CHAPTER 8

Contributing

The contribution of migrant nurses

The contribution migrant nurses are making to organisations in Britain rests on the concepts of diversity management and capacity building. Firstly, the theoretical concept and practical application of diversity within the workforce is currently receiving considerable attention in the literature. With greater acceptance of labour mobility, mergers and market expansions, corporations are becoming more and more multinational, resulting in an increasingly mixed workforce[1]. Increased demographic diversity is also the result of increased international migration and the implementation of equal opportunities policies in the UK[2]. However, the implications of diversity for management are not restricted to a drive towards equal opportunity quotas and the representation of the local community within the workforce in numerical terms[3]. The United Nations defined diversity in the following way[4]:

> *'Diversity takes many forms. It is usually thought of in terms of obvious attributes – age, race, gender, physical ability, sexual orientation, religion and language. Diversity in terms of background professional experience, skills and specialisation, values and culture, as well as social class, is a prevailing pattern.'*

This definition, like others, distinguishes between deep-level (attitudinal) and surface-level (demographic) diversity[5]. The deeper layer to diversity encompasses attitudes, values, beliefs, lifestyles and identities, invisible and often only known to the beholder. By contrast, surface-level diversity

concentrating on demographic differences can in organisations also include employment related aspects, for instance occupation, organisational status and ability[6].

Employees not only originate from a variety of demographic backgrounds, but also hold divergent underlying belief systems. Such obvious and hidden facets of personal identity affect how individuals relate to each other at work, how they communicate, what kind of attitudes and behaviours they display and how these influence group cohesion and integration. It is dangerous, therefore to stereotype individuals based on the demographic aspects of diversity. For example the category 'Black' can include people of numerous regional origins, such as Caribbean, African, Asian or European British[7]. At the same time individuals group themselves and gravitate towards existing communities which display very different types of behaviour. For example, Summerfield[8] found that following migration to London Somali women were more in control of their lives and integrated more easily than women from Bangladesh. Yet, for any outsider to assume certain behaviour patterns on the basis that someone is of Bangladeshi or Somali origin would be wrong.

The increase in diversity has led to a body of research which looks at its effects on organisational behaviour, such as productivity, conflict and group socialisation and management implications[9]. Studies have established that a diverse workgroup with a wider range of ideas and experiences can be more productive in tasks which require creativity and judgement[10]. To achieve this, strong workgroup commitment is required, which can be reached through

bringing people together, clear communication and clarity in objectives and decision making[11]. Yet problems in communication and social integration can affect commitment to the team and lead to a lack of identification with the groups' goals. As a result sub-groups can develop, conflicts arise and communication can break down[12].

Such antagonism can be prevented through careful management of the group, especially during the early, formative stages. Watson, Kumar and Michaelsen imply that group socialisation, provided it is managed constructively, could have positive long-term consequences for organisations, overriding the problems associated with differences. Watson, Kumar and Michaelson go on to stress that in order to achieve these positive group outcomes, managers need to provide the group with regular assessments and feedback on performance and group processes. As a result, group members can be encouraged to discuss how things are going and how problems could be addressed.

If such constructive management does not take place, Blau[13] and O'Reilly *et al.*[14] state that demographic diversity decreases social contacts, as individuals naturally relate to others whom they perceive as similar, thus reducing social integration, leading to low workgroup commitment. Therefore demographic heterogeneity can hamper the process of group formation and attitudes of stereotyping and prejudice can lead to in- and out-groups[15]. This can be reflected in the levels of commitment to and identification with the wider organisation[16].

Intolerance and discrimination can directly affect social identification within groups as well as commitment to groups, and indirectly they affect work outcomes such as turnover, performance and communication. This emphasises the importance of the concepts of work-related motivation and emotions at work and these can shed light on some of the underlying dynamics of the employment context, such as the aspects of work which individuals enjoy and receive satisfaction from. The correlation between work effectiveness and diversity among workers is reliant on mediating factors, such as supportive management, clear work goals and open communication and this can also be exacerbated by an organisation's culture.

Effective organisational management approaches consider the organisation's aim, often expressed in mission statements of which the following of a London-based NHS hospital is a typical example:

> *'Keeping the people of* [place] *in the best of health – caring for our community, our staff and our hospital. To do this we will: provide the best possible quality services, have close links with the community, continue the pursuit of clinical excellence, expand our academic teaching and research base.'*

Together with the national NHS strategy they point to the organisation aiming to achieve congruence between the internal organisational structures and procedures and the organisational environment in order to achieve specific results. Ultimately each organisation needs to define worthwhile internal and external organisational outcomes for itself, with inputs from its employees and

users, stressing the importance for a context specific definition of organisational effectiveness.

By applying the concept of capacity building to migrant nurses' contribution to a British organisation, the stereotypical 'North to South' exchange of knowledge and expertise is being challenged. Even though the concept of capacity building has its roots in international development, organisations world-wide utilise the individual competencies and capabilities of their members to increase their effectiveness.

Individual competence or *capability* is the *'ability or skill to do something, to understand and learn or to do or produce'* [17], the distinctive contribution made by individuals to the organisation or the rest of the team. Therefore even though managers attempt to direct the organisational behaviour of staff, it is down to the individual to make a difference and to contribute to organisational capacity[18].

The concept of capacity embraces a range of organisational dimensions[19] and in order to develop capacity the organisation has to reach congruence between internal organisational behaviour, such as management structures aimed to motivate employees and its external aims and objectives[20]. Organisational change in response to changes in the environment and the needs of service recipients is required in order to improve capacity. Such changes could include changes in recruitment strategy to address staff shortages or to achieve a workforce that is ethnically representative of the

local population with consequences for the way diversity is managed in practice. Achieving this can be a difficult process in large, bureaucratic organisations as they tend to find it more difficult than smaller organisations with fewer layers in the hierarchy to correct behaviour and learn from errors. Yet, not being able to adjust to a changing client demands and a changing environment stifles an organisation[21].

A key policy debate in the NHS is focused currently on capacity with the challenges of balancing limited financial resources with performance targets[22]. Capacity building as a concept is about more than resources, especially in the health care sector where relationships between staff and clients are the key to success[23]. Therefore approaches to capacity building need to take employee motivation and concepts of identity into account. This is especially crucial when the workforce is composed of individuals from diverse backgrounds, including refugees as one sub-group of internationally qualified nurses[24].

For individual migrant nurses to contribute their individual capabilities to overall organisational capacity, the NHS as a whole and the employing health care Trusts need to manage diverse work teams constructively. Successful management of diversity is reflected in relationships at work, positive work-related emotions and work-related identities, issues discussed in the previous chapters. These in turn can lead to committed employees who are more inclined to engage in organisational citizenship behaviour which is discretionary and a matter of choice[25] and contribute their skills and knowledge to the organisation[26].

The NHS organisational capacity objectives are set out in the government's reform agenda with some of the key points being an expansion in staff numbers and a redesign of jobs by creating smaller, integrated teams. In part the government plans to meet these objectives through improving staff morale and building people management skills[27]. Achieving capacity within organisations is to a degree derived from *'effective management of people, their commitment to and involvement with the organisation'* (Mullins, 2002). Within multi-cultural organisations the successful management of diversity seems to be the basis for capacity.

The survey data in the empirical study showed that most respondents perceived their organisation as slightly more effective than innovative and perceived their promotion opportunities as quite high. Thus even though organisations may be viewed as performing effectively, their openness to change, reflected in innovation was not seen as quite as high:

Table 8.1 Nurses' perceptions of the organisation

Variable	**Mean**	**Standard Deviation**
Organisational Effectiveness	4.69	(1.15)
Organisational Innovation	4.49	(1.14)
Promotion Opportunity	5.31	(1.33)

Further analysis showed that respondents' perceptions of organisational effectiveness were the result of a combination of personal identities, namely feelings of happiness at work; commitment to the organisation and workgroup

and managerial factors, namely the management of equal opportunities and supervisor support – confirming that human resource components are a key factor in achieving organisational capacity.

Figure 8.1 Personal and managerial factors related to capacity

Personal factors:	Feeling of happiness at work
	Commitment to the workgroup
	Commitment to the organisation
Managerial factors:	Management of equal opportunities
	Support received from supervisors

This also reflects in the personal accounts given by migrant nurses and their managers about the contribution newcomers are making to existing workgroups and the wider organisational objectives. This section commences with positive expressions of migrant nurse's contributions before going on to some of the obstacles to them contributing.

Positive expressions of migrant nurses' contributing

When asked how they would describe their personal contribution to the wider workgroup the following remarks are typical examples of how migrant nurses view the value they are adding:

- *'I share my previous experience'*
- *'I am a good team player, motivated, give encouragement and support to my colleagues'*

- *'I cover for colleagues on holiday or sick leave or* (when we are) *short of staff, I help other teams when necessary'*
- *'I am supportive, caring, enthusiastic'*
- *'I am honest and have a good sense of humour'*
- *'I am dedicating my whole life to the patients, to the management, to the ward to run smoothly'*

The contribution of past experience, given as one example to a current job may seem logical, yet as in some cases past experience can differ greatly from what current employment expects indicating a difficult transition. To be co-operative and supportive to colleagues in the work-team may not explicitly be stated in an employment contract, but is an essential aspect of capacity as it 'oils the wheels' of the organisation, also called pro-social organisational behaviour or organisational citizenship behaviour. Such contributions to the functioning of the work-team are likely to strengthen workgroup commitment.

As pointed out above there are key stages in the integration process which are accompanied by a range of emotions with migrants reporting that they feel more *confident* and *trusted* once they are granted their registration with the Nursing and Midwifery Council.

The following comment made by a 28-year-old nurse from Moldova illustrates the progression from the ignored newcomer to the trusted professional whose opinion is valued by other team members:

'In the beginning it was really hard, they don't trust you. I tell them I am a nurse, but they ignored me. I thought it was because of my English. Little by little I started to say my opinion about diagnosis and tried to make conversation. After 6 months they started to ask me, 'What is your opinion?'

Therefore, contributing to capacity is a process marked out by the newcomer feeling more positive about language, the employment context, relationships and their own confidence to contribute as they integrate with integration being a two-way process whereby British-trained nurses also get to know the 'stranger' and show an interest in her or his opinion and experience. The examples presented are based on migrants experiencing this process of inclusion.

Contributing individual capabilities to the workgroup and wider organisation can take many forms. While some duties are expressed in professional codes of conduct, many are not and rest on individuals taking initiative. The list of how individuals enhance their workplaces is endless and the following are just a few examples:

- Volunteering to cover for colleagues who are ill
- Showing an ambition in learning new procedures
- Translating for medical staff or patients
- Applying past teaching experience by mentoring junior health care staff
- Contributing cultural knowledge related to patient care in a cross-cultural setting
- Viewing accountability as an incentive to enhance personal knowledge

Cultural understanding

The following quote was made by a migrant nurse who had worked in a Muslim country leading her to view patients' privacy as important, something that is also part of the British approach to nursing. Her manner of working ensures strict personal privacy, something that is valued by her manager who may know that not all the nurses adhere to similar standards:

'The manager I worked with was very happy when I washed a patient, because I kept the privacy all the time, because I was used to it already. Even giving the commode, some of the nurses don't close the curtains, just give the commode and it is in full view of the other patients. Then there was a patient and she was changing her bra. I came and closed the curtains to give her privacy, but her response was, 'Oh, nurse I don't mind.'

Many migrant nurses, particularly from African countries are used to work very independently, in rural areas often being one of only a few health care professionals accessible to the population. They therefore have to carry out tasks that only a medical doctor would do in a Western country. Yet, they are not allowed to utilise some of these skills in the British NHS which has strict professional boundaries. Instead of getting frustrated, successful integration into the work team is signified by an acceptance of the differences in the way health care systems operate. This nurse from the Congo had adopted such attitude:

'In Congo they carry out the task allocated to the doctor, but here the nurse is accountable for his action. The nurse must be very careful in practice, but it

helped me to develop myself and it is a motivation for me to learn more and to assure good practice.'

Working as part of a diverse team, migrant nurses can sometimes offer a new perspective on routine practices. With, particularly Filipino nurses being recruited in high numbers on some hospital wards they can have a real influence the work-culture there. A NHS human resources manager whose hospital employs high numbers of migrant nurses directly recruited from the Philippines, conducted an analysis of patients' complaints about nursing care. He concluded that none related to Filipino nurses:

'80-90% of complaints by patients are around attitudes of staff, generally nursing staff. Some of this may be related to cultural differences in some way. But there is no problem with the Filipino nurses, and no complaint has ever been made about them.'

Other managers point to the 'American approach' to nursing that many of the Filipino nurses bring who had already migrated from the Philippines to Saudi Arabia before coming to the UK. This process of multiply exposure to different cultures in itself makes them more adaptable to different organisational settings.

Yet others confirmed that the recruitment of Filipino nurses has a measurable impact on the way their hospital is managed. For example in the case of St. Mary's NHS Healthcare Trust in London, the change in recruitment policy away from employing expensive agency nurses towards recruiting large

numbers of full-time nurses from the Philippines, has, according to Osborne[28] led to improvements in patient care as well as staff morale. Overall the hospital progressed from a one-star rating to three-star rating and Osborne concluded that large-scale international recruitment could have a positive effect on organisational capacity, at least in the short term. This not only had a positive impact on vacancy figures and turnover, but also released financial resources for other needs.

Another form of contributing culturally is by the usage of languages spoken by migrants. Most of them speak more than one language with English commonly being their second or third language. When qualified translators are not at hand, colleagues and doctors frequently draw on the migrant nurses' multiple language skills. For a minority of patients the ability of a nurse to be able to communicate with them in their mother tongue plays a distinctive role in helping them to trust the health care they receive, thus aiding recovery.

Organisational citizenship behaviour

Getting to know colleagues, and starting to feel more confident within the British nursing system can be motivating to practice organisational citizenship behaviour, thus exceeding role expectations crucial for the smooth running of the organisation. Employees decide to contribute above the written obligations, 'to go beyond the call of duty' which can take a range of forms from being concerned about colleagues' well-being to spending extra time

with concerned patients or organising informal training sessions for junior staff.

Strong intrinsic motivation can led to nurses investing their private time to develop their professional knowledge, ultimately using this to advance their careers as well as contributing to organisational objectives. The following example was given by a migrant nurse from Ghana who wanted to develop her skills related to administrative tasks, documenting patient care which form part of her nursing job:

'On my day off, if I was at home, I sometimes called them, asking 'Should I come today?' Just, you know, to be in the office, to learn one or two things in the office.'

Organisational citizenship behaviour can also draws on migrants' previous experience for example by using previous clinical, managerial or teaching experience to facilitate others' professional development. Even though the following nurse did not immediately receive formal acknowledgement in form of promotion and pay increase, she later went on to train as a mentor and teaching others comes naturally to her as a result of her past experience:

'On our ward we have a number of health care assistants, who are on a pre-registration course. So, they need a mentor and I help them, because I used to teach in a School of Nursing in Rwanda.'

To take such initiatives reflects commitment to the organisation and ones colleagues, but it also confirms a strong professional career commitment,

adapting skills gained in the past in order to benefit the current organisation. It also becomes clear that professional development is not something that should be left to managers to organise and even newcomers are called to take initiative in shaping their professional future however foreign the professional culture may still seem.

Professional experience

The fact that many migrant nurses bring many years of professional experience with them is confirmed by some of the hospital managers' comments in the empirical study. Managers point out that internationally qualified nurses are very experienced nurses and once they have done their supervised practice programme, they are able to function quickly as fully registered nurses. Unlike newly qualified nurses, migrant nurses are mature individuals who don't need to be shown how to do basic nursing tasks.

When asked about the capacity that migrant nurses are adding to the hospitals, managers highlight several dimensions. Firstly, past experience is seen as an asset. One manager gave an example of a nurse's past experience of treating patients with TB, a disease on the increase in Britain, particularly in London:

'We have some migrant nurses who have come from South Africa. They now work in the TB service and obviously their experience of TB in Africa and TB here adds to the breadth of support that can be given.'

Secondly, managers note the personal attributes and emotional strength that migrant nurses and particularly some of the refugee nurses bring to the organisation. These attributes reflect in motivation and leadership skills on the ward:

'I don't know if it is because of their refugee status, but they are a very, very vocal group. They are very good practitioners and they are very keen, very motivated. They provide very good leadership on the ward. You know we are very lucky to have them.'

Thirdly, the professional experience of many migrant nurses also reflects in their cultural understanding as pointed out above and the value they add to a diverse workforce, examined next.

Adding diversity

As noted above, access to employment for internationally qualified nurses who migrate independently of recruitment agencies is more difficult than for directly recruited nurses. Many migrants of the former sub-group come to Britain for non-nursing related reasons and may not have undertaken clinical duties for a number of years. In addition family commitments may have inhibited full-time work and others may not be aware of employment routes into nursing. Thus some of these nurses may need to refresh their clinical skills in addition to adapting to the British nursing ethics. Some managers are aware of these additional burdens on migrant nurses and the following example of a change in hospital recruitment policies outlines the long-term

organisational benefits of supporting nurses who are already settled within Britain and intend to stay here:

'Our Trust has consciously made the decision to view the local population in terms of filling our vacancies and more so in terms of staff retention. From our research of why staff leave, we know that they can't stay any more in our local area because of housing, they often don't have their friends and London is an unknown area. So we made the decision generally to try to recruit locally. And actually one of the strategies of our recruitment and retention policy is to train our own people. So we are looking at people within the community, developing their skills, developing their confidence to apply for health care assistant positions, then train them to have the skills to go for a nursing profession. Previously, a year to 18 months ago we have done an overseas recruitment campaign in the Philippines and followed government guidelines. We have supported 60 overseas nurses to adapt to the culture and the NHS. Because they are qualified nurses, they don't need any additional nursing input, but they need that adaptation process. That went very successfully, but in view of our local strategy about local employment and elements of the number of applications that have local addresses, we decided to tap into that. So, we made a conscious decision not to recruit actively from abroad. Recently we had a big campaign and we advertised and we reviewed all our applications, we kept it to the London area and from that we actually had 159 applicants, that was then short-listed down to.'

Direct recruitment from the Philippines may appear as successful as these nurses' up-to-date nursing experience enables them to adapt quickly. Yet it

has to be stressed that in order to retain recruited staff, a recruitment strategy is needed, encouraging migrant nurses who already live in Britain to integrate into health care employment.

Another example of such a strategy is that of Guy's and St Thomas' NHS Hospital Trust in London which launched a major local recruitment campaign in early 2003 to help the Trust's workforce to better reflect the diversity of the local community[29]. The argument of reflecting the local community in which the health care service operates is strongly advocated by employers and voluntary or community organisations. Often the ethnicity of the NHS workforce does not represent the ethnic mix of diverse communities and it is a well documented difficulty to attract for example Bangladeshis or Pakistanis into nursing. Employing more nurses from diverse backgrounds is therefore seen as adding real value to the organisation:

'I think also the value for me is supporting people who want to make their home in East London. I think the Trust has a commitment as the largest local employer. Our Chief Executive is committed to employ local people and it is quite popular at the moment, but it is more of supporting people in the profession they choose and bringing them into the health service.'

Thus migrant nurses are appreciated as employees because of their professionalism based on past working experience and personal maturity as well as the diversity they add to work teams.

Problems associated with migrant nurses' contributing

Some of the obstacles migrant nurses face when trying to integrate into British health care employment are illustrated above. Some of these hindrances are overcome as the nurses adapted, but others can still pose a stumbling block for the nurses to contribute to the best of their abilities.

Problems related to cultural differences and diversity

A lecturer involved in teaching migrant nurses described some of the cross-cultural problems that particularly refugee nurses encounter during the early phases of their journey of adaptation to British nursing practice:

> *'This nurse was struggling because he or she was a refugee and was in a war area. So the objective was that they save lives, irrespectively of where dignity comes in or respect comes in. In a war torn area you don't think 'Oh I should cover the patient with a blanket when I do a bed-bath. I need to ensure privacy' or whatever. For them to come to this country and practise differently takes time. He has no concept how to handle a bed-bath with dignity and respect and thereby it conflicts with UK nursing.'*

Aspects as ensuring privacy are important as they define a contribution to quality of care. Yet, many migrant nurses have in the past worked in systems that were lacking finances, equipment, reference books leading to different standards in hygiene, privacy and the range of tasks carried out by qualified nurses. Such working environment with fewer regulations can also lead to the nurses being met with more respect than they get in Britain.

With a large aspect of the organisational effectiveness of hospitals being measured on the patient's satisfaction with the care they receive, developing skills of effective cross-cultural communication between nurse and patient are a direct contribution to capacity building[30]. As was noted above in relation to work-related relationships, particularly in the beginning some migrant nurses also experience lack of trust or respect from patients. They find that similarly to some colleagues, patients also find it difficult to distinguish between professional competence and superficial attributes such as language skills and skin colour:

'What can I say if the English nurses speak very good English. I think the patients can trust them more, unless they see our experience and then can trust us too.'

Managing a diverse work team means overcoming those communication problems among staff as well as with patients as cross-cultural misunderstandings can escalate if no effort is made to really understand what the meaning behind certain words is. A manager gave this illustration of how cultural miscommunication can have far-reaching consequences on another's' well-being, in this case the patients':

'A young man, in his 20s came in for relatively minor surgery. The nurse on night shift was a Nigerian nurse and was doing the round and noticed that he wasn't sleeping and said to him 'What's the matter with you?' and he said, 'Well, actually' and he had been psyching himself up to say this all day, 'I am really scared about tomorrow.' And what she said to him was, 'Don't be such a big baby, go to sleep now.' And he was devastated by it and at the time I

think he felt very small indeed. After the surgery he thought about it and he was quite angry about it and it became a formal complaint.'

The nurse had behaved in the way that was expected of her in Nigeria, but it had upset this British patient immensely. Subsequently her perceived lack of ability to offer support to the patient led to questions about her professional capabilities in Britain, yet it was an issue of miscommunication.

The cultural differences also become apparent as they interrelate with professional standards and diversity issues.

Problems related to professional nursing

Despite their many years of experience some internationally qualified nurses feel that the nursing policies and procedures in Britain are so different that they have little to contribute. Moreover, migrant nurses can resent the fact that additional training is required of them in order to be able to conduct certain procedures. Particularly where this relates to procedures such as intravenous catheterisation which many have carried out routinely in other countries:

'Oh my God, those policies, some I don't know, we are not given time to read the policies. They relate to any nursing task, it is also something of a barrier. Every time you do something like IV and catheterisation, you go and read up. Here they say I have to go for training, but I did that back home.'

Thus institutional hurdles to full professional integration can remain even after migrant nurses have gained access to employment and registration. Although there may be professional justification, such as maintaining nursing standards for these policies and procedures, they can appear suffocating to some migrant nurses who may be more used to practical hands-on procedures than to written policies.

The British health care system also gives more power to patients than some of the migrants were used to and nurses in Britain are held to be more accountable than may be the case in some developing countries. This leads to a fear of litigation and disciplinary action among all groups of nurses but particularly newcomers to the system. Yet, patient's rights can also inhibit their rate of recovery if they do not move from dependency to helping themselves.

From the patient's point of view legislation helps to ensure that they are being cared for and given the power to be pro-active if they are not satisfied with any aspect of their care. For migrant nurses this type of working environment often differs greatly from what they were used to. Thus some nurses need more time and management support to get used to this 'patient-empowered' working environment. Such differences in nursing tasks are closely related to different nursing roles in Britain compared to other countries and can be perceived to undermine competencies.

For example, elements of personal care, such as washing and feeding patients are in some countries either done by care assistants or the patients' relatives. Yet British nursing ethics regard these tasks as part of patient care undertaken by nurses (even though practice may differ from this idealistic approach in many UK hospitals). Such tasks may resemble for some migrant nurses a direct extension of the reproductive, caring role of women[31], which differs from the professional status they experienced in the past:

'In Bulgaria, in the hospital, the nurse don't wash the patients. I studied for 3 years to be a nurse. I not studied to wash the patients.'

A lecturer involved in the running of adaptation programmes confirms that the NHS nursing tasks sometimes conflict with those that many internationally qualified nurses are familiar with. He emphasises the basic nursing responsibilities criticised in the above comment, as important contributions to comprehensive nursing:

'If you are a staff nurse you can do the basic things. But it is not the basic things that are important, but the ability to analyse the situation. If you bath a patient you don't just do that, but you observe the patient for any bruises, cuts, bleeding, anything. And it is the contact with the patient, bathing, talking etc. that gives you the confidence. The patient may be depressed and if you just bath them, you miss all that. If you are adapting you need to learn that area.'

This indicates an individual's need for support, communication and feeling accepted particularly during the early stages while newcomers try to

understand their new workplace and try to figure out how they can best contribute. It also implies that managers should be prepared to review practice in light of what migrant nurses who have worked in different health care systems have to add and thus the establishment of open communication systems is fundamental. An unwillingness on behalf of managers to reflect and be open to change policies and procedures can not only hamper migrants' integration, but moreover organisational development. A female refugee nurse from Africa said:

'We can't progress with all those problems on the ward. The ward manager is very reluctant to change, he doesn't discuss problems.'

Some migrant nurses clearly make suggestions for improvement, but some feel that their suggestions are ignored, or that their colleagues are not truly open to be challenged.

Problems with the retention of migrant nurses

A desired organisational outcome of recruitment, professional development, promotion and management support for the migrant nurses is that they subsequently choose to stay with the organisation out of their own free will, not because there are no alternatives. With recruitment as well as the retention of trained nurses being a problem for many NHS Trusts, especially in urban areas, 'nurses staying with the organisation' is considered an important organisational goal. Some nurses may continue working, but with less overall job satisfaction and with a lower level of 'affective' commitment: for example, nurses may stay because of lack of alternative employment but

not because they are really happy with the organisation[32]. In order to determine possible precursors of an individual's tendency to stay or to quit a current job, Mobley *et al.*[33] introduced the topic of employees' turnover and the intention to quit a particular job. This work was followed by further theoretical contributions on 'job satisfaction' and 'organisational commitment' which were found to be relevant antecedents to employee turnover[34].

Table 8.2 demonstrates that levels of job satisfaction among the empirical survey respondents were reported as slightly higher than the intention to stay with the organisation, which could indicate that internationally qualified nurses would stay within their profession, even if they change the employing organisation:

Table 8.2 Intention to stay and job satisfaction

Variable	**Mean**	**Standard Deviation**
Job Satisfaction	4.99	(1.20)
Intention to leave/stay	4.78	(1.45)

Therefore high levels of experienced job satisfaction do not necessarily lead to individuals wanting to stay with the organisation that employs them. There may be other reasons for wanting to stay, such as migrants feeling settled in the area where their hospital is situated.

Several NHS managers are now realising that the direct overseas recruitment of migrant nurses to fill existing staffing vacancies is only a short-term solution with many not wanting to settle in Britain as this manager has experienced:

'From a retention point of view, it is probably positive. Those Swedish nurses will probably only stay a few years and the Australian, New Zealand nurses, but some of the other nurses who live in the local area will add value by staying.'

The retention of migrant nurses however has been much debated in the recent press. Hall wrote in the Telegraph that four out of ten nurses from abroad are planning to leave London for other jobs. Particularly two thirds of nurses directly recruited from the Philippines are said to be planning to migrate on to America which is also recruiting nurses for its staff shortages[35]. Thus the employment of migrant nurses who came independently of work and intend to stay in Britain offers comparatively more real value from a recruitment point of view.

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