loss, occupational stressors, lack of familiarity with the language, novelty, and discrimination. At times the stress of these factors creates physical and mental health concerns. Developing a sense of belonging is critically important to immigrant women and nurses as it alleviates chief complaints of loneliness and depression (Anderson, 1985; Anderson, 1987; Jackson, 1996; Lynam, 1985).

No research was located on the transition experience of nurses to practicing in Canada. Further, no research was found related to the most common groups of new nurses from other countries: Philippines, Britain, United States of America, or Australia. Because so little of the research related to migration is based in nursing, one must be cautious to consider the varying contexts within which nurses are experiencing their transition to practicing in Canada. Highlighting these issues from the literature is only the beginning of an exploration of the migration experience of nurses. This provides a foundation upon which further study can commence to understand the experience of nurses and make comparisons to the present literature.

Research Question

The research question addressed in this study was: What are the experiences of nurses, educated in a country other than Canada, as they make the transition to practice in Canada? The research method used to address this question will be described in the next chapter.

< Chapter 3 >

Methods

This chapter will outline the study design including a description of research methods, sample, data collection, and ethical considerations.

Ethnographic Methods

A qualitative design using ethnographic methods of data collection was chosen to be used for this study as understanding of a given cultural group, nurses educated outside of Canada, was sought to provide descriptions of the transition experience to practicing in Canada. This method provided flexibility in the direction of the research as the study unfolded to bring a greater understanding of the ways in which people make meaning of their world (Morse, 1989). The ethnographer “attempts to learn what knowledge people use to interpret experience and mold their behavior within the context of their culturally constituted environment” (Morse, p. 30). Through discovery and representation of the true nature of social phenomena, ethnographic methods were well suited to describing peoples’ social reality (Hammersley, 1992). Ethnographic methods are useful in defining a problem that is unclear and exploring associated factors to enable better understanding and provide opportunities to address the issues (LeCompte & Schensul, 1999). The researcher learned from the nurses educated outside of Canada what the “world” is like to them. “People *construct* the social world, both through their interpretations of it and through the actions based on those interpretations” (Hammersley, p. 44).

In-depth interviews achieved the purpose of this study – to describe and understand the experiences of nurses educated outside of Canada in making the transition to practice in Canada. The use of ethnographic approaches to interviewing enabled the transition from

broad questions to contrast questions to explore similarities and differences between experiences within a theme (Morse, 1995). In ethnographic interviews topics emerge naturally as the participants describe their everyday experience. The researcher uses neutral probes to direct the interview and expound dense descriptive data (Bauman & Greenberg, 1992). Through exploring and understanding the experiences of nurses educated outside of Canada in their transition to practice in Canada, knowledge about the social contexts of the nurses was developed. This knowledge will be useful in predicting potential needs of future nurses experiencing a similar transition, as well as behavioral and emotional responses to the transition process. Learning from the participants' experiences, the data has been interpreted to provide an understanding of the transition process experienced by nurses educated in countries other than Canada to practicing in Canada.

Sample

For the purposes of open-ended, in-depth interviewing it is important that the participants will be able to provide a rich description of their transition experience to practice in Canada. For this reason purposeful sampling was utilized. Through purposeful sampling the researcher selects information rich cases to allow for the most insightful data collection for in-depth study in answering a particular question or exploration (Coyne, 1997). The nurses selected were recognized as key informants being able to provide insight into the experience under study. They were willing and able to discuss and examine their transition experience to practicing in Canada as nurses educated outside of Canada. Beyond simply telling their story, the participants were able to explore their experience through in-depth reflection and introspection. These nurses have engaged themselves in a unique professional

transition. There was a change not only in their practice setting, but in the whole social context within which they practice nursing.

When this study was designed certain assumptions were made as to the willingness of nurses to participate in research on this topic and the merit that would be intrinsically recognized for participation. It was assumed by the researcher that participants in this study would recognize the benefits of the research as outweighing any potential risks as well as recognizing opportunity for involvement. It was believed that these interviews would provide a debriefing for nurses educated outside of Canada about their experiences and, in turn, allow them to feel valued and heard as individuals. Several participants expressed relief in being able to finally share their experiences. They were appreciative that someone would listen to their stories. This led to the assumption that nurses are altruistic and desire to help others. By participating in this research they may have provided assistance to other nurses educated outside of Canada. One participant described how she hoped this study would help create change to benefit future immigrant nurses. Another assumption surrounded the belief that the transition experience to practice in Canada for a nurse from another country is challenging and would benefit from the help and support of others. The nurses in this study described various support networks that they valued: professional, work, and social.

Some of the participants were recruited through the RNABC. One of the registration advisors was identified as a key contact related to her interaction with nurses educated outside of Canada when they initially register with the RNABC. Potential participants were identified by the registration advisor from the database of registrants and sent an information letter (refer to Appendix B) about the study. Upon receiving an information letter from the RNABC, the potential participant contacted the researcher directly to express interest in

participation. Another method of recruitment was to place an advertisement in *Nursing BC* classifieds (refer to Appendix C). Respondents to the advertisement were sent an information letter and then confirmed their interest in participation. The sample availability was known by RNABC registration demographics. Two participants were recruited from the letters sent by RNABC and three were recruited from the advertisement in *Nursing BC*. Colleagues and friends sharing information about the study enabled the recruitment of the other eight participants.

The sample for this study comprised 13 registered nurses who were born outside of Canada and completed their basic education in a country other than Canada. They were enrolled into the study through purposeful sampling. The participants had to be fluent in English and currently employed in British Columbia within the Greater Vancouver Regional District. The sample was composed of nurses who have moved to Canada and started to practice nursing within the past 5 years. This ensured that the nurses were able to recall their experiences and challenges of transition while not being so far along that it may be difficult to remember the experiences and the supports utilized. Gaining entrance and being accepted by the group is critical (Burns & Grove, 1997). In this study, experiences, not people per se, were the objects of purposeful sampling (Coyne, 1997; Sandelowski, 1995). The size of the sample was shaped by practical considerations such as the amount of time available to the researcher and restricted by volunteering of nurses and the criteria for participation. Saturation of data was also a factor; that is, there was information redundancy. When themes were identified in the data, it was decided if the next few data samples fit into these themes, and if the themes represented the experience being studied. The last four interviews, although valuable demographic contrasts, generated few new ideas and were more a confirmation of

themes already identified. At this point the data was saturated and data collection was complete (Beveridge, 2003). Sampling adequacy is evident by saturation and replication of data accounting for all aspects of the experience (Morse, Barrett, Mayan, Olson & Spiers, 2002). Sandelowski describes an adequate sample as enabling in-depth case-oriented analysis that results in a new dense understanding of the experience under study. In this study, the sample comprised three of the four most common groups of nurses from other countries: Australia, Britain, and the Philippines. No nurses from the United States of America responded to any of the recruitment measures. Each of the participants shared detailed insight into their experiences in making the transition to practice in Canada, which enabled the generation of new knowledge that will be explored in Chapter 5.

Purposeful sampling incorporates different approaches to achieve variability. Sandelowski (1995) defines these strategies as demographic variation, phenomenal variation, and theoretical variation. Demographic variation relates to people-related characteristics. This was initially utilized to ensure that the sample was inclusive of nurses from a variety of the more common countries from which nurses migrate to Canada. Phenomenal variation is associated with the target experience being studied. Another aim of the sampling was to have a mix of social identities, for example, age, marital status, work experience, employment status, etcetera, to enable the experience to be explored from a variety of perspectives. Information collected on the nurse demographic forms (refer to Appendix D) at the time of initial contact with a potential participant assisted in selecting appropriate nurses to meet the selection criteria. Some nurses were not selected as participants as they had lived in Canada for greater than five years; completed nursing education in Canada prior to registering and beginning to practice; or were not qualified as a Registered Nurse.

Description of the Participants

A description of the participant demographics provides context to the experiences described. The 13 nurses who participated in the study were from Australia, Britain, and the Philippines as shown in Table 1 (page 24). Two male participants were included in the sample as potential contrasting cases. Attempts were made to recruit males from other countries for further comparison. There was also a mix of marital and family status that allowed for comparison of experiences. The nurses were employed in a variety of work settings that provided interesting elements of contrast in the analysis. Most were employed on a full-time basis, but one was unemployed at the time of interview as she had been in a contract position that had expired and needed to resolve some issues related to her immigration status before she could secure employment. Over half of the nurses in this study came with the intent of staying or decided to stay in Canada after some time. Some of those with a work permit have begun the process to become a permanent resident or have decided to renew their permit to enable them to extend their stay.

Table 1

Demographic Summary of the Participants

n=13

Gender	Male	2
	Female	11
Age	Mean	35
	Range	25 – 57 years
Marital Status	Married	7
	Single	6
Family Status	Have children	5
Citizenship	Australia	3
	Philippines	6
	UK	4
Length of time in Canada	1+ year	4
	2+ years	3
	3+ years	3
	4+ years	3
	Mean	2.4 years
	Range	1 – 4 years
Immigrant Status	Landed Immigrant	6
	Permanent Resident	1
	Work Permit	6
Education	Degree	9
	Diploma	4
Workplace	Acute Care	7
	Education	1
	Intermediate Care	1
	Operating Room	3
	Rehab	1
Current Employment	Full-time	12
	Unemployed	1

Data Collection

The principal investigator interviewed each participant once. Initially it was proposed that participants may be interviewed up to two times; however, the time allotted in one interview session was ample for each participant to share details of their experience. Adjustment to the number of interviews was based on the level of data saturation achieved within the ongoing analysis; that is, there was no need identified to interview greater than 13 participants. Interviews were chosen as the primary data collection tool to enable the capturing of the nurses' stories. The interviews occurred in a location desired by the participants, most often in the participant's home. The participant was encouraged to ensure that the location had an undisturbed, quiet, and relaxing atmosphere. Each interview session was tape-recorded to allow the researcher to give complete attention to what was being said. Field notes were kept of the interview setting, events that transpired during the interview, general mood and tone of the interview, non-verbal communication of the participant, patterning of actions and responses, use of metaphors to represent experience, and reflections of the researcher (Fetterman, 1998; Morse, 1989).

To understand the transition experience of nurses educated outside of Canada the interviews focused on the meanings of individuals' actions and explanations. An open-ended interview guide, with trigger questions and prompts, was developed to assist the researcher in maintaining focus of content throughout the interviews; however, the participants primarily directed the interviews and were allowed to speak for themselves (refer to Appendix E for interview questions). The researcher prompted the participant to further explore the experience and offer insight into key phrases and varying examples.

A researcher cannot be disconnected from the social world being studied.

Ethnographic interviewing makes the contribution of the researcher in the research setting explicit through engaging in reflexivity (Morse, 1989). The analysis process needs to include questioning of the relationship and encounters between the researcher and the participants (Anderson, 1991). After each interview I made notes about the session, including questions raised for me and my reactions to what was being shared. According to Finlay (2002), “reflexive analysis in research encompasses continual evaluation of subjective responses, intersubjective dynamics, and the research process itself” (p. 532). Reflexivity acknowledges researcher bias and subjectivity and balances purposeful, personal analysis (Finlay).

Throughout the study I was forced to set aside my established thoughts on the experience of making the transition to practice in Canada and maintain an open mind so that I could learn from the participants. As I progressed through the analysis to make recommendations I needed to ensure the recommendations were based on the findings, not my preconceived ideas. It is critical that the researcher be engaged in qualitative research as an iterative process, moving between design and implementation, to constantly verify the reliability, validity, and rigor of the study (Morse et al., 2002).

Analysis

Data collection and analysis proceeded concurrently. Refer to Appendix F for the project timeline. As the researcher collected and reviewed the data, nurses were asked to clarify points that were unclear. This occurred during the interviews as well as in some informal conversations I had with a few participants individually during the analysis phase. This step was essential to guarantee the reliability of the data (Mackenzie, 1994). Each interview tape was transcribed by a transcriptionist who had signed a confidentiality

agreement. Microsoft Word and Excel programs were utilized to assist with the data management. The transcripts and tapes were reviewed for accuracy and to enable immersion in the data. Having a rich understanding of the data was essential to begin the process of analysis and interpretation. Ethnographic analysis goes beyond basic description of an experience to interpret aspects of social patterns (Morse, 1995). The data was systematically analyzed to identify emerging categories and recurrent ideas. The steps of “coding field notes and interviews, sorting to identify patterns, generalizing constructs and theories, and memoing to note personal reflections and insights” (Roper & Shapira, 2000, p. 93) were followed. As themes and patterns were identified the data was examined for repetition of these as well as for contrary cases. From this inductive process there was a synthesis of main ideas into a coherent account of the nurses’ transition experience.

Ethnography engages the researcher in a natural triangulation of data collection strategies: field notes, interviews, and examination of related literature (Roper & Shapira, 2000). The data from each source has been utilized to judge the validity of the data from the other sources. To ensure reliable and consistent data collection and analysis, the research supervisors reviewed the interpretations. The supervisors also assisted in raising the researcher’s awareness of issues and biases for further reflection.

Ethical Considerations

The proposed study was subject to review and approval by the UBC Behavioural Research Ethics Board. To initiate their participation, interested nurses contacted the researcher through a private voicemail. The process of achieving informed consent from the participants began with time for nurses to carefully consider participation and review detailed information about the study. Refer to Appendix G for the Informed Consent Form. The

consent was reconfirmed prior to the start of each interview. Confidentiality of the participants has been maintained through use of code numbers on all field notes, tapes, and transcripts of the interviews. In the compilation and reporting of the study findings no names or other potential identifying information have been utilized so as to minimize potential association of data to an individual participant. All documents and recordings have been kept in a locked file cabinet within the researcher's personal office throughout the duration of the study and after the completion of the study. Storing the data is necessary to enable its use for further publications.

It was recognized that the nurses may have felt a sense of vulnerability through participation in the study, particularly if the transition to Canada has been difficult with notable distress. Some may also have sensed a social stigma around being involved in research. Resource and support information were available in anticipation that the nurses may seek advice from the researcher throughout the interview, which would have been viewed as a component of social interaction and not separated from the research process. Help-seeking behavior is a social reality and was not dismissed as inappropriate within the research process (Dyck et al., 1995). For example, one participant questioned how she should follow-up on the concerns she had in her first position, which she felt forced to leave due to ongoing conflicts. By sharing appropriate resources, rather than offering specific advice, the researcher assisted the nurses in taking control over their experience (Anderson, 1991; Dyck et al.). The findings of the study will be described in the next chapter.

< Chapter 4 >

Findings

The aim of this study was to describe and understand the experiences of nurses, educated in a country other than Canada, as they make the transition to practice within the Canadian health care system. In this chapter the stories of nurses' experiences will be discussed in thematic categories that emerged throughout the analysis process. Initially in analysis, many preliminary themes and concepts were identified as common experiences amongst the participants or contrasting experiences that were surprising or unexpected. The interdependence and connectivity between the nurses' experiences led to the identification of more abstract themes and concepts. The concepts will be outlined through sharing excerpts of the in-depth interviews completed with the participants.

The stories of the participants illustrate the experiences of transition to practice in Canada as nurses educated in another country. These descriptions are organized chronologically, beginning with the transition period, understanding the reason to move, and progress to experiences of relocation misconceptions, challenges in adapting to Canada, isolation, professional support, questioning one's competence, feeling valued, and the importance of work and social support networks.

Reason to Move

The impetus to move to Canada varied amongst the participants; one of the participants had traveled to Canada in the past and had a friend in the city that provided support to her and her family coming to Canada. When asked about the role her friends played in her family coming to Canada she described it as:

It was probably part of the decision because, um, she had boys just a little bit older than my boys and they go to the same school. But I've always wanted to come back to [this city]. I've always said I want to come back. And [my husband] had just decided he had enough of the business and this ad just came in the paper sort of at the right time for all of us.

The novelty of travel and employment abroad was a factor for several other nurses in the study. One of the single participants had a simple way of viewing her adventure. *"I haven't got anything to rush back home for, so got to be somewhere on the planet. Here's a pretty nice place and I've got a lot of things I want to see and do."* The inspiration for others came as a result of disillusionment in their home country and viewing a move to Canada as a chance to start over and steer their lives in another direction. One participant shared:

Well, we had had some problems anyway in [home country], plus I was disillusioned with nursing, and we thought, you know, if we're going to kick start our lives again, we need to have a change. We need to completely change our lifestyle. We need to get away from all the old stuff and maybe set out a new. My husband had always wanted to come back to Canada but we were never in a position to do that.

One participant felt that the experience of working abroad would assist her in career advancement and better prepare her to teach nursing:

I came to Canada two years ago, and I decided that, um, I wanted to come and work in another country simply because I want to go into teaching nursing students. And I thought, um, that coming to Canada would be good for me in the sense of it would be more experience, and I would have more to offer my students later on.

The opportunities that Canada affords were the basis of the multifaceted reasoning of one participant's decision to move. For her it was not only the practice and learning opportunities, but the type of lifestyle her family could enjoy:

But I very much wanted to come to Canada: a) for the lifestyle, and b) I feel it is important sometimes to see how other health organizations operate and to actually have the challenge of, you know, perhaps learning new skills, new ways of working, particularly as you become more senior. You know, it's good that you can learn, adjust and prove to yourself that you're flexible.

For this nurse language was also a factor in where she decided to relocate her family. "A big choice was really I didn't have to particularly speak a different language So the language was important to me that I didn't have to sort of work in an area where maybe language would be a real barrier for me." In the end the success of the transition was judged by both personal happiness and that of her children as well as the match of the community principles of living with personal lifestyle choices:

My sort of issues were that I came so that my family could have a good lifestyle. You know, my children could go grow up in a country where I felt I liked the ethos of the country. You know, I like the multicultural approach. I like the way that's the justice. To me, I've not been disappointed. And I like the Canadian people. You know, I find them polite. I don't find there's the violence and the vandalism that you sometimes see, you know, in other places. The children are happy in school. So it's lifestyle as well as the job.

Having family that lives in Canada was the motivation for several participants to move here. Family can play an instrumental role in facilitating the transition to a new country. One participant described the role family played in her moving to Canada:

Everything was planned for us because our mom was here, um, working for a long time, so we practically just finished, um, BSN back home, 'cause there are no job opportunities whatsoever there, and it would be really beneficial for all of us to move, like, at the same time, because, anyway, we were classmates; we would be finished at the same time.

Some participants wanted to join their partner who lives in Canada. "My purpose of coming here is to visit my fiancée who is here on a working permit and the second is to take the Nursing Board exam." One participant was sponsored by his wife to come to Canada. "Basically my experience was, uh, I needed some work. I was sponsored by my wife, so in like in 2001 we got married and then after six months my visa arrived and I went, I came here December 2001." On arrival finding employment as a Registered Nurse (RN) proved to be challenging for this individual such that he took up menial jobs to earn an income:

I did cleaning with my wife . . . so I swallowed my pride you know, I didn't do that in my life like cleaning other's house. So vacuuming, you vacuum the house and then you know cleaning so, it's so hard you know. I told my wife that if I pass the RN exam I won't do that again We're all intellectuals I mean we're all educated, so we're professionals so as much as possible we practice our profession. So that's my pride.

Even though this nurse had multiple family members living in Canada, he had no idea of the challenges he would face in relocating and finding a job that matched his interests. The misconceptions nurses experience when relocating will be discussed in the next section.

Relocation Misconceptions

For the participants in this study, moving to Canada provided opportunities for professional growth and lifestyle improvements. Several participants were attracted by advertisements of Canada's nursing shortage or by agencies recruiting for nursing in Canada. Securing a nursing position that matched the professional interest of the individual proved to be more of a challenge than the nurses were led to believe. One participant described her issues with bureaucracy requirements of a work permit not correlating with the types of positions vacant in the job market:

It's really frustrating, because we read some ads that there's a shortage of nursing and you're here and you take the Board exam. I already renewed my license, but I haven't practiced yet. It's really frustrating but I'm not losing hope The problem is when I go to employers they can not employ me because it's a requirement that if you are a foreign worker under a work permit, then you must be on full-time. So I cannot work as a nurse because the position offered to start is in a casual position there is a shortage and I was informed by Health Match that if you have a work permit, you can work, so that is my hope. The employers have no control about immigration laws, so I understand the concern. No matter how they want to hire me but immigration won't. It's still another hindrance.

Another participant was challenged by his lack of work experience in Canada:

. . . I receive an e-mail that, ah, that they told me that ah, I need Canadian experience before, before, before they would hire me. But I told them I just passed the CRNE. It's a bit of irony because I just started so I don't have any experience. Because they told me they can't afford to train me like that, so I decided to apply in nursing home.

Although he did have some experience in acute care prior to moving to Canada, it did not meet the position requirements. He had this insight into the situation:

And then besides it's an irony because before the, the acute care management told me that I should attend refresher course before, before they hired me so right now I'm saving. I'm saving a lot for because I'm planning to attend a refresher course because I, I have a plan to work in acute care.

This direction provided by a prospective employer may help him achieve his goal of working in acute care. Others with a plan to work in a certain specialty or agency have been faced with misconceptions as to job stability and what a position entails. Several participants were involved in hospital restructuring that forced them to change positions. Some nurses found the position they were recruited for not to be what they expected:

I just thought these are special needs children, some of them were and, you know, had severe special needs but their seizure disorder was so bad and the problems that they were admitted with was so bad – the learning disability, the special need was not my main focus. . . . I think there was a job in [the other unit] I don't know, I don't know what their thinking was, maybe I should have asked them but. I've still got it, I've wrote down the things I was worried about and I can just remember being told, if you like special needs then you'll like [this unit].

This nurse recognized the niche she had found in nursing and questioned the recruiter on the fit of the position offered. Not wanting to lose an opportunity and feeling pressured, the nurse accepted an inappropriate position from which she quickly transferred. Another participant described that tension develops with new colleagues due to a lack of communication.

"There's misinformation at times, which if the minority who are giving us a bad time get

onto it, they feed that to the others, and then it's totally misconstrued and that's the unfortunate thing." She felt that if information about her interests and areas of expertise would have been shared on arrival, her transition may have been smoother.

Several of the nurses from Britain and Australia expressed concern about Canadian nurses being bitter about the positions they held. *"Some people felt, thought their job was in jeopardy because there's people here. So there's a lot of misinformation about the reasons we're coming and the roles we're playing."* This nurse went on to explain how she describes the role she plays. *"Well, I say I'm here because I'm a traveling tourist, I'm a working tourist. And they accept that really well."* A nurse working in another organization described a similar experience:

I think sometimes there has been a little bit of resentment sometimes felt when new grads want a job, and maybe someone experienced from outside the country comes in. But if you can work well, you soon are accepted within your, with your nursing colleagues, you know.

Several participants described units as having a range of clique mentalities that prevented them from feeling like valued members of the nursing team:

Some of the older foreign nurses on the ward that I was working on didn't take to me very well. I almost resigned because of the clique mentality that was on there. I kept thinking, "Why have they got a problem with me?" I've actually come here to help address their staffing issues because they had horrendous staffing problems on the unit when we first came from [Hospital A].

Although the influx of new nurses was meant to be a positive measure in addressing workload issues, it created work in providing orientation and minimized available overtime in some areas. One participant described her experience:

But it's funny how, one team in particular here has the attitude here of, "Oh, no, we don't have another one of these on our team do we? We just finished teaching one that means whipping you into shape, and then we've got another." But little do they know, they haven't whipped us into their shape at all, we just do it to shut them up. You know, we just do it because it makes it a lot more comfortable.

In adapting to their new work settings these nurses personally recognize the knowledge and experience they have and are aware of the standards for practice. They know the principles for care and the flexibility allowed within those guidelines. This was expounded by one of the participants:

It doesn't matter that you put your jars over there than over here exactly so, but this is the anal retentiveness I'm talking about. You know, I worked with an agency [back home], so I go to a different hospital every day. Do you think they're all the same? No way. And the nurses are all different.

Another nurse explained, "I kind of had to learn to stand up for myself and say, you know what, this is the way I trained, this is the way I work, this is me, and you have to accept it."

Often times international recruitment is thought to be synonymous with generous relocation packages. The expense and perseverance required to complete the process of being moved to another country to work overshadows the incentive offered by employers:

Yeah, I think you really have to want to come to continue on with the process. It does take so long. And, I know a lot of people said, yes, I want to come too, and they start

to look into it, and lot of work, too much work. It's very expensive to come here, not just airfares. But by the time you pay for all the RNABC all that they want, the visa, the medical, it's about \$1500, the relocater, without airfares or anything.

Nurses who migrate quickly discover that the promised monies cover a minimal amount of expenses. Most find that the cost of rent and other basic needs of moving is greater than the monetary incentive negotiated. According to one participant:

I was only ever reimbursed \$3000, and that was just like 3 months rent when I first got here. So all that did was pay for the rent. It didn't pay for any furniture that I had to buy. I couldn't ship furniture over because I didn't have enough money, because they just left me stranded.

Money is even further stretched when one comes with a family. Nurses need to realize that the basic reason to migrate should not be based on a relocation incentive alone as one participant describes below:

And recruitment when I came, there was a \$2000 sort of payment for you. Obviously you had to stay for 12 months, but it doesn't really go very far. By the time you paid your RNABC exam, your flight, especially if you're bringing family and your sort of first lot of rent things. So the money isn't the carrot really. I don't think the money, if you offered foreign nurses really big pay packets, I don't know that that would bring the nurses over that want to really stay, you know. And, you have to want the lifestyle, you have to want to be in the country, be willing to live the lifestyle.

For some, the relocation package is confusing and not what they were expecting. Also, payment of relocation funds is not received in full immediately on arrival. One nurse shared her experience:

It takes a long time for you to get your money back, your relocation money back. And when you do get it back, it's not as much as you what you expected to get. Um, they, they kind of don't tell you the truth. Um, they're very sketchy on that, really. They, it nothing was in black and white. I'd asked for, uh, my relocation package to be in, be in my contract; it wasn't And, uh, I feel that they, they didn't tell us the truth. I feel that they lied to us. And when you'd ask for more information, he would eventually get back to you, this [relocation assistant], but it would be, like, a week or a week and a half. Um, I've never heard from him again.

Strategies set-up to assist nurses in settling into a new location have at times become more of a frustration than a benefit. Further, there are many hidden costs to relocating and becoming employed in another country that are not discussed up front with prospective employees:

I mean no one really expects that, but there is some hidden costs that we don't know where at the time, things like the registration, the price of the union and registration is amazing. I mean we just fall over.

Another nurse also questioned how the fees collected are utilized. “Which also means, where does the money go to? I've got no idea. And the union, where does that money go to?” Many of the nurses interviewed compared the professional fees being paid in Canada as being exorbitant to what they paid in their home country.

Difficulty also arises when nurses educated outside of Canada are confronted with their colleagues' misconceptions about what they have received for coming to work at the organization. One of the participants explained:

Often people say how long are you staying, oh, I'm going home in whatever the month they came. But you only just got here, well the contract is only 12 months.

They pay \$100,000 to get you out here. Oh really. Where's the \$100,000? I didn't see any of it.

Nurses recruited to specific organizations and positions often sign a time limited contract, which in most cases can be extended with mutual agreement of the employee and the employer. Nurses who come to Canada on a work visa and choose to stay are required to renew their work visas and eventually apply to be permanent residents or landed immigrants. The decision to stay in Canada indefinitely can be a difficult decision, especially when family members are still in the home country. Also, the process required to be able to stay in Canada long-term is daunting to some so they return home. Colleagues who have not faced the challenges of bureaucracy related to immigration are unable to empathize with these nurses and the tedious applications they are required to complete. Providing support to colleagues in their initial stage of transition to Canada is also hard at times. The following section will further explore the challenges experienced by the participants of this study in adapting to Canada.

Challenges in Adapting to Canada

Many Canadians assume that moving from one Western nation to another must be relatively easy as our countries have so many similarities. In my interviewing, nurses from Britain and Australia described more challenges in their transition to Canada than nurses from the Philippines. There may be multiple reasons for this trend in the data; however, naivety and personality conflicts are two prominent influencing factors. Being prepared for the adaptation one is required to undergo when learning new surroundings and settling into a new job is essential. The process of adaptation was explored with a participant:

It's not easy, um, and it's not, it's sometimes the fact that you're learning a new job, you're settling into a new country, you've got exams looming, you're trying to fit in courses and orientate, and you're trying to settle your family as well. So it's quite a lot that goes on. And I think it takes six to eight months, and I would say the first six months definitely, is a period of time where you really are so on the go emotionally, physically, you know, you're just constantly adapting and adjusting and learning and, under pressure, really. That's the hardest period.

Another nurse also outlined the first six to eight months of being in a new place as the most difficult:

But it is a really heart wrenching transition when you first come here. And I wish it didn't have to be, because it is such a beautiful place. And it is such a really good experience once you're into it. It's a whole different way of life and it's a really good way of life, too. But you've just got to really rough it out those first six to eight months and get through it. But I'm glad I did. I'm here to stay now.

Trying to survive these initial months can be traumatic with feelings of isolation, lack of acceptance, and loneliness. For some this becomes a burden that is too heavy to bear as indicated by one of the participants:

Yeah, I think, yeah, I just couldn't, couldn't take it. It was intolerable to the point that I decided, that's it. I always, when I came here I said I'd give myself six months and if I was unhappy, I would leave after six months. But as it turned out, I was so unhappy I thought enough is enough. But yeah, I think I got used to it but it was still the right decision to leave.

This nurse did not leave the country as she was able to find a position within the organization in which she found greater job satisfaction; however, she may have just as easily chosen to return home. Participants like this nurse who experienced significant trials in their transition to Canada were emotional when sharing their stories. A year or more later, the hurt is still fresh, unresolved, and not healed. Understanding the challenges faced by these nurses may help others adapt to Canada more easily in the future.

Differences in principles of function were hurdles. Several participants described their workplaces as being stiff and rigid with little openness to change. *"And they're very, very stuck in their ways; they won't change. They don't want to change, and when change is, is put in place, they really resent it. They set up a huge barrier."* One of the other participants compared her experience with the change process she was familiar with in her home country:

And we do find that, at home we're taught to challenge things all the time and ask why, and here, that's not a very popular thing to do. And when you ask why it's just because we do it, which we're taught that's not an acceptable answer. If you come to a "it's because," then you have to find the reason why, and if you can't find the logical reason why then it needs to be looked at, perhaps come up with a change to improve on that, but that doesn't seem to be a thing here A lot of things are just accepted as fait de complie, which is the way we're taught is not acceptable. You know, if it's just because, may be there's a better way to do it and let's look at it. And everybody gets in and does that But once something is in place, nothing can shift it. It's like the Rocky Mountains, it can't be moved. And we stand by and wait and our

suggestions don't go anywhere. I find nursing frustrating from that point of view, anyway.

Although these nurses poignantly outlined systemic issues they encountered, they also were reflective and recognized personal responsibility in the process of adaptation. Some talked about the impact of personal perspective and attitude on situations:

You have to actually enjoy the place where you are while you're there, because you really don't know how long you're going to be there for. So you have to actually embrace where you are and make the most of where you are.

Trying to understand how one's attitude affects their colleagues is valuable as well. One of the nurses tried to empathize with what it would be like to gain a colleague from another country with different ideals and ideas related to practice:

And I think if you're a nurse, I don't know if it's my attitude, you know, I respect all my nursing colleagues, and sometimes we all have different personalities, we all have different strengths to bring. You know, when you have nurses come over to what is your home country, it may not always be bringing what you are used to, but sometimes they can offer something from it. But you know, you have to fit in, and when you come to a, it's like if you go to a new hospital, you know, if you're not going to fit in, you're not going to make an effort to you know fit in, you can question, but how you do the question and the asking is the difference. It's attitude. It's your accountability.

One participant detailed a greater accountability for addressing issues faced in the transition process. She would like for others to be able to learn from her experience:

People who come here, they bitched and complained about stuff, gone home and haven't sort of said, "Well, how can we fix it?" It might not be for me or you, but coming down the line, you know, it might be.

Another participant explained the need for nurses to be responsible for addressing issues internal to the profession. *"It's up to us to resolve those problems in our own profession because we'll destroy ourselves if we don't."* This nurse shared the valuable lessons she has learned about supporting her colleagues and functioning within a team:

We're all nurses together. We shouldn't be eating each other. We should be helping each other. And you know what, I am different to you. I nurse differently to you, but at the end of day, my goals are the same as yours. My patients are of number one importance to me. It shouldn't be the way I speak; it shouldn't be the way I make a bed. It's my nursing care, and my goals are the same as yours. So, you know, learn to live with it because I'm the same as you deep down.

In sharing this with her new colleagues, she was able to convey that she was "one of them." Although there were outward differences, their goals in providing nursing care were the same and, therefore, they could relate to each other in their commonality.

Adapting socially was another challenge described. *"I find it hard to, like, yeah, switch your mode from nursing there to nursing here, at the same time, adjustment for myself. Like socially I, I can't talk to anybody. It's like no friends."* The need to adapt and make the most of the environment was the impetus personal change for one nurse:

I found trying to fit in very hard, as I said, in with the Canadian nurses. It took that probably about a year and, uh, I found that I had to be more open to people. I had to,

um, put myself out there to be accepted, whereas in [home country] I didn't have to do that, but here it was quite hard work doing that.

Becoming comfortable in a multicultural society and socializing with others with different backgrounds was a new experience for some of the Filipino participants in this study:

We, we're not used to dealing with, um, a different culture, um, entirely different, entirely different from us. Um, just like here, if you go to the community centres, it's very multicultural. It's kind of hard because we never had friends who are Caucasian, or we never had friends who are East Indian, and, I don't know, sometimes you can offend somebody by mentioning something, and you won't even know it. So, that too, it's, it's also hard, because just learning how the cultures are here, learning ourselves and finding our identities, and our place here in Canada, too, at the same time.

These nurses developed friendships with people from various cultural backgrounds and describe feeling more comfortable with diversity and not being bound to their own cultural group. Most of the Filipino participants in this study made purposeful decisions not to be secluded within Filipino groups. They define Canada as being multicultural and desire to experience living in such a society.

Several participants outlined specific practices in the workplace as challenges. The broader role of the nurse in the healthcare team was an adjustment for some. One participant explained:

At home, um, I wasn't challenged, perhaps, as much as I was here at the beginning. I had the knowledge, but I just didn't really use it, it was based on my ability in [home country], as we have doctors there that, that do everything, and you as a nurse care

for the patient, and, and do, do your nursing duties. Here in Canada, you're expected to do a little bit more, and I found . . . really paying attention to those things much harder, and 'cause I'd never done it before.

In particular, the nurse's involvement in checking charts and developing and maintaining medication records was a surprise for some. *"We didn't do all the, um, the thing I found quite shocking here with the way we check the charts and we get involved with the medication record sheet. We have nothing whatsoever to do with that in [home country]."* *"Our MAR system, at the hospital, it's just deplorable. There are so much medication mistakes,"* stated another nurse. These nurses described systems that appeared to be more streamlined in the processing of orders and limit a certain amount of human error that may occur when an order is processed.

Multiple participants talked about common, everyday items that are taken for granted, namely a driver's license. Obtaining a driver's license is a right of passage that many of us pass through as we become young adults. It was a shock to many to learn that the license they have had for years is no longer valid after three months of living in Canada:

And the fact that, um, you can only use your [home country] license for three months; that's another thing we didn't know about. We thought we could drive, and be fine for a year or so, 'cause you had a working permit note. We didn't know we had to sit a driving test, we didn't know we had to do the knowledge test. These are, these are things that I feel they should have in a pack for foreign nurses when they come in Canada. These are basic things that we have in [home country] that you know about because you live there and you've grown up there. But when you're coming to a different country, you don't know.

In describing the folly of many people's misconception about the validity of their driver's license, one nurse recognized the implications of not being informed and having appropriate licensure:

People are under the impression that we can keep driving on our [home country] license for 12 months so long as we got the initial license, and that's not true. Because our [home country] license is only good for 3 months, and once our [home country] license is dead, so is our international license, 'cause you have to have a valid, I mean our license is still valid at home, but it's not valid here any more after 3 months. So people are under the misconception that they can keep doing that. And some do. But if you get into a big car accident, you will be buggered because it wouldn't be legal. But you know that's not something that we're aware of. And until we go through the pain of it, we don't, a lot of people aren't aware.

The challenge in procuring a new license and transferring insurance can create more bumps along the road due to people's lack of knowledge of the required processes. The expense of vehicle registration and insurance can be a shock:

I didn't know that you only had 3 months to get your Canadian license for instance. Let's take that. I've just got my Canadian driver's license in November. If I had known, I could have bought all my car insurance documents over with me. They are valid for the first year you're here. You've got to get your Canadian's driver's license within 3 months of being here for your [home country] car insurance to be valid here for you to be able to get a discount.

The nurses in this study were frustrated with having to take another exam. It is an added item on the "to do" list of the international migrant in the midst of a busy and stressful time of transition. According to one of the participants:

Having said that, for the first 12 months, you're so busy having colds, settling down at home, sitting the RNABC exam, and then of course there's the driver's license, which is the other thing that you retake. So you have 3 months of driving and then you have to re-sit the driver's license, which is something on its own.

Not being able to drive or knowing how to access cost and time efficient transport in a city can have an isolating effect. The feelings of isolation experienced by the participants in this study will be described in the next section.

Isolation

When moving to a new country people often automatically have a sense of isolation as they leave behind family, friends, and all that is familiar. *"We left our two daughters behind in [home country]. They were young adults. I missed my youngest daughter's 18th birthday and my eldest daughter's 21st birthday being here. It was heartbreaking leaving them behind."* There is a sense of abandonment in the words of this mother as her need for a new start in life separated her from her daughters causing her to miss some milestones in their lives. Living in new surroundings that may be unlike any setting one has been in before can be frightening, especially when one does not have an established support network. *"I'd never lived in a high rise before. I was isolated in a high rise in a big city. My family was 6,000 miles away."* Although this nurse was living in a large city with a myriad of resources in close proximity, she was overwhelmed in her experience and was not at all equipped with the information she needed to easily adapt to her new surroundings. The feeling of isolation

can have a crippling effect on one's self-esteem and well-being. One of the participants shared her experience of feeling isolated:

But when you come across as a foreign nurse, you've given up everything. And you're just kind of reaching out for help and just for contact, and there's nobody there for you. So it's really hard. And they really need to look into that. Get some really good support.

Feeling alone and not having any supportive resources can be disabling. People flounder in situations that they describe themselves as having the skills to cope. They have a heightened sense of vulnerability related to the fact that they are outside of their comfort zone. One participant described:

And, and because I was so unhappy I couldn't really verbalize that too, at home and I, I am very good at like just taking things in their course, but at home I would have perhaps taken, taken that and said, you know what, I'm really doing my best here and this really, this is not helping, but I couldn't, I was just. . . I was just, like I said, I was just I can't find a word, I was just overwhelmed. I couldn't deal with that.

People want to be able to reach out to the support they have established in life when they encounter struggles; however, even making a long distance phone call was troublesome enhancing the sense of isolation:

I couldn't even have long distance phone calls at the time because we had no credit history so I was really isolated. I was crying out for help to Human Resources, and there was nobody there to help me from a foreign nurse's point of view. It was all about bureaucracy. It was not about let's give this girl some support. Let's put her in touch with other people who have been through the same process. Shed the same

tears. Shouted at the walls, banged their head against the walls because they're coming up against the same things – nobody to give me useful, practical information. Oh you know, this is the way you get through this. This is who you contact for this. There was no one.

The support mechanisms and groups the nurses thought would be a help to them faltered and failed. *"Except none of that really happened, it didn't take off. And now it's completely gone. I think they've forgotten about us."* This nurse was informed of plans for an event to enable nurses educated outside of Canada to connect with other nurses who were new to Canada, but the schedule of events and meetings never materialized. Nurses independently sought out each other and in round about ways became acquainted with nurses educated outside of Canada that worked at other organizations. Several nurses who participated in this study were linked with an assistant to help in their relocation and finding accommodation on arrival. I was told multiple stories of nurses being placed in inappropriate housing matched with homeowners or roommates that were more antagonistic than welcoming. What was meant to be a beneficial initial social contact became a factor in nurses withdrawing and isolating themselves. According to one of the nurses in this study:

I think if they had, um, if the Human Resources department had said to us, you know, this is the hotel, this is the Days Inn Downtown; just book in there, and go and stay there and then phone us in a couple days once you're more settled, and, um, come and speak to us, and we will give you a resource person, another nurse, from a foreign country. Even if she had been Canadian, it really wouldn't have mattered; as long as it had been somebody that, that lived here and had been here for a little while, and who would know where the basic things were, and help you meet people.

Um, you know, I, I didn't see anybody for about six weeks; it was, like, six weeks before I started my orientation, and, um, you know, when you're, when you're living downtown and you're in your room, you can't come out of the room, 'cause you don't want to go in sit in the lounge area where this woman was because then I'd be invited to go to church and I'd have to make up all these excuses.

Even those who had family in Canada felt isolated. Family members that arrived together felt comfort in having another person with them in the same situation, but did not feel that they could relate to the family members that were already established in the country:

When we came, we don't have friends here, we don't know anybody. We have our cousins, but they speak (family member: we didn't grew, grow up with them, they were born here) they speak straight, you know, English, you know; we can't really understand, and they're like, yeah, we were like, so shy, we were.

A sense of isolation and being different also develops when one cannot find material items or entertainment that is familiar to them. *"The shows on TV; it's like, I can't even appreciate. And the food here, it's like, there's no Filipino food."* Participants described searching for items that reminded them of home. One nurse had a contest with her colleagues to make food from her home country. This is an example of the ingenuity of people in finding mechanisms that create a sense of comfort and support. Nurses may search for support in several arenas including: professional bodies, such as government, nursing association or union, or professional practice groups; workplaces; and social networks. The experiences of the nurses in this study in seeking support and reflecting on what support was provided versus their expectations will be explored in the following sections.

Professional Support

One of the main challenges in obtaining support is knowing where to find it. Some participants learned about agencies after they had arrived and settled which would have been helpful to them prior to them even moving. One nurse talked about the potential to connect with government agencies in her home country to assist in the migration process:

Get all the information you can from your own consulates in the country where you live, and get them to help you because there's recruitment people that can help you.

And find out what's required and get a work visa before you get here.

In interviewing the participants, it was surprising to find that nurses from the Philippines appear to be more proactive in linking with government agencies than nurses from Britain or Australia. Two nurses had a discussion about the benefits of Human Resources and Skills Development Canada (HRSDC):

Oh, you know community resources. Like how do you call it? (Human Resources) Human Resources? Because you go to Human Resources, they provide you free advice, financial too. If you need money, they will . . .

When I'm doing my review, they gave money for my babysitter so I can do it.

Plus if you go there, they will give you a free bus ticket. If you find a job, they will give you \$50.

It's a job. . .

You can use the computer.

They can do your resume.

A couple participants described Health Match as being a very important resource for them in searching for nursing positions:

Yes, it's Health Match BC. So they were the really the first one who helped me giving me information Health Match has some more information about hiring foreign nurses. So I was able to know more about information, so that was helpful – that saves me money because they gave me resources which are free.

The British and Australian nurses tended to use recruiting agencies more, which was problematic for some as they discovered that the agency staff did not truly comprehend the transition process of moving to Canada. One participant described:

They don't know a great deal. When we emailed them back or talked to them on the phone, they're not aware of a lot of these things. They basically, their job was basically to find us, to find somewhere here to position us, or find who goes to them and says, "This is what we want," and they find us, or we say we want to go to here, and they find the job. And then they marry us up. Once they've got us in line with the registration or licensing people, immigration and the hospital, the hospital offers, gives us a job offer. Immigration says, okay, we'll process your stuff, and we do what we have to do with the minimum. There's no backing there.

One nurse was extremely frustrated when the agency she was working with closed mid-way through her completing the process of being able to work in Canada. *"I had to finish it all off myself. She was no help to me whatsoever. I shed many tears."*

Nurses from other countries expressed confusion around the separation of the nursing association and the union. From the stories I heard, no representative from either organization took time to explain the purpose and function for two distinct bodies. This led to questioning the value of the organizations:

I don't find the union helpful at all. Um, I feel that they get their money for nothing.

Um, they never kind of come up to the units and see how things are going. Um, I don't know what they're meant to do for me.

Nurses seeking information and further assistance in the transition process at times incorrectly contacted agencies that did not handle the issue of concern and became more frustrated by the perceived lack of support.

Several participants linked with professional practice groups for specialties such as gerontology and the operating room. They described these groups as having a good support structure with monthly meetings and regular newsletters. Some participants linked with other support groups to assist in their transition. *"Luckily we have, we call it, Filipino nurses support group that they, for free, they give review for free. It's like a study group. We don't have a teacher, just a study group."* Workshops targeted to nurses educated outside of Canada were also thought to be helpful:

And I was thankful for the RNABC because they offered a seminar to the foreign educated nurses which are very beneficial and advantage for us in giving us orientation about the health care system and the standards of practice here in British Columbia.

The nursing registration body was useful in providing clarity on scope and standards of nursing practice through provision of written materials and consultation with practice advisors. *"So there are, you know, like the RNABC, I think they're a good body. I found they sent me quite a lot of information on accountability, you know, standards and issues like that, they're pretty good."* Several nurses described the need for the nursing association registration department and employer human resources departments to develop a greater

understanding of the experience of the transition by nurses educated outside of Canada to working here:

I wish they had a department that deals with foreign nurse issues and, again, get some foreign nurses working within that department that know what it's like to go through this whole process. And not just on the end of a telephone flicking through your charts and folders, saying, you haven't got enough hours in obstetrics or you haven't got enough hours in peds. This is what you've got to do. Again, I think they really could get some support groups going for foreign nurses. Just somebody there that you can talk to, that's not condescending. Somebody who can give you some really good useful information and say to you, 'I know what you're going through because I've been through it myself. And hang on in there, because it does come through in the end.' And it is worth it in the end. Just that kind of support would be really good.

Many participants described communication delays from RNABC that left nurses frustrated and unsure of their status and progress in the registration process. One participant explained:

I mean, you know, they say ah the problem with RNABC sometimes when, when we don't follow it up, they won't reply like that. You know, I experienced that that's the first one so I waited like one month for their response so, so after one month I phoned them so you know like make me concerned about the TSE. So I'm wondering if support is enough. So I wrote a letter and then there's no response for after a month, so I kept on waiting and then I decided to phone them. You know sometimes when you left a message; you have to wait for at least one to three days for the response.

One participant concluded, *"You know RNABC itself, if you leave a message they don't reply. So you have to go there personally. So that makes time slower."* For those who are still overseas achieving efficient communication can be even more difficult. One participant described her experience:

So it was terribly, terribly slow, and terribly, terribly frustrating. And a lot of the other people have said similar things, except the others haven't some of them sort of got it going in 16 to 18 months There was a lot of silences in between there. I had to keep prompting, what's going on? And you'd wait 3 weeks thinking, "Oh, the post." And then you'd ring up and, "Oh, somebody hadn't processed that, it's on somebody's table." The college was the biggest pain in the neck. For me, that caused me the most, caused me all sorts of – 8 months of phone calls and letters and all that sort of stuff.

One cannot assume that the registration process in another jurisdiction will be quick and easy simply because one has a reputable education and extensive work experience. Even those recruited to specific contract positions encountered lengthy delays in obtaining their registration:

It was like, every step forward seemed to be two steps backward over time. It did get frustrating. When you know you've got the job, and they ring up and say when are you coming, and you say I still haven't got a work visa and I still haven't got my letter to say I can sit the exam. And then the interim permit that was another one we had to apply for, yeah, it's just seemed they made it hard when they so desperately wanted nurses.

Nurses educated outside of Canada who responded to an advertised nursing shortage believed they could be of benefit to a Canadian organization in filling needed positions while taking advantage of a personal opportunity for themselves. The lengthy migration and registration process coupled with the experience of transition to a new workplace soon caused the nurses to question their competence and personal value in the health care system.

Questioning One's Competence

Anxiety is pervasive when people start new jobs. Even the most experienced, well educated nurses I interviewed questioned their abilities in beginning to practice in Canada. *"I think it's obviously when you've got experience; it's thinking, 'Well, will I know what I'm doing?'"* Other nurses questioned if they had made the correct decision in moving to Canada. *"I used to go to work on the bus thinking I can't do this. I really don't want to be here anymore. What did I do this for?"* The novelty phase of migration described in the literature seems to end soon after arrival and beginning to work. Nurses repeatedly told of their disillusionment with their position and doubted their abilities to succeed:

As I said, the first few weeks were hell. I just didn't want to do it. I just felt like I was falling short even though I've been an ICU nurse. Sometimes I just told myself I don't know anything, why do I want to do this. It's just the difference in the transition. It's just different expectations, and it was meeting those expectations, I didn't know if I was up to it. I must be because I'm still here.

One nurse described the feelings she had her first week of work: *"I can just remember being just totally overwhelmed, really frightened, like really what have I done? What have you done?"* This nurse had specific concerns that she had identified prior to coming to Canada:

Before we came for definite, it would be said, I was worried about going into a [the specialty] because I knew nothing about. I was worried about going into acute care and I'd been at acute care for about four years. I was very concerned about IVs because I knew they did a lot of IVs and I'd done IVs but I knew it was different here and I didn't have – it wasn't something that I had a lot of experience doing.

Although this nurse had a sense of one aspect of practice that would be different for her, she did not understand the intricacies of the practice change as the environment was basically unknown to her. Initially when beginning to work in a new position one nurse said, *"I didn't even want to touch the pumps. I fear have fear of the unknown!"* One of the other participants was able to further identify specific aspects of practice of which she could improve her knowledge prior to moving:

Probably the fact that, um, things would be different. Um, you do things differently here. The assessments – that was a huge concern. I was so worried about that. And, uh, I used to think oh my god, they're going to test me, and what if I get it wrong, and I'll look like a real idiot, and look like, you know, I don't know anything, and that was the other thing that was worrying, that you'd been trained for such a long such a while. I've been qualified twelve years, and you, you think oh god, I'm supposed to know everything, but what if I don't? Well, I know I don't know everything, but I'm going to look really stupid and inadequate. And, uh, that was, probably for the first four months I felt like that – very inadequate.

She still questioned her ability to perform certain skills and make critical judgments; however, she had taken time to identify her learning needs and implement a learning plan that enabled her to feel more comfortable in her transition to practice in Canada. These

nurses have described differences in practice and personal issues that caused them to personally question their competence to practice. Several nurses told stories of their experience in having their competency questioned by colleagues.

When describing having their competency challenged, the participants implied this to be a demeaning experience especially as questioning was often done inappropriately in the presence of others and not framed as constructive feedback. One participant explained:

There was a group of people who particularly gave me a hard time wouldn't appreciate that just because I couldn't do what they've been doing for the last five, six, or fifteen years, did not mean that I was crap at my job – it just meant that I was from a different country and had different background from they had and just a little patience would have gone a long way.

This nurse longed for someone to take a moment to empathize with her and help her understand her role and how she could succeed. The stress of the transition and constant pressure in the workplace she recounted made her “*feel like a crap nurse, feel like I knew nothing and which is true enough, I didn't know about [the specialty]. I was terrified. I think some people didn't understand how difficult it was.*” This nurse equated the lack of mutual understanding between her and her colleagues to speaking different languages:

Who said, 'For one minute never think cause you're going to an English speaking country that you're going to know what they're talking about or they'll know what you're talking about because they won't.' And of course she's been to England enough; it was interesting. And sure enough, sometimes, I feel like I'm talking Japanese.

Not feeling empowered to be able to ask clarifying questions in a supportive environment prevented this participant from understanding the expectations being made of her. Being able to have an open dialogue about expectations throughout the transition period, standards for practice, as well as policies and procedures that is constructive in building knowledge and skill is essential. A participant in another practice setting shared her experience of being made to feel incompetent:

And when you're being targeted everyday because you do something a little different, but when you go and look at all the books, you are well within the bounds, but because they haven't seen it, it doesn't exist, and they will scream across the room at you, in front of surgeons and everything and make you feel big enough to crawl under the bed. It becomes that you see your name beside that person you want to go home sick.

She found the department to be inconsistent and never knew how her orientation would be day-to-day. It does not appear that any of those supporting her in the orientation period took time to assess her competencies and develop a plan for the shift that would meet her learning needs. This participant commented on her experience:

I went to another where I was treated like I'd left my brain on the tarmac out at [the airport]. Then I go to another one and they treat me like, "Oh you know what to do, get on with it," which doesn't worry me or doesn't worry most of us. So it depends where you were, what your orientation was. Prior knowledge was irrespective and if you don't know just ask me. Well, what do you know? Or it was like you're a dummy and I have to teach you everything, to scrub your hands, to put your gloves on, stuff

that you've been doing since you were qualified. So it depended on who you got and where you got, as to what happened to you.

Experiencing doubt from others related to one's competence to practice may cause an individual to become more assertive or defensive. Many nurses migrating to Canada to work have been practicing for years. They are confident in their skills and abilities to nurse. One of the older participants in this study made the expectations she had of her new colleagues clear:

And I've found the best way that I've made my stamp with them is to stand my ground, and I've actually said to them in meetings, if you have a problem with the way I practice, I would really appreciate you coming to me. Don't talk about me behind my back because that is not the way to resolve problems. Come to me. I'm amenable. If we can't get it solved here, we can go see the manager.

This nurse was proactive in trying to prevent a breakdown in communication between her and her colleagues by presenting herself as approachable and open to feedback. As an individual it can be challenging and daunting to assert oneself to the regulatory body when one's competence is questioned.

"You recognized our experience but you're not going to recognize our qualifications." There was a repetitive theme in the interviews with nurses from Australia and Britain, in particular, that having to take the Canadian Registered Nurse Examination (CRNE) questioned their competence to practice in an insulting manner. A criticism by one nurse in the study:

Um, one thing that I suppose for me that really annoyed me was sitting the RNABC exam because before you come, it took a good 12 months to go through the RNABC to get your registration, and I don't for one minute think they should be lax in checking

out your qualifications and things like that. But actually when you have gone through and, like myself, I've done nursing, midwifery. I've done a neonatal intensive care recognized course, I've done public health nursing course, I've got my degree and my Masters, and it was all within, you know, the [college in home country] recognized it, and you know, I've kept up to date professionally, and I was experienced. To come over and sit the RNABC exam is a little bit insulting, a little bit unnecessary, I think in some cases. I mean, I found the exam very easy. I was most unimpressed. And actually, when you're an experienced nurse and sit that exam, you've then got to go back and think, well, what would I have done if I was just newly qualified, because some of the questions we would do some thing, whereas, in fact, what you had to put was call for help, when you would do two things, which were on there, but you know, you'd be marked on that. So, for me, I was a bit annoyed about that. And I actually think, because some countries, where the standard of nursing education is considered quite good, for example, I think the UK, Australia, Canada, you know, some of these countries do have a good standard of nurse training. I think yes you should always check out references, you should always make sure that they are registered, but to sometimes have to come and re-sit that basic exam is ridiculous. Especially if you are, you know, well qualified and you are in a specialist area. And I think it would be more sensible to may be sit the more specialist exam, rather than have to do the whole gamut again.

As this infers, the CRNE is a basic test of knowledge that does not recognize a nurse's expertise and depth of specialized knowledge. The idea of being examined based on their

specialty area and having registration restricted to working in that area was proposed several times. One participant recalled:

I would rather have had, I remember mom ringing. She thought it was, she didn't believe I actually sat that exam. She thought like I had a test in the theatre to see, like to use all the equipment in there. Like she didn't believe that that's what I had to go through. She thought like I'd work there for a little while and then they'd give me a test to see if I could sort of stay in the theatre. Even if they did make it based on the department you did go and work in, it would make more sense.

The nurses acknowledged the need to ensure that nurses are qualified, but thought that for experienced candidates with reputable education and good references a more streamlined process could be implemented. *"And I know that the nurses registration has to be very careful getting back to that, of who they accept. But surely to goodness, they can look at the specific overall training of specific countries."* This caused them to question the purpose in them writing the CRNE. *"So that's what we just were, what are we doing this for? We saw it quite cynically as a revenue getting thing."* Some felt that they were being used for the benefit of creating revenue for the regulatory body.

The nurses I interviewed from Australia explained why they especially had difficulty in appreciating the need for a registration exam. *"In Australia, you don't sit the exams, so all we have to do is to prove your past experience, your education, etc."* Another nurse expounded on this wondering why interim permits could be granted on the basis of education, experience, and references:

And then when we found we had to do the exam, we couldn't understand that, and felt that was an insult because Canadians going to Australia don't have to do any exams.

And we felt, most of us, the New Zealanders and myself and Australians felt that why weren't our qualifications good enough when you give us an interim permit to work here, and you recognized our experience but you're not going to recognize our qualifications. We found that quite professionally an insult to our colleges and our abilities.

The nurses did not feel that the exam was a reflection of their experience and knowledge and left the exam wondering what purpose it served. One of the nurses remembered her thoughts:

So I thought, it's either really ridiculously easy or else I've just failed. So I just didn't even think twice about that. What the hell was that . . . And this exam here it is such a laugh. It was just ridiculous. And so I thought that was pretty futile.

The CRNE did not validate the nurses' advanced competencies or demonstrate value for specialized knowledge and experience.

Feeling Valued

The sense of being valued as a professional begins prior to setting foot in the workplace. A nurse's registration is extremely valued as it grants the ability to practice. In the province of British Columbia, registration cards are distributed annually in paper format. I never thought that people would associate their value as a nurse with the form of a registration card. One participant expounded:

But for registration and licensing I don't get the, for the life of me, see where . . . I didn't even get a badge! Where's the money go? What do I get from the \$300 whatever dollars? I get a little piece of paper. Not even a laminated piece of paper. It's not even a plastic card. It's just a piece of something that you can lose so easily.

One participant even shared his ideas for improving the look of the card with the association:

My frustration here professionally so like little things like the ID, registration, renewal the license, the registration ID. So I wrote RNABC regarding that because you know like um some of us won't be RNs for a long time, some of us will stay for five years, two years as an RN. So I recommend I suggested I wrote a letter I suggested to RNABC to make it like a credit card I mean like BC ID or like a credit card like that to make it more presentable because right now our IDs just a piece of paper ordinary ones. Anyways, I didn't receive ah um a response from them. So I wrote in our journals about it so I did receive but only just a minor one like I told them it won't cost like \$20 a year for the membership, you know it would like a lifetime like a ATM card, you know what I mean, like a better card.

The nurses in this study described multiple examples of how their perseverance throughout their transition to practice in Canada has resulted in them feeling valued and presented with further opportunities. Several talked about being mentors and preceptors. *"I fought really hard, and I have now been nominated and been working as a ward mentor for the last six months. I was actually nominated from other nurses on the unit, unbeknown to me."* Some had previous experience as a mentor and were happy to be able to further their experience here:

I am a mentor in my ward, and, um, I was a mentor in [home country], um, a preceptor. So, I was used to looking after students, and looking after newly qualified nurses, so when I came here, and um, my manager decided to, um, to do this, um, along with [a professor], um, I was really pleased, and what happened was the people were given you, you had to be nominated by your peers, and I was nominated, and uh, I had an interview, and, uh, I was successful.

Another participant described being entrusted with students as a highlight of her experience.

The ability for the nurses to be involved in the unit and have opportunity to provide feedback created a sense of being valued. One participant shared her experience:

They would thank me. Um, at the end of a day, or they'd say, "You're doing really well; we're really pleased with you." Um, my opinion would be warranted on some things. I would be invited to join committees. And, my input is quite important, I would say. Um, people come to me to ask advice, and, um, I'll, I'll give my opinion.

Opportunities to take on greater responsibility and fill advanced roles were a positive experience. *"Yeah, so that's really one of the good experiences. Like, you know, you get to be promoted, in a way. And being charge nurse, it's, like, a new thing for us, too."* Continued positive performance has promise to lead to further advancement. One participant explained:

You know, that my boss told me she'll give me more opportunities. For example, when I was registered nurse she told me if I can if I can do the, the function of [Director of Care], so after that maybe I can I can think about the position of like manager or administrator till my employer is giving me more opportunities.

One participant was supported to obtain specialized education to be able to work in the area of her interest:

In my case, here, because in [this hospital], they hired me first in the long-term care. And they ask me, "What is your dream?" "Oh, I want to be operating room nurse here in Canada." And now I got OR nurse. It's really happy, it's really my joy – OR nurse.

The investment in making the transition to practice in Canada is great both on the part of the nurse educated outside of Canada and the employer. For those nurses recruited to

specific positions, a one year contract is standard. The nurse has no obligation to the employer after the contract has expired; however, if the nurse has had a successful transition and is feeling settled in the practice setting, the decision to leave can be difficult. There are means for the employer to support nurses to extend their ability to work in Canada. One participant commented:

The other thing, when people have been here 6 months or 12 months, or not quite 12 months, maybe if someone backed up and said would you be interested in staying on, and how to go about renewing, that's sort of a pain. But you know there's no explanations for those things, like half way through our time would you consider extending. Some people need to be appealed to, and would stay if they were appealed to.

Employers can support nurses' application to renew work permits. For those wanting to stay in Canada long-term support can be provided in obtaining permanent residency.

Work Support Network

Starting to work in a new setting is anxiety provoking in itself; working in a new country the anxiety can be exponential. Several participants had been hired into positions prior to their arrival, yet came to the organization with little information about it and their colleagues knowing little about them. *"Yeah, probably, like I said, to have been greeted and sort of orientated to the hospital a little bit before we actually had to start work. Actually feel like you're being appreciated for sort of coming all this way."* Sharing an individual's skills and experience that are being brought to the new workplace may aid in extending a welcoming attitude. Based on the experience of one participant:

The senior staff are often unaware of our expertise or the terms of their employment. Meaning, the team leaders don't seem to get information to say this is [Nurse A], here is her CV, read it, and know where she is coming from. The information is there, but they don't get given it. It's all seems to stay in another office or they are not privy to it.

Recognizing the skill and experience that a nurse brings to the workplace demonstrates value for the individual and what the person has to offer. The participants described needing to prove themselves and being treated as if they had no knowledge and experience:

And I was treated like – I was told by one of the newly qualified nurses that a handover, somebody had said, 'Let's be careful [with participant] because she's a – we need to treat her like . . . ' what do they call it here? A new grad. 'We need to treat her like a new grad.' Which one I think said the nicest possible attention, but I don't really think it was. I think it was just another way of undermining me.

Another nurse could not understand why her expertise was not recognized. “You know, I didn't just walk in here and shuck everything off that I knew [from home], because the flight across [to here] doesn't suck my brains out.” She challenged people to take time to learn about her and not make assumptions about what she did and did not know:

One of the girls said, I said something to her, why don't you ask me. She said, well I don't know what you know. I said but why don't you ask. And that seems to be a problem. No one asks us, and they just assume we don't know, and then it becomes an insult and we just go on, okay.

Although one of the participants tried to adapt to the new work setting, it seemed to become increasingly more difficult for her. She described:

I'm good at putting my hand up and saying, you know I'm struggling here with this, and when I did that I felt it actually got worse. It became like I say a self-fulfilling thing for me and it was safe for them – it was like you know what, she can't do this, or no, she can't do this: Well, no, I couldn't but I know I can't and you having this crumby attitude is really not helping. Again, I normally I would have verbalized that, but I couldn't, I just sat there and I have to admit I was stupid and I just cried.

Over time this nurse reflected on the skills she had that she could have applied in this situation that may have assisted her in achieving a different outcome. She was able to learn from her experience, recognize the expertise she has, and apply her knowledge in challenging environments. She shared that she felt valued in her new work setting. *"I had people coming up to me saying, 'Oh, I'm so glad that you're here; it's so nice when you're here.'"*

"And, you know, you go to work and enjoy yourself because you're there for a long time, more than you are at home," described one participant when emphasizing the need for collegial relationships. When settling into a new place it is comforting to have some things that are familiar from home. For some of the nurses in this study having colleagues from their home country provided that link to home:

I was lucky I supposed that there were 3 other nurses [from home country] there. They were kind of like my lifeline, hearing [those] accents again. Having to start all over again, at least there were . . . girls there who understood me.

One nurse explained the benefit of having a preceptor who was also educated outside of Canada:

I was quite lucky that my preceptor was English for two of my shifts so I found working with her just great. She was like, oh you won't believe what we have to do with this and that was good cause she knew that I was going to go, 'What?'

The preceptor was able to anticipate what would be surprising and potentially difficult for the new hire. The participant was at ease as she knew she could ask questions and relate her current experience to that of her home country and the preceptor would understand her perspective. Knowing that a person has someone to empathize with is a comforting feeling. A nurse in another organization felt embraced more by other nurses who were educated outside of Canada than she did by Canadian nurses:

I found, um, the Canadian nurses here, um, Caucasian nurses unfriendly, not welcoming at all, very stand-offish, um, whereas the Filipino nurses and Asian nurses were, were more welcoming. As one had put it to me, that she had been an immigrant, too, and knew how, how it felt.

Others described having better relationships with their Canadian colleagues than they had expected. One of the participants expounded:

I think Canada has been everything I expected it would be, perhaps a bit more. I didn't expect the Canadian girls that I would work with to be as helpful, as supportive and as friendly as I found them. And it's not just the nurses. The unit clerks, the porters, you know, everybody in the hospital I work. You know I can't speak for anywhere else because my experience is in the one place, but generally I think they're an excellent group of people to work with. I admire some of their skills. I've learned new skills.

Several of the participants were able to connect with new graduate nurses and found the experiences of their transition to practice in Canada beneficial. The leadership within the unit, manager and educator, etc., was also instrumental in creating a supportive environment, described one participant:

We had an educator on the unit. She was very good. She was always really amenable to me as a foreign nurse. My colleagues were great once they kind of got used to me and the way I spoke. They were great. They were a big help. Because I was working with a lot of new grads that had just taken their Canadian nursing exam, just graduated, and they were a big help just chatting to them. They were really supportive, the girls here. And my manager at [Hospital A] was really nice, really good. She was almost, she kind of took me under her wing like a surrogate mother. But everybody was really supportive.

For those who were displaced from positions soon after arriving in Canada, feeling supported through a second job transition was critical. Being a part of a group of nurses involved in a displacement and transferring to a new unit helps alleviate feelings of isolation and being alone in the transition. One participant recalled her experience:

But when we talked to the manager there, she was very welcoming. She seemed to be flexible. She seemed to be really accommodating, and to be understanding of our situation, coming from extended care. And also, the good thing is, um, the staff on our floor from the extended care, we were all together in looking for the wards. We were approximately five nurses, and we all went to that ward. So that, um, made the transition also easier, having familiar people, you know, to adjust to the ward.

Receiving support and understanding from people in the workplace who have had similar experiences of transition as the nurse educated outside of Canada was stated as a need by several participants. According to one of the nurses in this study:

They need some kind of support link within their own group for foreign nurses, people that have been through the process. People who know how it feels. And workers that are actually nurses themselves. They know the difficulties that people are up against.

Some nurses took upon themselves to develop support structures for other nurses educated outside of Canada. "I have a habit of looking out for my colleagues, particularly southern colleagues. I look out for the Aussies and Kiwis a lot mainly because I'm a single person and older." At times the collegial support desired was found in a nurse at another organization.

One participant offered to be a resource to others:

Need a Kleenex, come to me. Yeah, we, we do support each other and I met a nurse just by chance who worked at [another hospital], who was in the same boat as me – she was struggling big time. Again she was in an area she knew but again she couldn't figure out the doctor's orders, she couldn't figure out what the heck she was supposed to be doing with these MARs and the different way of working just totally threw her.

When facing the challenge of adapting to new practices, policies, and procedures a nurse needs to be able to have resources that can be accessed and people that can be coaches in the adaptation process. One participant's story alluded to the need for the assurance in being able to turn to her colleagues:

But um, yeah, just trying to make some kind of connection with them instead of just you know blinking them off and letting someone else, an educator or someone, deal

with it. And maybe just standing up for that person a bit, finding out what they have done and what they are capable of doing.

She appreciated the role of the educator, but wanted to be able to trust that her colleagues would also facilitate her learning. To improve his skills, another participant purposively used the teaching/learning strategies of observation and return demonstration:

If you ask them, "How can you do this?" You know some person if you approach, I'm not comfortable in doing this, I can do this, but can you watch me. You know what, if you ask them, I'm not comfortable in doing this, they will say, okay I will do that and you look. So for the next time that you will do it, it will be easy for you. It's slightly difference, if you do it first. It's hard for you to do it, it's better if somebody is watching you.

By observing first, the nurse was able to visually understand the steps of the procedure. Then when doing the procedure initially with another nurse present, the participant was able to validate the process and receive immediate feedback on his skill.

Receiving performance feedback, especially if it is critical, can be difficult and make people defensive. One nurse shared a story about a mistake she had made in unwittingly following the advice of a novice nurse. The nurse who recognized her error was aggressive and confrontational shocking the participant and leaving her somewhat embarrassed:

But then, this other nurse that, when they witnessed then they said, "You know, if you need to talk, I'm here, okay. If you need any help, just let us know; we will help you." That was a very touching moment for me from the other nurses, because I thought everybody was like that.

The value of a support network cannot be overstated. Nursing is a challenging profession in which one can easily become disillusioned. Taking time to acknowledge the feelings and challenges experienced by colleagues is appreciated, as explained by one participant:

Just, you know, when you see someone in tears at work you know, not to think you know what, it's not my problem because I'm not directly involved. Just to go up to that person and say, you know, 'How are you doing? What's, what's, what are you finding hard?' Because it wasn't everything that finding hard, it was just specific things.

Because much of our life is spent at work, friendships often develop with co-workers that frame apart of one's social support network.

Social Support Networks

Not knowing any or few other people in a city may be an impetus for nurses educated outside of Canada to morph professional relationships into friendships. One nurse provided the details of her experience:

So we had to, to sum it up, we form our social relationships mostly with our work now. Like, um, you know, whether they're young, or, you know, more senior, it's like we go to functions with them now. We go [in runs] or potlucks, like, we, we go with them. And, you know, it's, it's good, because, in a way, it's like support emotionally, and it's like away from work, you can talk to them, not as, like, nurses like as friends, too.

For some coming to a multicultural nation like Canada has enabled the development of relationships with people from around the world. One participant described:

And I've made some good friends. I've got friends that have come over from other countries, Australia, South Africa, you know I work well with them, they work hard; we have a good line. And I also have made some very good Canadian friends, and I have actually found my Canadian colleagues to have been most helpful, you know, advising me on all sorts of things. You know, there was a time when I had a colleague, I bought my house. I didn't know where my house was because I'd only been there twice with the real estate agent. And one of my colleagues brought me and showed me around where I lived and, you know.

Being able to connect with people outside of work to share experiences and explore new things is a blessing. For those who came to Canada on their own they felt isolated in their initial period of transition. According to one of the participants:

And of course you know you have, you know nobody and you know not a soul, nobody knows you either, they don't anything about you so it's hard. I don't just mean in work; I mean outside of work. If work's crap and then you go home, you've got your friends and whoever, you can deal with it a bit better. You go home to people who don't know you either.

On her arrival, this nurse was fortunate in obtaining accommodation with two other nurses who were also educated outside of Canada. She found it helpful in knowing there were other people in the same position as her. One of her roommates had been in Canada for an extended time and was able to reflect on her experience at the same stage and provide advice to the new migrant:

If you hadn't by chance happen to live with someone or met someone through someone else who happened to be in the same position as you and I think to make the

connection with someone who is struggling too, cause a lot of people take it's like, you know they're not as sensitive as everybody else and don't take it to heart. So to meet someone like you that is really missing home and really struggling, not that it's a good thing that I'm struggling, but I think that's what helped me and you know, so having people to meet that are in the same boat as you for definite.

The participants described just having someone to be with who understands the other person as a common aspect of social support. This may be to have time to vent about work experiences and relationships or to participate in activities that provide a distraction from the reality of current challenges and frustrations. One participant explained:

You know it's so important like when you're finished work and you've got nobody, like nobody, it was so nice just to go out to dinner with somebody or just meet them for a drink or go to the cinema or just do something for just for maybe two hours to take your mind off the fact that you're on your own.

One participant had a system of support arranged with another nurse:

We'd get down to her place and eat food and have a really deep fall out about it all. And then we'd laugh our heads off and that was that. And then next week it was either her turn or my turn. And if something was extremely bad for us one week, we'd go out that evening and get it off our chest and go back to work the next day. So we found that helped us a lot, it helped both of us.

This structure allowed the nurses to have a routine debriefing that provided opportunity to reflect on their experiences and compare them to the stories of other nurses. It allowed the nurses to put their experience in perspective and look forward to the future, described one participant:

And other girls have similar stories and we just, this is what I'm saying to you, we just both laugh about it and move on. Now it's become a joke in our repertoire. We never mentioned who the person was. Some people don't even know where the story came from. But they know the story's out there.

Although it seems that some stories may evolve into what seems like mythical legends as they pass from one nurse to another, each story facilitates a learning opportunity. A story enables one to relay information in a non-threatening manner. *"We try to pass it on to one another without being too intrusive for one another, but I think it should be in some sort of information that's given so we understand when we get here."* People can learn from each other's experiences – what to do, what not to do – in order to make more informed personal decisions.

An interesting finding in this study was that some participants had no desire to socialize with people from their home country. One participant explained that he had extended family that lived near him, so he did not need to be a part of other social groups. The comment of one nurse about her socialization needs stood out to me. *"If I'd never seen another ex-pat I could still have been happy. So I didn't have a personal need that I had to have other foreign nurses to give me group support. That wasn't something I felt I needed."* This nurse came to Canada with her family and intended to move here on a permanent basis. She also was older and had a variety of experiences as a nurse. These factors combined with the fact that the family chose to move to Canada for the lifestyle and dynamics of the country may have influenced this decision.

Family members provided critical elements of social support for the 10 participants who had immediate family with them; however many did not expound on their experiences

in relation to being in Canada with their family. One participant explained the role her family members played, *"Yeah, that yeah, social aspect, too, um, but the emotional aspect, we have, you know, lots of support from our mom with each other, our brother, um, and from our aunt here."* It seems to be the support of family that helps individuals the most in getting through difficult times. For family that came together to Canada, they share a common dream of what life would be like in their new home. One nurse's spouse was her lifeline in what she described as months of hell. *"But my husband was really supportive through those 8 months. But he was really supportive. I think he must have shed as many tears as I did just, you know, everything we had given up."* They consoled each other as they questioned their decision to move to Canada and shared similar experiences in the transition to living in a new city and finding work. "we often sort of sat and held each other, *"Oh my god, what did we do this for?' We left everything behind. So it was equally as hard for him, even though he is Canadian."*

Summary

The nurses educated outside of Canada who participated in this study openly shared their experiences in making the transition to practice within the Canadian health care system. For most this was an emotional reflection on their expectations and the reality of how their journey unfolded. From their stories nine common experiences emerged and were explored to increase understanding of the transition process. A summary of the findings will be discussed in the next chapter followed by conclusions and resulting recommendations.

◀ Chapter 5 ▶

Summary of Findings, Conclusions, and Recommendations

As a nursing leader within an organization I had observed and heard stories of the struggles of nurses educated outside of Canada in making the transition to practice in Canada. This study was designed to describe and understand the experiences of nurses, educated in a country other than Canada, as they make the transition to practice within the Canadian health care system. Rich descriptions of the experiences of nurses were obtained with the use of the in-depth interviews. Interviews were completed with 13 nurses, 11 women and 2 men, who moved to Canada in the past five years. This method was valuable in being able to identify unanticipated issues of importance. Employing in-depth interviews enabled me to develop an understanding of their experiences that caused me to reflect and evaluate my personal conceptions and ideas about the transition experience. I was continually challenged to be reflexive and identify personal subjectivity in interviews and interpretation. Questioning my assumptions and interpretations through notes, analytical writing, and discussion with colleagues, my supervisory committee, and participants allowed me to clarify and redefine my perspective on the experiences of nurses educated in other countries related to their transition to practice in Canada.

The participants' description of their experiences in making the transition to practice in Canada led to a better understanding of why nurses choose to move, misconceptions that occur related to relocation, and challenges nurses have in adapting to Canada. Other themes identified in the findings include: isolation, professional support, questioning one's own competence, feeling valued, and the significance of work support and social support networks. A summary of the findings will be presented with a section for each theme

followed by conclusions of the study. The recommendations resulting from the findings will be discussed with respect to government sectors of human resources, customs, and immigration, regulatory bodies, health care organizations, future immigrant nurses, and research.

Summary of Findings

In this study it was found that for these nurses clinical issues in the provision of care were not the primary concern. The focus of their reflection related to the dynamics of interactions at work and with professional organizations as well as the basic needs and costs associated with living in Canada. I did not find the experiences of nurses to vary significantly based on gender. A difference was noted in the response to an extended struggle of securing permanent employment as a nurse. A male participant emphatically described this as affecting his pride. A female participant attempted to continually display understanding for the bureaucratic process and while frustrated, she tried to remain optimistic.

Reason to move. The reasons provided by the nurses in this study as to why they moved to Canada echo what was written in the literature: better economic, working, and living conditions; improved learning and practice opportunities; and novelty of travel and employment abroad (ICN, 2002a; Kingma, 2001). These same factors may attract nurses educated in Canada to move to other countries. Also, nurses educated outside of Canada may seek opportunities elsewhere after having spent a period of time here. Some of the nurses wanted to come to Canada because they and/or their spouse had previously visited or lived here. Having family or friends in the city to which they moved was also an influencing factor. It was interesting to find that those who followed other family members to Canada still had significant challenges in the transition process. Similar to other participants they

described difficulty in obtaining work that matched their professional interests, making new friends, and finding their way around a new city. Some participants felt that their family members who had lived in Canada for an extended time could not relate to them being from another country as the family was too enmeshed in Canadian society. Rather than providing the support envisioned by the new immigrants, these family members heightened the participants' sense of being different and feeling isolated. Other significant findings related to misconceptions when relocating will be discussed next.

Relocation misconceptions. From the experiences of the nurses in this study the issue of credibility of recruiting agencies has been highlighted. Repeatedly the participants described a lack of understanding on the part of the recruiters as to the transition process and the requirements. Several also experienced agencies closing business and being left alone part way through the transition of moving to Canada. With the predicted increasing need to recruit nurses from other countries it may be essential that assessment and monitoring processes of recruiting agencies be implemented to ensure that the nurses are provided timely, accurate information and are supported across the continuum of their transition to practice in Canada. In the next section findings linked to the challenges in adapting to Canada will be explored.

Challenges in adapting to Canada. From the description in the findings I believe that the novelty of moving to a new country ends for nurses before they actually complete the move or soon after arrival. Upon arrival new immigrant nurses are balancing a new job, new country, exams, and orientation courses while trying to settle their family. Several participants clearly described the process of adaptation to last six to eight months. Nurses are often surprised by bureaucracy associated with immigration and expense of moving, living,

and working in another country. The participants tended to forget about the items and resources used every day that when in place are taken for granted. Acquiring a driver's license, insurance, utilities, and credit quickly became major frustrations for many. The literature described the potential for the stressors of migration to manifest as physical symptoms (Boyle, 2003; Lipson et al., 1997; Pilette, 1989). I am aware that some of my previous colleagues from other countries suffered various physical ailments; however, none of the nurses in this study described this as an issue. Each of them did describe experiences of psychological distress that has had a lasting impact. Nurses from the Philippines used more resources in preparing to move to Canada and to aid their transition to practice here. These nurses expected to face certain challenges and, therefore, may have adapted with more ease than nurses from Australia or Britain.

No matter where one lives there are basic needs and costs associated with living. For those who do not move often or have little knowledge of what it is like to live in different countries, it is easy to take these items for granted and not to think about the need to learn how to obtain basics such as utilities, insurance, and license to drive on arrival. Further understanding of the cost of living in another country would also be valuable. Some of the participants wanted detailed information about monthly living expenses such as rent and food with a comparison to similar expenses in their home country as well as professional fees, including annual registration fees and union dues. In the next section findings of the experience of isolation will be highlighted.

Isolation. A sense of isolation developed for participants as they felt that they were alone and overwhelmed with adapting to a new environment. Some had problems in being able to make long distance phone calls due to a lack of access to a personal phone initially

and no established credit history in Canada; this added to the sense of distance from what was familiar and comfortable. A relocation assistant was hired by a few organizations to help nurses in settling into a new city. Unfortunately, most of the participants felt that this assistant was more of a hindrance to them and did not provide the service they expected. Aspects of professional support discovered in the findings will be explored in the next section.

Professional support. If the impending nursing shortage is as great as predicted by Ryten (1997) and others should changes be made to government policies to enable more flexibility in the hiring of nurses? Why is there so much frustration amongst nurses educated outside of Canada when making the transition to practice in Canada? Currently nurses on a work permit are restricted to holding permanent full-time positions only. Many vacancies in nursing are relief positions due to leaves of absence for maternity or medical issues. Many units have ongoing relief needs that could be met by nurses educated outside of Canada. Collaboration between the government, regulatory bodies, and health care organizations would lead to greater flexibility for employers to be able to utilize nurses educated outside of Canada to meet the current vacancies.

Many of the nurses interviewed in this study did not access government resources that may have been of assistance in their transition to Canada. Some of the participants realized afterwards that using these agencies would have benefited them. It was surprising to learn that some people did not even realize they needed a work permit or residency status to work in Canada. This then begs the question what occurs when one proceeds through immigration when entering Canada. If a person states that he or she is coming to work in Canada, should a request not then be made to review appropriate documentation to permit employment?

Perhaps some of the frustration experienced by those who were delayed in beginning employment could have been minimized on arrival. Accessing government information may prevent delays and some frustrations altogether. Agencies that the participants valued included Canadian consulates, Human Resources and Skills Development Canada, and Health Match. If these services were highlighted to nurses as they initiated the process of moving to Canada and at points throughout the application process, perhaps there would be opportunity to better prepare nurses as to what they will encounter when living in Canada. For example, the nurses in this study felt it was important to have basic information about taxes, utilities, insurance, driver's licenses, and renewal of work permits. These organizations could provide this type of information on a summary page with the inclusion of specific resource contact information.

Multiple issues were raised by the participants in this study in relation to registration in Canada. The requirement to write the CRNE, a basic certification exam, was particularly contentious. Some questioned whether a restricted registration for those nurses on a work permit may enable recognition of their expertise and specialty while not requiring them to write the exam if they are not planning to stay in Canada permanently. A query was also made as to whether the CNA specialty certification exams were sufficiently valid and reliable for one to be registered in a specific area of practice. Nurses in specialty areas, such as the operating room and maternity, believe that the CNA specialty certification exams would better test the knowledge and expertise they bring to the clinical setting. The CRNE provides a baseline assessment of the knowledge required to practice as an entry-level nurse; while a certification exam tests specialized, expert knowledge in a particular area of nursing. To be registered without completing the CRNE would require a restricted registration, which may

be feasible for those nurses with a work permit on a one-year contract to work within a specific position. If these nurses choose to become permanent residents and/or work in other areas then a requirement to write the CRNE would be essential. It would be beneficial for the regulatory body to provide information to the experienced nurses as to why the CRNE is necessary and the benefit it provides in the assessment of nurses' core competencies.

Communication between the RNABC and applicants/members was also described as frustrating and needing improvement. The participants stated that often times there were delays in response from RNABC. Many times when calling in, people were forced to leave a message as they were unable to speak with someone directly about their issue. Some of the participants felt that their written letters were ignored altogether. When in the application process, several participants described having a sense of ambiguity as to their status with the regulatory body. They were not informed if their application had been received or if additional information was required. With some of the participants there was discussion about improving an applicant's ability to check the status of their application and approval for registration. One idea proposed was to be able to access a personal file online that would indicate registration status.

Supportive resources offered by the regulatory body were appreciated by nurses. In 2003, RNABC Practice Advisors facilitated a workshop for nurses educated outside of Canada that provided an orientation to the health care system and standards for practice. Nurses that I interviewed who attended this workshop felt that the session was valuable and hoped that similar sessions would be scheduled in the future. Many of the participants connected with professional practice groups or other nursing networks that were beneficial to them on a professional level. The nurses often described seeking out these groups

independently. A basic list of such resources would be useful for new registrants to receive with their initial registration. Next findings from the theme of questioning one's competence will be presented followed by a section on feeling valued.

Questioning one's competence. Nurses educated outside of Canada need to develop an understanding of how their education and experience fits within the Canadian health care system. Nurses applying to tertiary or quaternary care settings are frustrated when they are declined and informed that they need to have work experience in Canada. They need to recognize that their competencies may be better suited to secondary level care and that they would benefit from initially working in a less acute environment.

Feeling valued. While nurses need to feel connected and supported, they also described the need to feel valued. A surprising issue that was raised in some of the interviews with nurses in this study was the format of the registration card. There is pride associated with being able to use the title Registered Nurse, but a paper registration card is not demonstrative of the value related to the position. One participant suggested a more durable format similar to a driver's license. Findings related to support in the workplace will be expounded on in the next section.

Work support network. Employers have identified challenges in the immigration restrictions related to the need to have permanent full-time positions to offer individuals on a work permit. Organizations need to implement flexible hiring practices to enable them to fill their vacancies and increase the potential to hire nurses educated outside of Canada. For units that have ongoing vacant temporary positions, some organizations have successfully utilized an over-hire strategy to meet the demands. This enables the hiring of nurses into permanent full-time positions to meet the staffing needs of a unit.

When recruiting new staff it is important that organizations be clear in the offer presented. Some of the participants described the need for job stability and security. They accepted positions without knowing the future direction and plans for the organization. It would have been appreciated if the employer would have been upfront and honest about the potential for restructuring. Clarity on relocation stipends and how they would be paid was also needed. It was clear in the interviews that not all of those who had been recruited to positions understood that they were only to receive assistance with their costs, not that their entire relocation would be paid for. Some negotiations were completed verbally and not specified in writing, which caused nurses to become distrustful when what they believed had been agreed upon did not come to fruition.

There was a repetitive theme in some of the interviews related to desired improvement of networks of nurses educated outside of Canada within an organization and local area. Some were informed of plans for networking events, but the promise never came to pass. Davis and Maroun (1997) note that it is beneficial for organizations to have support programs that address the transition process with a focus on the culture and customs of the setting and region. Several participants would have valued being able to liaise with another nurse who had been educated outside of Canada, or with someone who was at least very familiar with the experience. One nurse felt that it would be advantageous to have a nurse work within Human Resources specifically to assist nurses from other countries. The literature shows that the health care system and its professionals do not function in a supportive role in receiving and addressing the stresses and concerns of peoples' everyday lives (Anderson, 1985; Anderson, 1987; Anderson et al., 1993; Dyck, Lynam, & Anderson, 1995). Health care needs to be more effective in understanding the social context and cultural

values of people's lives to enable the provision of and connection to meaningful resources (Anderson et al.; Lynam, 1985; Schreiber et al., 1998; Yahes & Dune, 1996). Without supportive networks and resources, nurses felt isolated and forgotten. They did not feel that their role in the organization was valued. Life in Canada immerses people in a multicultural society. Several participants described an appreciation for being able to experience other cultural traditions and develop relationships with people from a broad cross-section of backgrounds. This enabled them to learn from others and develop a social network outside of the work setting.

As a new employee one wants to feel received and welcomed into the organization. Small gestures have a big impact when a person is feeling lost and overwhelmed in a new environment. One nurse described how she struggled to find her way to various departments in the maze of a hospital. After being recruited from thousands of miles away and relocating her family, her sense of value suddenly decreased when no one met her on arrival or took time to show her the building. Besides knowing the physical layout, it is also important to understand the professional organization and learn the "who's who" in an agency. In a multifaceted approach, simple contact lists can be one method used to aid a new employee in learning this information.

While all of the participants appreciated the orientation they received when beginning to work in Canada, some highlighted improvements that could be made. In their initial shifts, nurses are matched with a nurse who is a preceptor to assist them in their transition to the new practice setting. It was noted that education is needed for preceptors as to how to support an experienced nurse from another country versus a new graduate. Continuity of preceptors was also valued. Participants that were paired with different nurses each shift felt that this

contributed to a disruptive and inefficient learning process. Nurses need to be assertive in expressing their personal learning needs to enable a successful transition. Once a preceptorship is complete, nurses work independently and may feel alone in the practice setting. The development of a mentor relationship can assist the transition to independent practice as nurses feel comfortable in approaching a specific colleague for assistance and feedback.

From the description of experiences of the nurses in this study it was noted that work setting may have an impact on the ability of nurses to adapt well to a new work environment. While the basic principles of nursing do not change regardless of where nurses work, some areas are more structured with defined routines and procedures. In this study nurses that worked in Labour and Delivery, Oncology, and the Operating Room described being able to more readily assimilate into their positions.

The experience people bring to a new position may invoke learning opportunities for others. One of the participants described feeling demoralized when others made assumptions that she did not know anything about various procedures. She yearned for someone to take time to ask her, "What do you do where you're from?" This nurse is an expert practitioner. She recognized that there may be variation in policies from one organization and country to another, but the basic principles of nursing remain the same. The ability to provide constructive feedback that enables learning while building on one's foundational knowledge is key for nurses to create a supportive, challenging work environment.

It is recognized that each individual brings a certain skill set and area of expertise to the practice setting. It is valuable for new staff to learn which people are resources for various subspecialties. Likewise, it is important to recognize the experience that nurses

educated outside of Canada bring to the workplace. Such information may be presented in staff biographies that are posted on the unit. Within a multicultural team there needs to be recognition of others' values and priorities for the use of time as being legitimate (Giger & Mood, 1997). Informal social gatherings also provide opportunity for staff to learn more about each other. One participant suggested having a potluck of international food as a welcome gathering for nurses from other countries. Other key findings related to social support will be highlighted in the next section.

Social support network. Those nurses that moved to Canada with their family noted greater expenses in moving and living; however, they benefited from sharing a common dream of living and working in Canada. They also valued the social support provided by their family members. Nurses who came on their own were forced to build new social support networks. There is an impression that single nurses may be less likely to stay in Canada permanently as they lack the family ties.

Conclusions

There are five key conclusions that can be drawn from this study:

- Nurses immigrating to Canada often lack information about the bureaucratic processes of settling in a new country and the resources that are available to them to facilitate the settlement process.
- Despite much publication of a nursing shortage in Canada, nurses have difficulty securing nursing positions that match their professional interests.
- When beginning to practice in a new position all people have a certain sense of anxiety. All of the nurses in this study at various times questioned their own competence and whether they had made correct decisions in moving to Canada. Nurses educated outside

of Canada who had years of work experience prior to moving encounter constant pressure to perform at advanced and expert levels with little insight into the regression to being a novice when initially beginning a new position.

- Nurses with experience in other countries struggle with the requirement to write an entry level exam upon initial registration in Canada. The need to write the CRNE frustrated and annoyed nurses. They felt that this indicated a lack of recognition of their skill and experience and was a personal insult to them.
- The stress of migration has a lasting impact. Participants told me about events that happened over a year ago from which they still had not healed. They hesitated to participate and openly share because of the depth of emotions attached to their experience. At the conclusion of each interview, though, each participant appreciated being able to share their experiences as they made the transition to practice in Canada. In-depth interviewing is valuable in describing issues of a topic and exploring associated factors to make recommendations to address them.

Recommendations

Recommendations for Government. The following recommendations for government resulted from the findings of this study.

- Expand options for types of positions in which a nurse with a work permit may be employed.
- Highlight services provided by consulates, Human Resources and Skills Development Canada, and Health Match to nurses as they initiate the process of moving to Canada and at points throughout the application process.

- Provide basic information about the costs associated with living in Canada (e.g., taxes, utilities, insurance, driver's licenses, and renewal of work permits) upon expression of interest in moving to Canada and upon receipt of an application for a work permit or landed immigrant status.
- Improve screening at customs for reason of entering the country and appropriate documentation.
- Assess and monitor the credibility of health care recruiting agencies.

Recommendations for Regulatory Bodies. Recommendations for regulatory bodies that were identified from the findings will be presented in this section.

- Develop mechanisms for applicants and members to self-check their registration status.
- Improve communication as evidenced by timely and direct access to appropriate staff and better response time with acknowledgement of communication received.
- Upon expression of interest in moving to Canada and with each application package, provide detailed information on costs associated with registering and working as a Registered Nurse within the province including: application fee, examination cost, medical requirements, criminal record checks, annual registration, and union fees.
- Provide information about the CRNE to nurses educated outside of Canada, including why the examination is required and the benefit it provides in assessing competency to practice.
- Facilitate a workshop for new nurses to provide orientation to the Canadian health care system and the standards for practice.
- Provide a list of resources, such as professional practice groups and other nursing networks, to nurses with initial registration.

- Explore options for formal recognition of registration and its ongoing renewal.

Recommendations for Health Care Organizations. Recommendations for health care organizations are outlined in this section.

- Create regular full-time over-hire positions to facilitate the hiring of nurses educated outside of Canada to meet staffing needs.
- Develop a written contract individualized for each nurse recruited from outside of Canada outlining the amount of the relocation stipend and a payment schedule.
- Assign a nurse to work with the Human Resources department specifically to assist nurses from other countries.
- Meet new employees at the entrance when they first arrive on the site and provide a basic orientation to the physical space.
- Provide contact lists of important contacts within the organization on arrival to assist nurses in recognizing the resources that are available.
- Provide networking opportunities for nurses educated outside of Canada. This may be planned social events or distribution of a contact list of other nurses educated outside of Canada who are willing to support or mentor new immigrant nurses.
- Develop mentorship programs to support new hires beyond the orientation and preceptorship periods.
- Provide continuity of preceptor(s).
- Educate preceptors on how to support nurses with various levels of experience.
- Within each unit post staff profiles that are initiated when hired and regularly updated to highlight each nurses area of expertise and specialized skills.

Recommendations for Future Immigrant Nurses. The recommendations presented thus far have been associated with the impact that policies and work environments have on the experiences of nurses educated in other countries in their transition to practice in Canada. The following recommendations are directed to future immigrant nurses.

- People who immigrate need to develop awareness and be prepared for challenges they will encounter when moving to and beginning to work in another country.
- Prior to moving it is essential to have a clear understanding of the potential to find work and the legal requirements to work in another country.
- Having realistic expectations of the transition process and the length of time it takes to relocate may assist in preventing frustration.
- Completing some research as to how to time the different components of relocation is also beneficial in strategizing to minimize delays. Depending on whether a nurse is coming to Canada on a work permit or as a landed immigrant or if a job is being sought in a specific region, there is variability in the best order to obtain a job offer, complete the registration process, and fulfill immigration requirements.
- Develop an understanding of the cost of living in another country. Obtain detailed information about monthly living expenses such as rent and food as well as taxes and professional fees, including annual registration fees and union dues.

Recommendations for Research. As a result of this study, recommendations for further research have been developed.

- An assessment of the type of shortage needs to be completed to enable appropriate communication of the needs and recruitment of nurses that will best meet the demand. Research is needed to define the nursing shortage and determine the skill sets required.

There are a myriad of advertisements in magazines and newspapers for nursing positions in Canada. If the volume of advertisement is an accurate reflection of nursing vacancies one may assume that there is a nursing shortage in Canada. If the shortage is specific to a subspecialty then it is not necessary to attract nurses who do not have applicable experience. A high demand for nurses in a broad range of areas may require the need for adjustments in policy to increase opportunities for nurses with a work permit.

- Nursing is a global profession; nurses are needed everywhere. Research on globalization trends may assist in predicting needs and creating strategies for recruitment and retention. The issue of globalization applies to health care in general. Many other health care professions are impacted by the effects of migration. Physicians, for example, move to different centres to encounter a variety of educational experiences in their residency and fellowship. Inter-professional research would enable a common understanding to be developed as to the experience of health care professionals educated in other countries as they make the transition to practice in Canada. This may enable the formation of collaborative systems to improve support mechanisms and policies for immigrant professionals.
- From the interviews with nurses in this study it was clear that there is a continual need to demonstrate that care is provided according to best practice. Ongoing research is required to demonstrate that the best care is being provided in the best setting. When nurses begin to work in a new organization they often encounter policies and standards that are different to those at their previous workplace. Some examples that the participants in this study highlighted include medication administration, checking of charts, and transcription. Discussion of variations in practice, that is, nurses' experiences in their

home country versus their experiences in Canada, could lead to research as to what is best practice, which could result in organizational improvements or reaffirm current practice.

Nurses educated in countries other than Canada may provide the impetus for new, innovative practice initiatives through sharing their experiences from another practice setting.

Summary

This study has provided insight into the experiences of nurses, educated in a country other than Canada, as they make the transition to practice within the Canadian health care system. Developing an understanding of these experiences led to an exploration of the interactions of the immigrant nurse with government, regulatory bodies, organizations, staff nurses, and other nurses educated outside of Canada. The participants' description of their experiences of making the transition to practice in Canada provided the opportunity to identify systematic improvements for government human resources and immigration sectors, regulatory bodies, and health care organizations to consider and future directions for research.

References

- Anderson, J. M. (1985). Perspectives on the health of immigrant women: A feminist analysis. *Advances in Nursing Science*, 8(1), 61-76.
- Anderson, J. M. (1987). Migration and health: Perspectives on immigrant women. *Sociology of Health & Illness*, 9(4), 410-438.
- Anderson, J. M. (1991). Reflexivity in fieldwork: Toward a feminist epistemology. *Image: Journal of Nursing Scholarship*, 23(2), 115-118.
- Anderson, J. M., Blue, C., Holbrook, A., & Ng, M. (1993). On chronic illness: Immigrant women in Canada's work force – A feminist perspective. *Canadian Journal of Nursing Research*, 25(2), 7-22.
- Aroian, K. J. (1990). A model of psychological adaptation to migration and resettlement. *Nursing Research*, 39(1), 5-10.
- Aroian, K. J. (2001). Immigrant women and their health. In J. J. Fitzpatrick (Ed.), *Annual review of nursing research: Focus on women's health* (pp. 179-226). New York: Springer.
- Aroian, K. J., Norris, A. E., Patsdaughter, C. A., & Tran, T. V. (1998). Predicting psychological distress among former Soviet immigrants. *International Journal of Social Psychiatry*, 44(4), 284-295.
- Barry, J., Sweatman, L., Little, L., & Davies, J. (2003). International nurse applicants. *Canadian Nurse*, 99(8), 34-35.
- Bauman, L. J., & Greenberg, E. (1992). The use of ethnographic interviewing to inform questionnaire construction. *Health Education Quarterly*, 19(1), 9-23.
- Bernstein, J. H., & Shuval, J. T. (1998). The occupational integration of former Soviet

physicians in Israel. *Social Science Medicine*, 47, 809-819.

Beveridge, S. (2003). *Sampling in qualitative research* [On-line]. Available:

<http://www.ischool.washington.edu/harryb/courses/LIS570Winter03/THING.doc>

Boyle, J. S. (2003). Culture, family, and community. In M. M. Andrews, J. S. Boyle, & T. J. Carr (Eds.), *Transcultural concepts in nursing care* (4th ed., pp. 315-360).

Philadelphia: Lippincott.

Branswell, H. (2003). *More nurses working full time, a major shift from casual work, report shows* [Online]. Available:

http://mediresource.sympatico.ca/health_news_detail.asp?channel_id=0&news_id=22

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Burner, O. Y., Cunningham, P., & Hattar, H. S. (1990). Managing a multicultural nurse staff in a multicultural environment. *Journal of Nursing Administration*, 20(5), 30-34.

Burns, N., & Grove, S. K. (1997). *The practice of nursing research: Conduct, critique, & utilization* (3rd ed.). Philadelphia: W. B. Saunders.

Canadian Nurses Association. (2002a). *Highlights of 2001 nursing statistics* [On-line].

Available: <http://www.can-nurses.ca/pages/bookstore/catalogue/index.htm> (R-Z; Registered Nurses Statistical Highlights)

Canadian Nurses Association. (2002b). *Planning for the future: Nursing human resource projections*. Ottawa, ON: Author.

Coyne, I. T. (1997). Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries? *Journal of Advanced Nursing*, 26(3), 623-630.

Cravener, P. (1992). Establishing therapeutic alliance across cultural barriers. *Journal of Psychosocial Nursing*, 30(12), 10-14.

- Das Gupta, T. (1996). Anti-Black racism in nursing in Ontario. *Studies in Political Economy*, 51(Fall), 97-116.
- Davis, C. R., & Maroun, V. M. (1997). Immigrant nursing personnel: The view from CGFNS. In J. A. Dienemann (Ed.), *Cultural diversity in nursing: Issues, strategies, and outcomes* (pp. 13-19). Washington, DC: American Academy of Nursing.
- Dijkhuizen, S. R. (1995). Meeting the basic and educational needs of foreign nurses. *Journal of Continuing Education in Nursing*, 26(1), 15-19.
- Dyck, I., Lynam, J. M., & Anderson, J. M. (1995). Women talking: Creating knowledge through difference in cross-cultural research. *Women's Studies International Forum*, 18(5/6), 611-626.
- Fetterman, D. M. (1998). *Ethnography: Step by step* (2nd ed.). Thousand Oaks, CA: Sage.
- Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research*, 12(4), 531-545.
- Fox, P. G. (1991). Stress related to family change among Vietnamese refugees. *Journal of Community Health Nursing*, 8, 45-56.
- Franks, F., & Faux, S. A. (1990). Depression, stress, mastery, and social resources in four ethnocultural women's groups. *Research in Nursing & Health*, 13, 283-292.
- Giger, J. N., & Mood, L. H. (1997). Culturally competent teamwork. In J. A. Dienemann (Ed.), *Cultural diversity in nursing: Issues, strategies, and outcomes* (pp. 33-43). Washington, DC: American Academy of Nursing.
- Godfrey, K. (1999). Foreign affairs. *Nursing Times*, 95(48), 32-33.
- Hammersley, M. (1992). *What's wrong with ethnography?* New York: Routledge.
- Hurh, W. M., & Kim, K. C. (1990). Correlates of Korean immigrants' mental health. *Journal*

- of Nervous and Mental Disease*, 178, 703-711.
- International Council of Nurses. (2001). *Ethical nurse recruitment* [On-line]. Available: <http://www.icn.ch/psrecruit01.htm>
- International Council of Nurses. (2002a). Career moves and migration: Critical questions [On-line]. Available: <http://www.icn.ch/CareerMovesMigangl.pdf>
- International Council of Nurses. (2002b). ICN develops principles for ethical recruitment of nurses. *International Nursing Review*, 49, 69.
- Jackson, D. (1996). The multicultural workplace: Comfort, safety and migrant nurses. *Contemporary Nurse*, 5(3), 120-126.
- Kingma, M. (2001). Nursing migration: Global treasure hunt or disaster-in-the-making? *Nursing Inquiry*, 8(4), 205-212.
- Koerner, J. G. (1997). Cocreation of culture through choice. In J. A. Dienemann (Ed.), *Cultural diversity in nursing: Issues, strategies, and outcomes* (pp. 63-69). Washington, DC: American Academy of Nursing.
- LeCompte, M. D., & Schensul, J. J. (1999). *Designing and conducting ethnographic research*. Walnut Creek, CA: Altamira Press.
- Lipson, J. G., McElmurry, B., & LaRosa, J. (1997). Women across the life span: A working group on immigrant women and their health. In *Global migration: The health care implications of immigration and population movements* (pp. 47-65). Washington, DC: American Academy of Nursing.
- Lynam, M. J. (1985). Support networks developed by immigrant women. *Social Science Medicine*, 21(3), 327-333.
- Mackenzie, A. E. (1994). Evaluating ethnography: Considerations for analysis. *Journal of*

- Advanced Nursing*, 19, 774-781.
- Matuk, L. C. (1996). Health status of newcomers. *Canadian Journal of Public Health*, 87(1), 52-55.
- Meleis, A. (2003). Theoretical considerations of health care for immigrant and minority women. In P. St. Hill, J. G. Lipson, & A. I. Meleis (Eds.), *Caring for women cross-culturally* (pp. 1-10). Philadelphia: F. A. Davis.
- Meleis, A. I., & Im, E. O. (1999). Transcending marginalization in knowledge development. *Nursing Inquiry*, 6(2), 94-102.
- Meleis, A. I., & Rogers, S. (1987). Women in transition: Being versus becoming or being and becoming. *Health Care for Women International*, 8, 199-217.
- Morse, J. M. (1989). *Qualitative nursing research: A contemporary dialogue*. Rockville, MD: Aspen.
- Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002, Spring). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods* [On-line serial], 1(2), Available: <http://www.ualberta.ca/~ijqm/englsih/engframeset.html>
- Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals* (2nd ed.). Thousand Oaks, CA: Sage.
- Noh, S., Wu, Z., Speechley, M., & Kaspar, V. (1992). Depression in Korean immigrants in Canada II: Correlates of gender, work, and marriage. *Journal of Nervous and Mental Disease*, 180, 578-582.
- Pacquiao, D. F. (2002). Foreign nurse recruitment and workforce diversity. *Journal of Transcultural Nursing*, 13(2), 89.

- Pearce, L. (2002). World of difference. *Nursing Standard*, 16(32), 14-16.
- Pilette, P. C. (1989). Recruitment and retention of international nurses aided by recognition of phases of the adjustment process. *Journal of Continuing Education in Nursing*, 20(6), 277-281.
- Registered Nurses Association of British Columbia. (1998). *Standards for nursing practice in British Columbia*. Vancouver, BC: Author.
- Registered Nurses Association of British Columbia. (2001). *RNABC membership*. Vancouver, BC: Author.
- Reimer Kirkham, S., Smye, V., Tang, S., Anderson, J., Blue, C., Browne, A., Coles, R., Dyck, I., Henderson, A., Lynam, M. J., Perry, J., Semeniuk, P., & Shapera, L. (2002). Rethinking cultural safety while waiting to do fieldwork: Methodological implications for nursing research. *Research in Nursing & Health*, 25, 222-232.
- Roper, J. M., & Shapira, J. (2000). *Ethnography in nursing research*. Thousand Oaks, CA: Sage.
- Ryten, E. (1997). *A statistical picture of the past, present and future of registered nurses in Canada*. Ottawa, ON: Canadian Nurses Association.
- Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing & Health*, 18, 179-183.
- Schreiber, R., Stern, P. N., & Wilson, C. (1998). The contexts for managing depression and its stigma among black West Indian Canadian women. *Journal of Advanced Nursing*, 27, 510-517.
- Shin, K. R., & Shin, C. (1999). The lived experience of Korean immigrant women

acculturating into the United States. *Health Care for Women International*, 20, 603-617.

Tabone, S. (2000). 2000 update: Foreign nurse recruitment. *Texas Nursing*, 74(8), 9, 15.

Williams, J. (1992). Orienting foreign nurse graduates through preceptors. *Journal of Nursing Staff Development*, 8(4), 155-158.

Witchell, L., & Ousch, A. (2002). Managing international recruits. *Nursing Management*, 9(3), 10-14.

Yahes, E., & Dunn, A. K. (1996). Enculturation of foreign nurse graduates: An integrated model. *Journal of Continuing Education in Nursing*, 27(3), 120-123.

Appendix A: Summary of Literature Reviewed

Researcher & Date	Project Title	Purpose	Study Design	Findings
Anderson (1985)	Perspectives on the health of immigrant women: A feminist analysis	To identify the primary concerns of women surrounding their health; to understand the experiences of women surrounding help-seeking; to explore if women have perceived any discriminations toward themselves as immigrant women.	Phenomenology Sample: 14 women; 6 Indo-Canadian 8 Greek Location: Canada	<ul style="list-style-type: none"> - Health care system not viewed as a potential source of support for emotional concerns (IC) - Perception that Canadians are not approachable - Belief that health care professionals would not understand their problems (IC) - Loneliness and depression not perceived as health problems - Need for more effective health care
Anderson (1987)	Migration and health: Perspectives on immigrant women	To explore women's health and the ideological structures within the health care system that shape women's experiences.	Phenomenology Sample: 36 women; 27 Indo-Canadian 19 Greek Location: Canada	<ul style="list-style-type: none"> - Housework and childcare women's responsibility - Language training beyond reach - Feelings of loneliness, depression, and isolation most overwhelming - Women see health professionals as not understanding their situation
Anderson, Blue, Holbrook, & Ng (1993)	On chronic illness: Immigrant women in Canada's work force – A feminist perspective	To understand how the process of migration and the status of "immigrant woman" structure life experiences.	Ethnography Sample: 30 women; 15 Chinese 15 Euro-Canadian Location: Canada	<ul style="list-style-type: none"> - Keep illness secret due to fear of losing job - For health professionals, medical management takes precedence over concerns of everyday life - Knowledge of life circumstances needs to be utilized on a day-to-day basis in clinical practice
Aroian (1990)	A model of psychological adaptation to migration and resettlement	To explore the conditions under which migrants experienced psychological distress and the sources of their well-being.	Grounded Theory Sample: 25 Polish; 15 men, 10 women Location: USA (Seattle)	<ul style="list-style-type: none"> - Migration extremely stressful - Positive aspects of experience: self-growth, financial opportunities, freedom - Central categories to process of migration and resettlement: loss and disruption, novelty, occupation, language, subordination, feeling at home
Aroian, Norris, Patsdaughter, & Tran (1998)	Predicting psychological distress among former Soviet immigrants	To investigate whether age, gender, marital status, education, employment, length of time in the U.S. and immigration demands are predictors of psychological distress in a sample of former Soviet immigrants.	Quantitative – correlational Tools: Demands of Immigration Scale (DI), Symptom Checklist 90-R (SCL-90-R) Sample: 1647 Russians; 706 men, 934 women Location: USA (Boston)	<ul style="list-style-type: none"> - Difference in psychological distress as a function of age, gender, level of education; not marital status - Suggested interventions toward increasing language skill, knowledge about novel situations, alleviate feelings of loss, not feeling at home, feeling discriminated against
Bernstein & Shuval (1998)	The occupational integration of former Soviet physicians in Israel	To investigate the dynamics of occupational status persistence and psychosocial well-being of physicians who immigrated to Israel from the former Soviet Union during their first five years in Israel.	Quantitative – cohort follow-up Sample: 333 Russians; 146 men, 187 women Location: Israel	<ul style="list-style-type: none"> - Soviet physicians have better relationships with patients and their families - Support through rigid licensing procedure - Occupational status persistence: young people have more success than older - Time plays an independent role in psychosocial well-being

Das Gupta (1996)	Anti-black racism in nursing in Ontario	To describe the experience of racism in nursing in Ontario.	Case study Sample: 2 Black female nurses Location: Canada (Ontario)	<ul style="list-style-type: none"> - Selection of nurses for leadership positions ad hoc - Outreach strategies to fill positions not consistent - Subjectivity and bias in decision-making when pre-screening, checking of references, interviews, and internal transfers left to individual discretion - Pattern of segmentation of work along racial lines
Dyck, Lynam, & Anderson (1995)	Women talking: Creating knowledge through difference in cross-cultural research	To describe the research process of a cross-cultural study investigating the health care experiences of Chinese Canadian and Indo-Canadian women.	Ethnography Sample: 29 women	<ul style="list-style-type: none"> - The organization of health care institutions and practices, based on a biomedical model, act against gaining information about the social phenomena within which women's health experiences and needs are contextualized. - Class positioning of researchers important throughout research process. Power shifts between researchers, research assistants, and participants. - Women positioned within society as members of racialized groups frame their interactions; experiences fragmented by social divisions, such as class. - Reliance on others to access and interpret health care information.
Fox (1991)	Stress related to family change among Vietnamese refugees	To identify changes in the structural and functional dimensions of family life and assess their impact on spousal relations.	Ethnography Sample: 30 Vietnamese women Location: USA (Chicago)	<ul style="list-style-type: none"> - Nuclearization of the family - Increased affectivity, spousal interdependency, and emotional involvement related to being separated from family and friends - Perceived decrease in spousal affectivity led to women feeling lonely and isolated and having a decreased ability to cope in unfamiliar setting - Women had increased participation in decision-making when having income of their own; also increased self-worth
Franks & Faux (1990)	Depression, stress, mastery, and social resources in four ethnocultural women's groups	To examine the interrelationships of depression, stress, mastery, and social resources in four ethnocultural women's groups.	Cross-sectional survey Sample: 212 women Location: Canada (Ontario)	<ul style="list-style-type: none"> - Stressors: Housing and transportation major concerns; medical expenses the least concern - Asians most reluctant to ask for assistance - High depression scores consistent throughout all groups - Best model for predicting depression among the collective groups included perceived stress and mastery
Hurh & Kim (1990)	Correlates of Korean immigrants' mental health	To investigate major structural and situational variables related to Korean immigrants'	Quantitative Tools: Center for Epidemiologic Studies Depression Scale (CES-	<ul style="list-style-type: none"> - Better mental health associated with satisfactory family life, marriage, employment - Ethnic attachment variables are

		mental health and theoretically explore the meaning of the empirical findings.	D), Health Opinion Survey (HOS), Memorial University of Newfoundland Scale of Happiness (MUNSH) Sample: 622 Koreans; 334 men, 288 women Location = USA (Chicago)	significant mental health correlates for women - Most employed wives have double burden of performing household tasks and working outside the home combined with strong adherence to Korean gender-role ideology; may explain increased somatic impairment in those with higher individual earnings
Jackson (1996)	The multicultural workplace: Comfort, safety and migrant nurses	To generate a clearer understanding of the lived experiences of nurses from culturally diverse backgrounds as they enter and become part of the nursing workplace	Phenomenology Sample: 9 female nurses Location: Australia	<ul style="list-style-type: none"> - Need to belong and to have a place is compelling and important - Stress often described as stemming from communication problems - Loneliness is uncomfortable and disturbing; presence of strong network outside of nursing did not assuage the effects of loneliness with the working environment - Finding a place relates to belief that one has a stake in work environment - Realization that hostility/violence not only the domain of nurses from other countries, but experienced by local nurses as well; leads to more support and warmth towards new staff
Lynam (1985)	Support networks developed by immigrant women	To investigate how women with young children who have immigrated to Canada and settled in an English speaking region defined their needs; and to identify who the women perceived as sources of support in meeting their needs.	Ethnography Sample: 12 women Location: Canada (BC)	<ul style="list-style-type: none"> - Need to feel that they belong. - Sense of isolation related to a lack of a mutual basis of understanding - Sources of support [sequential pathway] = kin (family), insiders (people who have common understanding, usually from ethnic community), outsiders (unfamiliar people, agencies, resources) - Outsiders lack understanding of cultural values guiding social interactions or cultural context within which social resources or services developed; leads to misunderstood intentions and avoidance of contact - Beneficial if professional assists in developing community contacts; resources to be described in terms meaningful to the women
Matuk (1996)	Health stats of newcomers	To develop an understanding of the health status of the new immigrant population.	Survey Tool: Newcomers Health Survey Sample: 548; 307 men, 241 women Location: Canada	<ul style="list-style-type: none"> - Most newcomers have no difficulty accessing needed care or services for health problems - Most rate health as good to excellent and are happy; these levels decline with age

			(Windsor, Ontario)	<ul style="list-style-type: none"> - Most report life to be very to fairly stressful; women more stressed than men - Common stressors: employment, language barriers, securing affordable housing - Many have low level of social support
Noh, Wu, Speechley, & Kaspar (1992)	Depression in Korean immigrants in Canada II: Correlates of gender, work, and marriage	To test competing explanations generated by the double burden and power perspectives in Korean immigrants.	Quantitative – epidemiological survey Tool: CES-D Sample: 860 Koreans; 455 men, 405 women Location: Canada (Toronto, Ontario)	<ul style="list-style-type: none"> - Female immigrants more likely to be depressed than male related to role overload/demand - Unmarried immigrants have higher depression rate than married - Men capitalize better on the mental health benefit of social resources such as education, marriage, employment, and income
Schreiber, Stern, & Wilson (1998)	The contexts for managing depression and its stigma among black West Indian Canadian women	To discover the basic social process by which black West Indian women in Canada manage depression and move toward recovery.	Grounded Theory Sample: 12 Black West Indian women Location: Canada (Ontario)	<ul style="list-style-type: none"> - “Being strong” is the basic social process to resolve or ameliorate depression; four stage process that includes dwelling on it, diverting myself, regaining my composure, trying new approaches - Being strong occurs within overlapping social contexts: cultural stigma of depression, male-female roles and relationships, and belief in Christian doctrine - Racism part of their existence, but choose to rise above it
Shin & Shin (1999)	The lived experience of Korean immigrant women acculturating into the United States	To reveal and understand the true meaning of the acculturation experience of Korean women immigrants.	Phenomenology Sample: 6 Korean women Location: USA (New York)	<ul style="list-style-type: none"> - Experience evolves through four interrelates stages: dreams (of a better life), conflicts (dichotomy between life in Korea and U.S.), renunciation (will not return to Korea), remorse (longing for life in Korea)
Yahes & Dunn (1996)	Enculturation of foreign nurse graduates: An integrated model	To identify the continuing education needs of foreign nurse graduates.	Cross-sectional survey Sample: 7 Directors of Nursing Location: USA	<ul style="list-style-type: none"> - Need to address cultural variance related to: verbal style, non-verbal communication characteristics, culturally determined gender roles, and assertive behavior - Assessment of speech mechanics for clarity and coherence - All staff to be educated on issues of pluralism and cultural diversity; recognition of individuals as resources

Appendix D: Nurse Demographic Form

(Confidential)

Name: _____ Code #: _____

Site: _____ Code #: _____

Unit: _____

Education: _____ (diploma/degree)

Country where education was completed _____

Employment: Full-time _____ Part-time _____ Casual _____
Hours/week _____ Hours/week _____

Title of current position: _____

How long have you been in this nursing position? _____

Previous experience in nursing: _____

Where were you born? _____ What is your country of citizenship? _____

Where did you live prior to moving to Canada? _____

How long have you lived in Canada? _____

What is your current immigrant status? _____

Age at last birthday: _____ (years)

CONTACT INFORMATION

Telephone number: _____

Mailing address: _____

Appendix E: Interview Questions

- Tell me about your experience moving to Canada.
- Describe your experiences as a nurse educated outside of Canada in making the transition to practice in Canada.
- What were your greatest concerns when beginning to practice in Canada?
- What have been some of the highlights of your experience?
- Tell me about your experiences these past months.
 - Tell me about what you did for yourself.
 - Tell me about what you have been doing with other people.
 - Tell me about your experience with the organization and the support it has provided.
 - Tell me about the professional resources you have used.
 - Tell me about the community resources you have used.
- How important were these resources/supports in helping you transition to practice in Canada?
 - Explore the meaning or significance of resources/supports.
- What other services or supports that you would have valued in this transition process?
Please describe them.

Prompts

- Can you tell me more . . .
- In what way . . .
- So what you're saying is . . .
- What was that like for you?

Appendix F: Timeline

Phase	Date	Activity
Preparation	March – October 2003	Write proposal
	October 2003 November 2003	Committee accepted proposal Proposal submitted to Behavioural Research Ethics Board Gatekeepers have been identified and their support garnered
	January 2004	Approval received from Behavioural Research Ethics Board Recruitment of sample; Provide study information to potential participants
Field Work	February 2004	Informed consent obtained from participants First interviews completed
	March – April 2004	Recruit more participants Ongoing transcription and analysis of the narratives Primary analysis and interpretations of the data completed and submitted to supervisors for review
	May – June 2004	Informed consent obtained from participants First interviews completed
	July – August 2004	Ongoing transcription and analysis of the narratives
Analysis	September – October 2004	Analysis and interpretations of the data completed and submitted to supervisors for review
	November 2004 – January 2005	Analysis and interpretations of the data completed Developed first draft of thesis and submitted to supervisors for review Participants contacted for clarification as needed
	February – March 2005 April 2005	Completed draft of thesis and revisions Thesis accepted Dissemination of results